NorthCare Network

Quality Assessment and Performance Improvement Plan (QAPIP)

FY25 QAPIP and Workplan
FY25 Annual Effectiveness Review &
FY26 QAPIP and Workplan

Reviewed and Approved by: Quality Management Committee – 1.23.26
Reviewed by: NorthCare Leadership – 1.23.26
Reviewed and Approved by: NorthCare Governing Board – 2.11.26

Contents

Executive Summary 3
Organizational Structure 4
NorthCare Organizational Chart 4
NorthCare Governing Body 6
NorthCare Substance Use Disorder Policy Board 6
NorthCare Committee Chart 7
FY25 QAPIP....11
FY25 QAPIP WORKPLAN....35
FY25 QAPIP Effectiveness Review 40
Quality Management System 41
Quality Management Workplan 41
Quality Assessment Activities 41
Stakeholder Input and Assessment of Consumer Experience with Services 41
Provider Network Monitoring 56
Utilization Management and Authorizations 62
Credentialing and Qualification for Scope of Practice....77
Oversight of Vulnerable Individuals / LTSS 78
Behavior Treatment Review 92
Event Reporting and Notification 97
Performance Measurement....101
Performance Bonus Incentive Program 108
Practice Guidelines....111
Verification of the Delivery of Medicaid Services....112
Performance Improvement Projects 113
Special Populations 119
Technology 120
Conclusion 122
FY26 QAPIP....123
FY26 QAPIP Workplan 148
FY26 Ongoing Satisfaction Survey Performance Improvement Project (PIP)....157

Executive Summary

NorthCare Network, as the Prepaid Inpatient Health Plan (PIHP), is responsible for monitoring the overall Quality Improvement and Quality Assurance activities of the organization and the contracted providers. Responsibilities of the Quality Management Program are outlined in the Quality Assessment and Performance Improvement Plan (QAPIP). The scope of NorthCare's QAPIP program is inclusive of all Member Community Mental Health Service Programs (CMHSPs) and their respective provider networks and the Substance Use Disorder (SUD) Providers. Michigan Department of Health and Human Services (MDHHS) requires each PIHP to have a QAPIP that meets the standards outlined in the Medicaid Managed Specialty Supports and Services Contract and the Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans. The review includes the components of the QAPIP, performance measures, and improvement initiatives based on the MDHHS PIHP contract, managed care rules and results of annual external quality reviews. The QAPIP and annual effectiveness review is reviewed and approved by NorthCare's Quality Management and Oversight Committee and Board of Directors on an annual basis. The QAPIP effectiveness review covers the prior Fiscal Year (FY); October 1 through September 30, and is due to MDHHS by February 28, each year.

The QAPIP's effectiveness and progress are strengthened by the creation of next year's QAPIP. NorthCare's QAPIP consists of eight areas reviewed annually for effectiveness. The FY25 QAPIP and associated work plan starts on page 11 and includes the following elements and highlights:

I. Introduction
II. Purpose
III. Quality Improvement Authority and Structure
IV. Quality Management System (components and Activities)
    a. Increase in QI/UM staff
    b. Changes to performance measures
    c. Data analytic capabilities and the use of technology
V. Procedures Adopting & Communicating Process & Outcome Improvements
    a. Updates to clinical practices
    b. Website redesign
VI. Evaluation
VII. References
VIII. Attachments

In meeting the QAPIP requirements, NorthCare conducts an annual review of the effectiveness of components under the Quality Management System within the QAPIP. In addition, the QI Work Plan is reviewed annually, and any goals not met by year-end are carried forward into the next year's work plan. New goals and objectives as well as recommendations made by the EQRO (External Quality Review Organization) and MDHHS may be included in the QI Work Plan. The FY25 QAPIP effectiveness review begins on page 40. The FY26 QAPIP and Work Plan starts on page 123.

Throughout this document, the terms 'beneficiary,' 'enrollee,' 'member,' and 'consumer' may be used interchangeably. All refer to the individual served. In some situations, a person may 'enroll' in an insurance plan, while in other contexts they may be considered the 'beneficiary' of that program. Generally, the term consumer is used for individuals open to CMHSP or SUD services.

Organizational Structure

NorthCare Network's organizational structure is intentionally designed to support ongoing evaluation of its QAPIP. Clear lines of oversight and responsibility, defined committee roles, and systematic reporting processes ensure that performance data is reviewed, and that improvement activities are monitored, implemented, and sustained. The QAPIP is reviewed by the Board of Directors annually. The Board of Directors oversees the QAPIP via frequent updates on progress based on analysis of data. Communication about the QAPIP, including updates on progress and ongoing activities is provided throughout the agency and with providers via various committees. NorthCare maintains responsibility for the evaluation and monitoring of its program providers and evaluation of the annual QAPIP. Policy and procedure guidelines promote uniform practice. The Clinical Practice Guidelines are reviewed in the Clinical Practices & Quality Improvement committee and are available on the NorthCare Website. The SUD Operations Manual is reviewed with the SUD providers and is also available on the NorthCare website. Providers attest to understanding where to access these guidelines, on an annual basis. NorthCare conducts annual provider audits through CMHSP or SUD site reviews, with additional clinical chart reviews and targeted data assessments performed as indicated. Providers consistently falling below audited expectations are required to complete corrective action plans to improve measures. Data is shared at the various committees and annual reports are publicly available on the NorthCare website.

NorthCare Organizational Chart

The Board of Directors (Board) serves as NorthCare's Governing Board, overseeing the organization's business, property, and overall operations. The Board is responsible for approving policies, plans, contracts, and financial reports, and it holds the authority to hire the Chief Executive Officer (CEO). In FY23 Megan Rooney became the CEO. The CEO establishes a leadership team responsible for leading each area of the agency. The CEO reports to the Board the outcomes of various quality efforts and improvement initiatives of the agency. The Board approves the PIHP QAPIP developed by the Quality Improvement team and also authorizes the annual QAPIP effectiveness review. Throughout the year, the Board receives data and updates related to key elements of the QAPIP to support ongoing oversight and decision-making.

The Medical Director provides general oversight and consultation for psychiatric, medical services, and additional behavioral health services for NorthCare. The Medical Director consults with clinical staff regarding utilization management, quality, health and safety, and other concerns during regularly scheduled meetings for mental health and substance use disorders. The Medical Director participates in risk management activities and serves as a liaison with community physicians. The Medical Director also provides consultation for inpatient psychiatric continuing and retrospective stay reviews, as well as inpatient Electroconvulsive Therapy (ECT) treatments.

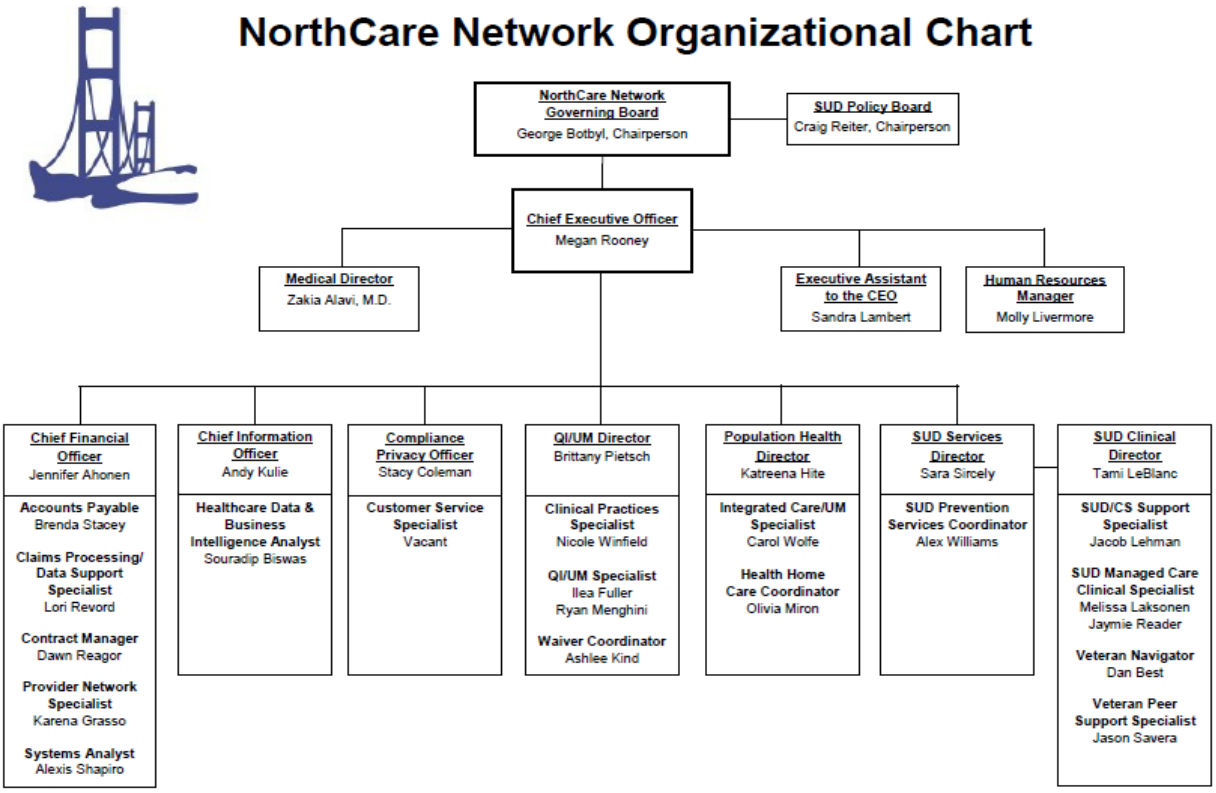
CMHSP and SUD providers participate in various committees. Committees review applicable data, discuss current MDHHS mandates/requirements, provide support and suggestions for improvement, and discuss any concerns or barriers they are experiencing. They provide input into processes, especially as it pertains to changes in the Electronic Medical Record (EMR). NorthCare has a committee specific to the EMR, as the EMR is shared between the PIHP and the five regional

CMHSP's with appropriate firewalls between the entities, so information is only visible to the correct parties.

The following organizational chart, as of 11.24.25, reflects the agency structure in FY25.

In FY25, the Senior Clinical Director retired. This position was not filled. The agency decided to increase its Quality Improvement and Utilization Management (QI/UM) team to focus on reviewing the quality management program and quality improvement efforts of the agency. One QI/UM position was filled in October 2024. The second QI/UM position stared January 2025. It is recognized that quality improvement, utilization management, and clinical practices often overlap and intersect. Population Health is a subset of Quality and will remain part of the QI/UM team but took a leadership role. The positions of QI/UM, Population Health, Integrated Care, Waiver Coordinator, and Clinical Practices will all work closely to address CMHSP quality. Additional staff are consulted as necessary. For SUD quality, the SUD Services Director, SUD Clinical Director, and staff overseeing SUD Health Homes, prevention, priority populations, and access will serve as the clinical leads in consultation with the QI/UM Director.

Other changes in FY25 include the addition of a Health Home Care Coordinator position. The Healthcare Data & Business Intelligence Analyst position was re-worked to include more responsibilities and be more focused on data needs to support the clinical workflow.



NorthCare Organizational Chart
Updated 11/24/25

NorthCare Governing Body

The NorthCare Board of Directors is comprised of members of the CMHSPs Boards of Directors. The Board reviews and approves the QAPIP and receives updates on QAPIP functions. Meeting minutes are available upon request or available on NorthCare Network's website: https://northcarenetwork.org/board. The following table details board membership as of 7.15.25. There were two changes in board membership in FY25; Gale Eilola (Copper) replaced Jim Tervo, who moved to an Alternate replacing Richard Herrala, and Mike Patrick (Hiawatha) replaced Dr. John Shoberg. The Chair, Vice-Chair, and Secretary remain the same.

Name	Credentials	Organization	Appointed
1. Gale Eilola	Retired	Copper Country CMHSP	2/2025
2. Michael Koskinen	Retired	Copper Country CMHSP	1/2014
3. Patrick Rozich, Secretary	BA, MA-Retired School Superintendent	Copper Country CMHSP	1/2014
4. Jim Tervo, Alternate	Inventory Control Retired	Copper Country CMHSP	1/2014
5. Joe Bonovetz	Retired Letter Carrier County Commissioner	Gogebic County CMHSP	11/2015
6. Colleen Kichak	Retired	Gogebic County CMHSP	4/2022
7. William Malloy, Jr.	Retired Clinical Social Worker	Gogebic County CMHSP	4/2022
8. Susan Roberts, Alternate	Retired	Gogebic County CMHSP	4/2024
9. George Ecclesine	Retired -Real Estate, HR, Banking	Hiawatha CMHSP	7/2015
10. Mike Patrick	Retired	Hiawatha CMHSP	7/2025
11. Craig Reiter	County Commissioner	Hiawatha CMHSP	9/2024
12. Ann Martin	Retired Teacher, Master's Degree in Education, County Commissioner	Northpointe CMHSP	5/2017
13. Mari Negro	MCAO and Retired Publisher	Northpointe CMHSP	1/2014
14. Kevin Pirlot, alternate	Self-Employed	Northpointe CMHSP	4/2022
15. Kathy Thompson	Retired	Northpointe CMHSP	4/2024
16. George Botbyl, Chair	Retired LMSW	Pathways CMHSP	4/2015
17. Margaret Rayner, Vice-Chair	Retired RN	Pathways CMHSP	4/2022
18. Glenn Wing	Retired	Pathways CMHSP	2/2021

NorthCare Substance Use Disorder Policy Board

The SUD Policy Board is a committee of the Governing Board. Several members of the Governing Board are also on the SUD Policy Board. The board is comprised of one member from each county of the Upper Peninsula. The following represents board membership as of 6.30.25. There were five changes in board membership in FY25; Michael Yon (Gogebic) replaced Joe Bonovetz, Daryl Schroeder (Mackinac) replaced Corina Clark, Dr. Victoria Jakel (Dickinson) replaced Ann Martin, Patrick Johnson (Delta) replaced Steven Viau, and Steve Gromala (Menominee) replaced Connie Westrich. The Chair and Vice-Chair remain the same.

Name	County	Appointed
1. Stephen Adamini	Marquette	4/2018
2. Roy Britz	Houghton	2/2019
3. Rick Capogrossa	Alger	4/2023
4. Randy Eckloff, Vice-Chair	Keweenaw	11/2014

5. Steve Gromala	Menominee	1/2025
6. Dr. Victoria Jakel	Dickinson	6/2025
7. Patrick Johnson	Delta	1/2025
8. Mike Koskinen	Baraga	11/2014
9. Damon Lieurance	Chippewa	10/2024
10. Nancy Morrison	Luce	11/2014
11. Robert Nousiainen	Ontonagon	9/2018
12. Patti Peretto	Iron	8/2022
13. Craig Reiter, Chair	Schoolcraft	1/2017
14. Daryl Schroeder	Mackinac	4/2025
15. Michael Yon	Gogebic	1/2025

NorthCare Committee Chart

NorthCare updates its Committee Fact Sheets on an annual basis. Committee Fact Sheets detail the purpose and deliverables of each committee. The NorthCare Leadership Team reviews and approves the Committee Fact Sheets.

- The NorthCare Leadership Team is comprised of NorthCare supervisory staff and key personnel. The Leadership Team provides oversight and guidance regarding NorthCare operations. It ensures that functions delegated to NorthCare Network and regional committees are being completed in a manner consistent with the contract and regional, state, and federal mandates.
- The NorthCare Health Information Technology Committee acquires and manages standards-based technology that supports PIHP and Provider clinical and business operations. The committee ensures compliance with oversight agency requirements, including those of the External Quality Review Organization (EQRO), the MDHHS, and Centers for Medicare and Medicaid (CMS)/ Office of National Coordinator (ONC), and ensures the confidentiality, integrity, and availability of electronic protected health information through regional collaboration and coordination of technical and security solutions.
- The regional ELMER Management (REM) Committee provides executive oversight with a regional focus to implement and maintain a reliable, efficient, and effective EMR that supports administrative, business, clinical documentation and reporting needs.
    - The regional Analytics Committee provides the information necessary to support business decisions from both clinical and administrative perspectives, while also overseeing and supporting data integrity and information. The committee supplies data analysis to enhance delivery of quality services and meet reporting obligations.
    - The regional Help Desk Committee ensures that regional shared technology is functioning at optimal levels and addresses problems that cannot be solved locally.
    - The regional Medical Records Committee has a medical records management function to minimize risks, optimize benefits, and comply with legal requirements of a hybrid medical record. This committee is committed to standardizing policies, procedures, and ensuring that the medical record maintains efficient clinical utility, required integrity, and uniform application of the system.

    - The regional TEDS Committee ensures that the EMR System (ELMER) Treatment Episode Data Set (TEDS) module is used uniformly across the region.
- The NorthCare Quality Management committee promotes objective and systematic measurement, monitoring and evaluation of clinical and non-clinical services, and implements quality improvement activities based upon these findings and the QAPIP. This committee promotes a culture grounded in the continuous quality improvement model, supporting development and implementation of improvement processes and the ongoing monitoring of their success.
    - The NorthCare Network Management committee ensures adequate provider capacity throughout the NorthCare Network to meet current and anticipated demands of services.
    - The regional Credentialing Committee promotes safe and effective treatment with credentialing and re-credentialing NorthCare Network healthcare practitioners and organizational providers. MDHHS requires credentialing to be housed in the Customer Relationship Management (CRM). If necessary, the committee may form workgroups to discuss this.
    - The NorthCare Health and Safety Committee reviews immediately reportable events, critical incidents, sentinel and risk events from CMHSP's and reported events from SUD providers to look for trends, address issues, and follow up with providers to ensure improved practice and overall safety of the environment.
    - The regional Clinical Practices and Quality Improvement (CPQI) Committee engages consumers and staff in accurate, data-driven affiliation-wide processes, resulting in quality and performance improvement, the achievement of standards, and the establishment of new standards. The CPQI Committee primary charge is to: 1. Implement the QAPIP while working to establish a culture based on the continuous quality improvement model as a means to develop and implement improvement processes and monitor their ongoing success; 2. Use data driven reporting to ensure progress towards quality improvement and compliance; 3. Review and address issues of non-compliance and follow-up/monitor plans of correction. Quality measures will focus on ensuring the full array of services is delivered in alignment with best clinical practices by a qualified workforce that supports the recovery of the individuals and families served, in accordance with the Michigan Mental Health Code, the Michigan Medicaid Provider Manual, and the MDHHS/PIHP Contract. The regional Behavior Treatment Committee (BTC) is a subcommittee of CPQI and is responsible for reviewing data trends from CMHSP BTCs and ensure consistent processes of conducting and completing behavioral treatment plans and other committee activities.
        - The regional Incident Reporting committee meets quarterly to ensure consistent reporting of incidents, within timelines determined by MDHHS, and monitoring to ensure quality care with minimal adverse incidents for individuals.
        - The regional Health Services Committee leverages health information technology and regional expertise to develop and deliver interventions to

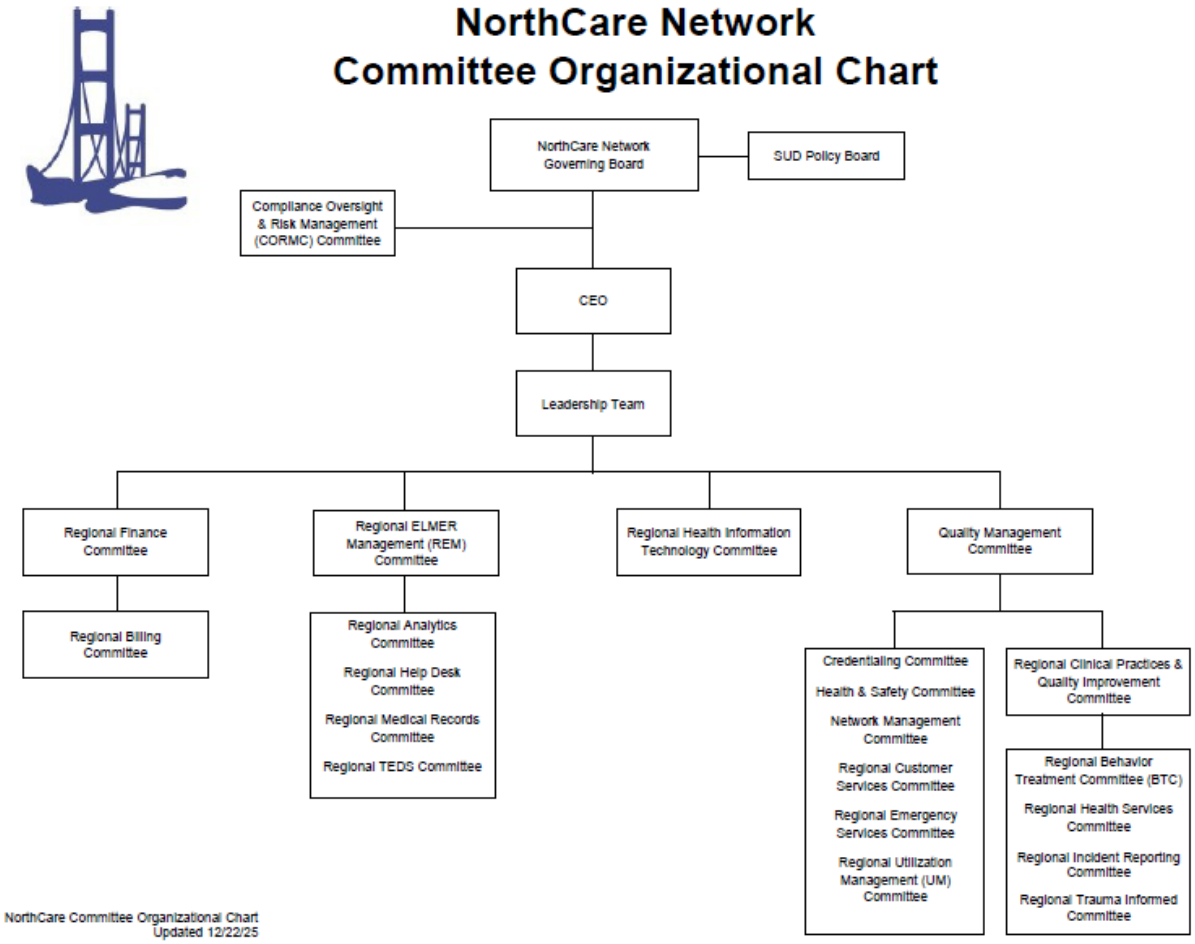
improve the whole-person health of people served under the Medicaid Specialty Mental Health Benefit.

- The NorthCare Trauma Committee is responsible for the agency's self-assessment every three years. Upon completion of the self-assessment, the committee ceases meeting until it is time to complete the self-assessment again.
- The regional Trauma Committee is composed of members from the CMHSP and SUD provider network, along with community members with lived experience. The committee meets quarterly to address trauma in the lives of consumers by ensuring a trauma-informed system that 1. Understands trauma and its impact on consumers, staff, and the community. 2. Promotes agency self-assessment. 3. Provides a safe and understanding environment for consumers and staff, and 4. Provides trauma specific services for all populations served. This committee adopts MDHHS definition of trauma; *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being*.
- There are also meetings with various contracted hospitals, individually, as a quality method to ensure that contract compliance and emergency service processes are working effectively and efficiently.

- The regional Emergency Services (ES) Committee seeks to fulfill Section 330.1206 of the Michigan Mental Health Code 1a. "*Crisis stabilization and response including a 24-hour, 7-day per week, crisis emergency service that is prepared to respond to persons experiencing acute emotional, behavioral, or social dysfunctions, and the provision of inpatient or other protective environment for treatment,"* and to fulfill Section 8 of the Behavioral Health and Intellectual and Developmental Disabilities Supports and Services Chapter of the Michigan Medicaid Provider Manual, "*The PIHP is responsible to manage and pay for Medicaid mental health services in community-based psychiatric inpatient units for all Medicaid beneficiaries who reside within the service area covered by the PIHP. This means that the PIHP is responsible for timely screening and authorization/ certification of requests for admission, notice and provision of several opinions, and continuing stay for inpatient services."* Additionally, the ES Committee addresses concerns related to Emergency Services availability and utilization and discusses any associated issues, including Information Technology (IT) systems and state-level mandates.
- The regional Customer Services Committee reviews customer service-related issues and events to ensure that regional programs can effectively implement necessary changes and monitor the public behavioral health service delivery system.
- The regional Utilization Management (UM) Committee monitors utilization of clinical resources and provides supports that ensure services are used only for authorized

purposes, uniformly available to eligible persons, and are provided in an effective and efficient manner.

- The regional Finance Committee makes recommendations on regional best practices for Financial Management that demonstrates our fiduciary responsibility as a “value” purchase for MDHHS.
    - The regional Billing Committee is a subcommittee of the regional finance committee. It ensures that the ELMER encounter submission module is complete and accurate, and used uniformly across the region. This is accomplished by identifying that current MDHHS Medicaid encounter submission requirements are followed as required per the MDHHS/PIHP contract. This may also include updates or modifications to the 3rd party billing section of ELMER, which in turn meets MDHHS expectations for capturing and reporting Coordination of Benefits information on the encounter claim. Committee members will work to define best practices around MDHHS reporting requirements by actively seeking guidance from regional billing staff, regional Finance Officers, our EMR systems vendor PCE and from the MDHHS Encounter Data Integrity Team (EDIT), when necessary.



FY25 QAPIP

The FY25 QAPIP begins on the next page. These 22 pages represent what the plan was in FY25. It is followed by the FY25 QAPIP workplan, which details the tasks and goals for the year. This is what is reviewed for effectiveness starting on page 40.

FY25

NorthCare Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN (QAPIP)

Quality Management Department
NorthCare Network
1230 Wilson Street
Marquette, MI 49855
Direct Line: 906-205-4347
Toll Free: 888-333-8030
Website: www.northcarenetwork.org
Email: bpietsch@northcarenetwork.org

Introduction

NorthCare Network is a regional entity under Section 1204(b) of the Michigan Mental Health Code and is governed by a board of directors with representation from the five-member Community Mental Health Authorities. NorthCare Network holds a Standard Contract with the Michigan Department of Health and Human Services (MDHHS) for the Medicaid Managed Specialty Supports and Services 1115 Demonstration Waiver, 1915 (c)/(i) Waiver Programs, the Healthy Michigan Program, the Flint 1115 Waiver and SUD Community Grant Programs and the MI Health Link Demonstration Program. NorthCare is also part of the Behavioral Health Home (BHH) and SUD Health Home (SUD HH) programs.

NorthCare Network is the prepaid inpatient health plan (PIHP) for the five Community Mental Health Services Programs (CMHSP) serving the Upper Peninsula: Copper Country Community Mental Health, Gogebic County Community Mental Health, Hiawatha Behavioral Health, Northpointe Behavioral Health System, and Pathways Community Mental Health. The counties which each serve is detailed below.

- Copper Country: Baraga, Houghton, Keweenaw, Ontonagon
- Gogebic: Gogebic
- Hiawatha: Chippewa, Mackinac, Schoolcraft
- Northpointe: Dickinson, Iron, Menominee
- Pathways: Alger, Delta, Luce, Marquette

This document outlines requirements for the annual QAPIP (Quality Assessment and Performance Improvement Program) as set forth in the PIHP/MDHHS Medicaid Managed Specialty Supports and Services Program Contract Attachment. It also describes how these functions are accomplished and the organizational structure and responsibilities relative to these functions.

This QAPIP aids in supporting NorthCare's mission, which is "NorthCare Network ensures that every eligible recipient receives quality specialty mental health and substance use disorder services and supports through the responsible management of regional resources." This mission guides the activities of NorthCare Network. It supports our vision to ensure a full range of accessible, efficient, effective, and integrated quality behavioral health services and community-based supports for residents of Michigan's Upper Peninsula.

We achieve this by staying true to our values.

- We believe in respect, consumer empowerment, person centered care, self-determination, full community participation, recovery, and a culture of gentleness.
  We endorse effective, efficient community-based systems of care based on the ready availability of a competent workforce and evidence-based practices.
- We believe in services that are accessible, accountable, value based, and trauma informed.
  We support full compliance with state, federal and contract requirements, and responsible stewardship.
- The right care, and the right time, for the right cost, and with the right outcome.

Purpose

The QAPIP is intended to outline requirements and provide guidance for carrying out several functions, including but not limited to:

- Outlining the quality improvement structure for the managed care activities of the NorthCare Network.
- Evaluating and updating, as appropriate, NorthCare Network's QI processes and outcomes.
- Monitoring and evaluating the systems and processes related to the quality of clinical care and non-clinical services that can be expected to affect the health status, quality of life, and satisfaction of persons served by Network Providers.
- Identifying and assigning priority to opportunities for performance improvement.
- Creating a culture that encourages stakeholder input and participation in improvement initiatives and problem solving.
- Stressing the value of employees; cooperation between employees; team building; and a partner relationship between the PIHP, Member CMHSPs, Network Providers, advocacy groups and other human service agencies within a continuous quality improvement environment.
- Promoting the basic quality management principle of prevention over remediation. It is less expensive in the long run to build quality into an organization's services than it is to expend additional resources on rework and dissatisfied customers.
- Providing guidance for the PIHP Performance Improvement Projects.
- Ensuring verification that services reimbursed by Medicaid were provided to enrollees by Network Providers according to the plan of service and adequately documented.
- Working with the Regional Clinical Practices/Quality Improvement Committee to assure implementation of evidence-based practices throughout the region.
- Meeting standards specified in the NorthCare Network Medicaid Managed Specialty Supports and Services Contract and QAPIP attachment, the ICO/PIHP Contract for the MI Health Link Project, quality assurance provisions of the Balanced Budget Act of 1997, as amended, Medicaid Managed Care Rules, and Accreditation Standards, as applicable.

We do this to achieve the following desired outcomes:

- Meet, or exceed, state performance metrics as well as improving performance for identified projects.
- Improved data analysis of critical incidents to reduce adverse effects on consumers and behavior treatment committee data to reduce the need for physical intervention.
- Ensure satisfaction of services and HCBS rules and quality clinical practice guidelines that are accessible to consumers and staff.
- Verify staff are qualified to complete their duties and there is network adequacy to provide necessary services.
- Ensure services meet Medicaid standards. Ensure appeal and grievance information is provided to members.
- Increase consistency in Utilization Management decisions across the region and assess the appropriateness of individuals' level of care and the services they are providing.

Quality Improvement Authority and Structure

The QAPIP is reviewed and approved on an annual basis by the NorthCare Network Governing Board. Through this process, the governing body gives authority for the implementation of this plan and all components.

NorthCare Network's Chief Executive Officer provides day-to-day guidance and authority to the QI/UM Specialist who is responsible for implementation of the QAPIP. The Performance Management Committee and Governing Board also receive routine reports on the progress of the QAPIP including performance indicators, quality improvement projects, progress and actions taken, and the results of those actions. The committee structure is designed to encourage contributions from a variety of sources, facilitate accountability, and ensure follow through on improvement efforts. NorthCare Network's Medical Director is involved in QI, UM, and credentialing activities and is available for consultation to any of the regional committees as requested, including review and consultation regarding sentinel and critical events.

The Customer Services Committee and NorthCare Network's Governing Board provide significant opportunity for involvement by primary and secondary consumers. Additionally, focus groups and surveys may be utilized to elicit consumer feedback.

Accountability and Responsibility

NorthCare Network Governing Board

- *Membership:* NorthCare Network's 15-member Governing Board includes three representatives from each of the five Member CMHSP Boards of Directors.
- *Role/Function:* The NorthCare Network Governing Board retains the ultimate responsibility for review and approval of the QAPIP, policy approval and governance. Functions include, but are not limited to:
- *Oversight of the QAPIP:* This includes documented evidence that the Board has approved the overall QAPIP and QI Plan. The Board's role is to monitor, evaluate and establish policy that supports improvements to care.
- *QAPIP Progress Reports:* The NorthCare Network Governing Board routinely receives written reports from the Chief Executive Officer describing performance improvement initiatives undertaken, the actions taken, and the results of those actions.
- *Annual QAPIP Review:* The NorthCare Network Governing Board formally reviews a written report on the operation of the QAPIP, at least annually.
- *Reporting Accountability:* The NorthCare Network Governing Board reports to stakeholders via committee and Board meeting minutes. The Governing Body submits a written annual report to MDHHS following its review, due February 28th, which includes a list of members.
- *Reporting Frequency:* Quarterly

Designated Senior Official

NorthCare's QI/UM Specialist is responsible for coordinating activities related to the design, implementation, management and evaluation of the quality improvement and compliance programs. Quality management works collaboratively with many different functional areas. Although each position identified below is not directly assigned to the quality management

function, they maintain an active role in quality related activities. The following grid provides a representation of what percentage of total time is spent by NorthCare staff on quality related activities. Much of NorthCare's quality management work is implemented through the various committees listed below.

Title	Department	Average percent per quarter devoted to QM
SUD Clinical Director	Clinical/ SUD Access	15%
Integrated Care / UM Specialist	Clinical	10%
Clinical Practices Specialist	Clinical	15%
Customer Service Specialist	Customer Service	10%
Data Analyst	Information Management	5%
Population Health Specialist	Integrated Care/Population Health	35%
Medical Director (Part-time)	Clinical	75%
Provider Network Specialist	Network Management	10%
QI/UM Director	QI	50%
Systems Analyst	Information Management	25%
Compliance-Privacy Officer	Compliance	25%

QAPIP Committee/Teams

NorthCare Network's QAPIP is implemented through various PIHP and regional committees/teams as listed below. All are ultimately accountable to NorthCare Governing Board and/or NorthCare Leadership. Regional committees are denoted with an "R" on the chart.

NorthCare Governing Board of Directors

A. NorthCare Compliance Oversight and Risk Management Committee (CORMC)
    1. NorthCare Medicaid Service Verification Team (MSV)
    2. NC Site Review Team (MH)
    3. NC Site Review Team (SUD)
B. NorthCare Leadership Committee
    1. NorthCare Information/Technology Management Committee
        a) Regional Elmer Management Committee (REM)
        b) Regional Analytics Committee
        c) Regional Help Desk Committee
        d) Regional Information Technology and Security Committee
        e) Regional Medical Records Committee
    2. NorthCare Quality Management Committee
        a) NorthCare Network Management Committee
        b) NorthCare Credentialing Committee
        c) NorthCare Health and Safety Review Committee
        d) Regional Grievance & Appeal Committee
        e) Regional Clinical Practices/QI Committee
            - Regional Behavioral Treatment Committee
            - Regional Health Services Committee
            - SUD Provider Clinical Meeting

- NC/UPHS-Marquette QI Committee
- NC/My Michigan Sault QI Committee
- NC/Willow Creek QI Committee
- NC/Aspirus QI Committee
- Regional Trauma Informed Committee

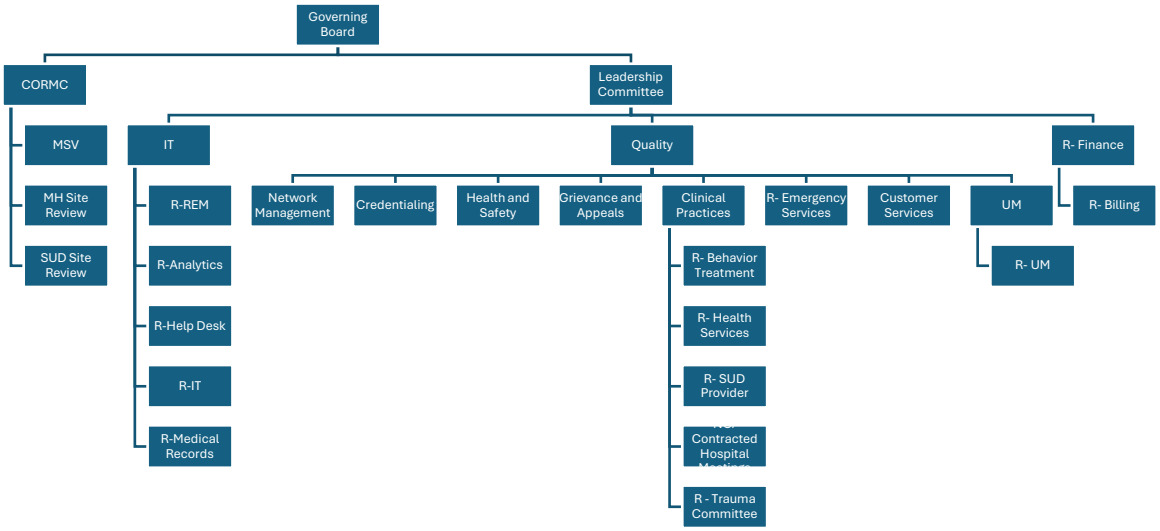
f) Regional Emergency Services Committee

g) NorthCare Utilization Management Committee

- Regional Utilization Management Committee

h) Regional Customer Services Committee

3. Regional Finance Committee
   a) Regional Billing Committee



Each committee has an approved "Fact Sheet" which documents the committee charge, reporting requirement(s), membership, deliverables, and meeting frequency. Project specific or time specific workgroups are established as appropriate.

Additionally, each CMHSP has a quality improvement process to address quality issues within its operations. Each CMHSP also has a customer services meeting for increased consumer involvement and voice. Regional satisfaction results are shared and reviewed by NorthCare Network. NorthCare reviews the CMHSP websites and publications annually.

Substance Use Disorder (SUD) services are delivered through a network of contracted provider organizations. No managed care functions are delegated to SUD providers. To ensure representation, SUD providers are involved in the Regional SUD Provider Clinical Meetings and concerns are brought to leadership.

Quality Management System

NorthCare Network's Quality Management System combines the traditional aspects of quality assurance and adds the elements of continuous quality improvement. The Quality Management System helps NorthCare Network achieve its mission, realize its vision, and live its values. It protects against adverse events, and it provides mechanisms to bring about positive change while ensuring quality services. Continuous quality improvement efforts assure a proactive and systematic approach that promotes innovation, adaptability across the Network, and a passion for achieving best practices.

The *Quality Management System* includes:

- Predefined standards
- Formal and informal assessment activities
- Measurement of performance in comparison to standards
- Strategies to improve performance that is below standard

The various aspects of the system are not mutually exclusive. However, for descriptive purposes, the following table separates the components.

QUALITY MANAGEMENT SYSTEM			
Quality Standards	Assessment Activities	Performance Measurements	Improvement Strategies
▪ Federal & State Rules/Regulations ▪ Stakeholder Expectations ▪ MDHHS Contract ▪ Provider Contracts ▪ Practice Guidelines and Evidence Based Practices ▪ Network Standards ▪ Accreditation Standards ▪ Network Policies and Procedures ▪ Delegation Agreement ▪ Clinical Documentation Standards ▪ AFP/ARR	▪ Quality Monitoring Reviews ▪ Accreditation Surveys ▪ Credentialing ▪ Risk Assessment/ Management ▪ Utilization Reviews ▪ External Quality Reviews ▪ Stakeholder Input ▪ Sentinel Events ▪ Critical Incident Reports ▪ Documentation Reviews ▪ Medicaid Service Verification ▪ Performance Improvement Projects ▪ Critical Event Reporting	▪ MDHHS MMBPIS ▪ Audit Reports ▪ External Quality Reviews (HSAG) ▪ MDHHS Site Reviews ▪ Outcome Reports ▪ Benchmarking ▪ Grievance & Appeals ▪ MDHHS Performance Based Incentive Pool	▪ Corrective Action/Improvement Plans ▪ Improvement Projects ▪ Improvement Teams ▪ Strategic Planning ▪ Practice Guidelines ▪ Organizational Learning ▪ Administrative and Clinical Staff Training ▪ Cross Functional Work Teams ▪ Reducing Process Variation

Quality Standards

Quality Standards provide the specifications, practices, and principles by which a process may be judged or rated. NorthCare Network identifies and sets standards by reviewing, analyzing, and integrating such areas as:

- Performance expectations of network providers for both clinical services and administrative functions
- Government regulations/rules
- Practice Guidelines
- Accreditation and/or Network Standards
- External review findings
- Utilization Management and Authorizations

Quality Assessment Activities

Quality assessment consists of various strategically planned activities that help to identify the actual practices, attitudes, performance, and conformance to standards that are enhancing or inhibiting the achievement of quality. Obtaining stakeholder input is critical to quality assessment activities.

Stakeholder Input

NorthCare Network recognizes that a vital aspect of any continuous improvement system is a means to obtain stakeholder input and satisfaction information. Stakeholders identified to provide input to NorthCare Network may include individuals who are or have received services, staff, contract service providers, families/advocates, and the local communities, representing both internal and external customers.

Input is collected to better understand how NorthCare Network is performing from the perspective of its stakeholders. The input is continually analyzed and integrated into the practices of the PIHP, as feasible. NorthCare Network's Customer Services Committee and Governing Board both provide opportunity for stakeholder input. NorthCare Network encourages stakeholder participation on other committees as appropriate. Each Member CMHSP will ensure that there is adequate input from stakeholders for local decision-making. Surveys are sent to staff periodically, as determined necessary, to identify training needs.

SUD providers are invited to provide input in the regional SUD clinical meeting. Grievance and appeals are also a valuable source of stakeholder input, as well as consumer satisfaction surveys and targeted surveys based on program (e.g., the BTC bi-annual survey).

The table below summarizes methods and sources for obtaining stakeholder input.

STAKEHOLDER INPUT METHODS AND SOURCES						
Type of Input	Consumer	Staff	Providers	Family/ Advocates	Community	MDHHS/EQRO
Interviews	MDHHS Site Reviews, Accreditation, Satisfaction Surveys, Person Centered Planning (PCP) process	Performance Evaluations, Termination/Exit Interviews	ORR Site Visit, Contract Provider Quality Review	MDHHS Site Reviews Fidelity Reviews of Evidence Based Practices	Open Door Policy of the NorthCare Network CEO	MDHHS Site Reviews, External Quality Review Organization (EQRO)– under

						contract w/MDHHS
Suggestions	Ongoing opportunity through PCP process	Supervision, Suggestion for Improvement process	Quality reviews	Ongoing opportunity through PCP process per consumer choice	Focus Groups or Public Forums	MDHHS, EQRO
Forums	Consumer advisory committees, Board meetings	Team/Dept Meetings, All staff meetings	MDHHS Review, Contract negotiations, meetings	MDHHS Review, Advisory committees	MDHHS /EQR/ Accreditation Reviews, Annual PRR forum, Public comments at Board meetings	MDHHS, EQRO
Surveys	Consumer surveys, Health Plan Survey per Accreditation	Staff surveys	Provider surveys, Accreditation surveys	Satisfaction surveys	Stakeholder Surveys	MDHHS, EQRO
Assessment of experience with services/ organization	Ongoing through PCP process, progress notes, d/c summary, Various regional committee membership	Performance evaluations	Quality review of provider, AFC licensing reports	Regional committee membership	Community Needs Assessment	MDHHS, EQRO
Due Process Grievance, Appeals, Medicaid Fair Hearings	Filing of appeals and grievances	Review dispositions with staff	Review dispositions with providers	Due Process	Comments via NorthCare Network Website	MDHHS, EQRO
Complaints	MDHHS-ORR Audit reviewed as completed Compliance Complaints	Recipient Rights Complaints as mandated reporters Compliance Complaints	Recipient Rights Complaints as mandated reporters Compliance Complaints	RR Complaint, Compliance complaint process, Customer Service compliant process	RR Complaint, Compliance complaint process	MDHHS, EQRO

Ongoing Assessments of Consumer Experiences with Services and the PIHP

NorthCare Network conducts assessments of member experiences with its services. These assessments must be representative of the individuals served, including individuals receiving long-term supports or services, and the services and supports offered. Members of services are encouraged to complete the satisfaction survey. Surveys were previously mailed to a sample of individuals monthly, and the survey is always available online via the NorthCare website. To increase consumer input, CMHSPs have provided this survey link on appointment reminder cards, posted it in waiting room lobbies, and it has been advertised in the annual consumer newsletter. In FY25, NorthCare is implementing a Satisfaction Performance Improvement Project (PIP) to increase the number of returned surveys.

Results will be used to improve services, processes, communication, etc. Processes found to be effective and positive will be continued, while those with questionable efficacy or low consumer satisfaction will be revised by:

- Taking specific action on individual cases as appropriate.
- Identifying and investigating sources of dissatisfaction.
- Outlining systemic action steps to follow-up on the findings.
- Informing practitioners, providers, recipients of service, and the NorthCare Network Governing Board of assessment results.

Just as the original processes must be evaluated, the interventions used to increase quality, availability, satisfaction, and accessibility to care and services must also be assessed. Therefore, all actions taken as a result of assessments will be evaluated periodically. Quality improvement is never static, and it is an expectation that all evaluation efforts will be examined on an ongoing basis.

Provider Network Monitoring

NorthCare Network conducts annual site reviews of organizational providers with whom we directly contract to ensure compliance with all contracted functions as well as state and federal mandates.

NorthCare Network's process is a systematic and comprehensive approach to monitor, benchmark, and make improvements in the provision of mental health and substance use services. NorthCare Network conducts annual (at minimum) site reviews to evaluate:

- Compliance with regional, state, federal and accreditation standards through annual site visits
- Compliance with delegated functions, if applicable
- Clinical documentation reviews
- Verification of Medicaid services
- Clinical Implementation of effective treatments

The Provider Network Monitoring process provides NorthCare Network the ability to:

- Establish clinical and non-clinical priority areas for improvement
- Use a number of measures to analyze the delivery of services and quality of care
- Establish performance goals and compares findings and ratings with past performance
- Provides performance feedback through written reports
- Requires an improvement/corrective action plan from providers in areas not achieving targets or in non-compliance with accepted standards
- Ensures implementation of the improvement plan by providers

Utilization Management and Authorizations

NorthCare Network implements a Utilization Management Plan within the provisions of its Standard Contract with Michigan Department of Health and Human Services (MDHHS). NorthCare Network has oversight authority and performs utilization management functions sufficient to control costs and minimize risk while assuring quality care. The UM Plan establishes a framework for oversight and guidance of the Medicaid and MHL Programs by assuring consistent application of program/service eligibility criteria, and in decisions involving the processing of requests for initial and continued authorization of services.

Utilization Management is committed to not only reviewing practices related to resource utilization, but also to taking action to modify inappropriate, inefficient or ineffective utilization. Many of the NorthCare Network Utilization Management functions overlap or are reliant on coordination with Quality Assessment & Performance Improvement, Provider Relations, Regional Clinical Practices and Quality Improvement Committee, Claims/Reimbursement, Management of Information Services and other managed care functions. Successful interface among the various functions of the PIHP is essential for effective and efficient management of resources, identification of gaps in service delivery and resolution of over- and under-utilization of services and resources. Interface between Utilization Management and other PIHP functions occurs through exchange of data, information and reports, joint participation in a variety of committees and collaboration in planning, projects, and operational initiatives.

Compensation to individuals or entities that conduct utilization management activities cannot be structured to provide incentives to the individual or entity to deny, limit, or discontinue medically necessary services to any recipient.

Some UM activities overlap with other areas and may be led by various committees but be pertinent to UM, such as recidivism for inpatient psychiatric admissions. UM areas of focus include over and underutilization, appropriate level of care, eligibility criteria, and medical necessity for specific services.

Credentialing and Qualification for Scope of Practice

The NorthCare Network Credentialing Committee is responsible for applying legal, professional and ethical scrutiny to applicants seeking to be credentialed as a provider in the network and to approve the re-credentialing of existing providers. NorthCare Network retains final authority for the credentialing of individual and organizational providers as a member of the provider panel employed or under contract. The qualifications of physicians and other licensed and unlicensed behavioral healthcare practitioners/professionals employed by or under contract to the PIHP are reviewed according to the NorthCare Network Credentialing and Privileging Policies to ensure they are qualified to perform their services. Continuous monitoring of the credentialing program occurs across the network to ensure compliance and identify quality or network issues. Organizations are responsible for ensuring that individual practitioners/providers, employed or under contract, and organizational providers meet all applicable licensing, scope of practice, contractual, and payor requirements.

NorthCare Network requires professional staff in the network to have a documented review and approval of their clinical privileges as needed to assure services provided to the network members are delivered by qualified and competent staff. Minimally, this is done as part of the initial credentialing/re-credentialing process and when duties/responsibilities change in terms of primary eligibility group a person is working with and/or scope of work.

NorthCare Network and network providers shall train new personnel regarding their responsibilities, program policy, and operating procedures and identify staff training needs and provide in-service training, continuing education and staff development activities according to NorthCare Network's Training – Personnel Policy and the Training-Network Provider Policy.

Oversight of Vulnerable Individuals

NorthCare Network utilizes the appropriate qualified clinical staff and various reporting mechanisms and data sets to identify vulnerable individuals and events that put them at risk of harm, including required health measures and health assessments. Such events and data, that are not a product of a protected peer review process, will be used to determine opportunities for improving care and outcomes and reported to the Compliance Oversight and Risk Management Committee as appropriate. Individuals with increased needs due to multiple conditions may be referred to the Behavioral Health Home (BHH), Substance Use Disorder Health Home (SUDHH), or Integrated Care Team (ICT) meetings with the Medicaid Health Plan, Upper Peninsula Health Plan (UPHP). If an issue that places an individual at imminent risk to health or welfare is identified, NorthCare will take immediate action to ensure their safety. NorthCare will invoke an immediate review and require a response by the Provider, within seven (7) calendar days.

Home and Community Based Service (HCBS) recipients, individuals on c-waivers, and individuals receiving Long-Term Services and Supports (LTSS), as well as those with various health conditions involved in Integrated Care Team meetings or the Health Homes are considered vulnerable and will be considered in data review. Some populations require the use of MDHHS developed tools or have data collected and reported on via Care Connect 360.

Behavior Treatment Review

NorthCare Network's Clinical Practices Specialist will review analyses of data from Member CMHSP behavior treatment review committee(s) on a quarterly basis where intrusive or restrictive techniques have been approved for the use with beneficiaries and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis. Patterns and trends will be evaluated for possible system and/or process improvement initiatives and will be reported to NorthCare Network's Clinical Practices and Quality Improvement Committee. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plan Review Committees and that have been approved during person-centered planning by the beneficiary or his/her guardian may be used with beneficiaries. Data includes numbers of interventions and length of time the interventions were used with the individual.

Event Reporting and Notification

Each Network Provider will record, assess, and report critical incidents according to NorthCare Network policy. They will analyze at least quarterly the cumulative critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents and report the outcome of this analysis to NorthCare Network. NorthCare Network's Health and Safety Review Team will analyze aggregate data to identify any trends or patterns and may follow-up on individual events as warranted. The Health and Safety Review Team will report aggregate high-risk areas and concerns to NorthCare Network's Compliance Oversight and Risk Management Committee as appropriate. Member CMHSPs utilize NorthCare Network's Incident Report Module to report all events defined below. Specialty residential providers will report incidents to the CMHSP, either via electronic or paper process. Other Network Providers, including residential SUD treatment providers, may

continue to report on paper. Select incidents will be reviewed during the NorthCare Health and Safety meeting. Analysis and trend lines will be reviewed frequently.

A. Critical Events: Critical Event Reporting will be uploaded nightly to MDHHS's CRM by PCE (NorthCare Network's software vendor) automatically. This Critical Incident Reporting System captures information on five specific reportable events based on varying populations as mandated by MDHHS. Detailed requirements can be found in NorthCare Network's Incident, Event & Death Reporting & Monitoring Policy and the PIHP/ MDHHS Reporting Requirements Policy.

B. Event Notification: The PIHP is also required to immediately notify MDHHS of specific events as outlined in the MDHHS Reporting Requirement Policy and NorthCare Incident, Event & Death Reporting & Monitoring Policy.

C. Sentinel Events, as defined in the MDHHS Reporting Requirement Policy must be reviewed and acted upon as appropriate and in accordance with NorthCare Network's Incident, Event & Death Reporting & Monitoring Policy.

D. Risk Events are additional events that put individuals at risk of harm, including at minimum: actions taken by individuals that cause harm to themselves or others; two or more unscheduled admissions to a hospital within a 12-month period; emergency use of physical management by staff in response to a behavioral crisis, and police calls by staff under certain circumstances. For detailed information refer to PIHP/ MDHHS QAPIP Guideline. NorthCare Network's Health and Safety Review Team and CMHSP staff review trends and follow up as indicated.

E. All unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed. Unexpected deaths include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect. Unexpected deaths are marked as either critical, sentinel, or both. Specifics for reporting are included in NorthCare's Incident, Event & Death Reporting & Monitoring Policy.

Critical Incidents are automatically uploaded into the CRM nightly via information transfer from PCE. Immediately reportable events and SUD sentinel events are manually uploaded into the CRM within the specified timeframes identified in the MDHHS guidelines. Remediation details for events, as necessary, are also submitted via the CRM.

LTSS (Long Term Supports and Services)

The following services are noted as LTSS services per the 1115 Pathway to Integration Waiver:

- Respite,
- CLS (Community Living Supports),
- PDN (Private Duty Nursing),
- Supported/Integrated Employment,
- Out of Home Non-Vocational Habilitation,

- Goods and Services,
- Environmental Modifications,
- Supports Coordination,
- Enhanced Pharmacy,
- PERS (Personal Emergency Response System),
- Community Transition Services,
- Enhanced Medical Equipment and Supplies,
- Family Training, Specialty Therapies (Music, Art, Message),
- Children Therapeutic Foster Care,
- Therapeutic Overnight Camping,
- Transitional Services,
- Fiscal Intermediary Services, and
- Prevocational Services.

The PIHP must have mechanisms in place to assess the quality and appropriateness of care furnished to beneficiaries using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan. Mechanisms are in place 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. This is achieved by, but not limited to review, analysis, and monitoring of person-centered planning, IPOS reviews/amendments, and standardized assessment scores that support level of care such as the Level of Care Utilization System (LOCUS). For individuals on a waiver, or attempting to be on a waiver, there is additional paperwork and approval process for waiver covered services identified above. The new 1915(i)SPA waiver also has additional process and scrutiny for identification of individuals receiving the services that are considered LTSS and qualifying for1915(i)SPA.

External Quality Reviews

1) MDHHS *Site Reviews*

Follow up activities for site reviews conducted by MDHHS are carried out and/or monitored by NorthCare Network's Network Management and/or Quality Management Committees. To best address local concerns, each Member CMHSP may be asked to draft a remedial action plan for all citations for which the Member CMHSP has been identified as being out of compliance. NorthCare Network will consider each response for inclusion in the Plan of Correction submitted to MDHHS. NorthCare Network also provides consultation for Member CMHSPs and monitors the implementation of improvement activities.

2) *External Quality Review Organization*

The Michigan Department of Health and Human Services (MDHHS) will arrange for an annual, external independent review of the quality and outcomes, timeliness of, and access to covered services provided by the PIHP. The External Quality Review (EQR) includes an on-site review of the

implementation of the QAPIP. The EQR also validates methodologies used in conducting the required performance improvement projects (PIP) as well as validates performance measure data collection and reporting to MDHHS. The PIHP addresses the findings of the external review through its QAPIP. The PIHP develops and implements performance improvement goals, objectives and activities in response to the external review findings as part of this QAPIP. A description of the performance improvement goals, objectives and activities developed and implemented in response to the external review findings will be included in the PIHP's Quality Improvement Plan and provided to the MDHHS upon request. The MDHHS may also require separate submission of an improvement plan specific to the findings of the external review.

Performance Measurement

NorthCare Network measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data. Through monitoring and evaluation, the efforts and resources of the Network can be redirected to obtain the desired outcomes.

By using performance indicators, the variation between the target desired and the performance being measured can be identified. Indicators are used to alert NorthCare Network and the Network Providers of issues that need to be addressed immediately, to monitor trends and contractual compliance, and to provide information to consumers and the public. Performance indicators are the foundation to control and improve processes.

Performance indicator results are used to guide management decision-making related to:

- Strategic planning
- Resource allocation
- Modification of service delivery
- Administrative process changes
- Staff training, credentialing and privileging
- Other activities identified by our various stakeholders

Performance Indicators [Measures]

NorthCare Network's Quality Oversight Committee monitors performance indicators for individual Member CMHSPs and collectively for the region. The QAPIP is utilized to assure that at least the minimum performance level on each indicator is achieved. A plan of correction that includes a review of possible causes for outliers is required from any Member CMHSP for each Performance Indicator out of compliance for two consecutive quarters. NorthCare Network's Quality Oversight Committee and/or QI/UM Specialist will monitor any plans of correction. Performance data is reviewed and discussed with the various QAPIP committees.

- Michigan Mission Based Performance Indicator System (MMBPIS)

NorthCare Network utilizes performance measures established by the MDHHS that address areas of access, efficiency, and outcomes and report to the State as established in the contract. NorthCare Network and Member CMHSP staff will ensure the reliability and validity of the data on these indicators across the Network and that these conform to the "Validation of the Performance

Measures" of the BBA protocols. The Quality Oversight Committee will review MMBPIS results. Member CMHSPs and SUD Providers who are out of compliance with MDHHS and/or NorthCare standards will work with NorthCare Network QI/UM Specialist and the Quality Oversight Committee to ensure the implementation of effective improvement plans.

- MDHHS is moving toward nationally recognized measures via a 3-year quality transformation roll out. The MMBPIS measures will be phased out over that period and replaced with the new quality measures. Measurement years will be calendar years starting 1.1.25. It is anticipated that in 2025 MMBPIS and the new measures will both be calculated; and the new measures will be informational only. The measures will also be stratified by race/ethnicity, biological sex, and geography. Measures that are separated by child/adult will also stratify based on age.

    i. The new measures are not entirely new to us. They come from the Behavioral Health Core Set required by CMS.

	Measure	Program	Domain
ADD	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	BHCS	MH
CDF	Screening for Depression and Follow-up Plan*	BHCS	MH
FUH	Follow-up After Hospitalization for Mental Illness*	BHCS	Access
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	BHCS	MH
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	BHCS	MH
FUA	Follow-up After Emergency Department Visit for Substance Use*	BHCS	Access
FUM	Follow-up After Emergency Department Visit for Mental Illness*	BHCS	Access
IET	Initiation and Engagement into Substance Use Disorder Treatment	BHCS	SUD
MSC	Medical Assistance with Smoking and Tobacco Use Cessation	BHCS	SUD
AMM	Antidepressant Medication Management	BHCS	MH
ACC	Access to Care—appointment within 10 days of request	Final Rule	Access

- Regional Measures

NorthCare Network may establish and monitor additional performance indicators specific to an individual program for the purpose of identifying process improvement projects. Performance indicators employed should be objective, measurable, and based on *current* knowledge and experience to monitor and evaluate key aspects of care and service. Performance goals and/or a benchmarking process are utilized for the development of each indicator.

- NorthCare Network will ensure compliance with and sustainability to meet performance measures as outlined in the contract between the State of Michigan - Michigan Department of Health and Human Services with NorthCare Network and the Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans.
- NorthCare Network will participate and collaborate with the ICO/Medicaid Health Plan (MHP) in regular and ongoing initiatives that address methods of improved clinical management of chronic health conditions and methods for achieving improved health outcomes for Members enrolled in any Medicaid program with the ICO/MHP.

Outcomes Management

NorthCare Network's Clinical Practices and Quality Improvement Committee will establish outcome measures and conduct quality improvement efforts to assure effective clinical practices based on a recovery and trauma informed system of care.

In FY2023, NorthCare upgraded ELMER vitals to include hip-to-waist circumference measures. This allows for early detection of metabolic syndrome for individuals on psychotropic medications, receiving health services from the CMHSPs. Early detection enables staff to implement lifestyle interventions like physical activity and dietary changes to reduce the chances of people developing metabolic syndrome conditions: diabetes, hypertension, and obesity.

New to FY25, NorthCare will, in accordance with MDHHS policy, monitor the transition of care for individuals between levels of care, between populations, between residential to outpatient settings, and between the legal system, as well as between PIHPs and from Medicaid Health Plan to PIHP (or vice versa), as applicable and as data allows.

Practice Guidelines

NorthCare Network's Clinical Practices Specialist is charged with the task of overseeing the adoption, development, implementation and continuous monitoring and evaluation of Practice Guidelines when there are nationally accepted, or mutually agreed upon (by MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices, and promising practices that are relevant to the individuals served. Working with the regional Clinical Practices/Quality Improvement Committee, NorthCare's Quality Management Committee, and the regional UM Committee newly implemented treatment practices required by MDHHS are monitored and measured for effectiveness for all populations. The NorthCare Network Practices Guideline Manual provides information regarding the process for the adoption, development, implementation, monitoring, and evaluation of the guidelines. This manual can be found at NorthCare Network Clinical Practices Guideline Manual.

NorthCare must disseminate all practice guidelines it uses to all affected providers and, upon request, to beneficiaries. Beneficiaries are informed of the guidelines annually in the newsletter. CMHSP staff attest to having access to the guidelines annually. SUD provider staff attest to having access to the guidelines and, more importantly, the SUD operations manual- which is an SUD focused guide. NorthCare must ensure decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. NorthCare must ensure services are planned and delivered in a manner that reflects the values and expectations contained in practice guidelines adopted.

Additionally, for emergency services, NorthCare Network member CMHSPs use the MCG Indicia tool embedded into the regional preadmission screening form to assist in determining medical necessity for inpatient psychiatric admission.

To ensure fidelity to practice, NorthCare and the affiliate CMHSPs will participate in Michigan Fidelity Assistance Support Team (MiFAST) reviews, as required by MDHHS. MIFAST is required prior to implementation or use of specific Medicaid codes or modifiers and is available ongoing.

Verification of the Delivery of Medicaid Services

Verification of Medicaid services is conducted in accordance with NorthCare Network's Medicaid Service Verification Policy. This process is to ensure Medicaid services were furnished to enrollees by member CMHSPs, providers, and subcontractors with corrective action taken as warranted.

Improvement Strategies

Establishing and successfully carrying out strategies to eliminate outliers, incorporate best practices, and optimize consumer outcomes is key to continuous quality improvement. The particular strategy or sets of strategies used vary according to the situation and the kind of improvement that is desired. The following provides a brief description of some of the improvement strategies utilized.

Performance Improvement Projects (PIP)

Standards published by the Centers for Medicare and Medicaid Services (CMS) require that the PIHP (Prepaid Inpatient Health Plan) conduct, "performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction."

NorthCare Network must engage in at least two affiliation-wide projects during each waiver period, which must address clinical and non-clinical aspects of care. Project topics are either mandated by MDHHS or selected by the PIHP in a manner that takes into account the prevalence of a condition among, or need for a specific service by, the organizations' consumers, consumer demographic characteristics and health risks, and the interest of consumers in the aspect of service to be addressed. Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care; while non-clinical areas would include, but not be limited to, appeals, grievances, trends and patterns of incident reports as well as access to, and availability of, services.

Projects selected may fulfill both MDHHS/HSAG and applicable accreditation requirements. The Performance improvement projects must be included in the QAPIP and must include the following elements:

1. Measurement of performance using objective quality indicators.
2. Implementation of interventions to achieve improvement in the access to and quality of care.
3. Evaluation of the effectiveness of the interventions based on the performance of measures.
4. Planning and initiation of activities for increasing or sustaining improvement.

PIP's are selected based on requirements of the PIP structure when possible. The HSAG validated co-occurring disorder treatment PIP was selected and modified as there is not enough ethnic variation in the UP to create a PIP centered around racial disparity.

When determining a PIP, NorthCare meets with the region via regional committee to discuss possible PIP topics. A topic is picked if it has the most regional support and the initial data review

supports the need for a PIP that meets any of the criteria of the PIP structure. NorthCare then continues PIPs until improvement is shown that allows for sunsetting of the PIP. At times, a PIP will need to be modified based on additional discovery found in the data or review of literature.

Oversight of the PIPs is achieved through collaboration with regional committees and workgroups. Improvement is tracked on an ongoing basis through reviewing and updating the workplan, data collection reports, and analysis of the data. Results are communicated to appropriate committees and stakeholders.

NorthCare PIPs include:

1. To Increase the Percentage of Individuals Ages 12 and Older Who Are Diagnosed With a Co-Occurring Disorder That Are Receiving Co-Occurring Treatment.
    a. This HSAG validated PIP started in FY22, with the goal of increasing the percentage of individuals who are diagnosed with a Co-occurring disorder (COD) for children ages twelve to twenty-five and adults ages twenty-six and older who are receiving integrated COD treatment. Co-occurring is defined as having both a mental health and substance use diagnosis. The hope is that both populations will improve in their respective percentages of individuals with co-occurring needs being treated with co-occurring treatment.
2. Starting in FY25, NorthCare is implementing a new non-clinical, non-HSAG validated, PIP to increase the number of satisfaction survey responses received.
    a. This PIP will increase options for responses by increasing the number of formats and methods.
    b. The survey will be available to consumers utilizing SUD providers as well; although the methods will be limited.
    c. There will be increased data collection and analysis from the additional data obtained.
    d. Responses will be used to improve the network.

Utilization Management (UM)/Authorization strategies

NorthCare Network UM activities are specifically designed to ensure only eligible beneficiaries receive plan benefits; that services received meet medical necessity criteria and are linked to other services when needed. To achieve these goals, various methods are used that focus on eliminating outliers, incorporate best practices, and optimize consumer outcomes. To improve overall quality of consumer outcomes and consistency in the amount, scope, and duration of services, clinicians use the NorthCare Network level of care placement protocols to guide level of care determinations. This clinical decision-support tool allows for greater consistency in level of care assignments and aimed at reducing variances in service delivery. Staff also use MDHHS required tools to assess the appropriateness of care given the individuals population status, including LOCUS, CAFAS/PECFAS, DECA, and in FY25 MichiCANS, and, once available, the WHODAS-2. Finally, utilization review activities are employed which include monitoring of individual consumer records, specific provider practices and system trends. Review and monitoring activities are used to determine appropriate

application of guidelines and criteria for decisions involving level of care assignments, service selection, authorization, and best practices. Tracking consumer outcomes, detecting over utilization/underutilization and reviews of outliers are also the subject of utilization review efforts. In FY25, a dashboard for over/underutilization is being created using the PowerBI program. This will significantly increase the data capabilities associated with utilization management and allow for both qualitative and quantitative review.

Quality Measures

NorthCare reviews the following quality measures to ensure quality care.

- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD): The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
- Plan All-Cause Readmissions (PCR): For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.
- Initiation and Engagement of Substance Use Disorder Treatment (IET): The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement.
- Follow-Up After Emergency Department Visit for Mental Illness (FUM): The percentage of emergency department (ED) visits for members six years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness.
- Follow-Up After Hospitalization for Mental Illness (FUH): The percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.
- Follow-Up After Emergency Department Visit for Substance Use (FUA): The percentage of emergency department (ED) visits among members aged 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up.
- Antidepressant Medication Management (AMM): The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment.
- Spirometry Testing for Newly Diagnosed COPD (SPR): Percentage of adults with newly diagnosed COPD who receive spirometry testing within six months of diagnosis.
- Preventative Dental Examination: presence of a dental exam every two years for all individuals with Medicaid Dental Coverage.

- Well-Child Visits in the First 30 Months of Life: Assesses children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life. Assesses children who turned 30 months old during the measurement year and had at least two well-child visits with a primary care physician in the last 15 months.
- Child and Adolescent Well-Care Visits: Assesses members 3-21 years of age who received one or more well-care visits with a primary care practitioner or an OB/GYN practitioner during the measurement year.

Procedures for Adopting and Communicating Process & Outcome Improvements

NorthCare Network will incorporate the Home and Community-Based Services (HCBS) Quality Framework developed for the Centers for Medicare and Medicaid (CMS) into its Quality Management Program. This Quality Framework is intended to serve as a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of services and supports provided by NorthCare Network's provider network. The Framework focuses attention on critical dimensions of service delivery and the desired outcomes of the four functions of quality management: design, discovery, remedy and improvement. Further, definitions of the functions of quality are:

- Design: Designing quality assurance and improvement strategies for a program at the initiation of the program.
- Discovery: Engaging in a process of discovery to collect data and direct participant experiences to assess the ongoing implementation of the program, identifying both concerns as well as other opportunities for improvement.
- Remedy: Taking actions to remedy specific problems or concerns that arise.
- Continuous Improvement: Utilizing data and quality information to engage in actions that assure continuous improvement in the program.

Focus will be on the following seven broad categories as outlined by CMS:

1. Participant access
2. Person-centered planning and service delivery
3. Provider capacity and capabilities
4. Participant safeguard
5. Participant rights and responsibilities
6. Participant outcomes and satisfaction
7. System performance

Suggestions for improvement can come from a variety of sources. Feedback from consumers, advocates, stakeholders, network providers, MDHHS, and NorthCare Network Personnel is incorporated into the QI Plan's components and activities. NorthCare Network's QI Work Plan will identify measurable objectives, as well as the individuals and/or departments responsible for each objective. Also included will be a timeline for completion of tasks and schedule for ongoing

monitoring as appropriate. This document details the specific actions NorthCare is completing related to quality improvement and is a working document. The document will be reviewed and updated at the quarterly Quality Management meetings.

Evaluation and Monitoring

A meeting is convened if NorthCare becomes aware of any significant provider-related issues of quality concern. Issues would be added to the Quality Improvement Workplan. The Quality Improvement Workplan is a document that summarizes areas of quality concern, the intervention plan in place for improvement, and the staff responsible for the implementation and target resolution dates. The Quality Improvement Workplan considers severity, duration, frequency, and if the concern is clinical or not. Items in the workplan will be monitored quarterly unless otherwise specified. The workplan is a living document, updated throughout the year.

NorthCare Network's QAPIP is reviewed and updated at least annually with input from various stakeholders and approved by the Governing Board. The NorthCare Network Governing Board and NorthCare Network Quality Management Committee are responsible for the evaluation of the effectiveness of the QAPIP. This Annual Effectiveness Review includes analysis of whether there have been improvements in the quality of health care and services for recipients because of quality assessment and improvement activities and interventions carried out by the PIHP. The analysis considers trends in service delivery and health outcomes over time and includes monitoring of progress on performance goals and objectives. Information on the effectiveness of the QAPIP must be provided annually to network providers and to recipients upon request. This annual analysis will be provided to the MDHHS annually and no later than February 28.

NorthCare Network publishes an Annual Performance Management Report that provides a summary of accomplishments and highlights from the previous Fiscal Year as well as key information that will identify whether current systems and processes are providing desired outcomes. This report will be posted at www.northcarenetwork.org, posted at NorthCare Network's main office, a copy sent to all Network Providers and members of NorthCare Network Governing Board and copies provided to stakeholders as requested.

Additionally, the Network Adequacy standards are also completed annually, and this information is provided to MDHHS by February 28th each year. Identified concerns are brought to the attention of leadership, provider network management, and contract committees.

References

- The Balanced Budget Act of 1997 (BBA)
- MDHHS /PIHP Master Contract
- MDHHS Michigan Mission Based Performance Indicator System V6.0 Codebook
- ICO/PIHP Contract for the MI Health Link Demonstration Program
- NorthCare Network Policies -- www.northcarenetwork.org

Attachments

A - Acronyms Used in this Document
B – Work Plan

Approvals

Reviewed/Revised Date: 8/23/24
Quality Management Committee Approval: 8/26/24
Policy Committee/CEO Approval: 8/28/24
Board of Directors Approval: 9/11/24

Attachment A- Acronyms used in this document

BBA – Balanced Budget Act
BHH – Behavioral Health Home
BTC – Behavior Treatment Committee
CEO – Chief Executive Officer
CMH – Community Mental Health
CMHSP – Community Mental Health Service Program
CMS – Centers for Medicare and Medicaid Services
COD – Cooccurring Disorder
EBP – Evidence Based Practices
EQR/EQRO – External Quality Review / External Quality Review Organization
HSAG – Health Services Advisory Group (External Quality Review Organization contracted by MDHHS to conduct annual reviews of each PIHP.)
HCBS – Home and Community-Based Services
HIPAA – Health Insurance Portability and Accountability Act
HMP – Healthy Michigan Plan
ICO – Integrated Care Organization
I/DD – Intellectual/Developmental Disability
LTSS – Long Term Supports and Services
MDHHS – Michigan Department of Health and Human Services
MI – Mental Illness
MHL – MI Health Link Demonstration Program
MHP – Medicaid Health Plan
PIHP – Prepaid Inpatient Health Plan
PIP – Performance Improvement Project
PMC – Performance Management Committee (A NorthCare Network Committee represented by Directors of each Member CMHSP and NorthCare Network's CEO)
QAPIP – Quality Assessment and Performance Improvement Plan
QC – Quality Council
QI – Quality Improvement
QIP – QI (Quality Improvement) Plan
SUD – Substance Use Disorder
SUDHH- Substance Use Disorder Health Home
UM – Utilization Management

FY25 QAPIP WORKPLAN

Objective/Activities	Lead	Previous Measure	Goal Measure	Start/ Frequency/ Due Dates	Status / Recommendation	Guiding Criteria (CFR, contract, C-waiver)
Performance Indicators and Measures						
PI1: PAS within three hours. NorthCare will continue to exceed the 95% expectation for this measurement and will continue to measure and report PI timely. Review situations with multiple PAS's for the same individual on the same day.	QI	99.5% (based on average of Q1-2)	Requirement is 95%. Our goal to strive for is 100% but accept 95% as minimum standard.	FY23 (mid) Quarterly Ongoing	Continue / bring to CPQI, QM, and PMC	Contract MMBPIS Standards
PI2a: BPS within 14 days: Given FY24 new measurement goals, NorthCare will seek to improve this measure beyond the 75th percentile of 62%. PI will be reviewed with each CMH and data presented to appropriate regional meetings.	QI	56% (based on average of Q1-2)	62%	FY23 (mid) Quarterly FY24Q2 and Ongoing	Continue / bring to CPQI, QM, and PMC	Contract MMBPIS Standards
PI2b/e: SUD admissions in 14 days: NorthCare will identify providers by way of PI2b/e monitoring report that fall below the goal and work with them to address barriers.	QI / SUD	58.5% (based on average of Q1-2)	68.2% (MDHHS benchmark)	FY23 (mid) Quarterly Ongoing	Continue / bring to SUD regional meeting, QM, and PMC	Contract MMBPIS Standards
PI3: Ongoing service within 14 days: Given FY24 new measurement goals, NorthCare will seek to improve this measure beyond the 50th percentile of 72.9%. PI will be reviewed with each CMH and data presented to appropriate regional meetings.		64% (based on average of Q1-2)	72.9%	FY23 (mid) Quarterly FY24Q2 and Ongoing	Continue / bring to CPQI, QM, and PMC	Contract MMBPIS Standards
PI4a: Follow up to hospitalization within seven days: NorthCare will achieve 95% compliance every quarter and will require corrective action plan if any CMH is not within 95% two or more quarters in a row. Data will be reviewed at appropriate regional meetings.	QI	95% 99% (based on average of Q1-2)	95% Requirement is 95%. 99% is goal to strive for but accept 95% as minimum standard.	FY22 Quarterly Ongoing	Continue / bring to CPQI, QM, PMC, and ES meetings. Bring hospital specific information to contracted hospital quality meetings.	Contract MMBPIS Standards
PI4b: Follow up to detox within seven days: review all exceptions; and run the data separate from MH data.	QI	95%	95%	FY24 Quarterly Ongoing	Bring to SUD regional meeting	Contract MMBPIS Standards
PI10: Recidivism: Achieve under 15% recidivism every quarter. A corrective action plan will be required for any CMH outside 15% for 2+ quarters in a row.	QI	7.35%	<15% The standard is under 15%. Our goal is under 10% but will accept under 15%.	FY23 (mid) Quarterly Ongoing	Continue / bring to CPQI, QM, PMC, and ES meetings. Bring hospital specific information to contracted hospital quality meetings.	Contract MMBPIS Standards
Identification of trends for any statistical decline in performance measures. Address trends with appropriate providers.	QI	NA		FY24 Annual Ongoing	Continue / bring to CPQI, QM, and PMC	
Identify trends in recidivism and 7-day follow up; their relationship to inpatient ALOS, and correlations between the 3. Address trends with appropriate providers.	QI	NA		FY24 Quarterly Ongoing	Continue / bring to CPQI, UM, PMC, and hospital specific information to contracted hospital meetings.	
Improve timeliness of priority population admissions for SUD populations by developing a monitoring method and monitoring frequently. Overall decrease in number of out of compliance priority population admissions.	QI / SUD	NA	80%	FY24 Quarterly Ongoing	Continue / bring to SUD regional meeting, QM, and PMC	
Increase validation checks to ensure appropriate populations are included in PI reporting and update system logic to remove members admitted that are mild/moderate for 2a/b, 4a, and 10.	QI	NA	100% accuracy	FY24 Once 4.1.24		
Compare with PBIP data to better impact employment and housing related concerns.	QI			FY24 Quarterly 10.1.24	Continue	PBIP reporting
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Performance Improvement Project - Increase the percentage of individuals ages 12+ who are diagnosed with cooccurring disorders that are receiving cooccurring treatment						

Baseline Data Calendar year 21 – 17.78%. NorthCare will review data timely and bring to appropriate meetings to discuss improvement strategies.	QI / SUD / Data	NA	Better than 23	FY23 Quarterly Ongoing	Continue / bring to CPQI, UM, PMC, and PIP workgroup	QAPIP
Offer consultative services to CMHSPs to improve co-occurring illness, via contract with psychiatrist board certified in addiction medicine.	SUD / ICT	Began June 23	Increased utilization from 23	FY23 Monthly Ongoing	Continue	QAPIP
Performance Improvement Project						
Increase the responses to the satisfaction survey	CS/ QI	FY25 start date – baseline data		FY25	Start/ Continue	QAPIP
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Event Reporting – Increase data reporting capability by building better reports and using the data to analyze improvements in the quality of healthcare and services for members.						
Utilize Power BI for better data analysis and review data during the Health and Safety Committee (internal) and Regional Incident Reporting (regional) meetings.	QI	NA	Begin use	FY23 Quarterly Ongoing	Continue	QAPIP
Increase timely categorization of incidents as being critical, sentinel, risk, immediately reportable to 95% within three business days of incident.	QI	NA	95%	FY23 Quarterly Ongoing	Continue / given methods at the time in FY23, average of 93%, however improved data capabilities available in FY24 show unfavorable difference.	QAPIP
Ensure individuals living in residential living arrangements are in the correct level of care; ensuring discussion of transition for any found in appropriate levels of care.	QI / CP	Completion of quarterly review	Completion of quarterly review	FY23 Quarterly Ongoing	Continue / recommend setting a schedule for this activity	QAPIP
Review RCA Outcomes data to assess common causal factors for possible improvement project.	QI / CP	NA	Annual review	FY23 Annually Ongoing	Continue / determine if completion during site review makes most sense or mid-year review	QAPIP
Review all untimely deaths with NorthCare Medical Director and trend data over time.	QI / CP	NA	Monthly	FY24 Monthly Ongoing	Continue	QAPIP
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Behavior Treatment Plan Review – NorthCare will complete analysis of BTC data and implement systemic change related to data findings as necessary.						
NorthCare will collect quarterly data from the CMH's and present data at the regional BTC meeting and internal health and safety committee meeting. Determine the "why" of the incident.	QI / CP	Completion of quarterly review	Completion of quarterly review	FY23 Quarterly Ongoing	Continue / bring data and specific consumer concerns to each CMH.	42 CFR 438.100 (b)(2)(v). Balanced Budget Act of 1997
NorthCare will utilize data to determine improvements/ changes in care due to BTC both on select individuals and programmatically. Review interventions and incidents; specifically 911 use and physical management.	QI / CP	Reduction in use of physical management (325 events)	Reduction in use of physical management	FY23 Quarterly Ongoing	Continue / bring data and specific consumer concerns to each CMH.	42 CFR 438.100 (b)(2)(v). QAPIP
Analysis of BTC survey data to determine any concerns related to the program.	QI / CP	Completion of survey (311 responses)	NA – biannual	FY24 Biannual Ongoing	Continue	42 CFR 438.100 (b)(2)(v).
HCBS Modifications – Modifications of HCBS conditions will be supported by an assessed need that is justified in the person-centered plan.						
Review of HCBS limitations at annual site reviews.	QI	NA	Begin review	FY22 Annually Ongoing	Discontinue; will follow MDHHS HCBS Monitoring Technical Requirement	42 CFR §441.301 (c)(4)(vi)(A-D)
Monitoring of HCBS limitations and ensure that the limitation is justified and addressed in the person-centered plan.	QI	NA	Unknown baseline; ultimate goal 100%	FY22 Annually Ongoing	Discontinue; will follow MDHHS HCBS Monitoring Technical Requirement	
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Member Experience with Services – Use of an annual assessment addressing member experience, national data, LTSS, focus areas, and NCI results to address dissatisfaction and improve overall consumer satisfaction.						
Update the electronic process to achieve higher response rates to customer satisfaction survey.	CS	Low	25%	FY23 Annually 9.1.24	Continue	

Analyze satisfaction survey data, address areas of dissatisfaction, and publish associated interventions in annual QAPIP effectiveness review.	CS	NA		FY23 Annually 2.28.25	Continue	
Evaluate program satisfaction rate for all, including those receiving LTSS services.	CS	NA		FY24 Annually 2.28.25	Continue	42CFR438.10e.2.x
Grievance and Appeals – ensure grievance and appeals are completed timely, provide appropriate						
Pull a random sample, by provider, of ABD notices to ensure ABDs have all necessary elements, are written at an appropriate readability, and are completed timely.	CS	80%	90%	FY22 Quarterly Ongoing	Continue	42 CFR 438.400, 42 CFR 438.210, 42 CFR 438.408
Ensure grievance letters are written to the member, error free, and written at an appropriate readability via quarterly reviews.	CS		90%	FY22 Quarterly Ongoing	Continue	42 CFR 438.400
Review grievance extension letters to ensure they are error free and completed on the developed template.	CS			FY23 Quarterly Ongoing	Continue	
Acknowledge receipt of each member appeal timely.	CS		100%	FY22 Quarterly Ongoing	Continue	42 CFR 438.406
Create a mailing policy and procedure to ensure mailings are completed in a timely manner.	CS	NA	Completion of policy	FY24 Once	Completed	
Provide training regarding the difference between an extension request and ABD delay.	CS			FY24 Once		
Review targeted scenarios to ensure ABD completion – decision delays and commencement date of services	CS			FY25 Quarterly	start	
Application Programming Interface – API – NorthCare will implement a patient access API and provider directory API.						
Implement a Patient Access API by participating in a statewide workgroup and working with EHR vendor to achieve publicly accessible standards.	IT			FY22 Once 10.1.24		42 CFR §431.60; CMS Interoperability and Patient Access Final Rule (CMS-9115-F).
Implement a provider directory API to ensure access to published provider directory information.	IT			FY22 Once 10.1.24	Continue	42 CFR §431.670
Update the website to be more user friendly and accessible to multiple stakeholders and developers.	IT			FY24 Once 10.1.24		
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Practice Guidelines – Ensure development of requested CPGs, adoption of updated MDHHS CPGs, and dissemination of all CPGs to regional providers.						
Ensure review and updates to CPG's annually. Providers to acknowledge updates.	CP	Annual	Attestation from each CMH LMS user and SUD providers	FY23 Annually 1.25.24	Continue / make part of annual training requirements	QAPIP
Create/find and implement CPG related to eating disorders as requested in the Clinical Practices / Quality Improvement committee meeting.	CP	One time	Adoption of guideline	FY23 Once 4.1.24	Continue / options presented, to be voted on in FY24	
Review of effectiveness of CPGs based on available data regarding a particular guideline.	CP	Annual review	Annual review	FY23 Annually Ongoing	Continue	
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Credentialing and Re-credentialing – Ensure consistent factors considered during credentialing and recredentialing (grievances, PI, utilization, appeals, member satisfaction, and provider reviews) and that MDHHS requirements are met.						
Develop and implement detailed credentialing/recredentialing file auditing plan addressing credentialing/ recredentialing requirements, citations, and recommendations made in HSAG review. Developing an area in ELMER for region to utilize for credentialing/recredentialing of staff that will	PNM	Annual audit	Decreased number of charts out of compliance. Spec was created this month and plan is to implement and train region before the end	FY22 Annually September	Continue	42CFR438.214

capture all required information of the staff as well as timeframes effective.			of FY24 and begin utilizing it in FY25 as a region.			
Ensure non-licensed providers meet all Medicaid requirements.	PNM	Annual audit	Decreased number of files out of compliance.	FY22 Annually September	Continue	
Conduct annual audit of all delegates performing credentialing activities according to audit plan.	PNM	Annual audit	Decreased number of files out of compliance.	FY22 Annually September	Continue	
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Verification of Services – Medicaid Service Verification – Complete Medicaid Service Verification timely and address any barriers identified for services delivery and health outcomes.						
Obtain / maintain compliance with requirements for Medicaid Service Verification. Share data in appropriate committees.	CO	90%	95%	FY22 Annually Ongoing	Continue / in FY22, 331 SAL/Claims were reviewed for 100% compliance.	QAPIP
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Utilization Management – Improve consistency in UM decisions across various areas of need, such as: residential level of care, eligibility criteria, medical necessity criteria for specific services.						
Review underutilization and denoted reasons for underutilization in progress notes, periodic reviews, and other sources.	UM			FY23 Biannual Ongoing	Continue / introduction of new reporting tool, Power BI, will greatly assist with analysis	
Review overutilization of services as indicated by additional authorization requests.	UM			FY23 Biannual Ongoing	Continue	
Discuss Interrater reliability (IRR) in the state PIHP workgroup for statewide consistency.	UM	NA	Use of IRR for pre-admission screenings	FY23 Annually Ongoing	Continue	Parity – required use of MCG tool for inpatient; workgroup discussing IRR
Complete a sample of chart reviews to ensure accuracy and completeness of charts and compliance with C waiver requirements and CFR.	UM			FY24 Biannual Ongoing	Continue	MDHHS C-Waiver Code of Federal Regulations (HSAG)
Determine the utilization and authorization mean and median for all services during a given time period to analyze the variance and determine appropriate benefit plans	UM			FY25	Start	
Compare like services for areas that are lacking a service	UM			FY25	Start	
Complete targeted reviews as necessary in areas necessary such as % of the population in each LOC	UM			FY25	Start	UM plan
Review penetration rates, by CMH, by program	UM			FY25	Start	UM plan
Access to Services – Improve consistent access to services across the region						
Review a random selection of screenings for screener approval rate, determination at BPS, and other factors to identify trends and address any concerns. (second opinions, calls by agency, duplicate screenings, crisis and access interaction, etc.)	UM			FY24 Quarterly Ongoing	Continue / previous data based on centralized access at the PIHP. In FY24, distributed to CMHs	
Review data related to Emergency Services (ES) such as Average Length of stay, recidivism, 7-day follow up, IPOS amendments post hospitalization (change in need), hospital denials, ER boarding, diversion rates, denial trends)	UM			FY25	start	
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Provider Network Management – Ensure there is an adequate provider network.						
Review the service array and address areas of deficiency.	PNM / QI			FY23 Annually Ongoing	Continue	42CFR438.207

Review ABD capacity related denials and address areas of deficiency.	PNM / QI	3% of FY23 denials were due to capacity	2%	FY23 Quarterly Ongoing	Continue	
Expansion of Behavioral Health Home (BHH) providers; specifically CSS in FY25.			Recruitment of additional providers. GLRC joined the BHH panel in FY24	FY23 Monthly Ongoing	Continue	BHH Handbook
Create and run report to assess significant changes in provider network or membership, including location of providers to members.	QI			FY24 Annually Ongoing	Continue	HSAG Standard 4 / Element 4
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Long Term Services and Supports – LTSS – Compare services received by LTSS consumers vs what was authorized in their plan (over/under utilization of LTSS services).						
Review individuals in AFC level of care that do not have a matching LOC in the system to determine if AFC level of care appears appropriate	QI / CP / UM	Review five cases per quarter	Review five cases per quarter	FY23 Quarterly Ongoing	Continue	
Review underutilization of authorized LTSS services.	QI / UM	Review ten cases per quarter	Review ten cases per quarter	FY23 Quarterly Ongoing	Continue	
Oversight of Vulnerable Individuals –Integrated/Coordinated Care - Care coordination between the behavioral health and physical health providers will occur.						
Individuals receiving specialty care will have the recommendations of those providers incorporated into their behavioral health IPOS and a consent to share information. This will be reviewed via annual site reviews.	ICT	92.6%	95%	FY22 Annually Ongoing	Continue	
Behavioral Health Home (BHH) services will expand for individuals with at least one co-morbid physical health condition at the CMHSPs.	PHS	154 enrollees, six HHP's (Aug 2024)	175 enrollees	FY23 Monthly Ongoing	Continue	
Use health home data to create quality improvements within the programs and expand the programs appropriately.						
CMHSP's will expand the provision of H0034 – Medication Training and Supports, S9445 Patient Education individual, T1001 and T1002 RN/Nursing Services.	PHS			FY23 Annual Ongoing	Continue	Health Services Committee
NorthCare and UPHP will have bi-monthly data collaboration workgroup meetings to address shared member health care outcomes and gaps.	ICT	7603 unduplicated shared members (FY24Q1-3)		FY23 Bi-monthly Ongoing	Continue	
Individuals with high ER utilization, that are enrolled in MI Health Link, will reduce ER visits and increase preventative care by coordination between the PIHP and MHP.	ICT			FY23 Monthly Ongoing	Continue	
Transition of Care – Care will be coordinated when transitions are occurring.						
The Medicaid Health Plan (UPHP) will be notified of all psychiatric hospitalizations and discharges for shared members.	UM	100%	100%	FY23 Weekly Ongoing	Continue	PIHP-MHP Joint Care Protocol Workgroup
Individuals discharging from the psychiatric unit will have a follow up appointment within seven days (see PI4a).	QI		95%	FY23 Quarterly Ongoing	Continue	MMBPIS
Waiver transitions to another PIHP area will be coordinated as they occur.	WC			FY24 PRN Ongoing	Continue	
Waiver Services – Ensure timely HSW recertifications and pended cases.						
NorthCare will provide ongoing monitoring to the CMH's about expiring cases.	W.C.			FY24 Monthly Ongoing	Continue	Result of performance issue
NorthCare will notify the CMH CEOs of data and data will also be shared in regional meetings.	W.C.			FY24 Monthly Ongoing	Continue	Result of performance issue
Review of service utilization specific for waiver services/waiver individuals	w.c.			FY25	start	

FY25 QAPIP Effectiveness Review

The FY25 QAPIP Effectiveness Review begins on the next page. It details the various areas of NorthCare performance and progress on the quality plan for FY25. It also indicates initiatives that are ongoing into FY26.

FY25 QAPIP Effectiveness Review

Quality Management System

NorthCare Network quality management focuses on areas for review based on mandates and recommendations from auditing bodies, questions posed from the field, and concerns noted when conducting monitoring activities and analyzing data and utilization. NorthCare utilizes Centers for Medicaid and Medicare Services (CMS) and Michigan Department of Health and Human Services (MDHHS) regulations and rules, contract requirements, and evidence-based practices to set expectations for clinical and administrative functions. The timing of various MDHHS and Health Services Advisory Group (HSAG) audits is often mid-year for the Quality Assessment and Performance Improvement Plan (QAPIP) and workplan. Therefore, there may be additional quality related activities that are completed during the year that are in addition to the QAPIP and workplan.

Quality Management Workplan

The FY25 QAPIP Workplan focused on many areas. Key highlights are listed below:

- Regional Adverse Benefit Determination (ABD) training course which garnered over 100 participants.
- The development of 11 benchmarks/standards along with a standard ABD review tool.
- The development of a 5-part training series on Person Centered Planning, including supplemental training regarding the Home and Community Based Services (HCBS) rules.
- The development of a standard review tool for Level of Care Utilization Summary (LOCUS) assessments.
- Review of chart audits and increased details provided to improve quality.
- Website upgrades for sharing information.

Quality Assessment Activities

The following provides details about each quality initiative in FY25. Activities not completed during FY25 will be carried forward into FY26 unless otherwise specified for discontinuation.

Stakeholder Input and Assessment of Consumer Experience with Services

Satisfaction surveys, grievances, appeals, and information available via the Application Programming Interface (API) and website are evaluated as part of the consumer service experience.

Satisfaction Survey

Midway through FY24, the satisfaction survey was re-worked. The questions were revamped and reordered. The 15-question satisfaction survey was developed by looking at resources online with regional input and remade at a 6.1 reading level, satisfying the standard of having public facing materials at 6.9 reading level. It was also made into an electronic format using Microsoft Forms. The link and QR code to the survey are available on the NorthCare website, on posters in waiting rooms, and on appointment reminder cards. Paper surveys are also available. Some CMHSPs mail paper surveys directly to individuals, while others mail invitations to complete the survey online, including a link and QR code on the invitation. CMHSP case managers are instructed to offer the

satisfaction survey as part of the annual person-centered planning process. Substance Use Disorder (SUD) residential providers encourage completion of the survey when someone starts treatment and is discharged from treatment. They also have a survey specific to their agency; which may account for low completion rate.

Previously the SUD providers did not administer the old satisfaction survey. However, the following table represents the changes in the questions that were previously used in the CMHSP satisfaction survey.

	Old Survey	New Survey
1	Appointments are scheduled at times that work best for me.	I know where to voice concerns about services and feel safe doing so.
2	I am informed of my rights as a Community Mental Health (CMH) or Substance Use consumer	Appointments and services are available at times that work well for me.
3	I feel welcomed and comfortable where I receive services.	Staff included me in making decisions and let me pick my goals.
4	Staff speak in ways I can understand easily.	I chose who was involved in developing my plan with me.
5	I know what to do if I have a concern or complaint.	I had a chance to review and make changes to my plan.
6	Staff are sensitive to my cultural/ethnic and spiritual background.	I know what to do if I am in crisis.
7	Staff are sensitive when I am discussing my past.	Services have helped me.
8	I am aware of the types of services available.	I am better able to do the things I want to do because of services I have received.
9	I was able to get the type of services I feel I needed.	I have learned skills to handle difficult times.
10	My wishes about who is, and who is not, given information about my treatment are respected.	Staff are welcoming and make me feel comfortable.
11	I feel involved in my care and included in the decision-making process regarding my services.	Staff have helped me reach my goals and/or work towards reaching them.
12	I feel staff see me as a whole person and address all my needs.	I was told about services that are available.
13	I am satisfied with the telephone crisis service when calling the crisis line after 5pm.	Staff coordinate care with my doctors and agencies I use.
14	I am able to communicate with my CMH/SUD provider easily.	Staff helped me find supports outside of my current services when needed.
15	I would recommend these services to a friend or relative.	I am satisfied with the services I receive here.

In FY25, there were 341 survey responses regarding CMHSP performance. Most of these responses were from Hiawatha Behavioral Health, who sends many surveys via mail. Most survey responses were from adults receiving services for mental illness. Those that are blank didn't indicate a population or age.

Count of Survey Responses by CMHSP	
Copper	53
Gogebic	15
Hiawatha	191
Northpointe	41
Pathways	41
Grand Total	**341**

Count of Survey Responses by Age			Count of Survey Responses by Population	
(blank)	10		(blank)	15
Adult Services	270		Intellectual/Developmental Disability	71
Child/Youth Services	61		Mental Illness	255
Grand Total	**341**		**Grand Total**	**341**

When adding "strongly agree" and "agree" together, there were three questions below a 90% satisfaction rate; "I am better able to do the things I want to do because of services I have received," "I have learned skills to handle difficult times," and "Staff helped me find supports outside of my current services when needed." All responses were above 88%.

This is an improvement from FY24, when there were two questions below 88% and another two questions below 90%. Plus, a negative response regarding the crisis answering service. The five questions in FY24 that did not meet 90% were:

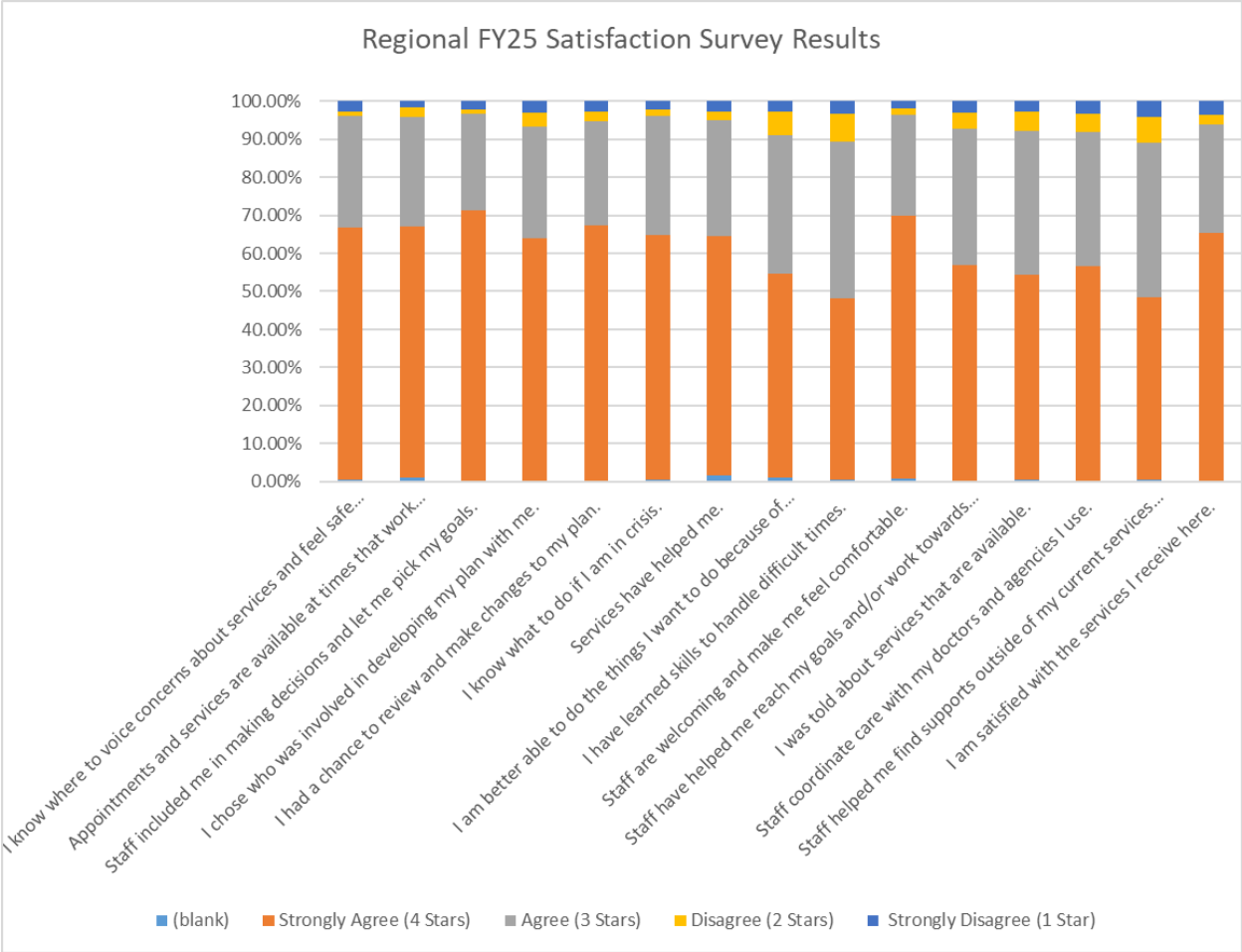
- 6. Staff are sensitive to my cultural/ethnic and spiritual background.
- 7. Staff are sensitive when I am discussing my past.
- 13. I am satisfied with the telephone crisis service when calling the crisis line after 5pm.
- 14. I am able to communicate with my CMHSP/SUD provider easily.
- 15. I would recommend these services to a friend or relative.

In FY25, survey questions are categorized into four main themes; A – comfort, B – planning, C- goal progress, and D – staff presentation /assistance. Question 1 and 2 related to comfort and scored an average of 95.16%. Questions 3-5 are related to planning and scored an average of 94.72%. Questions 6- 9 relate to goal progress and scored the lowest at 91.86%. Questions 10-14 relate to staff presentation/ assistance and scored lower at 91.91%. Question 15 is an overall question of satisfaction and is not part of any theme category. This overall satisfaction response was 93.55%.

Regional data is highlighted below. Columns labeled blank indicate there was not a response to that question in that percent of respondents.

Regional Answers Percent	(blank)	Strongly Agree (4 Stars)	Agree (3 Stars)	Disagree (2 Stars)	Strongly Disagree (1 Star)
1. I know where to voice concerns about services and feel safe doing so.	0.59%	66.28%	29.33%	1.17%	2.64%
2. Appointments and services are available at times that work well for me.	1.17%	65.98%	28.74%	2.35%	1.76%
3. Staff included me in making decisions and let me pick my goals.	0.29%	70.97%	25.51%	0.88%	2.35%
4. I chose who was involved in developing my plan with me.	0.00%	63.93%	29.33%	3.81%	2.93%
5. I had a chance to review and make changes to my plan.	0.29%	67.16%	27.27%	2.64%	2.64%
6. I know what to do if I am in crisis.	0.59%	64.22%	31.38%	1.47%	2.35%
7. Services have helped me.	1.76%	62.76%	30.50%	2.35%	2.64%
8. I am better able to do the things I want to do because of services I have received.	1.17%	53.37%	36.36%	6.45%	2.64%
9. I have learned skills to handle difficult times.	0.59%	47.51%	41.35%	7.33%	3.23%
10. Staff are welcoming and make me feel comfortable.	0.88%	68.91%	26.69%	1.47%	2.05%

11. Staff have helped me reach my goals and/or work towards reaching them.	0.29%	56.60%	35.78%	4.40%	2.93%
12. I was told about services that are available.	0.59%	53.67%	37.83%	5.28%	2.64%
13. Staff coordinate care with my doctors and agencies I use.	0.29%	56.30%	35.19%	4.99%	3.23%
14. Staff helped me find supports outside of my current services when needed.	0.59%	47.80%	40.76%	6.74%	4.11%
15. I am satisfied with the services I receive here.	0.29%	65.10%	28.45%	2.64%	3.52%



Individual CMHSP results for each question are reflected below.

I know where to voice concerns about services and feel safe doing so.						
	(blank)	Strongly Agree (4 Stars)	Agree (3 Stars)	Disagree (2 Stars)	Strongly Disagree (1 Star)	**Grand Total**
Copper		32	17	2	2	**53**
Gogebic		14	1			**15**
Hiawatha	2	126	60	1	2	**191**
Northpointe		29	11		1	**41**
Pathways		25	11	1	4	**41**
Grand Total	**2**	**226**	**100**	**4**	**9**	**341**

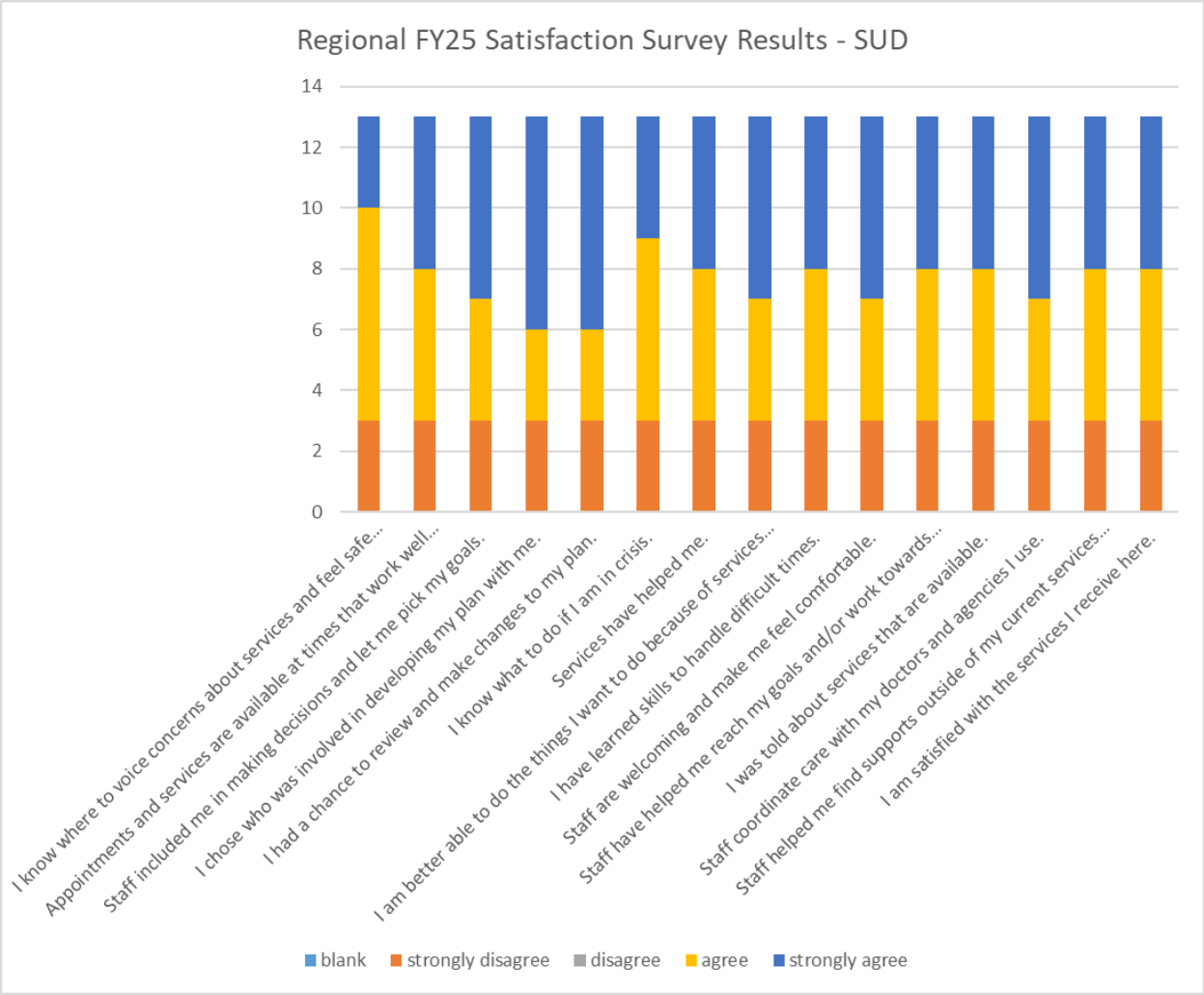
Appointments and services are available at times that work well for me.						
	(blank)	Strongly Agree (4 Stars)	Agree (3 Stars)	Disagree (2 Stars)	Strongly Disagree (1 Star)	**Grand Total**
Copper		32	18	2	1	**53**
Gogebic		13	1	1		**15**
Hiawatha	4	126	56	3	2	**191**
Northpointe		27	11		3	**41**
Pathways		27	12	2		**41**
Grand Total	**4**	**225**	**98**	**8**	**6**	**341**
Staff included me in making decisions and let me pick my goals.						
	(blank)	Strongly Agree (4 Stars)	Agree (3 Stars)	Disagree (2 Stars)	Strongly Disagree (1 Star)	**Grand Total**
Copper		33	18	1	1	**53**
Gogebic		14	1			**15**
Hiawatha	1	140	49	1		**191**
Northpointe		27	10	1	3	**41**
Pathways		28	9		4	**41**
Grand Total	**1**	**242**	**87**	**3**	**8**	**341**
I chose who was involved in developing my plan with me.						
	(blank)	Strongly Agree (4 Stars)	Agree (3 Stars)	Disagree (2 Stars)	Strongly Disagree (1 Star)	**Grand Total**
Copper		30	18	4	1	**53**
Gogebic		11	3		1	**15**
Hiawatha		128	60	3		**191**
Northpointe		25	10	3	3	**41**
Pathways		24	9	3	5	**41**
Grand Total		**218**	**100**	**13**	**10**	**341**
I had a chance to review and make changes to my plan.						
	(blank)	Strongly Agree (4 Stars)	Agree (3 Stars)	Disagree (2 Stars)	Strongly Disagree (1 Star)	**Grand Total**
Copper		35	15	2	1	**53**
Gogebic		14	1			**15**
Hiawatha	1	129	56	4	1	**191**
Northpointe		25	12	2	2	**41**
Pathways		26	9	1	5	**41**
Grand Total	**1**	**229**	**93**	**9**	**9**	**341**
I know what to do if I am in crisis.						
	(blank)	Strongly Agree (4 Stars)	Agree (3 Stars)	Disagree (2 Stars)	Strongly Disagree (1 Star)	**Grand Total**
Copper		31	21		1	**53**
Gogebic		13	1		1	**15**
Hiawatha	2	123	63	3		**191**
Northpointe		27	10	1	3	**41**
Pathways		25	12	1	3	**41**

Grand Total	**2**	**219**	**107**	**5**	**8**	**341**
Services have helped me.						
	(blank)	Strongly Agree (4 Stars)	Agree (3 Stars)	Disagree (2 Stars)	Strongly Disagree (1 Star)	**Grand Total**
Copper	1	29	21	1	1	**53**
Gogebic		13	2			**15**
Hiawatha	4	127	56	2	2	**191**
Northpointe		23	13	4	1	**41**
Pathways	1	22	12	1	5	**41**
Grand Total	**6**	**214**	**104**	**8**	**9**	**341**
I am better able to do the things I want to do because of services I have received.						
	(blank)	Strongly Agree (4 Stars)	Agree (3 Stars)	Disagree (2 Stars)	Strongly Disagree (1 Star)	**Grand Total**
Copper		28	19	5	1	**53**
Gogebic		11	4			**15**
Hiawatha	3	103	74	11		**191**
Northpointe		19	16	3	3	**41**
Pathways	1	21	11	3	5	**41**
Grand Total	**4**	**182**	**124**	**22**	**9**	**341**
I have learned skills to handle difficult times.						
	(blank)	Strongly Agree (4 Stars)	Agree (3 Stars)	Disagree (2 Stars)	Strongly Disagree (1 Star)	**Grand Total**
Copper		23	25	4	1	**53**
Gogebic		11	3		1	**15**
Hiawatha	1	92	85	13		**191**
Northpointe		17	16	5	3	**41**
Pathways	1	19	12	3	6	**41**
Grand Total	**2**	**162**	**141**	**25**	**11**	**341**
Staff are welcoming and make me feel comfortable.						
	(blank)	Strongly Agree (4 Stars)	Agree (3 Stars)	Disagree (2 Stars)	Strongly Disagree (1 Star)	**Grand Total**
Copper		33	17	2	1	**53**
Gogebic		14	1			**15**
Hiawatha	3	136	51	1		**191**
Northpointe		26	12	2	1	**41**
Pathways		26	10		5	**41**
Grand Total	**3**	**235**	**91**	**5**	**7**	**341**
Staff have helped me reach my goals and/or work towards reaching them.						
	(blank)	Strongly Agree (4 Stars)	Agree (3 Stars)	Disagree (2 Stars)	Strongly Disagree (1 Star)	**Grand Total**
Copper		29	21	2	1	**53**
Gogebic		14	1			**15**
Hiawatha		111	74	6		**191**

Northpointe		20	12	6	3	**41**
Pathways	1	19	14	1	6	**41**
Grand Total	**1**	**193**	**122**	**15**	**10**	**341**
I was told about services that are available.						
	(blank)	Strongly Agree (4 Stars)	Agree (3 Stars)	Disagree (2 Stars)	Strongly Disagree (1 Star)	**Grand Total**
Copper		28	21	3	1	**53**
Gogebic		12	3			**15**
Hiawatha	2	100	77	10	2	**191**
Northpointe		23	13	3	2	**41**
Pathways		20	15	2	4	**41**
Grand Total	**2**	**183**	**129**	**18**	**9**	**341**
Staff coordinate care with my doctors and agencies I use.						
	(blank)	Strongly Agree (4 Stars)	Agree (3 Stars)	Disagree (2 Stars)	Strongly Disagree (1 Star)	**Grand Total**
Copper		32	18	2	1	**53**
Gogebic		12	2		1	**15**
Hiawatha		106	74	9	2	**191**
Northpointe		24	11	4	2	**41**
Pathways	1	18	15	2	5	**41**
Grand Total	**1**	**192**	**120**	**17**	**11**	**341**
Staff helped me find supports outside of my current services when needed.						
	(blank)	Strongly Agree (4 Stars)	Agree (3 Stars)	Disagree (2 Stars)	Strongly Disagree (1 Star)	**Grand Total**
Copper		27	22	3	1	**53**
Gogebic		11	3		1	**15**
Hiawatha	2	92	82	12	3	**191**
Northpointe		18	17	3	3	**41**
Pathways		15	15	5	6	**41**
Grand Total	**2**	**163**	**139**	**23**	**14**	**341**
I am satisfied with the services I receive here.						
	(blank)	Strongly Agree (4 Stars)	Agree (3 Stars)	Disagree (2 Stars)	Strongly Disagree (1 Star)	**Grand Total**
Copper		34	16	2	1	**53**
Gogebic		13	1	1		**15**
Hiawatha	1	130	55	3	2	**191**
Northpointe		24	12	2	3	**41**
Pathways		21	13	1	6	**41**
Grand Total	**1**	**222**	**97**	**9**	**12**	**341**

There were 13 satisfaction surveys completed for SUD providers. All came from Sacred Heart. Of the 13, eight indicated they heard about the survey from staff, two from the waiting room, and one from the poster. The other responses did not indicate where the person learned about the survey.

NorthCare will bring the survey to the SUD clinical meeting as a reminder to provide this survey to individuals, discuss any barriers to providing the survey, and identify any other survey data the SUD providers are already collecting. This is an increase from ten SUD surveys in the past.



The goal of moving the satisfaction survey to an online electronic method was to increase the response rates. However, the results have shown the opposite. In FY23 there were 1058 responses, in FY24 there were 424 responses, and in FY25 there were 341. Some CMHSPs have been sending paper versions of the survey in addition to reminders to complete the survey electronically. This data will be provided to the regional Performance Improvement Project (PIP) leads for discussion and brainstorming options. Phase 3 of the PIP is to introduce technology, available in the lobbies, for completion of the survey. There is hope that this will increase the response rates.

The results of performance related to goal progress and staff assistance will be discussed. Internal staff discussions may lead to discussions related to appropriate objectives and the service array. The satisfaction of those receiving Long Term Services and Supports (LTSS) services is postulated the same as the survey results at large, since the majority of individuals served by CMHSPs are LTSS services.

Objective/Activities	Lead	Previous Measure	Goal Measure	Start/ Frequency/ Due Dates	Status / Recommendation	Guiding Criteria (CFR, contract, C-waiver)
Member Experience with Services – Use of an annual assessment addressing member experience, national data, LTSS, focus areas, and NCI results to address dissatisfaction and improve overall consumer satisfaction.						
Update the electronic process to achieve higher response rates to customer satisfaction survey.	CS	Low	25% / Increase not achieved.	FY23 Annually 9.1.24	Continue – implement technology in waiting rooms to increase rates	
Analyze satisfaction survey data, address areas of dissatisfaction, and publish associated interventions in annual QAPIP effectiveness review.	CS	NA	Scoring was the lowest in goal progress and staff assistance.	FY23 Annually 2.28.25	Continue and address in regional workgroup	
Evaluate program satisfaction rate for all, including those receiving LTSS services.	CS	NA	Total results applicable to individuals receiving LTSS services.	FY24 Annually 2.28.25	Continue	42CFR438.10e.2.x

Grievance and Appeals

For FY25, NorthCare resumed the responsibility for processing Medicaid Grievance and Appeals (G&A) for the Region for four of the five CMHSPs. One CMHSP retained behavioral health related due process matters. This change promoted the required responsibility for due process matters and increased oversight and compliance. Further, NorthCare was able to create a consistent and effective method for the flow of cases using the Electronic Medical Record (EMR) G&A Module. The module was used for documentation and tracking of all cases that were received. Appropriate privacy protections are ensured through use of the EMR messaging system for communications associated with G&A between NorthCare and the CMHSPs.

Grievances are the enrollee's expression of dissatisfaction with the PIHP or providers about any matter other than an Adverse Benefit Determination (ABD). Quality of care can be considered a grievance. In FY25 there were 69 grievances filed. Cases were adjudicated within the 90-day requirement with a focus on case closure determinations as soon as appropriate. Quality of care was the primary type of Grievance for the year. Collaborating closely with the provider agencies to coordinate appropriate and swift adjudication was a focus for the year and this will continue into the next year. Because the current category options limit our ability to accurately trend potential issues, NorthCare will expand the use of the 'subcategory' narrative field. This will allow us to capture more detailed information and improve our ability to identify and analyze emerging trends. In the first year of this change, we will develop a subset of categories with which to direct any necessary quality improvement activities.

Appeals are filed following an ABD. The Appeal process involves a review of that action. In FY25 there were 47 requests for a local appeal. All cases were adjudicated timely (30 calendar days for a Standard Appeal and forty-five calendar days for an extension). The average number of calendar days for completion was fifteen. One case was extended to allow for additional information to be provided with the authorized representatives' permission.

NorthCare offered reviews with providers and the CMHSPs for case dispositions and feedback on trending cases for their agencies. This increase in communication between the agencies and the PIHP related to Local Appeals has helped to foster more collaboration between the agencies and NorthCare. Having a single, designated point of contact for due process issues has enabled NorthCare to improve efficiency in several key areas. These improvements include faster processing, more thorough regulatory compliance reviews, and greater consistency throughout the

entire process. NorthCare has worked diligently to reduce response times for Appeals and Grievances and to ensure that all forward-facing materials are written at approximately a 6.9 Grade Point Reading Level. NorthCare strives to make our communications more accessible while still maintaining all required content and regulatory elements. In February 2025, NorthCare Network aimed to improve the quality of completion of ABDs. ABDs are issued to individuals when an adverse decision is made and outline the rights they have to file an appeal. NorthCare developed 11 benchmarks and standards, along with a standardized ABD review tool, to ensure consistency in our review of ABDs and to support ongoing monitoring improvement efforts. The benchmarks and standards were introduced along with the ABD review tool at a Regional ABD training which was held on 4.1.25. Over 100 participants from the CMHSP and SUD providers attended the training.

Standard	Goal	Benchmark
Narrative Written	100%	98%
6.9 Reading Level	100%	95%
Narrative Identified the Service and is Consumer Oriented	100%	95%
Narrative Explained the Rationale for Decision	100%	95%
Narrative Recommended Alternative Level of Care / Service	100%	95%
Alternative Level of Care / Service Referenced was an Attached Resource	100%	95%
Adequate Notice ABD was Provided within Appropriate Timeframe	100%	95%
Advanced Notice ABD was Provided within Appropriate Timeframe	100%	95%
Advanced Notice Exception – Verbal and Written Request Documented	100%	95%
ABD Decision Made by Appropriately Credentialed Staff	100%	95%
2nd Opinion Information (Mental Health Code) Information Provided	100%	95%

Findings and recommendations were addressed by quarterly monitoring, measurement, and evaluation over the course of FY25. A five percent sample garnered from the first month of each quarter in FY25 was reviewed by NorthCare Network. Quarterly reviews using the ABD review tool, and the 11 benchmarks and standards began in Q1 of FY25. Q1 results were used as the initial baseline. Q2 data results were not evaluated. Post intervention data measurement and evaluation began at the end of Q3 with the region wide ABD training on 4.1.2025 representing the primary intervention.

The 11 standards, associated benchmarks, and performance by each CMHSP is indicated in the tables below. All SUD providers are included under the "NorthCare SUD" Affiliate, highlighted in orange.

The data results from Q2 to Q3 showed improvement across six of the 11 standards. Four standards had no basis for comparison, and one standard regressed. FY25Q4 data reflected improvement from Q3 regarding six standards and three had regressed. One dimension reflected no change, and one dimension had no basis for comparison. FY25Q4 data results were used as the standard to meet the FY25 Measure Goal/Actual Achievement. It is recognized that the sample size is relatively small, and therefore there may be a dip in any one standard in a given quarter; however, overall consistent improvement across standards and quarters is the expectation.

There was significant regression for two agencies as it related to narratives being written. This standard seeks to simply measure if there is an explanation on the ABD as to why the ABD was created. Therefore, the benchmark is highest on this standard, as lack of a narrative impacts all the

other standards. It is also noted that the benchmarks on most standards were not met and may need to be adjusted to more accurately reflect baseline. However, the goal remains to achieve well written ABDs in all cases.

Narrative Written					
	No	NA	Yes	Percent	Performance Q3 to Q4
Copper			4	100%	0%
Gogebic	1		1	50%	-38%
Hiawatha			6	100%	20%
Northpointe	1		7	87%	1%
Pathways	4		2	33%	-60%
NorthCare SUD			5	100%	25%
NorthCare Total	**6**		**25**	**78%**	**-8%**

The Code of Federal Regulations, 42CFR438.10(d)(6), indicates that all written materials for potential enrollees be written using an easily understood language and format. HSAG/MDHHS indicates this is a 6.9 reading level. The format of the ABD is standardized, and the language outlining an individual's rights is required as part of the template. However, the narrative written by staff must be clear, concise, and easily understood by the reader. There was an overall increase in performance ensuring ABDs are completed at the 6.9 reading level. There was increased performance from Q3 to Q4 in FY25.

Written at 6.9 reading Level (or below)					
	No	**NA**	**Yes**	**Percent**	**Performance Q3 to Q4**
Copper	3		1	25%	Previous 0
Gogebic		1	1	100%	0%
Hiawatha	3		3	50%	-25%
Northpointe	1	1	6	86%	161%
Pathways	1	4	1	50%	150%
NorthCare SUD	3	2		0%	-100%
NorthCare Total	**11**	**8**	**12**	**52%**	**41%**

Ensuring the ABD is written in a consumer-oriented way shows dignity and respect to the individual and helps to ensure the ABD is understandable to the reader. There was increased performance in FY25Q4.

Narrative Identified the Service – Consumer-Oriented					
	No	**NA**	**Yes**	**Percent**	**Performance Q3 to Q4**
Copper	1		3	75%	75%
Gogebic	2			0%	0%
Hiawatha	1		5	83%	83%
Northpointe	2		6	75%	75%
Pathways	6			0%	0%
NorthCare SUD	4		1	20%	20%
NorthCare Total	**16**		**15**	**43%**	**87%**

The rationale for the decision is an important part of the narrative, explaining why the decision was made. This is valuable for individuals to know, important for appeals, and should be supported by the legal basis for the decision. There was improvement in Q4 from Q3.

Narrative Included Rationale					
	No	**NA**	**Yes**	**Percent**	**Performance Q3 to Q4**
Copper	1		3	75%	127%
Gogebic	1		1	50%	0%
Hiawatha	1		5	83%	152%
Northpointe	2		6	75%	0%
Pathways	5		1	16%	-52%
NorthCare SUD	3		2	40%	0%
NorthCare Total	**13**		**18**	**57%**	**232%**

Recommendation of alternative services or level of care is important for denials and terminations. This helps individuals know that while unable get the requested service, there are other options recommended. Clinical staff can provide a list of resources or help individuals get other services scheduled. Alternative recommendations documented on the ABD increased in FY25Q4 from Q3.

Alternative Services Recommended					
	No	**NA**	**Yes**	**Percent**	**Performance Q3 to Q4**
Copper	1		3	75%	50%
Gogebic	1		1	50%	0%
Hiawatha			6	100%	20%
Northpointe	1	2	5	83%	232%
Pathways	5		1	16%	-60%
NorthCare SUD	3		2	40%	-33%
NorthCare Total	**11**	**2**	**18**	**61%**	**35%**

Similar to above, the following table measures if alternative recommendations are documented in the chart. There were only a few ABDs reviewed where this was applicable, therefore the significance of this data is unknown.

Alternative Services Recommendations Attached					
	No	**NA**	**Yes**	**Percent**	**Performance Q3 to Q4**
Copper		4		NA	NA
Gogebic		2		NA	NA
Hiawatha	1	5		0%	-100%
Northpointe		7	1	100%	NA
Pathways		6		NA	0
NorthCare SUD		5		NA	NA
NorthCare Total	**1**	**29**	**1**	**100%**	**134%**

It is a requirement to provide the ABD timely. The next two tables both relate to timeliness and are split between Adequate ABDs and Advanced ABDs. Advanced ABDs, as the name implies, are to be

provided at least ten days prior to the effective date of the decision. There was regression in both, although the number of Adequate ABDs in the sample was minimal.

Adequate ABD Mailed Timely					
	No	**NA**	**Yes**	**Percent**	**Performance Q3 to Q4**
Copper		4		NA	NA
Gogebic		2		NA	NA
Hiawatha		5	1	100%	0%
Northpointe		8		NA	NA
Pathways		6		NA	NA
NorthCare SUD	1	4		0%	-100%
NorthCare Total	**1**	**29**	**1**	**50%**	**-50%**

Advanced ABD Mailed Timely					
	No	**NA**	**Yes**	**Percent**	**Performance Q3 to Q4**
Copper			4	100%	20%
Gogebic			2	100%	0%
Hiawatha			6	100%	0%
Northpointe			8	100%	0%
Pathways			6	100%	0%
NorthCare SUD	2	1	2	50%	-50%
NorthCare Total	**2**	**1**	**28**	**92%**	**-5%**

There are limited situations where advanced notice is not required, known as an advance notice exception. 42CFR 431.213 states an advance notice can be provided on the date of action if any of the following apply:

- The agency has factual information confirming the death of a beneficiary;
- The agency receives a clear written statement signed by a beneficiary that
    - They no longer wishes services; or
    - Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;
- The beneficiary has been admitted to an institution where he is ineligible under the plan for further services;
- The beneficiary's whereabouts are unknown, and the post office returns mail directed to them indicating no forwarding address;
- The agency establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
- A change in the level of medical care is prescribed by the beneficiary's physician;
- The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or
- The date of action will occur in less than ten days.

Few ABDs reviewed where this applied though the one reviewed showed positive result.

Advanced Notice Exception					
	No	**NA**	**Yes**	**Percent**	**Performance Q3 to Q4**
Copper		4		NA	NA
Gogebic		2		NA	NA
Hiawatha		6		NA	NA
Northpointe		7	1	100%	NA
Pathways		6		NA	NA
NorthCare SUD		6		NA	-NA
NorthCare Total		**30**	**1**	**100%**	**100%**

ABDs can be filled out by anyone, but someone operating within the scope of their practice should make the determination about services. For example, if therapy is being denied, a social worker, counselor, therapist, or doctor could make this determination. Conversely, if psychiatry were being denied, it should be the psychiatrist making that determination. In FY26, a field was added to the ABD to record the credentials of the staff making the determination.

ABD Completed by Appropriately Credentialed Staff					
	No	**NA**	**Yes**	**Percent**	**Performance Q3 to Q4**
Copper			4	100%	0%
Gogebic			2	100%	0%
Hiawatha			6	100%	0%
Northpointe			8	100%	0%
Pathways			6	100%	0%
NorthCare SUD			5	100%	0%
NorthCare Total			**31**	**100%**	**0%**

Finally, while anyone can request a second opinion for any reason, the Michigan Mental Health Code affords individuals rights to a second opinion related to access in Act 258 of 1974, section 330.1705, which states individuals have the right to request a second opinion if they are denied mental health services when applying or requesting access to services. The second opinion must be completed by a master's level social worker or psychologist, a registered professional nurse, or a physician. Section 330.1498e provides individuals with the option to request a second opinion regarding preadmission screenings for inpatient psychiatric hospital services. The review must be completed by a psychiatrist, physician, or licensed psychologist within three days, excluding Sundays and legal holidays. When there is a denial for these purposes, NorthCare looks to ensure that information regarding the individual's ability to request a second opinion is documented within the record.

2nd Opinion Information Provided (Mental Health Code)					
	No	**NA**	**Yes**	**Percent**	**Performance Q3 to Q4**
Copper		4		NA	NA
Gogebic		2		NA	NA
Hiawatha		5	1	100%	0%
Northpointe		7	1	100%	0%
Pathways		6		NA	NA
NorthCare SUD		5		NA	NA

NorthCare Total		**29**	**2**	**100%**	**300%**

Monitoring, measurement, and evaluation activities were conducted to address agencies providing ABDs to members that communicated a delay in making an authorization decision following the lapse of the 14-day timeliness standard. In FY25, there was a total of 77 cases where agencies improperly communicated to a member about a delay in decision timeliness in response to a standard authorization request for service(s). Prior to the intervention, there were a total of 38 cases. Post-intervention there were a total of 37 cases resulting in a 1% improvement. An extension letter was added to the EMR for staff to complete in situations where the decision is extended.

NorthCare Network was unable to measure service commencement timeliness due to continued development of EMR framework capabilities. This will allow future efforts towards valid and reliable monitoring of reports reflecting the data.

ABDs will continue to be reviewed on a quarterly basis into FY26. A comprehensive, pre-recorded ABD training was completed at the end of FY25 and was disseminated to agencies across Region 1 on October 31, 2025. A primary goal for FY26 is to increase the ABD sample size used to measure individual agencies.

Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Grievance and Appeals – ensure grievance and appeals are completed timely.						
Pull a random sample, by provider, of ABD notices to ensure ABDs have all necessary elements, are written at an appropriate readability, and are completed timely.	CS	90%	95% - four of the 11 Benchmarks for Q4.	FY22 Quarterly Ongoing	Continue Increase quarterly sample percent Comprehensive/Foundational ABD training will be provided to all agencies in FY26.	42 CFR 438.400, 42 CFR 438.210, 42 CFR 438.408
Ensure grievance letters are written to the member, error free, and written at an appropriate readability via quarterly reviews.	CS		90%	FY22 Quarterly Ongoing	Continue	42 CFR 438.400
Review grievance extension letters to ensure they are error free and completed on the developed template.	CS			FY23 Quarterly Ongoing	Continue	
Acknowledge receipt of each member appeal timely.	CS		100%	FY22 Quarterly Ongoing	Continue	42 CFR 438.406
Create a mailing policy and procedure to ensure mailings are completed in a timely manner.	CS	NA	Completion of policy	FY24 Once	Complete	
Provide training regarding the difference between an extension request and ABD delay.	CS	NA	Completion of Training 4.1.2025	FY24 Once	Complete	
Review targeted scenarios to ensure ABD completion – decision delays and commencement date of services	CS	NA	Delay = 1% improvement Commencement Date – No Measurement	FY25 Quarterly	Continue monitoring the use of extension requests and delay notices. Create a Tracking/Monitoring Report.	

Application Programming Interface & Website

In F25, NorthCare advanced several initiatives to improve data accessibility, transparency, and operational efficiency. Additional language was added to the website to help beneficiaries better

understand the availability of the patient access Application Programming Interface (API) which is made available to allow those beneficiaries to access their health data using applications of their choice. NorthCare worked closely with the EMR vendor to ensure our provider directory API contains all elements required under the Managed Care Rule, and we are continuing work with our website developer to establish a direct, automated connection between this API and the online provider directory.

Power BI use started in FY25 and continues to grow across the organization, with a number of dashboards—such as Incident Reporting and Utilization Management —nearing completion and providing some early insights.

A centralized Privacy and Security Event Management System (PSEMS) was implemented, following HSAG's suggestion, to ensure potential privacy issues are tracked and reported in a timely manner. In addition to helping track timelines for these events, the PSEMS will provide insight into privacy and security event patterns to better inform training gaps and help increase ongoing compliance with HIPAA and other confidentiality regulations.

The use of DocuSign for electronic Behavioral Health Standard Consent Form, MDHHS-5515, consent collection was implemented toward the end of the Fiscal Year to help support faster, more reliable care coordination for SUD priority populations, allowing our staff to communicate directly with providers earlier in the referral process.

Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Application Programming Interface – API – NorthCare will implement a patient access API and provider directory API.						
Implement a Patient Access API by participating in a statewide workgroup and working with EHR vendor to achieve publicly accessible standards.	IT		This was attended and completed.	FY22 Once 10.1.24	Completed	42 CFR §431.60; CMS Interoperability and Patient Access Final Rule (CMS-9115-F).
Implement a provider directory API to ensure access to published provider directory information.	IT		Started	FY22 Once 10.1.24	Continue	42 CFR §431.670
Update the website to be more user friendly and accessible to multiple stakeholders and developers.	IT			FY24 Once 10.1.24	Completed. Ongoing Maintenance will continue	

Provider Network Monitoring

The Network Adequacy standards are a set of three standards: (1) Time and Distance, (2) Provider-to-Enrollee Ratios, and (3) Timely Access. The Network Adequacy standards for FY25 identified at the beginning of the year were adjusted. Additional services for FY25 reporting were first identified by MDHHS as part of the Request for Proposal (RFP) process in September 2025 and additionally provided in December 2025 reporting procedures. Those identified services reviewed for time and distance requirements are listed below.

Adult	**Children and Youth**
Assertive Community Treatment (H0039)	Crisis Residential Programs (H0018)
Crisis Residential Programs (H0018)	Home-Based Services (H0036)
Opioid Treatment Programs (H0020)	Wraparound Services (H2021)

Psychosocial Rehabilitation Programs (Clubhouses) (H2030)	Intensive Crisis Stabilization Services for Children (Mobile Response with two-person team) H2011HT
Inpatient Psychiatric (0100, 0114, 0124, 0134, 0154)	Respite Services (T1005, H0045, S5151)
Community Living Supports (H2015)	Parent Support Partners (S5111-WP)
Skill Building (H2014)	Youth Peer Supports (H0038-WT)
Partial Hospitalization Programs (0912, 0913)	Inpatient Psychiatric (0100, 0114, 0124, 0134, 0154)
Targeted Case Management (T1017)	Pre-Admission Screen (T1023)
Pre-Admission Screen (T1023)	Autism Service Evaluations (90791, 90792, 96110, 96112, 96113, 96127, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, H0031)
Outpatient Clinical Mental Health (90832, 90834, 90837)	Autism Services (97153, 97154)
	Autism Services (97151, 97155, 97156, 97157, 97158, 0373T)
	Community Living Supports (H2015)
	Partial Hospitalization Programs (0912, 0913)
	Targeted Case Management (T1017)
	Outpatient Clinical Mental Health (90832, 90834, 90837)

In late December 2024, MDHHS sent the Network Adequacy reporting template and the County Designations for completion of FY24 Network Adequacy reporting. These status designations set the expectations for time/distance traveled between an individual's home and the location of services. This is most concerning for Marquette County as the "micro" classification is a shorter time/distance requirement.

County	**Status**	
Marquette	Micro	Pathways
Delta	Rural	
Alger	CEAC	
Luce	CEAC	
Iron	Rural	Northpointe
Menominee	Rural	
Dickinson	Rural	
Gogebic	Rural	Gogebic
Ontonagon	CEAC	Copper
Baraga	CEAC	
Houghton	Rural	
Keweenaw	CEAC	
Mackinac	Rural	Hiawatha
Schoolcraft	CEAC	
Chippewa	Rural	

Micropolitan ("Micro") refers to a CMS county-based geographic designation. Micro counties are counties with: (1) a population size greater than or equal to 50,000 persons and less than or equal to 199,999 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 99.9 persons per square mile; (2) a population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density greater than or equal to 50 persons per square mile and less than 999.9 persons per square mile.

Rural refers to a CMS county-based geographic designation. Rural counties are counties with: (1) a population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density of greater than or equal to 10 persons per square mile and less than or equal to 49.9 persons per square mile; (2) a population size less than 10,000 persons with a population density greater than or equal 50 persons per square mile and less than or equal to 999.9 persons per square mile.

Counties with Extreme Access Considerations (CEAC) refers to a CMS county-based geographic designation. CEAC counties are counties with any population size with a population density of less than 10 people per square

The standard is divided into two groups: inpatient psychiatric and partial hospitalization program services, and all other services. The inpatient requirements are drawn directly from the Code of

Federal Regulations (CFR) for Medicare Advantage enrollees. It does appear that Rural and Micro are inverted for inpatient services; however, this is how it is denoted in the CFR. To meet this standard, CMHSPs must comply with both the time and distance requirements for their services. Meeting only one of the two does not satisfy the standard. The expectation is that 85% of enrollees have access to at least one provider of each specialty type within the time and distance standards.

Service	CEAC	Rural	Micro	Metro	Large Metro
Inpatient	155min/140mi	90min/75mi	100min/75mi	70min/45mi	30min/15mi
All Other	118min/105mi	75min/60mi	70min/53mi	45min/30mi	20min/10mi

The second standard, the number of enrollees per provider, are broken between adult and youth. New Services for FY25 do not have standards yet, and data is collected as informational only. For services that include both time-and-distance standards and provider-to-enrollee standards, compliance with both requirements is necessary. Meeting only one does not satisfy the overall standard.

Adult		Children and Youth	
Service	**Standard**	**Service**	**Standard**
Assertive Community Treatment (ACT)	1:30,000 (Team: Medicaid Enrollee)	Home-Based	1:2,000 (Provider to Medicaid Enrollee)
Psychosocial Rehabilitation (Clubhouse)	1:45,000 (Provider to Medicaid Enrollee)	Intensive Care Coordination with Wraparound (ICCW)	1:5,000 (Provider to Medicaid Enrollee)
Opioid Treatment Programs	1:35,000 (Provider to Medicaid Enrollee)	Crisis Residential Program	8-12 beds per 500,000 Total Population
Crisis Residential	16 beds per 500,000 Total Population	Intensive Crisis Stabilization Services	FY25 Info Only
Community Living Supports	FY25 Info Only	Respite	FY25 Info Only
Skill Building	FY25 Info Only	Parent Support Partners	FY25 Info Only
Targeted Case Management	FY25 Info Only	Youth Peer Supports	FY25 Info Only
Pre-Admission Screening	FY25 Info Only	Autism Services	FY25 Info Only
Outpatient Clinical Mental Health	FY25 Info Only	Community Living Supports	FY25 Info Only
		Targeted Case Management	FY25 Info Only
		Pre-Admission Screening	FY25 Info Only
		Outpatient Clinical Mental Health	FY25 Info Only

For SUD, the PIHP must have each level of the ASAM available for both adult and youth populations.

Finally, the third standard is related to timely access. This is a new reporting requirement for FY25. For crisis residential and inpatient psychiatric services there is very little the PIHP or CMHSP can do to impact this timeline as it is dependent on these services having bed availability. Bed availability is influenced by the Certificate of Need process managed by MDHHS. In addition, many hospitals may have licensed beds available but lack the staffing necessary to operate them. As a result, the

total number of beds becomes an unreliable indicator of actual capacity. The new children's services are determined based on recommendations from the MichiCANS assessment. This assessment is required for all youth at intake and annually thereafter.

Service	Standard
Crisis Residential Programming	Within 24 hours of authorization
Inpatient Psychiatric Services	Within 24 hours of authorization
Pre-Admission Screening	Disposition completed within 3 hours (PI1)
Intensive Crisis Stabilization – Mobile Crisis	Within 2 hours (rural)
Assertive Community Treatment	Within 7 business days of assessment
Intensive Care Coordination with Wraparound	Within 10 business days of disposition date
Home-Based	Within 10 business days of disposition date
Respite	Within 10 business days of disposition date
Parent Support Partners	Within 10 business days of disposition date
Youth Peer Supports	Within 10 business days of disposition date
Autism Services	Within 10 business days of assessment

In FY24, MDHHS found NorthCare deficient in numerous areas. Adult unmet time-and-distance standards and provider-to-enrollee ratio standards included crisis residential and opioid treatment programs. Both of these services are contracted services. NorthCare does not have the ability to create these agencies as a PIHP. Additionally, NorthCare did not meet requirements for time-and-distance standards for adult Clubhouse or Inpatient Psychiatric services. While Clubhouse is developed by the CMHSPs, Inpatient Psychiatric services are a service that the PIHP has very little ability to impact. Creation of these services needs to follow the MDHHS Certificate of Need process.

For youth, time and distance standards were not met for Inpatient Psychiatric and Crisis Residential. Provider to enrollee ratio standards were not met for Crisis Residential, Home-Based, and Wraparound. Home-based services have been difficult to staff across the region, and some programs have provided care to more consumers than allowed by the required maximum consumer-to-provider ratio. Wraparound was barely utilized in FY25, making staffing difficult as the utilization need is low.

Of the deficiencies noted in FY24, Clubhouse, Home-Based, and Wraparound services are the areas most directly influenced by provider actions. The other services would be addressed through the expansion of contracts. In FY26, there have been network changes. NorthCare contracted with Harbor Hall to expand SUD services; however, this effort was nullified when Western UP Health Department closed its programs. These additional changes will be reflected in the FY26 QAPIP Effectiveness Review.

NorthCare had a goal of increasing the number of Behavioral Health Home (BHH) and SUD Health Home (SUDHH) providers in FY26. There were no new providers, however Upper Great Lakes Family Health Centers added a location in Menominee County. All providers have increased enrollment. The Western UP Health Department terminated their SUDHH program, which had reached a maximum of only two enrollees. This occurred as a part of the provider's closure of all SUD treatment services. As another element of network adequacy, NorthCare reviews primary language

information. While the Upper Peninsula is predominately white, English speaking, there are some provider options for alternative languages, primarily at various Adult Foster Care (AFC) homes.

Language Spoken and Location	Number of Staff
ALBANIAN	1
Copper Country - Stanton House	1
Farsi (Persian)	1
Copper Country - Behavioral Services	1
FRENCH	11
ALS - Cedar Hills	1
ALS - Hamilton	1
ALS - Hillcrest	1
ALS - Northern	1
ALS - Ripley Court	1
Marquette - Assertive Community Treatment	1
Marquette - Case Management / Services Coordination	1
Munising - Community Support & Employment	1
Sacred Heart Rehabilitation Center	1
War Memorial Hospital Outpatient Psychiatry	1
GERMAN	4
ALS - Cedar Hills	1
ALS - Norwood	1
Marquette - Outpatient/Therapy Services	2
GREEK, MODERN (1453-present)	1
Superior Rehabilitation & Professional Services - Direct	1
HINDI	1
DOT Caring Centers	1
ITALIAN	2
ALS - Cedar Hills	1
ALS - Ripley Court	1
JAPANESE	1
ALS - Cedar Hills	1
KOREAN	1
ALS - Cedar Hills	1
Other	2
ALS - Cedar Hills	1
ALS - Superior Home	1
SIGN LANGUAGES	15
ALS - Cedar Hills	1
ALS - Hamilton	1
ALS - Hillcrest	1
ALS - Life Options	1
ALS - Norwood	1
Bear River Health	1
Escanaba - Community Support & Employment	3
Escanaba - Health Services	1
Harbor Hall Inc	2
Marquette - Community Support & Employment	1
Marquette - Outpatient/Therapy Services	1
Sacred Heart Rehabilitation Center	1

SPANISH OR CASTILIAN	9
ALS	1
ALS - Cedar Hills	1
ALS - Life Options	1
ALS - Ripley Court	1
Bear River Health	1
Marquette - Community Support & Employment	1
Marquette - Outpatient/Therapy Services	1
Superior Rehabilitation & Professional Services - Direct	2
Grand Total	**48**

As part of network monitoring, NorthCare reviewed ABDs specifically related to capacity concerns. Monitoring activities occurred on a quarterly basis and used the ABD SQL server report and the MDHHS Quarterly Denial Report as a primary monitoring mechanism. Any agency that was found to have made an adverse decision in response to capacity was followed up to ensure the recipient's needs were met and how the capacity-related issue would be addressed. The number of ABDs and capacity related ABDs for each quarter in FY25 is represented below. Capacity-related ABDs were significantly lower during most months of FY25 as compared to FY24. The exception was in May, August, and September 2025. The variance for May and August was due to Pathways CMHSP losing a speech therapist, Home Based staff, and group therapy providers. The change for September was due to Northpointe CMHSP losing most of their Community Living Support Staff.

Type of ABD	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Adequate	179	97	120	105	99	107	79	97	100	129	105	94
Adequate Capacity	2	1	3	1				2	2		1	2
Advanced	435	436	398	464	502	442	569	499	519	555	478	502
Advanced Capacity	1	13			3	11	4	11		1	31	9
Grand Total	614	533	518	569	601	549	648	596	619	684	583	596
Total Capacity	3	14	3	1	3	11	4	13	2	1	32	11
Percent Total Capacity	**.5%**	**2.6%**	**.6%**	**.2%**	**.5%**	**2%**	**.6%**	**2.2%**	**.3%**	**.1%**	**5.5%**	**1.8%**

NorthCare is aware of network adequacy issues with a variety of the identified programs. There are no youth inpatient psychiatric beds in the Upper Peninsula (UP). NorthCare has contracted with a hospital in Wisconsin for services. There are no youth or adult crisis residential beds in the UP. On two separate occasions there has been an adult crisis residential provider in the UP, one in Marquette and the other in St. Ignace. Neither lasted, and both were converted into adult specialized residential homes. There has never been a youth crisis residential facility in the UP.

NorthCare had ACT services available in two counties in FY25. The ACT team model was found to be restrictive. By removing the team-based structure while continuing to provide comparable services, staff have been able to serve a greater number of individuals. Maintaining the required staffing levels to ensure fidelity to the ACT model has also been a persistent challenge. Home-based services have a similar concern. The limited caseload size is often exceeded as there are not enough staff to provide services. MDHHS has required every county to have a home-based team.

Staff also reported concerns about their ability to provide equine, music and art therapy, child therapeutic foster care, transportation, youth and parent support partners. These positions pose

barriers in response to hiring or contracting due to extreme lack of availability and variable limited utilization. Dialectical Behavioral Therapy was also noted as an evidence-based practice that was not provided due to lack of program and staff training.

Agencies should be participating in Michigan Fidelity Assistance Support Team (MIFAST) and Technical Assistance (TA) Reviews for Evidenced Based Practices that are consistent with MDHHS MIFAST requirements. In September 2025, Copper Country Community Mental Health completed a TA review for their Level of Care Utilization System (LOCUS). NorthCare Network will monitor MIFAST and TA reviews into FY26 to ensure quality and compliance.

Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Provider Network Management – Ensure there is an adequate provider network.						
Review the service array and address areas of deficiency.	PNM / QI			FY23 Annually Ongoing	Continue	42CFR438.207
Review ABD capacity related denials and address areas of deficiency.	PNM / QI	3% of FY23 denials were due to capacity	2%	FY23 Quarterly Ongoing	Continue	
Expansion of Behavioral Health Home (BHH) providers; specifically, Catholic Social Services in FY25.			Recruitment of additional providers. GLRC joined the BHH panel in FY24	FY23 Monthly Ongoing	Continue	BHH Handbook
Create and run report to assess significant changes in provider network or membership, including location of providers to members.	QI			FY24 Annually Ongoing	Continue	HSAG Standard 4 / Element 4

Utilization Management and Authorizations

Utilization

A primary goal as reflected on the FY26 QAPIP workplan is to monitor, measure, and evaluate the over and underutilization of services. NorthCare focused on increasing data capabilities in FY25 and purchased Power BI, a data analytics program. The first and primary report requested was to analyze utilization. Data from this report was not usable until the beginning of FY26, however the data highlights disparity between the NorthCare benefit plan by level of care, the average authorized amount of services, and the average utilized amount of services by service. NorthCare is utilizing this data to update the benefit plan and create a cleaner viewer-friendly format, inform clinical practice, and monitor utilization appropriate to authorization in FY26.

NorthCare levels of care are broken by population and severity. The levels of care include the following:

I/DD Adult	I/DD Child	SMI Adult	SED Child
Level 1 – 4, with 4 being the most severe. This is informed by the NorthCare I/DD Functional Assessment and in the future may be informed by the WHODAS-2.0.	Level 1 – 4, with 4 being the most severe. This is informed by the MichiCANS, however, the MichiCANS recommends services vs. a level of care.	Level 1 -6, with 6 being hospital level of care. This matches the LOCUS assessment; which is the MDHHS mandated tool to use for this population.	Level 1 – 4, with 4 being the most severe. This is informed by the MichiCANS, however, the MichiCANS recommends services vs. a level of care.

Currently, the benefit plans built within the EMR are listed under different naming conventions based on population and level of care, which creates confusion and inconsistency. This error could allot for authorization under multiple naming conventions; essentially inflating the benefit plan. This will be fixed in FY26 as part of the benefit plan overhaul and viewer-friendly update.

Initial review of FY25 data indicates that allowances within each level of care benefit plan are overly robust. Some levels of care had authorized services that would be better applied to different levels of care. Initial data also indicated discrepancy between the average authorization and average utilization of a service. Because individuals may have multiple authorizations for the same service and may even have multiple plans within a single year, the data naturally contains a degree of noise. Therefore, authorizations were divided by distinct consumers to try to best determine the average number of authorizations by person. Data will be reviewed, discussed, and practices will be updated at the regional Utilization Management Committee.

NorthCare also began review on specific assessment tools to determine utilization appropriateness. The LOCUS is the MDHHS standardized assessment tool for adults with Serious Mental Illness (SMI). The LOCUS is required to be utilized upon intake and annually thereafter.

During FY25 NorthCare Network developed a standard review tool and quarterly processes to monitor and evaluate LOCUS overrides. Overrides occur when the assessing clinician disagrees with the level of care recommendation generated by the LOCUS assessment and determines that the recommended level will not meet the individual's needs. As a result, the clinician overrides the recommended level of care to a higher or lower level of care. Overrides are not indicative of bad practice but could point to the need for training if the percentage of cases being overridden is excessive. MDHHS recommends an override rate of 10%. The following table reflects SMI cases only and excludes those with co-morbid I/DD diagnoses.

CMHSP	FY25Q1			FY25Q2			FY25Q3			FY25Q4		
	# Assess-ments	# Over-rides	% Over-rides	# Assess-ments	# Over-rides	% Over-rides	# Assess-ments	# Over-rides	% Over-rides	# Assess-ments	# Over-rides	% Over-rides
Copper	160	19	11.8%	177	18	10.1%	124	16	12.9%	126	17	13.4%
Gogebic	55	4	7.2%	69	6	8.6%	70	1	<1%	66	3	4.5%
Hiawatha	124	35	28.2%	178	52	29.2%	128	40	31.2%	158	42	26.5%
Northpointe	146	37	25.3%	170	50	29.4%	148	24	16.2%	154	43	27.9%
Pathways	188	63	33.5%	326	87	26.6%	246	61	24.7%	252	57	22.6%

From the reviews, 87 cases were identified in FY25 Q1 LOCUS Override Report in which individuals met independent criteria (high-risk members) but were overridden to a lower level of care without appropriate clinical rationale. Similarly, 89 such cases were identified in Q2, 57 cases in Q3, and 80 in Q4.

The above findings do not conclude that members' needs were not met by the agency. Rather, the analysis suggests areas for improvement as it relates familiarity with the LOCUS tool and clinical process, which are both items that can be addressed by training endeavors.

Staff reviewed LOCUS assessment scores, the assigned EMR level of care, and service authorization vs. utilization. Data reports are under construction in the Power BI data software

program and should be completed in FY26. Additionally, in FY26, there is a plan to create a data report for MichiCANS.

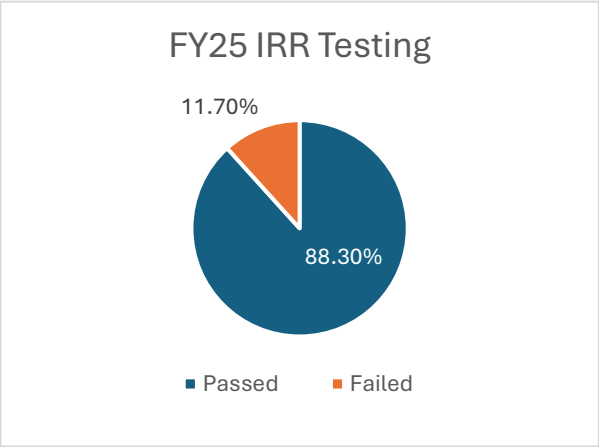
The LOCUS data below outlines the recommended level of care (LOC) compared to the LOC assigned in the EMR, ELMER, as well as the number of LOCUS overrides documented within the assessment. The ELMER LOC requires accuracy as it is informed by the most recent LOCUS LOC Recommendation and/or Override. A significant number of cases exist where the ELMER LOC was not informed by the most recent LOCUS Recommendation or Override. As over and underutilization of services continues to be monitored, measured, and evaluated, it is extremely important that the ELMER LOC variance is reduced to prevent significant data skewing. The variance between LOCUS overrides and ELMER LOCs did increase over the past year. The following table reflects all cases where a LOCUS was performed, and a variance was discovered between the ELMER LOC and the accepted LOCUS recommended LOC.

CMHSP	FY25Q1			FY25Q2			FY25Q3			FY25Q4		
	# Assess-ments	# vari-ance	% vari-ance	# Assess-ments	# vari-ance	% vari-ance	# Assess-ments	# vari-ance	% vari-ance	# Assess-ments	# vari-ance	% vari-ance
Copper	182	39	4.6%	177	26	6.8%	153	13	11.5%	145	21	6.9%
Gogebic	58	20	2.9%	69	19	3.6%	70	27	2.5%	66	25	2.6%
Hiawatha	171	46	3.7%	178	35	5.0%	164	39	4.2%	191	34	5.6%
Northpointe	188	42	4.4%	170	32	5.3%	171	28	6.1%	174	24	7.2%
Pathways	249	43	5.7%	326	62	5.2%	306	52	5.8%	309	57	5.4%

NorthCare is creating a time-limited LOCUS workgroup in FY26 to address LOCUS concerns. The designated LOCUS trainer(s) from each CMHSP have been identified and will work to develop internal training plans. NorthCare has created vignettes to measure Inter-Rater Reliability. NorthCare has created a LOCUS refresher training designed with help from the MDHHS LOCUS consultants. This training is recommended for all LOCUS users and will serve as a primary intervention and reference point for improving performance and addressing regression in override rates and independent-criteria determinations. As data is available for other assessments, other time-limited workgroups may also be created.

Inter-Rater Reliability (IRR)

In 2018, MDHHS focused on mental health parity. As a result of that focus workgroup, all Michigan CMHSP and PIHPs utilize the MCG standards for preadmission screenings for inpatient psychiatric hospitalization, mental health crisis residential services, or partial hospital programming. These standards provide recommendations related to inpatient level of care and are embedded into the pre-admission screening in the EMR. Annually, NorthCare requires emergency services staff who complete preadmission screenings, as well as



utilization management staff who conduct continuing stay reviews, to complete a vignette in the MCG learning management platform to assess their understanding of the tool. As the tool is typically updated each fall, the IRR vignette is assigned after the update, with completion due in mid-winter. Staff are allowed multiple attempts if they do not pass the first time. Staff are also allowed to access the non-interactive version of the guidelines at any time. The FY25 results are shown above on the left. The next round of results is due mid-January 2026.

IRR testing for all Region 1 LOCUS trainers will begin in FY26. The purpose of this testing is to ensure consistency and reliability in the training provided for all LOCUS users. Pain points resulting from FY25 quarterly reviews of LOCUS assessments highlighted the need for targeted intervention. To address these concerns, LOCUS trainer's scoring of vignettes will be monitored and evaluated to ensure mastery of foundational LOCUS assessment skills.

NorthCare is considering utilizing other elements available within the guidelines to help determine appropriate levels of care and/or particular services. This may be beneficial for services where MDHHS does not already have an identified tool, such as the LOCUS or MichiCANS, to suggest services or level of care.

Chart Reviews

As part of the MDHHS Waiver Corrective Action Plan (CAP) and the NorthCare QAPIP, and in an effort to improve the quality of consumer charts, NorthCare completed a review of a random sample of charts in October 2024 and again in March 2025. The chart reviews focus on reviewing cases for a variety of requirements that are also examined by MDHHS waiver reviews and by HSAG. The FY25 Chart Review tool was updated to include more standards from HSAG. These reviews also prompted changes to the FY26 Chart Audit processes, including a reorganization of the original chart tool to improve process flow and the integration of this tool into our EMR system. This change will allow for ease of access, data improvement, enhanced protection of Protected Health Information (PHI), and more effective data tracking. An additional benefit of integrating this tool to the ELMER Audit module is the ability to streamline the remediation process. CMHSPs will be able to respond directly to the audit findings by submitting a CAP to address any 'not met' criteria identified in the chart review. NorthCare's future projects include adding the Fiscal Year Chart Audit to the CMHSP Site Reviews and incorporating the ELMER audit tool into additional audits processes, including ABD Audits, HCBS Phase 3 and tri-annual HCBS audits, and various SUD audits.

In October 2024, 147 charts were pulled for the random sample, 52 of which were able to be reviewed. Charts were removed from the sample if they were only open to OBRA, crisis services, or because they were a new case that have not yet started services. In March 2025, 146 charts were pulled in the random sample, 46 of which were able to be reviewed.

As part of these reviews, NorthCare completed a summary of trends and sent the trends to the CMHSPs. In FY26, NorthCare will be increasing training efforts and continue further reviews. The concerns noted across both reviews in FY25 include:

- Amount, Scope, Duration, and Frequency of services clearly documented in the Individual Plan of Service (IPOS)

- Client needs and any deferral of these needs identified within the Biopsychosocial (BPS) and IPOS documents
- Underutilization of the identified medically necessary services
- Co-occurring needs not being clearly addressed

During the FY25 chart reviews, it was noted that co-occurring needs were often not clearly assessed in the BPS or adequately addressed in the IPOS. An additional review of co-occurring charts was completed. In this review, 43 charts were identified as having co-occurring needs during FY26 to date. This data was gathered from FY26 October Chart Audits, HCBS Chart Audits, Assisted Outpatient Treatment (AOT) Chart Audits, and hospital discharges. Charts were included in this analysis when evidence of co-occurring needs was present but not addressed in the BPS or IPOS, or when SUD needs were not identified as deferred in the IPOS.

Of the 43 charts identified, more than half (26) were not properly flagged as 42 CFR Part 2. Under 42 CFR Part 2, a chart must be designated accordingly when an individual is currently engaged in, or has previously received, SUD Treatment. Twenty-eight of these charts have an SUD diagnosis identified in our EMR. Five of these individuals were not open to CMHSPs at the time of the review. This information supports the need to increase awareness of co-occurring treatment and prompted the development of a "how-to" guide to assess for SUD during a BPS. This guide will support new clinicians, refresh the knowledge of seasoned clinicians, and assist Case Managers as they complete annual BPSs. The 'how-to' guide also supports documentation of the HH modifier: to educate people on what the HH modifier is and when to include this modifier on the SAL report for future tracking purposes.

Areas for follow-up improvement include identifying the need for SUD treatment, marking it as 'deferred' if the client declines the referral, and maintaining the golden thread of documentation to clearly reflect this process.

Like Services

A retrospective data review to monitor LOC placements was conducted in November 2025. The purpose for the review was to begin monitoring members ELMER LOC placements that were inconsistent with an agencies' ability to provide the supports/services specific to the designated LOC. For example, Level 4 placement recommendations are consistent with supports and services aligned with an Assertive Community Treatment (ACT) model in areas where ACT teams or comparable services are unavailable. All efforts were aimed at mitigating risk and meeting the members' specific treatment needs. Frequency and duration of enhanced services are assessed on a case-by-case basis. The following table reflects a frequency distribution of quarterly data from FY25 which attempts to outline counties that lack ACT programming but are still providing 'like services'. ACT is only available in Marquette and Houghton Counties. Other counties not reflected below were either not reviewed or did not have like-services provided.

CMHSP	County	FY25 Q1	FY25 Q2	FY25 Q3	FY25 Q4	Total
Copper	Baraga		3	1		4
Copper	Keweenaw				1	1
Copper	Ontonagon				1	1
Gogebic	Gogebic	6	5	9	10	30
Northpointe	Dickinson	10	16	12	13	51

Northpointe	Iron	4	12	3	6	25
Northpointe	Menominee	7	6	5	10	28
Pathways	Delta	2	1		3	6

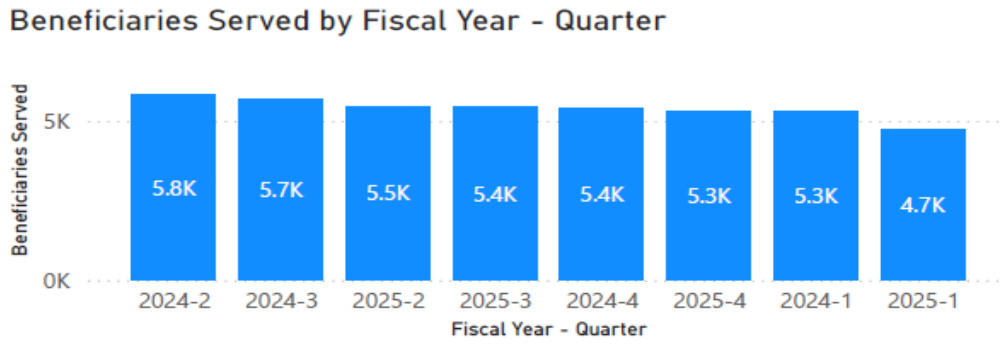
When ACT ended, Northpointe and Hiawatha moved their ACT consumers to a more robust outpatient case management program. Therefore, consumers may have access to increased levels of case management or Intensive Crisis Stabilization programming. Gogebic added BHH services to individuals' cases to increase nursing and peer/Community Health Worker supports.

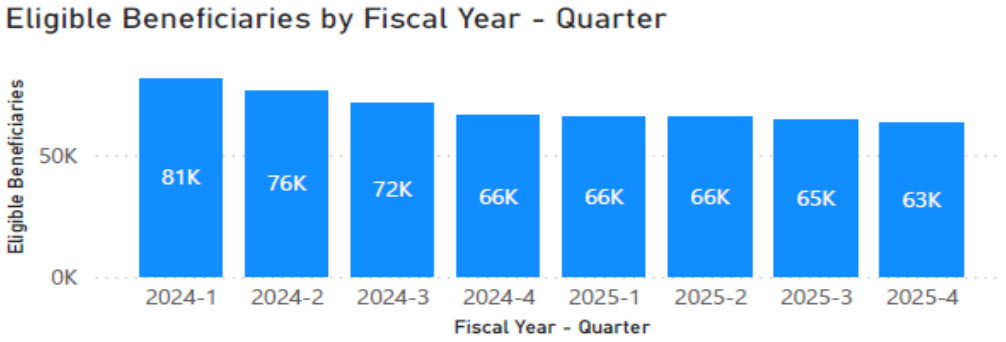
A deeper dive into individual cases will commence throughout FY26. A sample of cases will be reviewed to ensure that members receive the frequency and duration of supports and services consistent with an ACT level of care. Additional services or levels of care may be reviewed as determined necessary.

Penetration Rates

NorthCare reviews penetration rates and trends to help anticipate future utilization needs. Penetration rate is calculated by dividing the total number of unique Medicaid Eligible beneficiaries who received a PIHP funded service from either CMHSP or SUD network providers in a given quarter by the total number of unique Medicaid eligible beneficiaries listed in the Master Eligibility file for the same quarter. The same exercise is completed for those with Healthy Michigan. The numbers reflected below include both Medicaid and Healthy Michigan. This calculation is similar to the state logic used for Performance Indicator #5. The penetration rate is increasing due to the number of eligible beneficiaries decreasing.

	FY24Q1	**FY24Q2**	**FY24Q3**	**FY24Q4**	**FY25Q1**	**FY25Q2**	**FY25Q3**	**FY25Q4**
Served	5290	5805	5679	5414	4734	5455	5426	5293
Eligible	81366	76406	71524	66159	65906	65831	64582	63131
Rate	6.50%	7.60%	7.94%	8.18%	7.18%	8.29%	8.40%	8.38%





Many people served by the CMHSPs are eligible for the BHH program. Penetration rates of BHH enrollment at each CMHSP has been below 10% throughout FY25, despite increases in BHH enrollment with each provider. The percentage of enrolled eligible BHH beneficiaries is detailed in the chart below.

CMHSP BHH Penetration: BHH Eligible Medicaid Enrollees with Open CMHSP Services (September 2025)			
Health Home Provider	BHH Enrollees	Open at CMHSP, Eligible BHH	Penetration Rate for Eligible Beneficiaries
Copper	24	357	6.72%
Gogebic	16	280	5.71%
Hiawatha	47	553	8.50%
Northpointe	42	650	6.46%
Pathways	69	1031	6.69%

Staff Only Documentation

NorthCare became aware of increased 'staff only' documentation for BPS in FY24. Monitoring of the BPS, IPOS, IPOS Amendments, IPOS Periodic Reviews, and IPOS Pre-planning documents continued in FY24 and FY25. The review indicated an overall improvement. Combined data percentages for the fiscal year, including overall percentage changes, are reflected below. NorthCare provided updated training on 'golden thread' documentation, increased awareness of documentation policies, implemented system fixes within ELMER, and encouraged CMHSP staff to update their internal policies to improve 'staff only' documentation. There was a 4.87% improvement in the 'staff only' documentation with the greatest improvement in BPS Assessments and IPOS Periodic Reviews.

Previous responses from the CMHSPs regarding why BPS and IPOS documents may have been completed without the client present included: restrictions on billing two of the same service codes on the same day, inconsistent understanding of when a BPS should be updated, extenuating circumstances such as client no-shows, limited time, or expiring IPOS, and telephone conversations not being billed as face-to-face even though the consumer was still considered 'present'. Improvements appear to come from increased awareness that the BPS is not the only appropriate document for updating consumer demographics, greater use of IPOS Periodic Reviews, and encouragement of face-to-face services. Details of these improvements are reflected below.

Documents	Client Present	Staff Only	Total Sal	FY 25 Total % of Staff Only Documents:	FY 24 Total % of Staff Only Documents:	Improvement
BPS Assessment	3592	306	3921	7.80%	15.70%	7.89%
Initial BPS Assessment	2043	2	2045	0.10%	0.33%	0.23%
IPOS Amendment	2096	3573	5780	61.82%	69.70%	7.88%
IPOS Meeting	4721	64	4839	1.32%	2.80%	1.48%
IPOS Periodic Review	2988	812	3880	20.93%	30.61%	9.69%
IPOS Pre-Planning	4184	643	4900	13.12%	16.98%	3.85%
Grand Total	**19624**	**5400**	**25365**	**21.29%**	**26.16%**	**4.87%**

Objective/Activities	Lead	Previous Measure	Goal Measure	Start/ Frequency/ Due Dates	Status / Recommendation	Guiding Criteria (CFR, contract, C-waiver)
Utilization Management – Improve consistency in UM decisions across various areas of need, such as: residential level of care, eligibility criteria, medical necessity criteria for specific services.						
Review underutilization and denoted reasons for underutilization in progress notes, periodic reviews, and other sources.	UM			FY23 Biannual Ongoing	Continue / introduction of new reporting tool, Power BI, will greatly assist with analysis	
Review overutilization of services as indicated by additional authorization requests.	UM			FY23 Biannual Ongoing	Continue	
Discuss Interrater reliability (IRR) in the state PIHP workgroup for statewide consistency.	UM		Addressed in one meeting. Also discussed in 1:1 meetings with MCG.	FY23 Annually Ongoing	Continue with modifications – moved from discussion to use.	Parity – required use of MCG tool for inpatient; UM workgroup discussing IRR
Complete a sample of chart reviews to ensure accuracy and completeness of charts and compliance with C waiver requirements and CFR.	UM		Complete	FY24 Biannual Ongoing	Continue with modifications – inclusive of all charts (incorporating elements from c and i-waiver reviews)	MDHHS C-Waiver Code of Federal Regulations (HSAG)
Determine the utilization and authorization mean and median for all services during a given time period to analyze the variance and determine appropriate benefit plans	UM		Started	FY25	Continue	
Compare like services for areas that are lacking a service	UM			FY25	Start	
Complete targeted reviews as necessary in areas necessary such as % of the population in each LOC	UM			FY25	Start	UM plan
Review penetration rates, by CMH, by program	UM			FY25	Start	UM plan

Access to Services

NorthCare completes an access screening to determine whether residential SUD services are medically necessary for individuals seeking SUD treatment. Individuals who meet medical necessity criteria are then referred to network providers for residential services. NorthCare recognized the need to screen individuals more quickly. In FY24 there was an increased focus on screening individuals in real time as a continuation of the initial phone call, rather than scheduling for a later time. This effort continued and intensified in FY25, with the understanding that some individuals will still choose to be screened at a different time or may be in jail and therefore require scheduled outside of the 1-day window due to availability. The percentage of individuals receiving an SUD access screening within one day is reflected below.

FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25
79%	65%	64%	87%	79%	70%	81%	90%	91%

The expectation is that all individuals will receive treatment timely, including those that are considered a priority population. Priority Population individuals include those who are pregnant and injecting drugs, pregnant and using substances, individuals injecting substances, individuals at risk of losing custody of their children, individuals involved with the Michigan Department of Corrections (MDOC), and all others. The specific timeframes requirements for admission are indicated in the table below.

Population	Admission Requirement	Interim Service Requirement	Authority
Pregnant Injecting Drug User	1. Screened and referred within **24 hours**. 2. Detoxification, Methadone, or Residential – Offer admission within **24 business hours**. Other Levels or Care – Offer admission within **48 business hours**.	*Begin within **48 hours**:* 1. Counseling and education on: a. HIV and TB. b. Risks of needle sharing. c. Risks of transmission to sexual partners and infants. d. Effects of alcohol and drug use on the fetus. 2. Referral for prenatal care. 3. *Early intervention clinical services.*	CFR 96.121; CFR 96.131; Tx Policy #04
Pregnant Substance User	1. Screened and referred within **24 hours**. 2. Detoxification, Methadone, or Residential – Offer admission within **24 business hours**. Other Levels or Care – Offer admission within **48 business hours**.	*Begin within **48 hours**:* 1. Counseling and education on: a. HIV and TB. b. Risks of transmission to sexual partners and infants. c. Effects of alcohol and drug use on the fetus. 2. Referral for prenatal care. 3. *Early intervention clinical services.*	CFR 96.121; CFR 96.131;
Injecting Drug User	Screened and referred within **24 hours**. Offer admission within **14 days**.	*Begin within **48 hours** – maximum waiting time **120 days**:* 1. Counseling and education on: a. HIV and TB. b. Risks of needle sharing. c. Risks of transmission to sexual partners and infants. 2. *Early intervention clinical services.*	CFR 96.121; CFR 96.126;

Parent at Risk of Losing Children	Screened and referred within **24 hours**. Offer admission within **14 days**.	*Begin within **48 business hours**:* *Early intervention clinical services.*	MI Public Health Code Sec. 6232
Individual Under Supervision of MDOC and Referred by MDOC or Individual Being Released Directly from MDOC Without Supervision and Referred by MDOC	Screened and referred **within 24 48 hours.** Offer admission within **14 days**.	*Not required* *Begin within **48 business hours.*** 1. Recovery Coach Services 2. *Early intervention clinical services.*	MDHHS & PIHP Contract
All Others	Screened and referred within **7 calendar days**. Capacity to offer admission within **14 days**.	Not required.	CFR 96.131(a) – sets the order of priority. MDHHS/ PIHP contract

NorthCare has strived to improve the timeliness of priority population admissions in FY25. Monitoring occurs on a monthly basis. To obtain the information needed, reports in ELMER were modified to give specific information so that this monitoring can occur. Two reports are run in the ELMER system to identify timeliness of the screening and the timeliness of the provider who offered admission. Additionally, NorthCare has worked to ensure that interim services are consistently provided by bringing this function in-house. Following a screening, interim services are now offered to all individuals who meet Priority Population criteria.

These efforts are proving effective. The table below outlines the improvements observed over the years across the various Priority Populations. This data is provided to the SUD providers at the regional SUD provider committee meetings. Additionally, priority population timeliness is discussed at monthly provider meetings. Records found to be outside of the timeliness standards are reviewed with specific providers to ensure the data in the system is accurate.

Measure	FY22	FY23	FY24	FY25
Time between Referral and Offered Admission for Individuals who are Pregnant with IDU to Residential or Withdrawal Management	0%	0%	50%	50%
Time between Referral and Offered Admission for Individuals who are Pregnant with IDU to Outpatient	50%	0%	0%	NA
Time between Referral and Offered Admission for Individuals who are Pregnant to Residential or Withdrawal Management	0%	11%	25%	20%
Time between Referral and Offered Admission for Individuals who are Pregnant to Outpatient	40%	33%	25%	25%
Time between Referral and Offered Admission for Individuals who use IV drugs	84%	83%	77%	90%
Time between Referral and Offered Admission for Individuals who have CPS involvement due to their substance use	78%	92%	88%	96%

Time between Referral and Offered Admission for Individuals who have MDOC involvement	95%	69%	69%	89%

NorthCare began sending outcome letters to MDOC agents or Parole Officers when an individual with MDOC involvement receives a screening, provided that a valid consent to release information is in place. In addition, care coordination calls were provided to every individual who received a screening starting in FY25 to assist in facilitating admission to treatment. Individuals meeting Priority Population criteria were also contacted for care coordination once they entered treatment. A Care Coordination note was added to the ELMER system to better document this initiative. In FY25, 188 outcome letters were sent to MDOC agents.

In addition to MDOC-related care coordination, beginning in FY25, care coordination calls were provided to every individual who received a screening to assist in facilitating admission to treatment.

NorthCare is promoting access to Peer Recovery Supports in FY26 and has developed the Practice Guidelines for SUD Peer Recovery Support Services.

For Mental Health services, CMHSPs have managed their own access activities since 1.2.24. There are three key steps in the access process: screening calls, access screenings, and the intake disposition. Screening calls capture all incoming calls, including those that are not requests for services. Access screenings are brief clinical screenings completed when an individual is seeking services and typically take about 20 minutes. The intake consists of the full BPS assessment, which usually lasts around two hours and determines whether the individual progresses to treatment planning.

There were 6602 screening calls in FY25. Many calls resulted in a call back. Call backs may occur due to the individual's availability or because staff were unable to process the call at the time it was received. 'Information only' calls refer to situations where the caller was seeking or providing information but ultimately chose not to complete the access screening. Variation in the number of calls requiring a call back may reflect differences in process or documentation.

	Access Screening	Call Back	Crisis	Information Only	No-Show Second Opinion Screening	OBRA	Open Case Transfer	Second Opinion Request	Grand Total
Copper	569	21		24	3	66		6	689
Gogebic	312			263		124	2	2	703
Hiawatha	729	1014	3	200	2			4	1952
Northpointe	585	613	2	387					1587
Pathways	1289	82	4	280			1	15	1671
Grand Total	**3484**	**1730**	**9**	**1154**	**5**	**190**	**3**	**27**	**6602**

Affiliate	% Access Screen	% Call Back	% Info Only
Copper	83%	3%	3%
Gogebic	44%	0%	37%
Hiawatha	37%	52%	10%

Northpointe	37%	39%	24%
Pathways	77%	5%	17%

The number of access screenings increased in FY25. The denial rate increased at Copper, decreased at Pathways, and remained stable at the other CMHSPs. Region-wide, 2590 of the 3327 access screenings resulted in referral for CMHSP services. There were 153 'information only' screenings, 3 screenings that ended in crisis, and 581 denials. This data is reflected in the following tables.

# Access Screenings	Copper	Gogebic	HBH	Northpointe	Pathways
FY22	375	181	529	689	1214
FY23	364	191	526	665	1221
FY24	346	220	568	631	1151
FY25	486	244	726	586	1285

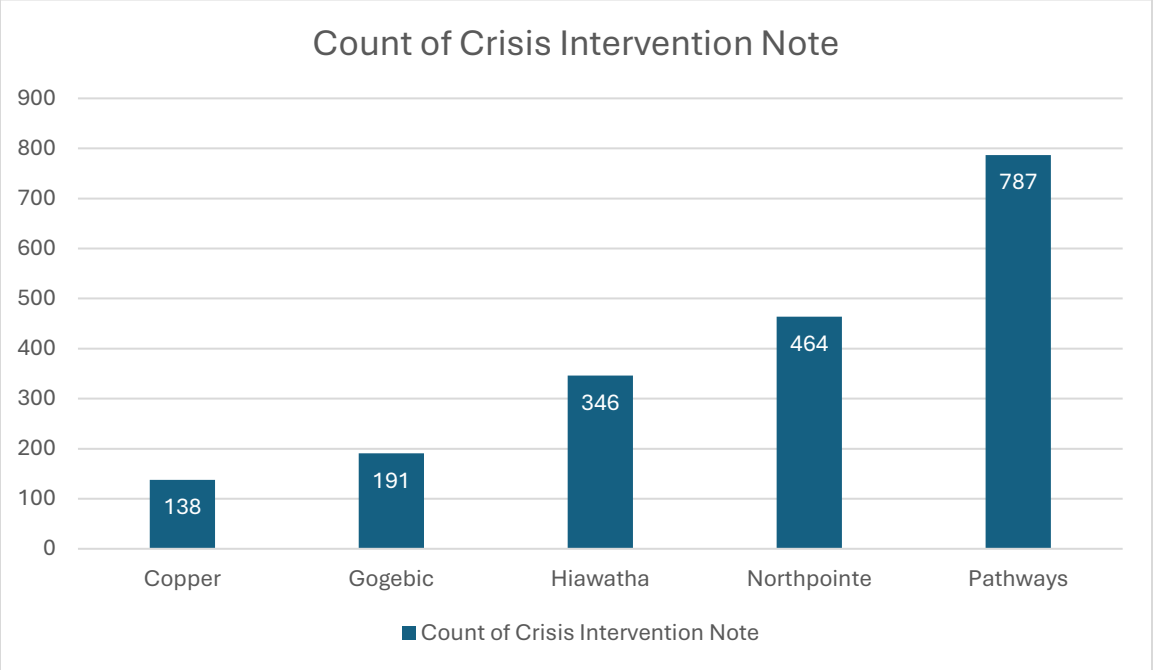
Denial Rate	Copper	Gogebic	HBH	Northpointe	Pathways
FY22	8.00%	2.21%	12.25%	8.42%	10.63%
FY23	13.46%	14.66%	15.02%	13.83%	12.78%
FY24	13.01%	12.27%	11.09%	13.15%	29.37%
FY25	23.25%	13.11%	11.57%	8.53%	23.50%

The BPS assessment is the final portion of access to services. This full assessment more accurately determines whether an individual needs and desires the intensive intervention of specialty behavioral health services. One benefit of CMHSPs completing access in-house is the additional knowledge they have of the individual at the time of BPS. Denial rates at the BPS did not change significantly between the period when NorthCare completed the access screening function and the period after CMHSPs assumed this responsibility. The largest change was at Pathways.

BPS Denial Rate	Copper	Gogebic	HBH	Northpointe	Pathways
FY22	4.94%	5.47%	7.74%	5.11%	9.63%
FY23	5.98%	7.75%	6.55%	6.37%	8.85%
FY24	5.45%	7.88%	6.83%	6.36%	6.34%
FY25	3.88%	7.18%	10.18%	6.27%	2.87%

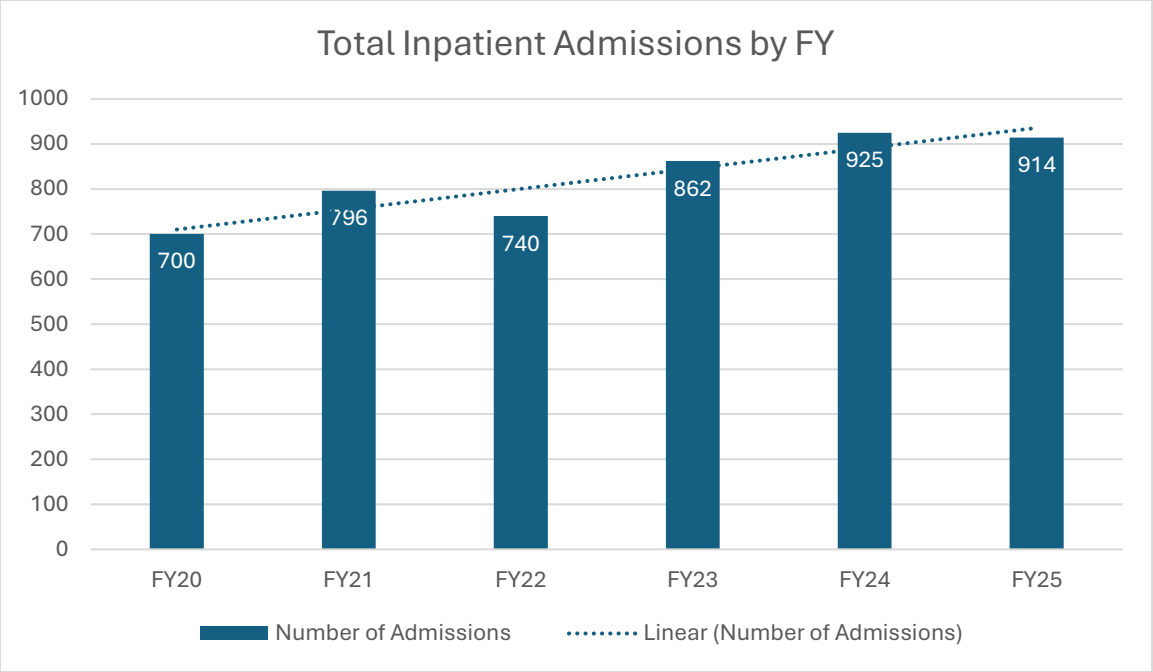
Generally, access to services refers to outpatient services; however, individuals also have access to crisis services. The State of Michigan has prioritized enhancing crisis stabilization and emergency services more supportive, timely, and accessible for individuals and their families or caregivers. To advance this goal, MDHHS has introduced several initiatives aimed at strengthening Intensive Crisis Stabilization Services (ICSS), with a focus on reducing reliance on emergency departments as well as diverting individuals from the criminal justice system. However, MDHHSs increasing interest in ICSS is concerning given the limited utilization of ICSS for children in FY25. Across the region, there were 19 requests for ICSS, of which only nine resulted in deployment (47%). In nine of the cases where deployment did not occur, the child presented at the office for quicker screening than the two-hour response requirement for mobile crisis. This pattern may be partially attributable to the FY25 structure of mobile ICSS for children, which required two staff to deploy, including at

least one master's-level clinician. NorthCare has preliminary data allows for initial inferences about regional experiences with emergency services, which can help guide further enhancement of crisis services. Regular crisis services, delivered by a single staff member and available in the office, Emergency Department (ED), or other community locations, are utilized when an individual in crisis is not requesting a preadmission screening for hospitalization and such a screening is not clinically indicated. A total of 1837 crisis intervention notes completed during the fiscal year. Crisis response and intervention are required for all individuals, regardless of age or insurance status. In some situations, CMHSPs may not be contacted to address a crisis if the ED addresses it independently.



While the goal of ICSS and all crisis services is to divert from hospitalization whenever possible, there are times that admission is necessary. Of the 2014 preadmission screenings in FY25, 914 resulted in admission. The graph below illustrates the trend in total inpatient psychiatric admissions by fiscal year as of November 7, 2025. The data indicates that over the past five years, we have observed a consistent upward trend in admissions, along with a stable average length of stay since 2022 at approximately ten days per episode of care. The accompanying table highlights the top five admitting hospitals in FY25, along with their respective average lengths of stay for all populations (adults and children).

It is important to note that pediatric admissions typically involve longer lengths of stay due to additional considerations such as consent for medication, discharge planning, and other care coordination requirements.



Top Admitting Contracted Hospitals	Average Length of Stay	Total Admissions
UP Health Systems- Marquette	11.03	236
Willow Creek	8.97	196
My Michigan – Sault	7.82	152
Forestview	11.26	47
Aspirus	6.21	39

NorthCare also reviews and monitors which hospitals the CMHSPs are referring to and the hospital's acceptance. Tracking this is new within the preadmission screening and is not widely used yet by all CMHSPs. NorthCare strongly encourages all CMHSPs to use this section of the preadmission screening to track this information. This information is critical for understanding referral patterns to contracted hospitals, as well as monitoring acceptance and denial rates.

NorthCare has a contractual requirement with hospitals to maintain a denial rate of no more than 5%. These insights help ensure compliance while also reducing patient wait times for bed offers. Ultimately, this supports timely access to care and helps identify and address barriers to treatment. Preliminary data for the top ten hospitals contracted in FY25, including acceptance and denial rates, is shown below.

Hospital	Accepted	Denied	Need Info	No Outcome
BCA StoneCrest	4.67%	36.45%	47.66%	11.21%
ForestView	8.45%	34.06%	41.96%	15.53%
Harbor Oaks	4.59%	47.25%	30.73%	17.43%
Havenwyck	6.97%	45.90%	31.97%	15.16%
HealthSource Saginaw	3.04%	46.09%	34.35%	16.52%
MyMichigan – Alpena	3.62%	46.15%	30.77%	19.46%
MyMichigan – Sault	17.73%	45.45%	26.36%	10.45%
Pine Rest Christian	9.76%	35.85%	39.27%	15.12%
UP Health Systems- Marquette	33.33%	25.29%	32.46%	8.92%

Willow Creek Behavioral Health	47.66%	26.17%	21.48%	4.69%
Total	**16.78%**	**36.94%**	**33.56%**	**12.73%**

As part of MDHHS's goal to support crisis services, NorthCare hosted the Behavioral Health Crisis Provider Training (BHCPT) which is a MDHHS approved training competency that is facilitated through Wayne State University. The training was developed to improve and expand crisis response in the State of Michigan. This training is a 40-hour training that follows the model below:

At the completion of skills day, the trainees are granted a certificate of completion, thus enhancing the workforce by allowing bachelor's level staff in a human service-related field respond to crisis intervention by billing the H2011 code. This training also satisfies the ICSS training requirements.

NorthCare has extended an opportunity to Wayne State to host the BHCPT training cohort in the Upper Peninsula, allowing staff to complete the mandatory 8-hour Skills Day locally. This initiative alleviates the burden of traveling downstate for certification. The Skills Day sessions were held from November 3–6, 2025. There were 53 total attendees.

NorthCare	Copper	Gogebic	Hiawatha	Northpointe	Pathways
2	4	10	0	12	25

Recognizing the value of sustaining this training within our region, NorthCare is exploring the development of a "Train-the-Trainer" program. This would enable a designated staff member to certify others locally, ensuring ongoing access to BHCPT training without the need for extensive travel. Planning this initiative is in its early stages, and updates will be shared with the region as they become available.

NorthCare is in the final stages of creating a comprehensive crisis training for all staff highlighting local concerns and documentation within the EMR. NorthCare anticipates that these efforts will

lead to greater awareness of the importance of updating the IPOS following stabilization from mental health treatment, increased development of proactive crisis plans, and a reduction in psychiatric emergencies and hospitalizations. This will be presented in FY26.

Objective/Activities	Lead	Previous Measure	Goal Measure	Start/ Frequency/ Due Dates	Status / Recommendation	Guiding Criteria (CFR, contract, C-waiver)
Access to Services – Improve consistent access to services across the region						
Review a random selection of screenings for screener approval rate, determination at BPS, and other factors to identify trends and address any concerns. (second opinions, calls by agency, duplicate screenings, crisis and access interaction, etc.)	UM		FY data reviewed.	FY24 Quarterly Ongoing	Continue as an annual data review.	
Review data related to Emergency Services (ES) such as Average Length of stay, recidivism, 7-day follow up, IPOS amendments post hospitalization (change in need), hospital denials, ER boarding, diversion rates, denial trends)	UM			FY25	start	

Credentialing and Qualification for Scope of Practice

NorthCare Network ensures due diligence through regional credentialing and re-credentialing processes designed to maintain a competent provider network for the individuals we serve. NorthCare monitors the credentialing and re-credentialing activities of contract providers during annual site reviews, while oversight of the subcontracted provider staff is delegated to direct contractors. NorthCare policies establish standards and guidelines for both NorthCare Network and Network Providers to ensure that clinical oversight, management, and services are delivered by providers who are fully qualified, competent, and in good standing. These policies also outline expectations for contract and sub-contract providers to comply with all applicable rules and regulations, including the Balanced Budget Act (BBA), MDHHS requirements, accreditation standards, and NorthCare Network's Credentialing Program. These standards apply to both individual and organizational providers.

NorthCare implemented a credentialing process within the EMR and deployed it across the region. Organizational providers are responsible for ensuring that individual practitioners-whether employed, contracted, or part of a subcontracted organization-meet all licensing, scope of practice, contractual, and payor requirements. NorthCare's onboarding credentialing checklist is used to verify that all required documents are obtained before the information is entered into the EMR. To support consistent communication during implementation, NorthCare established a Microsoft Teams channel for regional collaboration.

Objective/Activities	Lead	Previous Measure	Goal Measure	Start/ Frequency/ Due Dates	Status / Recommendation	Guiding Criteria (CFR, contract, C-waiver)
Credentialing and Re-credentialing – Ensure consistent factors considered during credentialing and recredentialing (grievances, PI, utilization, appeals, member satisfaction, and provider reviews) and that MDHHS requirements are met.						
Develop and implement detailed credentialing/recredentialing file auditing plan addressing credentialing/ recredentialing requirements, citations, and recommendations made in HSAG review. Developing an area in ELMER for region to utilize for credentialing/recredentialing of staff that will	PNM	Annual audit	Decreased number of charts out of compliance. Spec was created this month and plan is to implement and train region before the end of FY24 and begin	FY22 Annually September	Continue	42CFR438.214

capture all required information of the staff as well as timeframes effective.			utilizing it in FY25 as a region.			
Ensure non-licensed providers meet all Medicaid requirements.	PNM	Annual audit	Decreased number of files out of compliance.	FY22 Annually September	Continue	
Conduct annual audit of all delegates performing credentialing activities according to audit plan.	PNM	Annual audit	Decreased number of files out of compliance.	FY22 Annually September	Continue	

Oversight of Vulnerable Individuals / Long Term Services & Supports

Integrated Care

To support system level integration, NorthCare Network and Upper Peninsula Health Plan (UPHP), the Medicaid Health Plan covering the entire Upper Peninsula, collaborated to improve outcomes for joint members. NorthCare continued efforts initiated in 2014 to provide coordinated comprehensive care to all adults with severe mental illness (SMI), intellectual and developmental disabilities (I/DD) and children. A targeted, grant-supported Integrated Care Project between both payors continues to measure impacts on adults with SMI. In FY25 there were 8382 unduplicated adults with SMI served by these interventions. New metrics targeting children were added in FY25, with 1513 children served. Over six thousand (6249) of the shared members with UPHP received ongoing care from a CMHSP. Specific interventions for children in out-of-home placements were implemented, which covers approximately 60 children per quarter when data is exchanged.

NorthCare and UPHP meet bi-monthly in a data collaboration workgroup to share population level data. The organizations utilize a shared Tableau Symmetry dashboard, Care Connect 360, and UPHP's Healthcare Effectiveness Data and Information Set (HEDIS) Engine files to monitor progress and develop interventions. In FY25, the following HEDIS/CMS Quality Measures were addressed:

1. Follow Up after Hospitalization for Mental Illness
2. Follow-up after Emergency Department visit for Mental Illness
3. Follow-up after Emergency Department visit for Alcohol or Other Drugs
4. Dental Exam in the past 24 months
5. Diabetes Monitoring for adults with Schizophrenia or Bipolar Disorder
6. Cardiovascular Screening for adults dispensed Antipsychotic Medications
7. Anti-depressant Medication Monitoring
8. Colorectal Cancer Screening
9. Breast Cancer Screening
10. Cholesterol Screening for adults on psychotropic medications
11. Antipsychotic medication adherence
12. New: Follow-up Care for Children Prescribed ADHD Medication
13. New: Metabolic Monitoring for Children and Adolescents on Antipsychotics

NorthCare has elected to review all children and adolescents prescribed any psychotropic medications, which include anti-depressants, stimulants for ADHD, and antipsychotics.

The data files from UPHP's HEDIS engine are analyzed by NorthCare's Population Health Director, Integrated Care Specialist, and Healthcare Data and Business Intelligence Analyst, and are then

combined with other information from the EMR. These integrated data sets are shared with the nursing staff at each CMHSP in NorthCare's network to support client level interventions.

NorthCare's Analyst provides a return file identifying shared members who are not prescribed by the CMHSP. When a psychotropic medication is prescribed by a CMHSP prescriber, that prescriber orders the corresponding lab screening or testing for individuals with the identified need for intervention. NorthCare works with its EMR vendor, PCE, and Upper Peninsula Health Information Exchange (UPHIE) to ensure that Admission, Discharge, and Transfer (ADT) records, lab results, and Active Care Relationship information are shared with UPHP and other UPHIE users' EMRs for shared patients. NorthCare's providers continue to follow screening and referral procedures, as well as case management interventions, to support individuals in obtaining recommended screenings when NorthCare is not the prescribing or ordering provider. At the same time, UPHP provides care gap alerts to their providers regarding individuals' outstanding screening needs.

NorthCare also works with UPHP on three targeted Integrated Care Team (ICT) interventions for adults and children who have high emergency department utilization or recent and repeat hospitalizations.

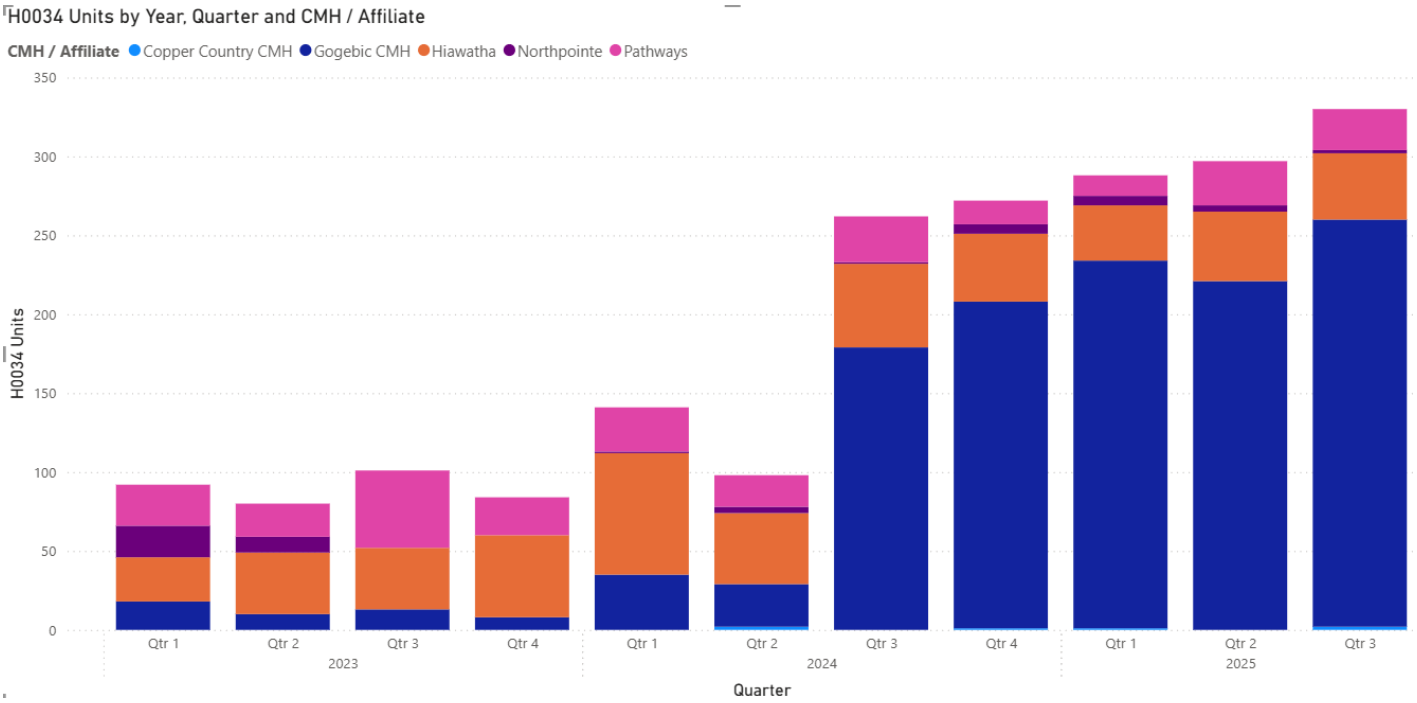
1. The High Utilizer ICT serves adults with SMI who are enrolled in Medicaid or Healthy Michigan Plans with UPHP and receiving services with a CMHSP in Region 1. In FY25, 142 unduplicated individuals were served in this intervention, a significant increase from 58 individuals in FY24. Of those serviced in FY25, 115 individuals completed integrated care plans. Among these, 35 closed with all integrated care goals met, 21 closed with some goals met, and only 7 closed with no goals met. An additional 41 individuals declined care coordination supports through an integrated care plan, and 11 individuals lost Medicaid coverage before establishing a plan or addressing their health care goals with the ICT supports. Overall, 75.6% of the people who agreed to participate in a payor-payor care coordination with UPHP and NorthCare/CMHSPs achieved at least some of their health goals with ICT support.
2. Shared members enrolled in the MI Health Link Program. In FY25, there were four individuals carried over from the year before and one new served.
3. Added in FY25, is a child and adolescent ICT which served 50 unduplicated youth 21 years of age or younger.

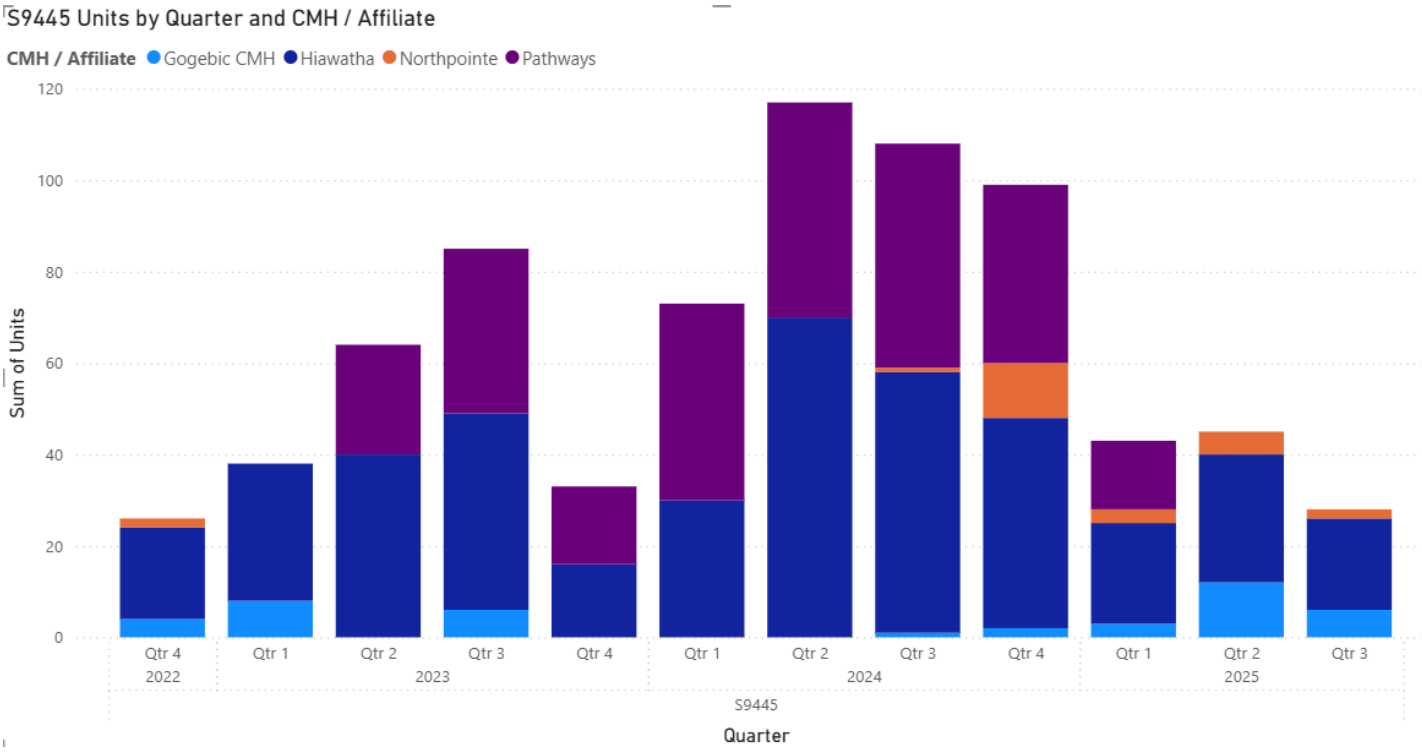
ICT interventions involve monthly monitoring meetings with both payors. NorthCare monitors care coordination provided by the CMHSP in collaboration with a UPHP care coordinator to ensure that services are delivered and that the shared member's needs contributing to increased hospitalization or emergency department utilization are addressed. UPHP ensures that individuals receive necessary prior authorizations for specialty services related to the underlying conditions driving higher utilization. When the primary need is behavioral health related, the CMHSP is responsible for care coordination and providing enhanced comprehensive services to address the condition. In most cases, the individual has needs in both payor domains. Each individual receives a person-centered care plan designed to address the underlying conditions and identify solutions that support improved health and overall the individual's health and well-being.

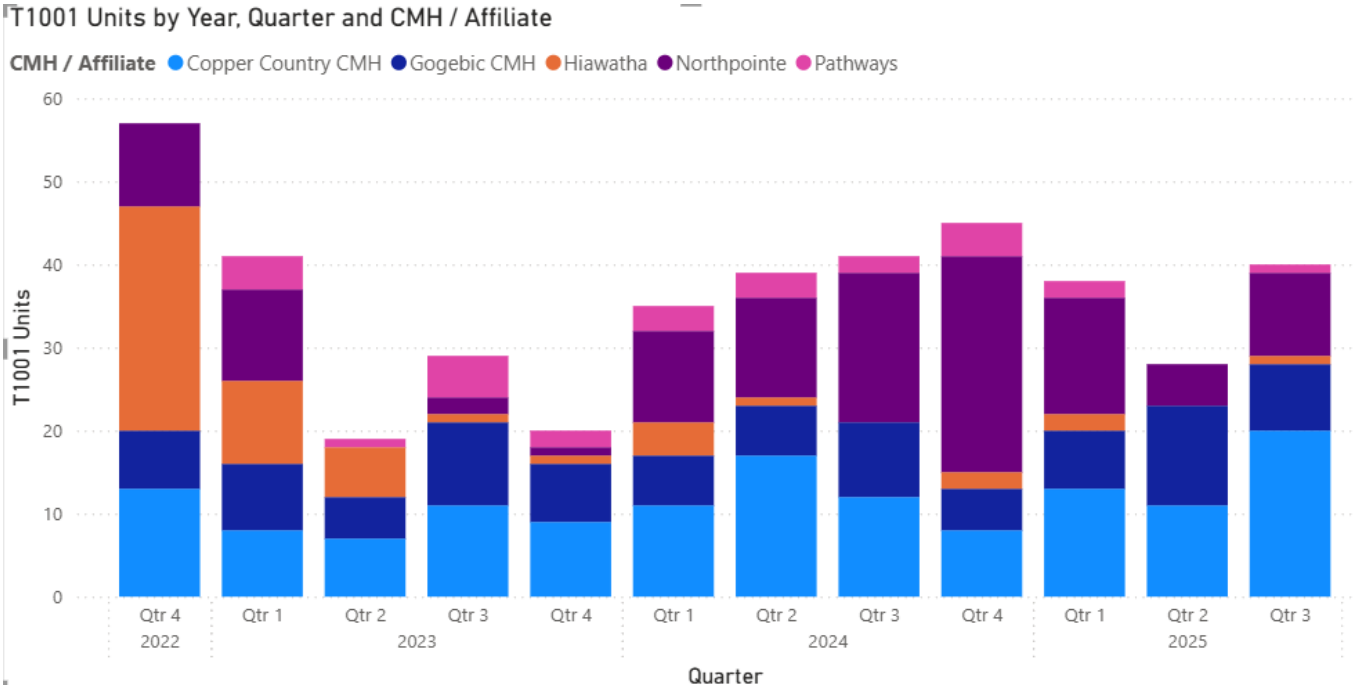
In addition to data sharing with UPHP, NorthCare uses our EMR and interfaces with the Michigan Health Information Exchange Network (MIHIN), UPHIE, and the MDHHS data warehouse to provide

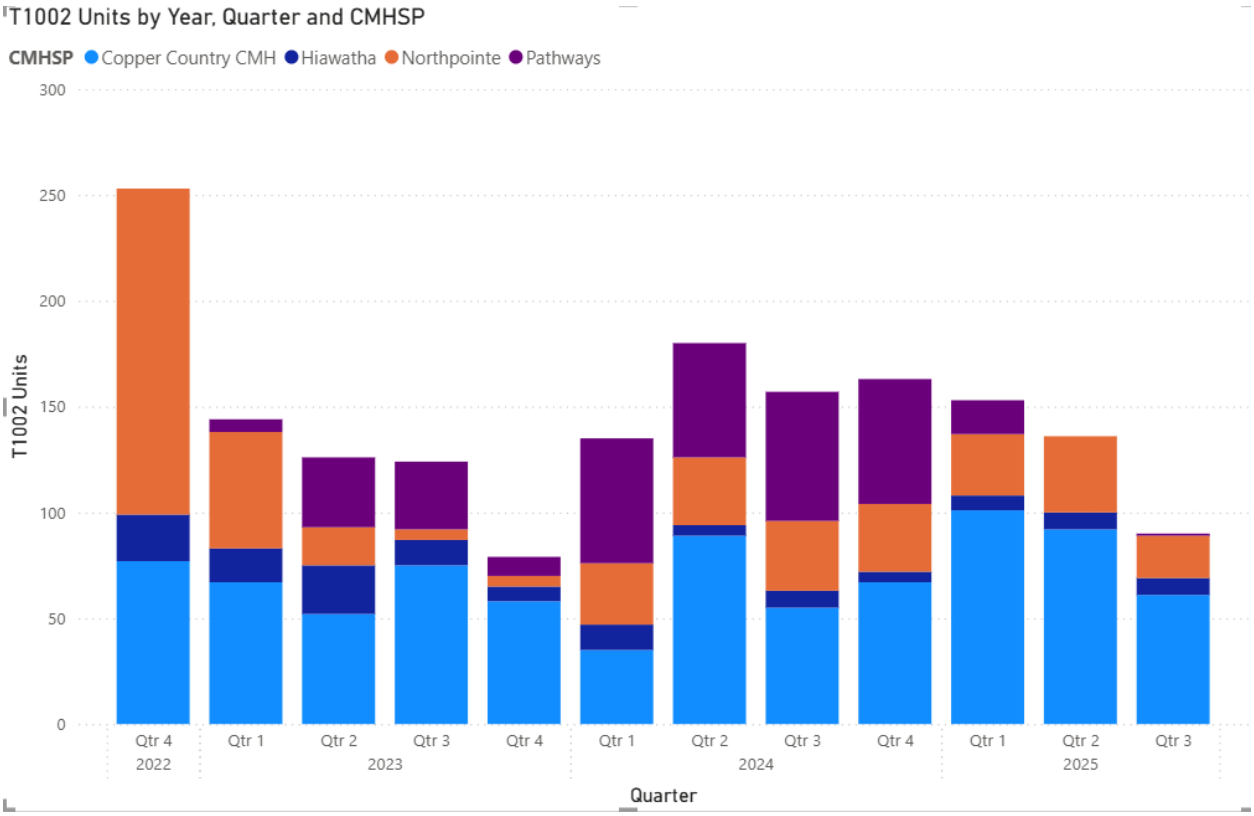
information electronically to facilitate care and coordination. The Active Care Relationship (ACRs) file is integrated within these systems. NorthCare sends and receives ADT records through the health information exchanges for all individuals treated by our network providers. We serve as the main hub for care coordination for people who are not enrolled in a health plan through targeted case management, peer support, and Community Health Worker (CHW) services. Lab results from labs/facilities participating in UPHIE are sent directly to NorthCare's EMR for people we have an ACR with. In FY25, there were 104 participating labs/health systems and there were 89,976 unique lab transmittals between NorthCare and UPHIE.

In FY25 nursing services experienced an overall increase in the number of units delivered forH0034, Medication Training and Support. Gogebic County CMH demonstrated the largest increase in utilization, while Hiawatha Behavioral Health and Pathways showed slight decreases. Northpointe remained relatively stable, and Copper Country CMH continued to deliver very minimal units of medication training and support. Utilization of the CPT code S9445, Individual Patient Education, had been rising in FY24 declined sharply in FY25. S9446 Group Patient Education, was used exclusively by Gogebic County CMH beginning in Q1 of FY25 and remained stable throughout the year at 18-19 units per quarter. Both T1001, Nursing Assessment, and T1002, RN Services have decreased from their peak utilization with fluctuations observed across FY24 and FY25. This data is represented in the graphs below.




S9445 Units by Quarter and CMH / Affiliate
CMH / Affiliate Gogebic CMH Hiawatha Northpointe Pathways
120
100
80
60
40
20
0
Sum of Units
Qtr 4
2022
Qtr 1
Qtr 2
Qtr 3
Qtr 4
2023
Qtr 1
Qtr 2
Qtr 3
Qtr 4
2024
Qtr 1
Qtr 2
Qtr 3
2025
S9445
Quarter


T1001 Units by Year, Quarter and CMH / Affiliate
CMH / Affiliate Copper Country CMH Gogebic CMH Hiawatha Northpointe Pathways
60
50
40
30
20
10
0
T1001 Units
Qtr 4
2022
Qtr 1
Qtr 2
Qtr 3
Qtr 4
2023
Qtr 1
Qtr 2
Qtr 3
Qtr 4
2024
Qtr 1
Qtr 2
2025
Qtr 3
Quarter



NorthCare continued to strengthen its care coordination and system of care initiatives in FY25, with a particular focus on expanding participation in Patient Centered Medical Home (PCMH) models of care. These models including the Behavioral Health Home (BHH) and the Substance Use Disorder Health Home (SUDHH) emphasize whole-person, team-based care. These models place the individual at the center of a coordinated network of providers who deliver services guided by each IPOS.

NorthCare's five CMHSPs have continued to increase enrollment in the BHH, a pilot program supported by MDHHS. NorthCare participates in the program as a lead entity. The five CMHSPs and Great Lakes Recovery Centers (GLRC) are Health Home Partners (HHP) delivering BHH services to persons with qualifying mental health conditions and at least one chronic health condition. The BHH is a PCMH recognized by the Center for Medicare and Medicaid Services under Section 2703 of the Patient Protection and Affordable Care Act of 2010 (ACA). It designed to help chronically ill Medicaid and Healthy Michigan Plan beneficiaries manage their conditions through an intensive level of care management and coordination. There were 408 unduplicated Medicaid beneficiaries who received BHH supports in FY25.

BHH core services include:

1. Comprehensive Care Management
2. Care Coordination
3. Health Promotion
4. Comprehensive Transitional Care
5. Individual and Family Support

6. Referral to Community and Social Support Services

In FY25, NorthCare met all pay for performance quality measures under the BHH model – the performance was measured on FY24 data. Those metrics included:

- Follow-up after Hospitalization for Mental Illness (FUH),
- Increase in Controlling High Blood Pressure (CBP-HH), and
- Access to Preventative/Ambulatory Health Services (AAP).

NorthCare also monitors the HHP performance in follow-up care after emergency room visits for people enrolled in a health home (in addition to across our system of care). Health Home staff are expected to respond to all ADT messages received through our EMR and provide transitional care management to any enrollee who experiences a hospitalization or rehabilitation stay for physical health needs. NorthCare expanded its ADT notification process so that alerts are now sent not only to the primary case holder but also to the Health Home staff assigned to each beneficiary's chart. This enhancement strengthens care coordination by ensuring timely awareness of critical events and supporting faster, more effective follow-up. All six BHH providers expanded their staffing structure in FY25, ensuring that each organization has at least 0.25 FTE dedicated to the program. This expansion also broadened the range of staff types involved, strengthening the multidisciplinary approach essential to the BHH model. Until FY25, four of the six partners operated a nurse driven BHH model. Northpointe added dual certified Peers and Community Health Workers (CHW) workers to each of their three locations for providing BHH interventions. Pathways added two health mentors who also work their InSHAPE program to provide lifestyle, community engagement, exercise, and dietary education and supports to BHH beneficiaries. The Pathways health mentors are also dual certified as CHWs as of FY25. Hiawatha added a CHW to their team to provide group education and wellness interventions. The CHW was in the process of obtaining a Peer certification at the end of FY25. Hiawatha and Northpointe have also incorporated more case manager involvement with care plan development and referring beneficiaries to the BHH program. Gogebic County CMH also added a Community Living Supports worker who completed her CHW certification.

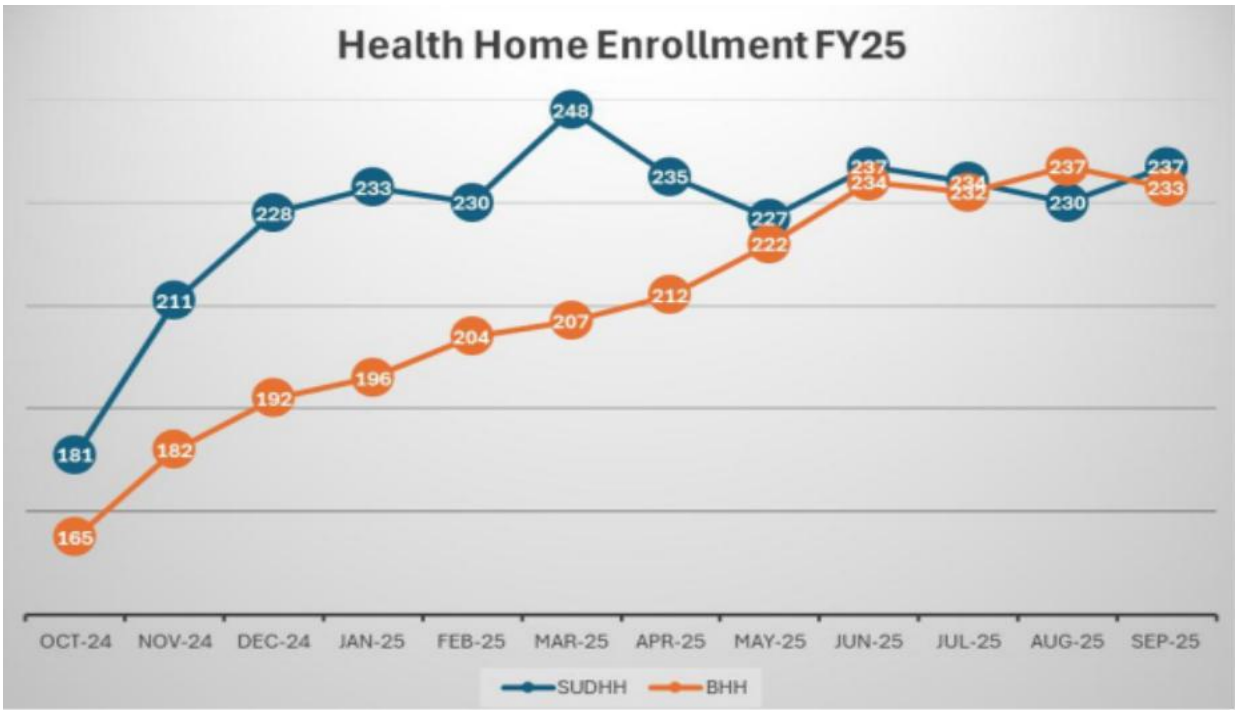
Copper Country CMH and GLRC developed their programs around Peer/CHW supports. GLRC has added additional Peers and continues to have the same ratio of supports from the Nurse Care Managers in their Integrated Care Clinics in Negaunee and Sault Ste. Marie. Copper Country added an RN dedicated 0.5 FTE to the BHH in the beginning of FY25 and were starting to work with their (long acting psychotropic) Injection Clinic to provide health home interventions and patient education on managing side effects at the close of FY25. Hiawatha Behavioral Health added a direct primary care provider to their clinic in FY25 who provides primary care to BHH beneficiaries. Additional details about this clinic can be found in the later section on CMHSP initiatives.

NorthCare serves as the Lead Entity for the SUDHH Program. The SUDHH model closely parallels the BHH structure, with the key distinction being its eligibility criteria. Individuals qualify for SUDHH services if they have an opioid use disorder, and beginning in FY25, those with stimulant and/or alcohol use disorders were also included. This expansion supports broader access to coordinated, whole-person care for individuals with complex substance use needs. Demographically, nearly half of all Region 1 SUD services admissions are for people with Alcohol Use Disorder. The expansion of SUDHH eligibility in FY25 to include stimulant and alcohol use disorders significantly

increased the number of beneficiaries who qualified for the program this year. NorthCare's SUDHH HHPs include the regional Federally Qualified Health Center – Upper Great Lakes Family Health Centers (UGL), Sacred Heart (an Opioid Treatment Provider,) Great Lakes Recovery Center (GLRC), Catholic Social Services (CSS), and Phoenix House which joined the network in FY25.

- UGL operates in five of the nine central and western counties of the Upper Peninsula.
- Sacred Heart serves individuals in Mackinac County.
- GLRC provides services across ten offices located in population hubs throughout all geographic subregions of Region 1.
- CSS operates in Marquette and Delta Counties and serves residents of Menominee, Dickinson, Alger, and Schoolcraft Counties.
- Phoenix House provides services in Houghton, Ontonagon, and Gogebic Counties.

Like the BHH, the SUDHH is approved under the ACA and includes the same six core services. In FY25, the SUDHH served 351 unduplicated Medicaid beneficiaries. Monthly enrollment across both programs in FY25 is shown below.



CSSs SUDHH program is driven by their Medical Director, a Board-Certified Psychiatrist and Addiction Medicine Specialist, Dr. Steven Miljour. Dr. Miljour's approach is to treat the SUDHH program like a prescription, which he recommends to all his SUDHH eligible Medicaid patients with *any* social determinant of health needs or co-morbid physical health conditions. The CSS approach has resulted in stable enrollment gains and a high-quality, physician-driven monitored process. GLRC's program is guided by a nurse care manager who services as the primary referral source and oversees ongoing monitoring of beneficiaries' health needs. This model also relies heavily on Peer Recovery Coaches (PRC) and Certified Community Health Workers (CCHW) who play key roles in delivering lifestyle interventions and supporting sustained recovery.

UGL SUDHH program is offered within a PCMH model and begins with either a physician referral or a referral from embedded mental health counselors to the Nurse Care Manager, CHW and Peer Supports who take on care coordination and SDOH interventions. Phoenix House manages their SUDHH program from a peer and mental health counselor driven engagement model and coordinates with primary care and medication assisted treatment providers via Memorandums of Understanding (MOUs). NorthCare uses the positives of each provider to drive performance and quality improvement with other SUDHH providers.

Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Oversight of Vulnerable Individuals –Integrated/Coordinated Care - Care coordination between the behavioral health and physical health providers will occur.						
Individuals receiving specialty care will have the recommendations of those providers incorporated into their behavioral health IPOS and a consent to share information. This will be reviewed via annual site reviews.	ICS	92.6%	95% Copper 63%, Gogebic 88.89%, HBH 85.2%, Northpointe 82.35%, Pathways 63.7%	FY22 Annually Ongoing	Continue. There was a decline in the performance in the region at incorporating the health goals, or with documenting refusal to address a physical health comorbidity, or lack of physical health comorbidities in IPOSs	PIHP-MHP Coordinating Agreement,
Behavioral Health Home (BHH) services will expand for individuals with at least one co-morbid physical health condition at the CMHSPs.	PHD	154 enrollees, six HHP's (Aug 2024)	175 enrollees. Actual enrollment by 9.30.25: 233 enrollees. six HHPs.	FY23 Monthly Ongoing	Continue. The current penetration rate for BHH at the CMHSPs is between 4-8% depending on the CMHSP. Many more individuals can be served than are. This is an increase from 1-3% penetration rates in FY24.	MDHHS Medicaid Provider Manual, BHH Handbook, PIHP-MDHHS Contract
Use health home data to create quality improvements within the programs and expand the programs appropriately.	PHD	Qualitative Measure; FY24 three of six HHPs offering Parapro supports	Qualitative: All HHPs offering Parapro supports (Community Health Workers, Peers, Housing Specialists)	FY24; annual review	CMHSP HHPs increased delivery of services within the health home from Community Health Workers, Peer Support Specialists, and Health Mentors at all CMHSP boards.	MDHHS Contract, Health Home Handbook
CMHSP's will expand the provision of H0034 – Medication Training and Supports, S9445 Patient Education individual, T1001 and T1002 RN/Nursing Services.	PHS	FY24: H0034 585 Units		FY23 Annual Ongoing	FY25: H0034 1,187 Units Continue	Health Services Committee
NorthCare and UPHP will have bi-monthly data collaboration workgroup meetings to address shared member health care outcomes and gaps.	ICS	7603 unduplicated shared members (FY24Q1-3)	FY25: 6,249 Unduplicated Shared Adults; 1,513 Children	FY23 Bi-monthly Ongoing	Continue. Number of individuals served based on Medicaid eligibility in the region.	PIHP-MHP Coordinating Agreement
Individuals with high ER utilization, that are enrolled in MI Health Link, will reduce ER visits and increase preventative care by coordination between the PIHP and MHP.	ICS	58 Adults in FY24. 142 Adults in FY25; New: Children's ICT, 50 persons under 21 years old served in FY25.	FY25 Goal 75 Adults, 25 Children. Goal exceeded.	FY23 Monthly Ongoing	Continue; Adult and adolescent ICT. MI Health Link program will end on 12.31.25 and that ICT will not continue in its current form – a replacement is expected.	PIHP-MHP Coordinating Agreement

LTSS

NorthCare developed an assessment tool in 2013 for use with individuals with Intellectual and/or Developmental Disabilities (IDD). The tool was designed to help identify and reflect the level of supports an individual may need across multiple functional domains. It evaluates key areas that may be impacted, including self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency, challenging behaviors, non-

aggressive behaviors, and significant health or other support needs. The tool produces a score ranging up to 96, with higher scores indicating greater levels of impairment and support needs.

The average score across 867 individuals was a 20.87 with the median score of 19. The average score of those with a Habilitative Supports Waiver was 24.8 with a median of 23; across 302 consumers. Finally, the average score for those living in a residential living arrangement was 24.12 and a median score of 22.25 across 263 consumers.

In FY25 NorthCare staff conducted a focused review of six consumer charts for individuals with low I/DD Functional Assessment scores (below 11). The review examined incident reports (when applicable), duration of residential placement, and other clinical documentation to evaluate whether medical necessity for residential services was clearly supported. This review served as a quality metric to ensure the appropriateness of residential placement decisions.

Findings indicated a need for enhanced staff training on the I/DD Functional Assessment tool and reinforcement of the requirement to complete the assessment annually. Although the I/DD Functional Assessment is completed alongside the BPS, some BPS documents lacked the "golden thread" necessary to substantiate medical necessity for AFC–level placement. In several cases, documentation reflected the preferences of guardians or individuals for AFC placement but did not sufficiently demonstrate the individual's clinical need for that level of care. NorthCare followed up with CMHSP staff to obtain additional documentation supporting the placements for the consumers reviewed.

Beginning at the end of FY26 and into early FY27, the World Health Organization Disability Assessment Schedule (WHODAS 2.0) will become the MDHHS-designated tool for determining eligibility for individuals with I/DD. Because the WHODAS is strictly an eligibility assessment and not designed to determine level of care, NorthCare will need to continue using the I/DD Functional Assessment —or identify an alternative assessment tool—to support level-of-care determinations and community placement decisions in FY26.

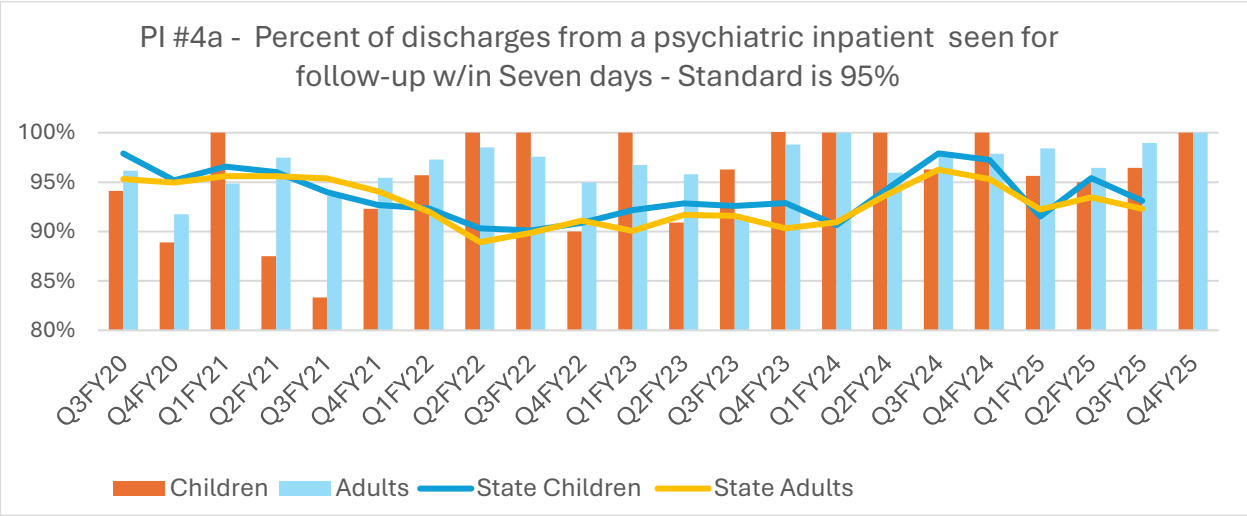
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Long Term Services and Supports – LTSS – Compare services received by LTSS consumers vs what was authorized in their plan (over/under utilization of LTSS services).						
Review individuals in AFC level of care that do not have a matching LOC in the system to determine if AFC level of care appears appropriate	QI / CP / UM	Review five cases per quarter	Review five cases per quarter	FY23 Quarterly Ongoing	Continue	
Review underutilization of authorized LTSS services.	QI / UM	Review ten cases per quarter	Review ten cases per quarter	FY23 Quarterly Ongoing	Continue	

Transition of Care

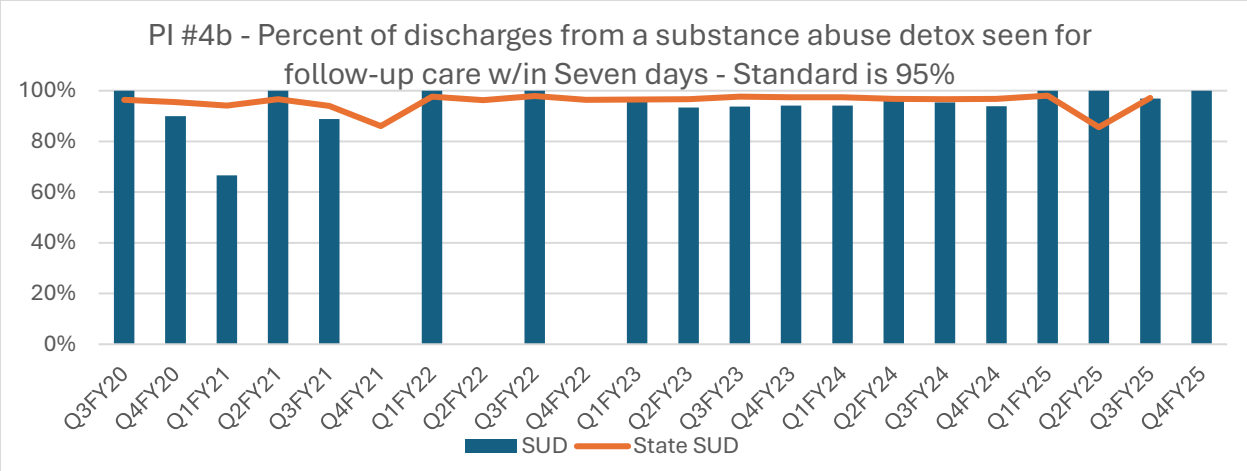
In compliance with the PIHP-MHP Coordinating Agreement, NorthCare provides a weekly report to UPHP identifying members who have been hospitalized in a psychiatric setting. Additionally, during continued stay reviews, if the member is found to have co-morbid physical and mental health conditions, a referral is made to the integrated health care team to assess and address any additional coordination of care needs. In FY25 there were 705 shared member admissions into inpatient treatment. Sixty-two of those admissions were referred to integrated care. Comparatively in FY24 there were 58 referrals for integrated care from 718 shared member admissions.

Discharging from the inpatient psychiatric unit to outpatient services is a time of transition. The expectation, per Michigan Mission-Based Performance Indicator System (MMBPIS), is to have 95% of individuals have a follow up appointment scheduled within seven days of discharge. There are exceptions allowed for those individuals who are choosing not to utilize follow-up care at the CMHSP. Similarly, for individuals receiving SUD detox, there is an expectation they are seen for follow up within seven days, unless they refuse. This standard is also set at 95%. The following table shows the NorthCare average compared to the state average for FY25. Note that Q4 information is not yet available for the state average. Highlighted cells represent data below expectation. Colored font indicates data below state average. The bar charts show performance over time. In FY26 this metric is changing to HEDIS measurement included in the CMS Adult and Child Core Sets available on page 107. HEDIS measures performance based on attendance and billing of applicable CPT codes vs. scheduled appointments. Therefore, the data will reflect a lower percentage, but the expectation has also decreased.

Percent of Discharges from Psychiatric Inpatient scheduled within Seven days				
	Q1	Q2	Q3	Q4
NorthCare Children	95.65%	95.00%	96.43%	100.00%
State Average Children	91.51%	95.42%	93.12%	
NorthCare Adults	98.41%	96.43%	98.98%	100.00%
State Average Adults	92.25%	93.48%	92.29%	



Percent of Discharges from SUD detox scheduled within Seven days				
	Q1	Q2	Q3	Q4
NorthCare Children	100.00%	100.00%	96.88%	100.00%
State Average Children	98.05%	85.59%	97.14%	



Waiver transitions are a critical point in the continuum of care. The three most common transitions are described below. Waiver transitions are not frequent but are monitored to ensure the transition is appropriate and is a smooth process for the member.

Transitioning from Children's Wavier Program to Habilitation Supports Waiver

Transitioning from the Children's Waiver Program (CWP) to the Habilitation Supports Waiver (HSW) is considered a priority for HSW enrollment. The transition to HSW from CWP is not required. However, if this is something the individual and family/guardian are interested in, NorthCare aims to start this transition process three months prior to a child aging out of the CWP. During this transition, the CMHSP begins assessing the individual's needs in relation to the HSW eligibility criteria. Through the person-centered planning process, discussions are held with the individual and often their guardian to determine if HSW enrollment will be pursued. This process begins with confirming that all HSW eligibility criteria are met and clearly reflected in the IPOS. A Major Life Activity Assessment must also be completed to verify that at least three domains are scored at a level 3 or higher. In addition, a QIDP must complete the certification form, and consent for HSW services is obtained. In FY25, Northcare did not have any CWP cases age-off and transition into HSW enrollment.

Transition from HSW to MI Choice Waiver

Some HSW enrollees may also be eligible for the MI Choice Waiver. These individuals must choose which waiver program to receive services and supports from. An individual cannot be enrolled in or receive services from both waivers at the same time. The MI Choice Waiver provides home and community-based services and supports for the elderly and adults with disabilities who are otherwise eligible for nursing facility services. This waiver allows individuals to receive supports in their own homes and promoting independence, and person-centered planning. The HSW provides supports to individuals with development disabilities who meet Medicaid eligibility, require and receive at least one habilitative service each month, and reside in a community setting. Eligible individuals must also meet the criteria for services available through an Intermediate Care Facility (ICF) for Individuals with Intellectual and Developmental Disabilities (ICF/IID).

To transition from HSW to the MI Choice waiver the PIHP must contact the MDHHS HSW specialist. This ensures justification for a transfer and supporting documentation is reviewed by MDHHS. The

MDHHS HSW specialist will then decide if they agree that the transfer is appropriate and will contact the MI Choice specialist. Lastly, a teleconference with all parties may be scheduled to ensure discussion of transition details, ensure evaluation of eligibility is met, and confirm that enrollment dates do not overlap. Disenrollment must occur on the last day of the month, with the start date of the new waiver occurring on the 1st of the following month. NorthCare had one HSW case transition to MI Choice for FY25.

Transition between HSW and iSPA

Individuals who are on a HSW waiver may be eligible for Behavioral Health 1915 (i)SPA services when they are seeking a service not covered by HSW, such as Housing Assistance. Should an individual be disenrolled from HSW due to not meeting all criteria, but still receive iSPA services, there is coordination at the CMHSP level to ensure a transition from HSW to iSPA enrollment. In addition, if an iSPA enrollee is approved for HSW enrollment, all HSW/iSPA leads at the CMHSP are notified of the transition and iSPA disenrollment is processed.

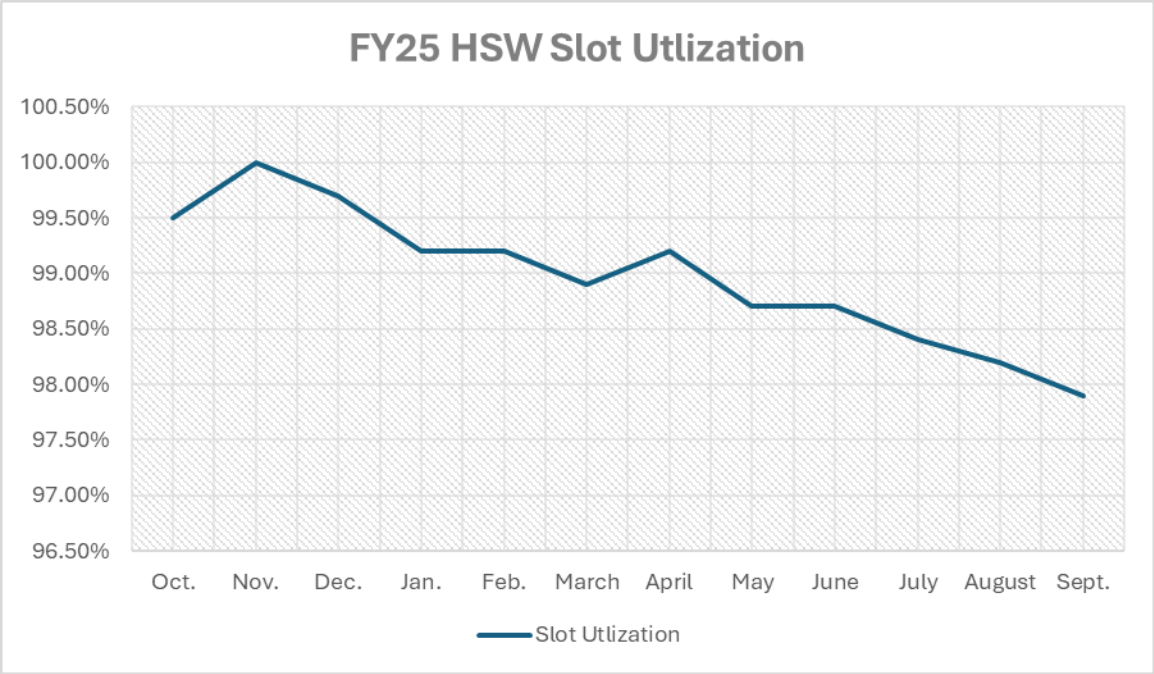
Objective/Activities	Lead	Previous Measure	Goal Measure	Start/ Frequency/ Due Dates	Status / Recommendation	Guiding Criteria (CFR, contract, C-waiver)
Transition of Care – Care will be coordinated when transitions are occurring.						
The Medicaid Health Plan (UPHP) will be notified of all psychiatric hospitalizations and discharges for shared members.	UM	100%	100% Completed	FY23 Weekly Ongoing	Continue	PIHP-MHP Joint Care Protocol Workgroup
Individuals discharging from the psychiatric unit will have a follow up appointment within seven days (see PI4a).	QI		95%	FY23 Quarterly Ongoing	Continue	MMBPIS
Waiver transitions to another PIHP area will be coordinated as they occur.	WC		Completed as necessary	FY24 PRN Ongoing	Continue	

Waiver services

Habilitation Support Waiver

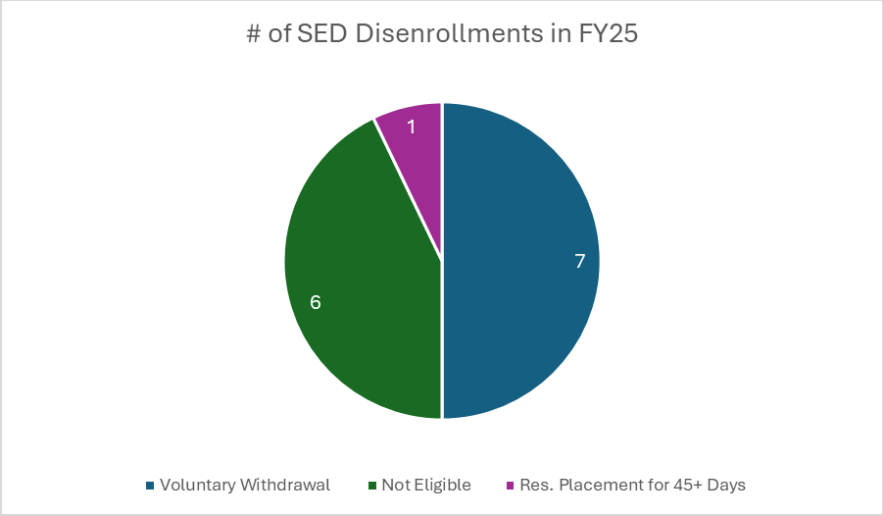
In FY25, NorthCare's HSW enrollment numbers per CMHSP went down in comparison to previous years' enrollment, shown in the table below. However, this did not affect our regional slot utilization, as NorthCare had a lower rate of disenrollment. We are required to meet a minimum of 95% utilization. We met this threshold throughout FY25 and consistently remained well above 95% utilization. Although utilization did decline over the course of the year, this trend is reflected in the line graph below. At the start of FY26, NorthCare Network was allotted 13 additional HSW waiver slots, taking our total from 379 to 392. We will continue to work towards fulfilling our additional slots.

	FY23	FY24	FY25
Copper	2	4	1
Gogebic	8	3	4
Hiawatha	6	2	0
Northpointe	7	11	6
Pathways	16	11	11
Total	39	31	22



Serious Emotional Disturbance Waiver

NorthCare Network started FY25 with 33 children enrolled on the Serious Emotional Disturbance Waiver (SED) waiver. Throughout the fiscal year, we disenrolled 14 SED cases. The disenrollment categories are shown below. Seven out of the 14 disenrollments were children that no longer met SED eligibility criteria and were transitioned to a lower level of services. This represents a positive outcome as these children demonstrated improvement while participating in the waiver program. The SED Waiver is designed as a short-term intervention, and these results support stabilization and promote successful outcomes.



Child Waiver Program

We started FY25 with seven children enrolled in the Child Waiver Program (CWP). Throughout the year we had two disenrollments, one child aged off the waiver and did not want to transition to HSW services; the other child moved out of the service area.

Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Waiver Services – Ensure timely HSW recertifications and pended cases.						
NorthCare will provide ongoing monitoring to the CMH's about expiring cases.	W.C.		Emails sent to leads quarterly.	FY24 Monthly Ongoing	Continue	Result of performance issue
NorthCare will notify the CMH CEOs of data and data will also be shared in regional meetings.	W.C.		Data provided to the CEOs monthly.	FY24 Monthly Ongoing	Discontinue	Result of performance issue
Review of service utilization specific for waiver services/waiver individuals	w.c.			FY25	start	

Home and Community Based Services

Home and Community Based Services (HCBS) aim to ensure individuals with LTSS are integrated into their community. Staff are responsible for ensuring that whenever an individual has limitations, the specific need is clearly supported through assessment. Documentation must reflect any positive interventions and less intrusive strategies previously used, as well as a defined fade plan with timelines for reducing or removing the restrictions. In addition, staff must ensure that the setting is not experienced as isolating or restrictive.

In FY25, NorthCare followed up with the secure setting scan results in coordination with MDHHS HCBS Transition Team. The secure setting scan was sent in FY24 via survey to every licensed residential setting. The purpose of the survey was to develop an inventory of all settings providing specific HCBS Medicaid funded services, and to identify the features of each setting. NorthCare and our five CMHSPs worked with the regional HCBS providers to ensure compliance in relation to the survey data.

Statewide, improving the documentation of HCBS limitations continues to be a priority. NorthCare identified gaps in its internal processes, including the absence of a consistent system to ensure all required information related to HCBS limitations was thoroughly and accurately documented. In FY25, NorthCare built and implemented enhancements to our regional IPOS form in the EMR to capture all the required elements. In addition to making enhancements to the EMR, Northcare developed an in-depth training explaining the process and expectations of how and why HCBS modifications should be documented.

Due to the MDHHS HCBS Centers for Medicare & Medicaid Services audit findings, Northcare was required to develop and submit a Corrective Action Plan (CAP). NorthCare's CAP included policy changes, additional training requirements, increased monitoring of HCBS cases, and encouragement of contract providers to follow HCBS compliance requirements. In FY25, NorthCare began reviewing HCBS cases in three distinct phases to ensure compliance with the HCBS Final Rule and MDHHS requirements:

- Phase 1: Focused on HCBS cases that include Behavioral Treatment Plans (BTPs). These plans often involve restrictive interventions. This required immediate attention to confirm

that limitations are justified, properly documented in the IPOS, and compliant with HCBS standards. Compliance was expected by December 31, 2025.

- Phase 2: Addresses HCBS cases with Positive Support Plans (PSPs). While PSPs are generally less restrictive, they still need review to ensure they do not inadvertently include limitations on rights or autonomy, and that documentation aligns with person-centered planning principles. Compliance was expected by December 31, 2025.
- Phase 3: Addresses all remaining HCBS cases that do not fall under the first two categories. This comprehensive review ensures that every HCBS enrollee's person-centered plans meet federal and state requirements for community integration, choice, and autonomy. Compliance is expected by June 30, 2026.

This phased approach allows NorthCare to prioritize the most critical cases first while ensuring full compliance across all HCBS cases within the required timeframe.

NorthCare will follow MDHHS HCBS monitoring requirements and technical advisory which includes a triannual review of all HCBS cases and annual on-site provider reviews once timelines and review tools have been finalized by the MDHHS HCBS transition team. These are expected in FY26 and will support all HCBS reviews in FY25 and FY26. The triannual reviews will start in FY27 where a review of one third of the HCBS cases will begin and continue through FY28 and FY29. After three years, all cases will have been reviewed.

Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
HCBS Modifications – Modifications of HCBS conditions will be supported by an assessed need that is justified in the person-centered plan.						
Review of HCBS limitations at annual site reviews.	QI	NA	all cases reviewed in FY25 were out of Compliance.; ultimate goal 100%	FY22 Annually Ongoing	Continue review during CMH site reviews per CMH HCBS CAP.	42 CFR §441.301 (c)(4)(vi)(A-D)
Monitoring of HCBS limitations and ensure that the limitation is justified and addressed in the person-centered plan.	QI	NA	all cases reviewed in FY25 were out of Compliance.; ultimate goal 100%	FY22 Annually Ongoing	Continue review during CMH site reviews per CMH HCBS CAP.	

Behavior Treatment Review

As previously discussed, in FY25, the CMS audited MDHHS related to HCBS. A CAP was developed, which each PIHP had to address. NorthCare began implementing the CAP in FY25. By the end of the calendar year 2025, review and correction of cases which have a behavior treatment plan or positive support plan were completed. All other HCBS cases are due for review and correction by July 2026. Specifically, the CAP directs NorthCare to ensure any individual with restrictions—whether imposed through a behavior treatment plan or their healthcare provider—has those restrictions clearly documented in their IPOS.

To achieve compliance, CMHSPs were required to provide NorthCare with a list of all consumers who had behavior plans for review. These plans were evaluated to confirm adherence to MDHHS standards, which defines restrictions as any limitation of a person's rights, use of intrusive treatment techniques, or administration of psychoactive medications for behavior control. NorthCare reviewed these plans, issued corrective feedback to CMHSPs, and confirmed that

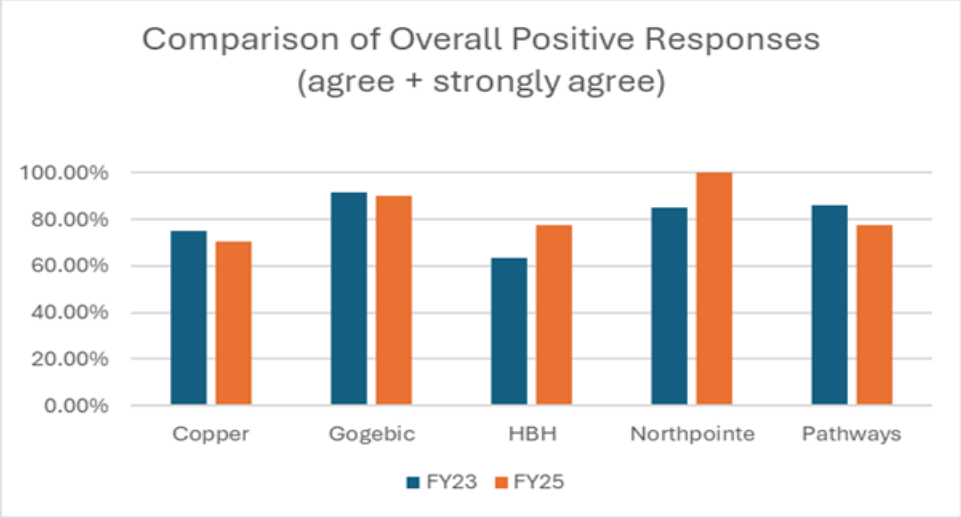
updated plans now meet compliance requirements. Additionally, NorthCare reviewed all individuals identified by CMHSPs as having Positive Supports Plans to ensure these plans did not include any form of restriction. When necessary, NorthCare communicated with CMHSPs to complete corrections to the IPOS or amend IPOS's appropriately.

Every two years, CMHSP Behavior Treatment Leads administer a survey to parents, guardians, staff, and individuals who have an active Behavioral Treatment Plan. As outlined in the MDHHS Technical Requirement for Behavior Treatment Plans (last revised September 13, 2024), a Behavioral Treatment Plan is developed following *"through assessment and evaluation..."* of an individual, *"for the purpose of treating, managing, controlling, or extinguishing predictable, or continuing behaviors that are seriously aggressive, self-injurious, or that place the individual or others at risk of harm."* The purpose of this survey is to gather feedback on the effectiveness and appropriateness of behavioral interventions and identify opportunities for improvement in service delivery.

The survey utilizes a Likert scale ranging from "Strongly Agree" to "Strongly Disagree," allowing respondents to express their satisfaction related to service quality.

Survey results are analyzed to pinpoint areas requiring attention through the Quality Improvement (QI) process to ensure that services remain person-centered and compliant with MDHHS standards of behavior treatment. Below are the current survey questions followed by the results of both FY23 and FY25. NorthCare looked at positive responses (agree and strongly agree) and compared them against the previous survey year by CMH. Hiawatha and Northpointe had a higher percentage of respondents overall indicate positively in FY25 to the following questions.

1.	This individual's behavior plan contributes to participation in the community to the maximum extent possible.
2.	This individual's behavior plan provides necessary strategies to prevent or reduce behaviors that compromise the individual's safety.
3.	The interventions in the behavior plan are based on careful assessment.
4.	I had opportunities to offer input into the development of the behavior plan.
5.	There was sufficient training to implement the plan correctly.
6.	Necessary changes in the behavior plan occur in a timely manner.
7.	Elements in the behavior plan seem too restrictive, too lenient, or just right.



In FY23, respondents were nearly evenly split between "Strongly Agree" (31.77%) and "Agree" (31.90%) when asked about the ability to offer input into the behavior plan. In FY25, the highest-rated response shifted to 37.47% selecting "Strongly Agree," representing a slight improvement, though not statistically significant. The "Neutral" category also improved, decreasing from 23.65% in FY23 to 17.44% in FY25. However, while "Disagree" showed a minor decrease (9.53% to 9.08%), the "Strongly Disagree" category increased notably from 5.70% in FY23 to 9.31% in FY25, indicating a decline in satisfaction among a subset of respondents. Individual input into the development of the behavior plan is critical. Providers responsible for implementing the plan need to understand the plan. This data was provided and discussed in the Regional Behavior Treatment Committee (BTC).

NorthCare reviews behavior treatment data quarterly during regional BTC meetings. The number of distinct individuals on behavior treatment plans averages around the mid-40s to mid-50s.

Q1	Q2	Q3	Q4
55	58	46	48

The reason a person is on a behavior treatment plan tends to be due to harm to self or others. The primary interventions used are restrictions on movement and medications for behavior control.

	Harm to Self	Harm to Others	Property Destruction	Physical Management – Emergency Use	Law Enforcement – Emergency Use
Q1	24	28	15	8	0
Q2	36	30	19	5	3
Q3	31	25	13	1	1
Q4	32	14	7	2	0

	Q1	Q2	Q3	Q4
Restrictive – Communication	4	5	3	0
Restrictive – Food	3	3	1	2
Restrictive – Other Limit on Rights	3	6	6	23
Restrictive – Freedom of Movement	22	25	23	6
Intrusive – Medication for Behavior Control	12	15	11	0
Intrusive – Encroach upon Bodily Integrity	2	3	1	1
Intrusive – Encroach upon Personal Space	3	3	3	7
Emergency – Physical Management	5	7	1	2
Emergency – Law Enforcement / 911	1	3	1	10

NorthCare also annually monitors CMHSPs via site reviews to verify compliance with MDHHS Technical Requirement for Behavior Treatment Plans. NorthCare also conducts monthly reviews of incident reports categorized as Risk, Critical, Sentinel, or Immediately Reportable. These reviews include investigations into potential correlations with behavior treatment plans, identifying unmet needs or necessary adjustments to current plans.

There are 22 Incident Reporting codes related to behavior. The following table reflects the description of the code and the number of times each code was used in FY25. While code use per person is more beneficial, this gives the behavior team a general sense to the behavior related

concerns applicable to individuals served and may direct them to review cases where a behavior treatment plan may be warranted. Elopement is also important data for HCBS to ensure that the appropriate documentation is in place for restriction of an individual's community access.

Code	Description	Count FY24	Count FY25
BC00	Preadmission Screening *New in FY24	19	37
BC01	Psychiatric Hospitalization	30	33
BC02	Threat of Suicide or Homicide	89	129
BC03	Non-Serious Physical Aggression	1182	1314
BC04	Verbal Aggression	693	831
BC05	Property Destruction	165	183
BC06	Elopement	53	103
BC07	Missing Person	4	5
BC08	Committed Criminal Offense	5	3
BC09	Victim of Criminal Offense	3	1
BC10	Inappropriate Sexual Behavior	62	93
BC11	Arrest	52	38
BC12	Conviction	5	2
BC13	Staff called 911 due to Behavior Crisis	73	73
BC14	Harm to Others resulting in Physical Injury	51	46
BC15	Harm to Others resulting in Hospitalization	1	0
BC16	Inappropriate Alcohol Use	6	32
BC17	Substance Abuse	10	13
BC18	Possession of a Controlled Substance	16	0
BC19	Other Behavior	553	779
BC20	Disruptive Behavior	429	681
BC21	Employment Related Behaviors	8	5

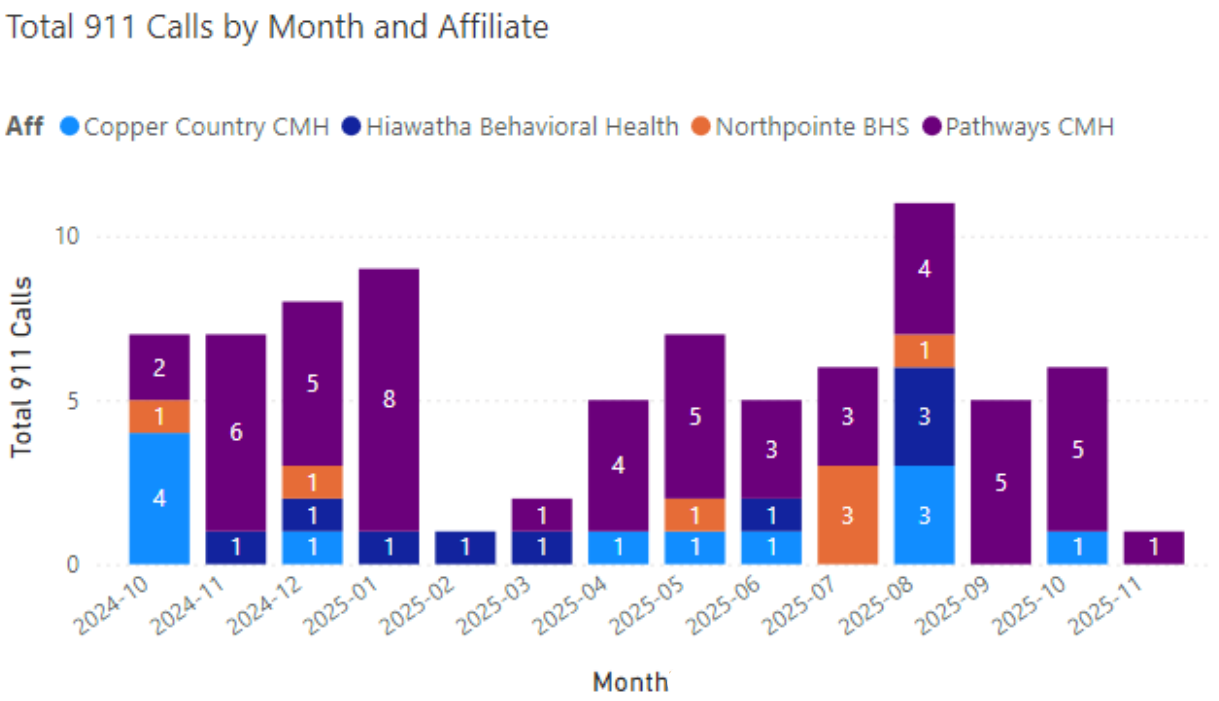
When a beneficiary has frequent incident reports, it may indicate treatment or support failure, especially when physical management or use of law enforcement is necessary. If use of physical management or law enforcement occurs three or more times in a 30-day period, the IPOS (and BTP, as applicable) should be reviewed and amendments made per the MDHHS Technical Requirement for Behavior Treatment Plans.

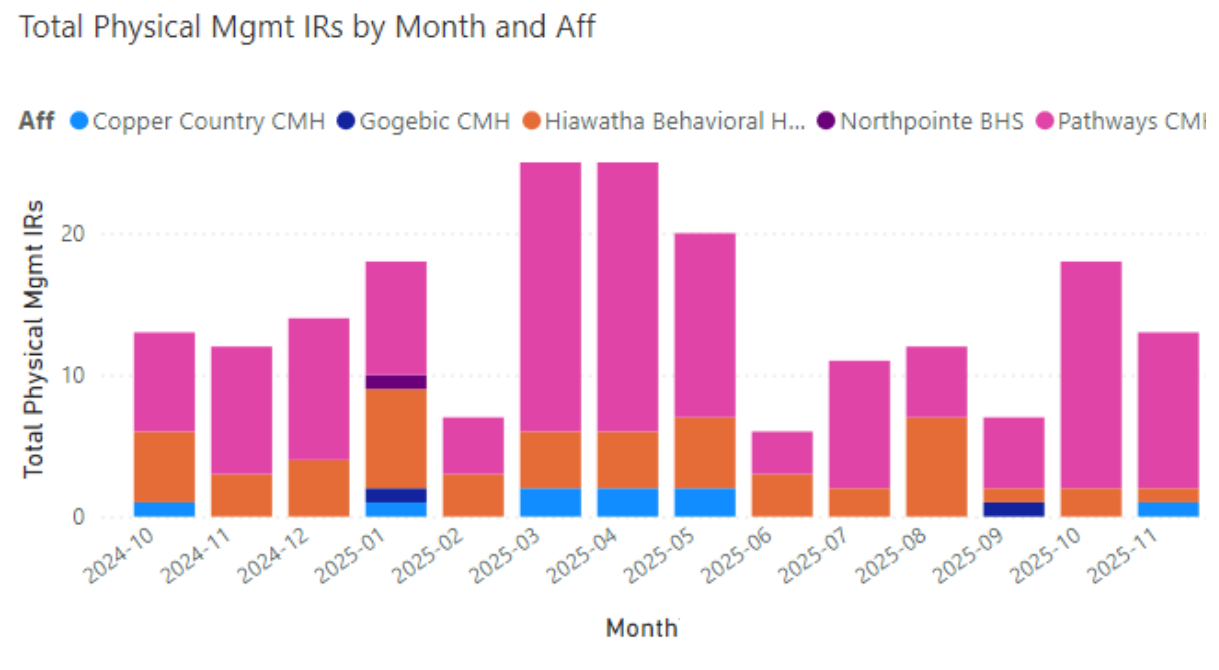
NorthCare reviewed the number of 911 calls and physical management incident reports for FY25. There are two working assumptions with this data: 1. Individuals that are having 911 called on them or physical management/intervention performed multiple times are reviewed by BTC, and 2. That the count isn't distinct. Therefore, the data below represents a count of incident reports coded as HS09 plus BC13. This means a consumer could have had three HS09 codes and no BC13 codes, vice versa, or a combination of both in the period.

BC13- Staff called 911 or Police Due to Consumer Behavior Crisis	Staff person called 911 or Police for assistance with a consumer during a behavioral crisis.
HS09- Physical Management Performed	Emergency physical management performed on a recipient, without injury apparent.

It was identified that there were eight distinct individuals that had three or more related incident reports in a month. Four of the individuals had multiple months with three or more related incident

reports. This data was shared with the CMHSP's, and their attention was directed to the need to review and adjust the IPOS accordingly. The number of 911 calls and physical management use is detailed in the charts below.





Objective/Activities	Lead	Previous Measure	Goal Measure	Start/ Frequency/ Due Dates	Status / Recommendation	Guiding Criteria (CFR, contract, C-waiver)
Behavior Treatment Plan Review – NorthCare will complete analysis of BTC data and implement systemic change related to data findings as necessary.						
NorthCare will collect quarterly data from the CMH's and present data at the regional BTC meeting and internal health and safety committee meeting. Determine the "why" of the incident.	QI / CP	Completion of quarterly review	Quarterly reviews completed.	FY23 Quarterly Ongoing	Continue / bring data and specific consumer concerns to each CMH.	42 CFR 438.100 (b)(2)(v). Balanced Budget Act of 1997
NorthCare will utilize data to determine improvements/ changes in care due to BTC both on select individuals and programmatically. Review interventions and incidents; specifically 911 use and physical management.	QI / CP	Reduction in use of physical management (325 events)	Reduction in use of physical management	FY23 Quarterly Ongoing	Continue / bring data and specific consumer concerns to each CMH.	42 CFR 438.100 (b)(2)(v). QAPIP
Analysis of BTC survey data to determine any concerns related to the program.	QI / CP	Completion of survey (311 responses)	Completed. Data reviewed and shared.	FY24 Biannual Ongoing	Continue	42 CFR 438.100 (b)(2)(v).

Event Reporting and Notification

An incident, also called an event, is any occurrence that is unexpected, accidental, or another issue documented on an Incident Report (IR). The purpose of the IR is to document the details of the occurrence, including who, what, where, when, and any contributing factors to the incident. Incidents are categorized based on severity and population. Certain types of incidents are reported to the MDHHS via the Customer Relationship Management (CRM) System.

Critical, sentinel, risk, and immediately reportable events are reviewed by NorthCare. Immediately reportable events, critical incidents for CMHSP, and sentinel events for SUD residential providers are reported to MDHHS via the CRM.

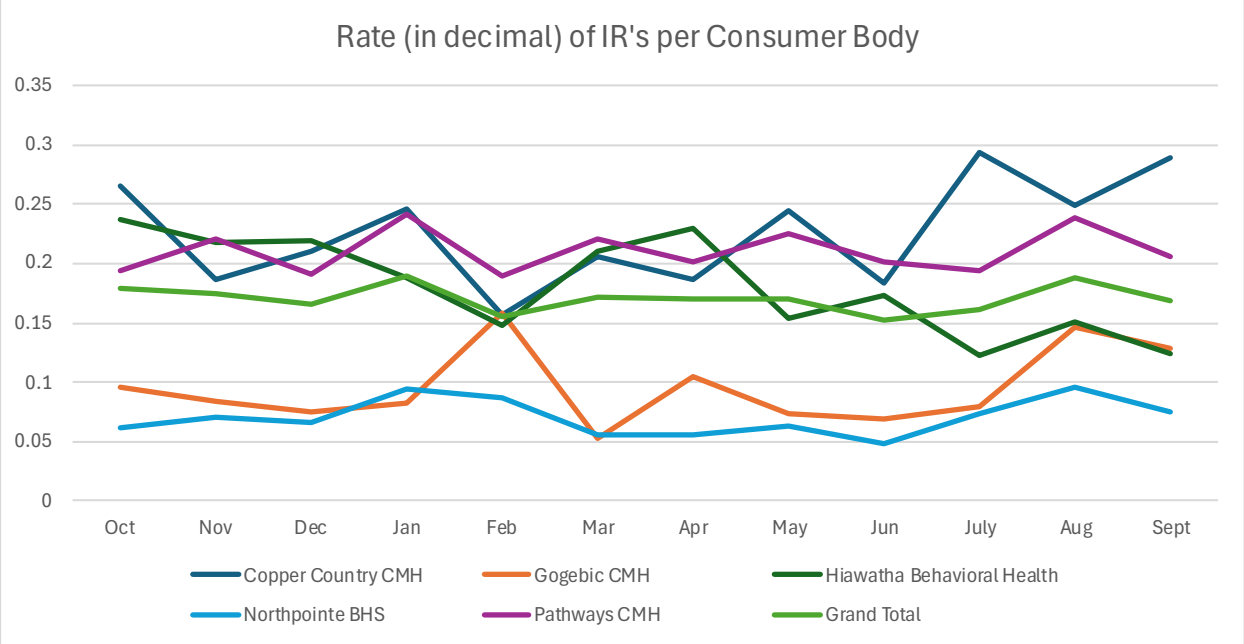
A CMHSP critical incident includes a death by suicide, non-suicide death, emergency medical treatment or hospitalization due to injury or medication error, or an arrest of a consumer. Each category has different populations that apply. "Critical incidents that are determined newsworthy" is a new category of an immediately reportable event. The other immediately reportable events include death due to staff action/inaction, open to investigation, relocation of consumer placement due to licensing suspension, relocation of a provider site for more than 24 hours, conviction of staff for job related offenses, and changes to the provider network that negatively impacts access to care. Risk events include events that put individuals at risk for harm and include harm to self, harm to others, or two or more hospitalizations within a year for any cause. For those individuals that have a behavior treatment plan, use of physical management and 911 calls for managing the behavioral crisis are considered risk events. Sentinel events, per the MDHHS/PIHP contract, are unexpected occurrences that cause a serious injury to the person, or the risk thereof, including death. SUD sentinel events are incidents that result in death, permanent harm, or temporary harm. Depending on severity these may include death, hospitalization due to illness or injury, emergency medical treatment due to injury, abuse or neglect allegations, arrest or conviction, serious challenging behaviors, or medication errors.

The total number of incidents, per month, for FY25 is reflected in the table below.

Total	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Total
Copper	188	132	149	174	111	146	132	173	130	208	176	205	**1924**
Gogebic	42	37	33	36	69	23	46	32	30	35	64	56	**503**

Hiawatha	246	226	227	195	153	219	239	159	180	127	157	129	**2257**
Northpointe	61	69	65	92	86	55	55	62	47	72	94	73	**831**
Pathways	389	443	384	485	381	443	405	453	403	389	480	412	**5067**
Grand Total	**926**	**907**	**858**	**982**	**800**	**886**	**877**	**879**	**790**	**831**	**971**	**875**	**10582**

When comparing the number of incidents per month to the number of open consumers a month, it allows for a generalized rate of incident reporting. It is recognized that approximately 85% of incident reports come from AFC consumers.



Critical, Sentinel, and Risk events, including death, are reviewed monthly by members of the NorthCare Health and Safety Committee, which includes the NorthCare Medical Director. Immediately reportable events are reviewed by the Quality Improvement/Utilization Management Director as they are reported. Incidents for mutual consumers served by the Medicaid Health Plan, UPHP, are reported to UPHP as well via monthly reporting. Data is taken to the regional CMHSP incident reporting group, and questions are discussed there to better inform practice. SUD data is shared with the respective SUD provider, and incidents in general are discussed at SUD clinical meetings.

The number of sentinel, critical, risk, and immediately reportable events for the fiscal year, by CMHSP, is detailed below. Additionally, the number of untimely deaths is also reflected.

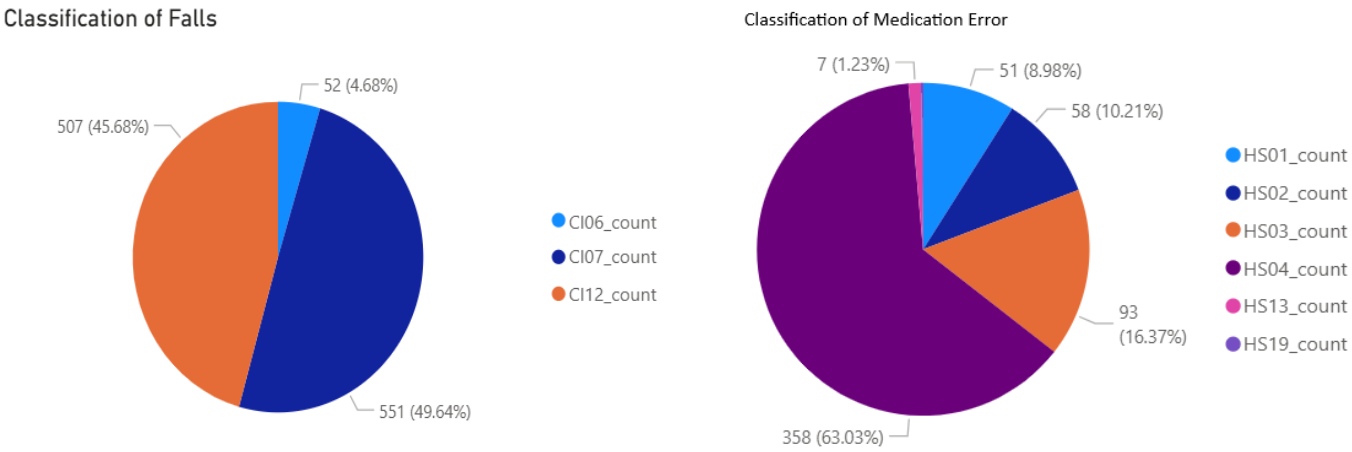
	Sentinel	**Critical**	**Risk**	**Immediate**	**Deaths**
Copper	6	18	21	4	13
Gogebic	13	7	11	0	6
Hiawatha	26	38	80	1	18
Northpointe	16	54	7	0	13
Pathways	6	93	197	2	17
Total	67	210	316	7	67

There were 959 distinct individuals associated with all the IRs in FY25. An in-depth review was completed for 121 of the charts. That review found that 14 individuals had active Assisted Outpatient Treatment (AOT) orders. Thirty-three had BTPs or Positive Support Plans. Most of the IRs documented were related to medication refusals and/or medication errors. These errors included instances in which the wrong medication was provided, doses were missed, or medication was dropped on the floor. Other frequently reviewed IRs involved injuries/falls, client substance using behaviors, and behaviors associated with mental health diagnoses.

Fifteen of these charts warranted further review and follow-up to ensure health and safety of the individuals served. These cases were discussed with the NorthCare Medical Director and any cases requiring follow-up or questions were communicated to the CMHSP.

There are three coding options to denote a fall, varying by the level of intensity. Most incidents caused no injury or indicated a non-serious injury. Only 4.68% resulted in serious injury. There are six codes related to medication errors. Most medication errors were missed medication doses and did not result in harm to the individual or emergency medical treatment.

CI06F- Accidental Serious Injury from Fall	Injury that required treatment at a hospital or clinic. Serious injury from a fall
CI07F- Accidental Non-Serious Injury from Fall	Injury from fall requiring first-aid administered in non-hospital, non-clinic setting, or no treatment at all.
CI12F- Falls with No Injury	Category for fall when no injury occurs, no treatment nor first aid required.
HS01- Incorrect Medication Given by Staff	Recipient received wrong medication from staff person, no medical treatment was needed.
HS02- Incorrect Dosage of Medication Given by Staff	Recipient received too much or too little medication from staff person, no medical treatment was needed.
HS03- Incorrect Time of Medication Administration by Staff	Recipient received medication at wrong time of day or before/after meals which was given by staff person, no medical treatment needed.
HS04- Missed Medication by Staff	Recipient did not receive prescribed medication from staff person for various reasons, no medical treatment needed.
HS13- Emergency Medical Treatment Due to Medication Error	Consumer required Emergency Medical Treatment due to Medication Error--but was NOT admitted into the Hospital. This includes Medication Errors made by staff, consumer self-administration errors, and errors made by other caregivers.
HS19- Hospitalization Due to Medication Error	Consumer required admission to a Hospital due to Medication Error. The admission may have followed Emergency Medical Treatment, if so, use this Hospitalization category. This includes Medication Errors made by staff, consumer self-administration errors, and errors made by other caregivers.



SUD providers report incidents to NorthCare. Those incidents meeting the threshold of SUD sentinel events are further reported to MDHHS. There were 35 medication errors and 36 ED visits in FY25. Two events were considered sentinel. Aside from DOT caring Centers, all other providers are locations operated by Great Lakes Recovery Centers.

	Med Error	ER Visit	Behaviors	Assault	SI/HI	Psych Screen	Arrest
Adult Residential Services	7	13	4	1	1	1	
Youth Residential Services		6	3	3			
DOT Caring Centers		1					
Men's New Hope House	12	6	1				
Teal Lake Residential	7	7	1			3	
Women's New Hope House	9	3	4				1
Grand Total	**35**	**36**	**13**	**4**	**1**	**4**	**1**

Each agency is responsible for remediation. Sentinel events require Root Cause Analysis (RCA). RCA is a problem-solving method used to identify the underlying causes of incidents. Typically, in the instance of death, a Mortality Review is completed as well as an RCA. Mortality Reviews are systematic processes used in healthcare to analyze patient deaths, identify root causes, and implement improvements to prevent future fatalities. Remediation is the process of improving or correcting a situation with the goal of mitigating future events. It looks at the details of this situation and then generalizes the information gleaned from the event to look at systemic issues and remediations. MDHHS requires remediation for late reporting, medication errors, and physical management resulting in injury, but may ask for remediation whenever desired.

NorthCare uploads critical incidents into the MDHHS CRM automatically each night. Once the CMHSP staff select an incident is critical and denote it reportable, it will be uploaded. These reports are due to MDHHS within 60 days of the end of the month of the incident, depending on the type of critical incident. NorthCare additionally manually adds immediately reportable events and SUD sentinel events into the CRM. NorthCare accesses reports in the CRM to verify that the number of incident reports in the CMHSP system matches the number recorded in the CRM. These

reports also make it easy to identify events in which the cause of death was still pending at the time they were reported to MDHHS. They also support verification of the status of required remediations. All FY25 remediations were submitted except for one, which remains under review. There were 20 remediations for FY25; seven for medication errors and 13 for late reporting of critical incidents across four CMHSPs.

NorthCare has been working with a group of PIHP leads to help develop, with MDHHS, an incident reporting technical manual as guidance for the field. This is still in development in FY26.

Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Event Reporting – Increase data reporting capability by building better reports and using the data to analyze improvements in the quality of healthcare and services for members.						
Utilize Power BI for better data analysis and review data during the Health and Safety Committee (internal) and Regional Incident Reporting (regional) meetings.	QI	NA	Begin use	FY23 Quarterly Ongoing	Continue	QAPIP
Increase timely categorization of incidents as being critical, sentinel, risk, immediately reportable to 95% within three business days of incident.	QI	NA	95%	FY23 Quarterly Ongoing	Continue / given methods at the time in FY23, average of 93%, however improved data capabilities available in FY24 show unfavorable difference.	QAPIP
Ensure individuals living in residential living arrangements are in the correct level of care; ensuring discussion of transition for any found in appropriate levels of care.	QI / CP	Completion of quarterly review	Completion of quarterly review. Please see the LTSS section.	FY23 Quarterly Ongoing	Continue / recommend setting a schedule for this activity	QAPIP
Review RCA Outcomes data to assess common causal factors for possible improvement project.	QI / CP	NA	Annual review	FY23 Annually Ongoing	Continue / determine if completion during site review makes most sense or mid-year review	QAPIP
Review all untimely deaths with NorthCare Medical Director and trend data over time.	QI / CP	NA	Monthly	FY24 Monthly Ongoing	Continue	QAPIP

Performance Measurement

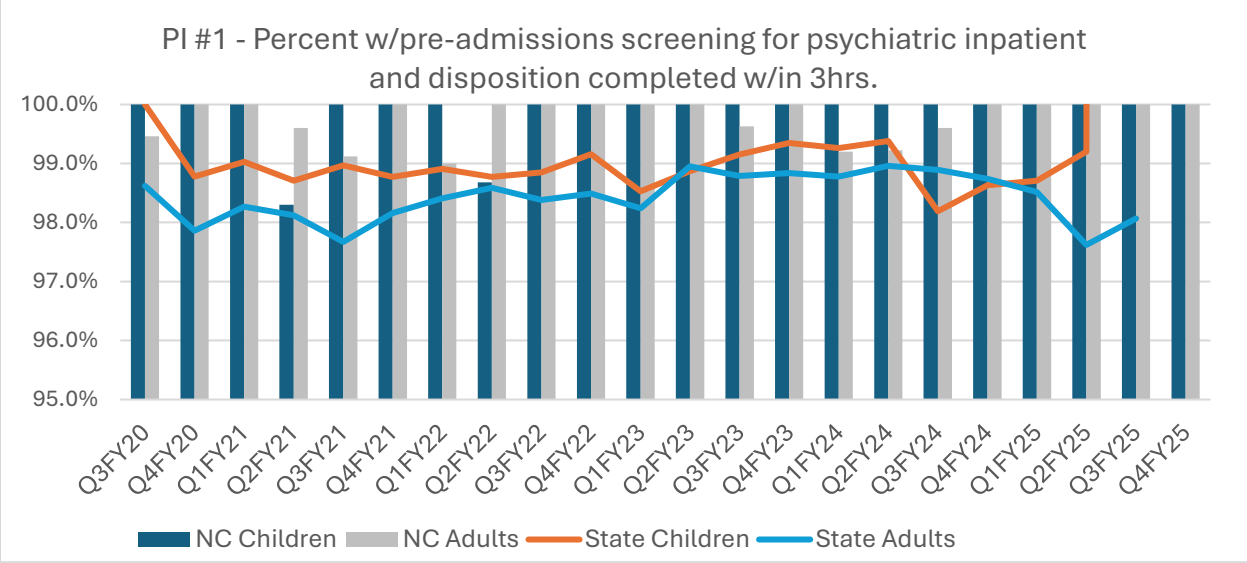
Performance Measurement in FY25 was measured in two ways. The first was the Michigan Mission-Based Performance Improvement Standards, which has been a long-standing version of measurement in Michigan for years. Its most recent revision was in 2020 related to Performance Indication (PI) 2 and 3. New in FY25, Michigan also began utilizing HEDIS measures. PI measures reflect scheduled activities, whereas HEDIS measures capture services that were actually attended and billed. As a result, the expectations and outcomes associated with each measurement vary. Additionally, HEDIS is dependent on claims and has an associated claims lag, as providers have 365 days to submit claims. HEDIS does prove beneficial however, as a number of providers can provide the service; not just those contracted with the PIHP.

The regional PI data for FY25 is presented in the tables below in comparison to the state average. Highlighted cells indicate performance below the MDHHS-identified performance expectations, while colored font reflects performance below the state average. State average information is not yet available for Quarter four of FY25. Long-term trends are also reflected in the charts. Any related HEDIS data is also reflected under each indicator and is denoted as HEDIS data.

PI1: Preadmission Screening within Three Hours

This measurement looks to ensure that individuals presenting in crisis are screened for appropriateness for inpatient psychiatric hospitalization within three hours of the request from the ED. This measurement is after medical clearance has been obtained. The standard is 95%.

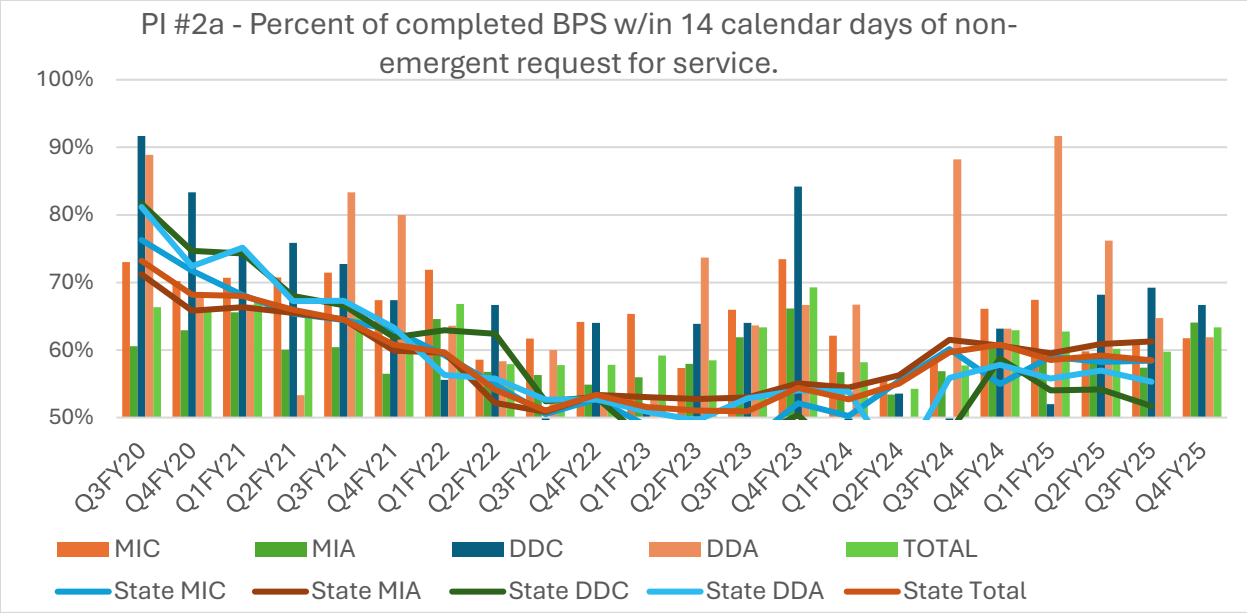
	Q1	Q2	Q3	Q4
NorthCare Children	100.00%	100.00%	100.00%	100.00%
State Average Children	98.71%	99.20%	98.18	
NorthCare Adults	100.00%	100.00%	100%	100.00%
State Average Adults	98.52%	97.62%	98.07%	



PI2a: Percent of Completed BPS within 14 calendar days of non-emergent request for service

This measure monitors the percentage of new persons during the quarter receiving a completed biopsychosocial (BPS) assessment within 14 calendar days of non-emergency requests for service by four subpopulations: Mentally ill adults, typically called serious mental illness (SMI), Mentally ill children typically called Serious Emotional Disturbance (SED), Intellectually/Developmentally Disabled adults, Intellectually/Developmentally Disabled children. The standard is 62%.

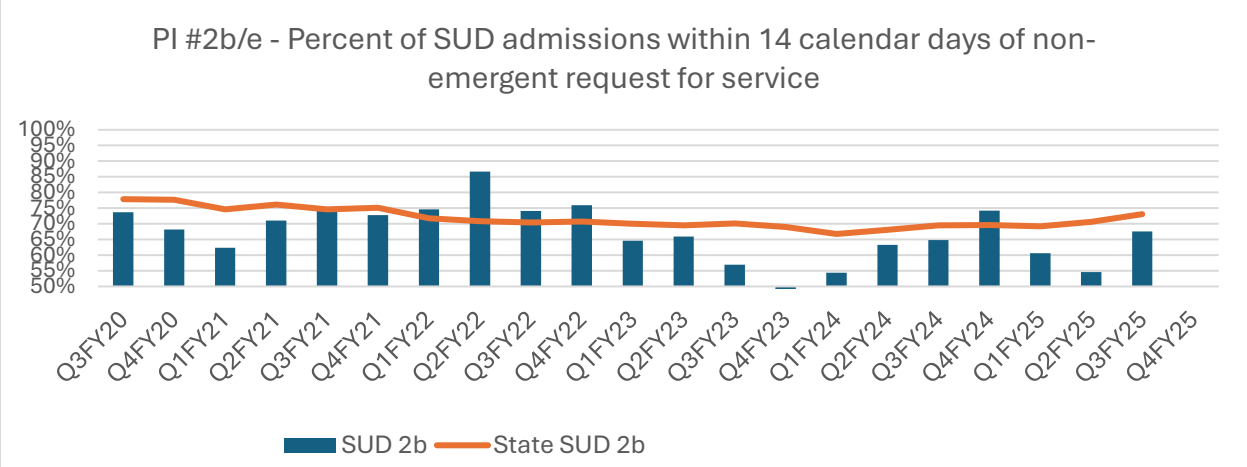
	Q1	Q2	Q3	Q4
NorthCare SED Child	67.42%	59.81%	61.50%	61.76%
State Average SED Child	58.99%	58.26%	58.43%	
NorthCare SMI Adults	58.78%	58.75%	57.39%	64.06%
State Average SMI Adults	59.51%	60.87%	61.28%	
NorthCare I/DD Child	52.00%	68.18%	69.23%	66.67%
State Average I/DD Child	54.04%	54.15%	51.69%	
NorthCare I/DD Adult	91.67%	76.19%	64.71%	61.90%
State Average I/DD Adult	55.76%	56.97%	55.31%	
NorthCare Total	62.76%	60.18%	59.74%	63.35%
State Average Total	58.54%	59.18%	58.49%	



PI2e: Percent of SUD admissions within 14 calendar days of non-emergent request for service

This measures the number of new persons during the quarter receiving face-to-face treatment or supports within 14 calendar days of a non-emergency request for services for persons with substance use disorders. The standard is 75.3%.

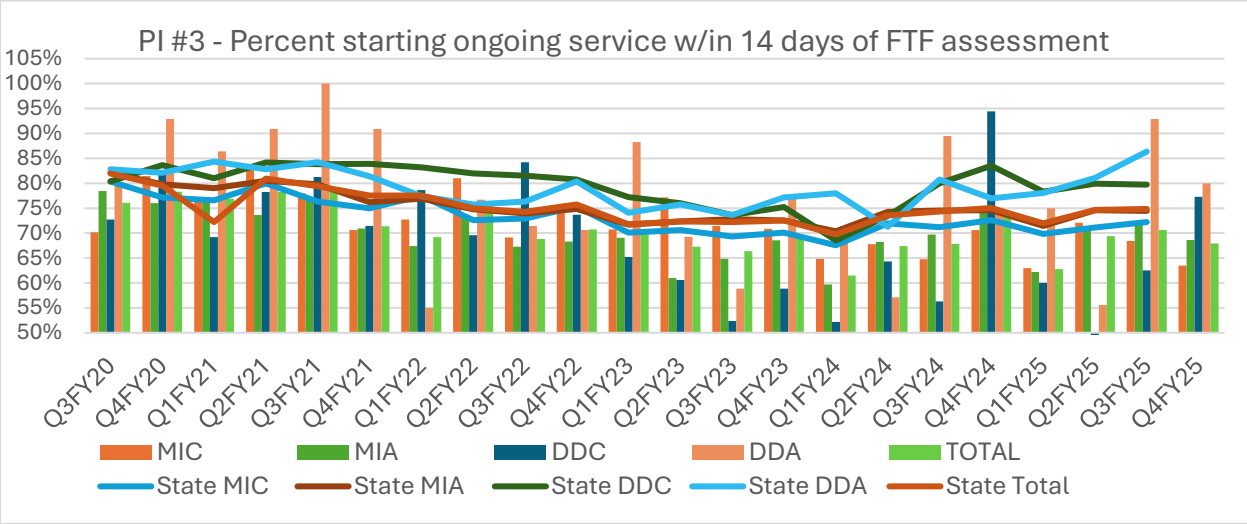
	Q1	Q2	Q3	Q4
NorthCare	60.57%	54.57%	68%	
State Average	69.20%	70.66%	73.11%	



PI3: Percent starting ongoing service w/in 14 days of FTF assessment

This measures the percentage of new persons starting on-going services within 14 days of completing a BPS broken by the four sub-populations. NorthCare quarterly percentages, by population, show ongoing challenges with indicator 3. This is due in part to the limited number of exceptions; as a result, no-shows, cancellations, and reschedules beyond 14 days negatively impact the percentages. The standard is 72.9%.

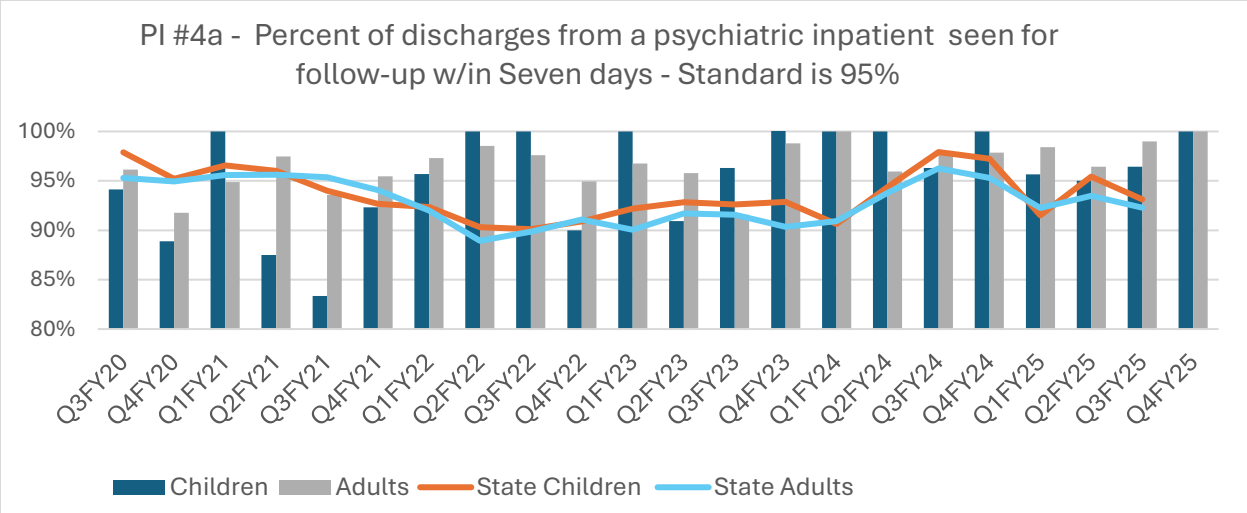
	Q1	Q2	Q3	Q4
NorthCare SED Child	62.98%	72.05%	68.45%	63.49%
State Average SED Child	69.86%	71.13%	72.19%	
NorthCare SMI Adults	62.21%	70.64%	71.69%	68.61%
State Average SMI Adults	71.41%	74.58%	74.47%	
NorthCare I/DD Child	60.00%	47.62%	62.50%	77.27%
State Average I/DD Child	78.30%	79.94%	79.70%	
NorthCare I/DD Adult	75.00%	55.56%	92.86%	80.00%
State Average I/DD Adult	78.07%	81.09%	86.36%	
NorthCare Total	62.76%	69.38%	70.59%	67.88%
State Average Total	71.98%	74.65%	74.84%	



PI4a: Percent of discharges from a psychiatric inpatient seen for follow-up w/in Seven days

This measures the percent of discharges from inpatient psychiatric hospitalization who were seen for follow-up care within seven days. The standard of 95%.

	Q1	Q2	Q3	Q4
NorthCare Children	95.65%	95.00%	96.43%	100.00%
State Average Children	91.51%	95.42%	93.12%	
NorthCare Adults	98.41%	96.43%	98.98%	100.00%
State Average Adults	92.25%	93.48%	92.29%	



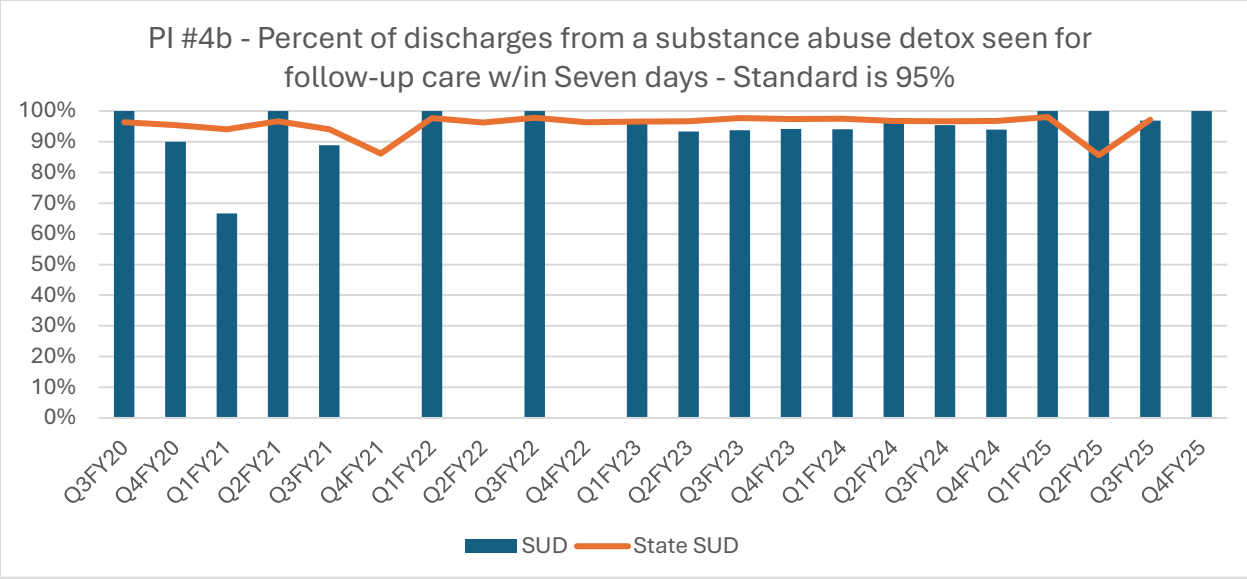
HEDIS measures, based on the most recent data available in Care Connect 360, show that approximately 80% of NorthCare consumers received a seven day follow-up appointment.

HEDIS - Quality Overhaul Regional Performance	Measure Date	Measure Date 6/30/2025	
Measure	**Benchmark**	**NorthCare**	**State**
FUH 30 AD: Follow-up After Hospitalization for Mental Illness within 30 days: Adults	62%	79.83%	65.51%
FUH 30 day: Children	79%	81.58%	81.79%

PI4b: Percent of discharges from a substance use detox seen for follow-up care w/in Seven days

This Performance Indicator measures the percent of discharges from substance use detox seen for follow-up within seven days. The standard is 95%.

	Q1	Q2	Q3	Q4
NorthCare	100.00%	100.00%	96.88%	100.00%
State Average	98.05%	85.59%	97.14%	



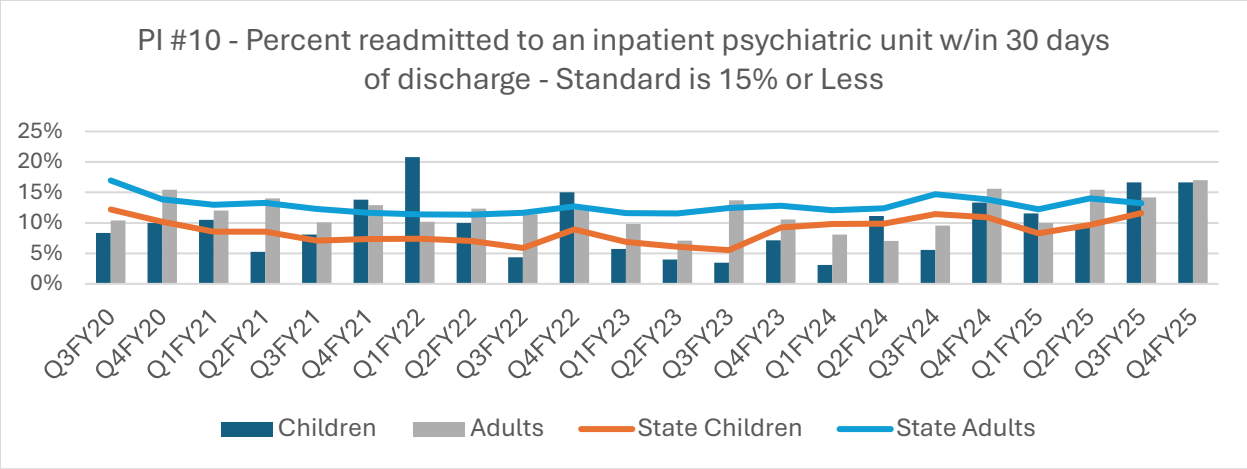
HEDIS measures, based on the most recent data available in Care Connect 360, show that 66% of children and 44% of adults received a seven day follow-up appointment. Both rates fall below the established benchmark.

HEDIS - Quality Overhaul Regional Performance	Measure Date	Measure Date 6/30/2025	
Measure	**Benchmark**	**NorthCare**	**State**
IET-14: Initiation and Engagement of Treatment for Alcohol or Other Drugs, first episode-Initial appointment within 14 days	40%	31.45%	37.01%
IET-34 day follow-up appointment	15%	12.21%	11.57%

PI10: Percent readmitted to an inpatient psychiatric unit w/in 30 days of discharge

This Performance Indicator measures recidivism, or readmission, within 30 days of discharge from inpatient psychiatric hospitalization. The standard aims to be below 15%.

	Q1	Q2	Q3	Q4
NorthCare Children	11.54%	9.52%	16.67%	16.67%
State Average Children	8.30%	9.68%	11.59%	
NorthCare Adults	10.00%	15.45%	14.17%	17.02%
State Average Adults	12.22%	14.04%	13.25%	



All CMS Adult and Child Core Set measures included in the MDHHS Behavioral Health Quality Overhaul are detailed below.

HEDIS - Quality Overhaul Regional Performance, Most Recently Available results via MDHHS' Care Connect 360 Data Warehouse	**Measure Date**	**Measure Date 6/30/2025**	
Measure	**Benchmark**	**NorthCare**	**State**
ADD INIT : Follow-up Care for Children Prescribed ADHD Medication, Initiation Phase	52.60%	49.07%	54.55%
ADD MAIN: Maintenance Phase	61.20%	54.23%	62.44%
FUH 30 AD: Follow-up After Hospitalization for Mental Illness within 30 days: Adults	62%	79.83%	65.51%
FUH 30 day: Children	79%	81.58%	81.79%
APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics	27.60%	41.57%	27.67%
APP: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	65.60%	57.14%	68.64%
FUA: Follow-up After Emergency Department Visit for Alcohol or Other Drugs within 30 days-Child	35.60%	66.67%	32.94%
FUA 30-Adults	36.30%	44.00%	39.34%
FUM CH: Follow-up After Emergency Department Visit for Mental Illness within 30 days: Children	60.80%	90.14%	72.83%
FUM AD- After ED use for Mental Illness	60.80%	69.81%	55.11%
IET-14: Initiation and Engagement of Treatment for Alcohol or Other Drugs, first episode-Initial appointment within 14 days	40%	31.45%	37.01%
IET-34 day follow-up appointment	15%	12.21%	11.57%
SSD: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotics		82.93%	78.92%
Diabetes Care for People with SMI: HbA1c Poor Control			
OUD: Use of Pharmacotherapy for OUD		84.57%	73.46%
SAA: Adherence to Antipsychotic Medications for Individuals with Schizophrenia		73.33%	62.25%

Objective/Activities	Lead	Previous Measure	Goal Measure	Start/ Frequency/ Due Dates	Status / Recommendation	Guiding Criteria (CFR, contract, C-waiver)
Performance Indicators and Measures						
PI1: PAS within three hours. NorthCare will continue to exceed the 95% expectation for this measurement and will continue to measure and report PI timely. Review situations with multiple PAS's for the same individual on the same day.	QI	99.5% (based on average of Q1-2)	Requirement is 95%. Our goal to strive for is 100% but accept 95% as minimum standard.	FY23 (mid) Quarterly Ongoing	Continue / bring to CPQI, QM, and PMC	Contract MMBPIS Standards
PI2a: BPS within 14 days: Given FY24 new measurement goals, NorthCare will seek to improve this measure beyond the 75th percentile of 62%. PI will be reviewed with each CMH and data presented to appropriate regional meetings.	QI	56% (based on average of Q1-2)	62%	FY23 (mid) Quarterly FY24Q2 and Ongoing	Continue / bring to CPQI, QM, and PMC	Contract MMBPIS Standards
PI2b/e: SUD admissions in 14 days: NorthCare will identify providers by way of PI2b/e monitoring report that fall below the goal and work with them to address barriers.	QI / SUD	58.5% (based on average of Q1-2)	68.2% (MDHHS benchmark)	FY23 (mid) Quarterly Ongoing	Continue / bring to SUD regional meeting, QM, and PMC	Contract MMBPIS Standards
PI3: Ongoing service within 14 days: Given FY24 new measurement goals, NorthCare will seek to improve this measure beyond the 50th percentile of 72.9%. PI will be reviewed with each CMH and data presented to appropriate regional meetings.		64% (based on average of Q1-2)	72.9%	FY23 (mid) Quarterly FY24Q2 and Ongoing	Continue / bring to CPQI, QM, and PMC	Contract MMBPIS Standards
PI4a: Follow up to hospitalization within seven days: NorthCare will achieve 95% compliance every quarter and will require corrective action plan if any CMH is not within 95% two or more quarters in a row. Data will be reviewed at appropriate regional meetings.	QI	95% 99% (based on average of Q1-2)	95% Requirement is 95%. 99% is goal to strive for but accept 95% as minimum standard.	FY22 Quarterly Ongoing	Continue / bring to CPQI, QM, PMC, and ES meetings. Bring hospital specific information to contracted hospital quality meetings.	Contract MMBPIS Standards
PI4b: Follow up to detox within seven days: review all exceptions; and run the data separate from MH data.	QI	95%	95%	FY24 Quarterly Ongoing	Bring to SUD regional meeting	Contract MMBPIS Standards
PI10: Recidivism: Achieve under 15% recidivism every quarter. A corrective action plan will be required for any CMH outside 15% for 2+ quarters in a row.	QI	7.35%	<15% The standard is under 15%. Our goal is under 10% but will accept under 15%.	FY23 (mid) Quarterly Ongoing	Continue / bring to CPQI, QM, PMC, and ES meetings. Bring hospital specific information to contracted hospital quality meetings.	Contract MMBPIS Standards
Identification of trends for any statistical decline in performance measures. Address trends with appropriate providers.	QI	NA		FY24 Annual Ongoing	Continue / bring to CPQI, QM, and PMC	
Identify trends in recidivism and 7-day follow up; their relationship to inpatient ALOS, and correlations between the 3. Address trends with appropriate providers.	QI	NA		FY24 Quarterly Ongoing	Continue / bring to CPQI, UM, PMC, and hospital specific information to contracted hospital meetings.	
Improve timeliness of priority population admissions for SUD populations by developing a monitoring method and monitoring frequently. Overall decrease in number of out of compliance priority population admissions.	QI / SUD	NA	80%	FY24 Quarterly Ongoing	Continue / bring to SUD regional meeting, QM, and PMC	
Increase validation checks to ensure appropriate populations are included in PI reporting and update system logic to remove members admitted that are mild/moderate for 2a/b, 4a, and 10.	QI	NA	100% accuracy	FY24 Once 4.1.24		

Performance Bonus Incentive Program

The Performance Bonus Incentive Program (PBIP) for FY25 consisted of two narrative deliverables to MDHHS: the Behavioral Health Treatment Episode Data Set (BH TEDS) Outcomes and Increased Participation in Patient Centered Medical Homes (PCMH) reports. The PCMH report findings and applicable programming are discussed in the section on Integrated Care on page 78.

The BH TEDS outcome report tracks performance in moving three populations of adults from dependent to independent living and into the labor force. Those populations include Intellectual

and Developmental Disabilities (I/DD), Serious Mental Illness (SMI), and Co-occurring SMI with Substance Use Disorder (COD). The following is the narrative component due from FY24, reflecting FY24 BH TEDS data related to housing and employment, along with associated analysis.

Section 1: Employment

Using unduplicated client counts for FY24 BH TEDS update records, a small denominator and minimal changes were noted in the I/DD population. There was no overall change in the rate of employment status. Two individuals became unemployed, and two became employed out of 157 update records. The total change in employment rate from FY23 to FY24 was a 0.65% increase in employment rate caused by a change in the denominator from 203 individuals in FY23 to 157 individuals in FY24. There was one less individual employed at the second measurement time (T2) than at the first measurement time (T1). Two individuals moved from 'not in the labor force' to 'potentially employable'. One individual moved from 'choosing not to work' to anything other than 'inmate.' There were no individuals who were noted to be incarcerated. There was a 0% change in the number of people who were not in labor force who are potentially employable. This population is relatively static.

Using unduplicated update/discharge records for individuals with mental illness, there was a small change in employment rates; 14 individuals left the labor force, 9 less individuals were employed with full or part time employment, and the employment rate decreased 0.77%. There was an increase in the percent of potentially employable individuals by 0.82%. In total, 31 people found new employment who were previously not in the labor force, and 44 people left the labor force from T1 to T2 in FY24. There was also a denominator change in this population from FY23 with 2026 individuals to FY24 with 1806.

For unduplicated individuals with substance use disorders, the employment rate was not statistically different at T1 than T2, a decrease of 0.88%. There were no measurable changes in incarceration rates impacting employment (1 individual). Five people (6.02%) rejoined the labor force and 26 (2.55%) people left the labor force between T1 and T2 for FY24.

Data for DD & MI individuals also demonstrates a static and not statistically significant change from T1 to T2 for FY24, or from FY23 T2 data. One additional person moved to employed status from FY24 T1 to T2 – or 33.3% change. There was no change in the number of potentially employable individuals, and a decrease of two people with a status of 'not in the labor force' – although this did decrease from FY23 to FY24 by 0.3%. The overall employment rate for this population increased by 2.17% in FY24.

Most individuals in our populations are relatively static with minimal overall changes between employment status. CMHSP and SUD Provider case managers, along with the SUD Health Home and Behavioral Health Home staff, work actively with Michigan Works! and Michigan Rehabilitation Services to support employment needs across all populations served. NorthCare's I/DD population works with several supported employment service providers for job training, and people can move into permanent employment from these programs on a regular basis. Because CMHSPs provide consistent support to help individuals who have disability-related symptoms prevent them from working to obtain SSI/SSDI, this likely contributes to some of the movement "out of the labor force" within the MI and SUD populations. Chronic understaffing across clinician, CLS, and case manager

and peer support positions has made it difficult to train additional staff in Benefit to Work coaching. However, the staff who are trained in Benefit to Work continue to be utilized regularly. The currently trained staff will eventually need to be replaced. NorthCare will identify opportunities for additional funding to supplement the lost units of service for additional staff to be trained. More Benefit to Work coaches would be expected to improve the movement of individuals from "not in the labor force" to "part-time employment."

Section 2: Housing

Living arrangements for individuals diagnosed only with I/DD had an increase in homelessness to a rate of 2.56% from 0.64%, from one individual to four individuals. Movement from provider owned into private/non-provider owned residences improved to 12 individuals, or 7.69% in a provider-owned setting.

For unduplicated individuals with mental illness, the rate of homelessness increased from 5.68% to 6.16% - 84 to 91 individuals between T1 and T2. This was an overall decrease from FY23 when 6.89% of people served were homeless at T2. People with mental illness moved from provider owned to not provider owned private residences – with ten less people overall, and six who moved from one setting to the other, 7.17% to 6.5% 106 to 96. This was a slight increase in rate, but a decrease in people overall who were in provider owned settings.

Homelessness decreased in the I/DD and SMI populations from 11.11% to 2.78% (15 people) in FY24 T1 to T2, however there was an increase in the number of individuals in provider owned vs. private settings from 4.44% to 6.11% (8 people to 11 people), one individual moved from provider owned to not provider owned.

Individuals with substance use disorders had a 0.2% increase in homelessness, from 97 people to 99 people in FY24 T1 to T2, but 14 individuals moved from homeless to anything but incarceration in that timeframe. This population's level of homelessness is relatively static.

For all populations in Region 1, the disparity in available low-income housing has worsened between FY23 and FY24. There are fewer low-income housing units available and greater demand as the region's overall population has increased. Additionally, middle-income households have increasingly occupied units that were previously accessible to lower-income individuals. Although there is a community-wide effort to expand housing through new developments, these projects primarily target middle-income households. Despite these challenges, movement from provider-dependent to independent living has gradually improved year over year, with more individuals residing in upon request dependent, private living settings.

Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Performance Indicators and Measures						
Compare with PBIP data to better impact employment and housing related concerns.	QI			FY24 Quarterly 10.1.24	Continue. Population rates of change are relatively static in percentage of employed and independently housed. This report will again be due for FY26.	PBIP reporting

Practice Guidelines

During FY25, there was a complete overhaul of NorthCare Network Clinical Practice Guidelines (CPG). The overhaul coincided with an updated agency website and a specific webpage dedicated to CPGs. All guidelines were reviewed, voted on, and approved by the Regional Clinical Practices Quality Improvement (CPQI) Committee. A master document reflecting all clinical practice guidelines, adoption date, and annual review date will be utilized to ensure a consistent and timely review for quality, accuracy, and relevancy to regional needs. A print version of all CPG's is available upon request, free of charge, and will be provided within five business days.

NorthCare has adopted practice guidelines from reputable sources such as the Veterans Administration, American Psychological Association, Substance Abuse Mental Health Service Administration (SAMHSA), Trauma Informed- Oregon (TIO), the Council of Autism Service Providers, and MDHHS. NorthCare further encourages use of Evidence Based Practices such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Prolonged Exposure Therapy, Assertive Community Treatment (ACT), Motivational Interviewing, Family Psychoeducation, and more.

Per MDHHS Trauma Policy, and to ensure a network that is trauma informed, NorthCare began the tri-annual required agency trauma informed assessment in January 2025 and completed the assessment in September 2025. The TIO Agency Self-Assessment Tool was utilized. The tool is a valid and reliable instrument used to evaluate an agency's overall performance in response to trauma informed care across five dimensions.

NorthCare Network conducted a region wide Trauma Informed project. All the CMHSP sites and NorthCare Network participated in a complete and thorough walkthrough evaluating environmental factors related to trauma informed care.

The quantitative and qualitative data was collected using the Trauma-Informed Environmental Checklist sourced from the Trauma Healing Project; a non-profit organization that is affiliated with TIO.

All sites received a personal and regional report. Several questions from the checklist were chosen based upon their high likelihood of traumatizing or re-traumatizing members as well as identifying trends across the regional site. The following themes were described in detail in the regional report but are summarized as overall intervention efforts.

1. Addition of Welcome Signs
2. Addition of Comfort/Healing/Meditation Room or Comfort/Privacy Quiet Areas
3. Addition of Lighting, both Natural and Artificial
4. Addition of Artwork or imagery that reflects empowerment, is culturally diverse, and completed by staff/members, which promotes soothing or calming, or reflects member accomplishment and outcomes
5. Addressing of Physical barriers which separate members from staff

Each agency was encouraged to consider the results and discuss modifications to the environment. Each agency was given the choice to determine how, or if, they will make changes, but this may be an opportunity for member involvement. Agencies are encouraged to complete environmental trauma assessments of their own in the future.

MDHHS practice guidelines are required, and therefore there is no control group to compare against to truly show effectiveness of the guidelines. Staff should implement evidence-based practices (EBP), including trauma-informed practices, whenever possible when applicable, and staff are adequately trained in the EBP. In FY27, NorthCare intends to monitor, measure, and evaluate the use of the PHQ -9 scores for those diagnosed with Major Depressive Disorder and determine outcomes of Therapy and Medication Interventions.

Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Practice Guidelines – Ensure development of requested CPGs, adoption of updated MDHHS CPGs, and dissemination of all CPGs to regional providers.						
Ensure review and updates to CPG's annually. Providers to acknowledge updates.	CP	Annual	Attestation from each CMH LMS user and SUD providers	FY23 Annually 1.25.24	Continue / make part of annual training requirements	QAPIP
Create/find and implement CPG related to eating disorders as requested in the Clinical Practices / Quality Improvement committee meeting.	CP	One time	Guideline was voted and approved on 4/22/2025.	FY23 Once 4.1.24	Complete	
Review of effectiveness of CPGs based on available data regarding a particular guideline.	CP	Annual review	Annual review	FY23 Annually Ongoing	Terminated	

Verification of the Delivery of Medicaid Services

NorthCare reviewed a sample of paid services, with sampling being separated by provider and sub-contracted providers. This resulted in five extracts of CMHSP service activity logs, five extracts of CMHSP claims from sub-contracted providers, and one extract of SUD providers. The top ten lines in each extract were selected after the data lines were randomized.

The following elements were reviewed:

1. Code is approved under the MDHHS/PIHP contract
2. Eligibility of the beneficiary on the date of service
3. Service is included in the beneficiaries IPOS
4. Date and time of service
5. A qualified practitioner provided service
6. Service falls within the scope of code billed/paid
7. Amount billed does not exceed the payer contracted amount
8. Amount paid does not exceed the payer contracted amount

A total of 29 unduplicated sub-contracted service providers, 34 unique CMHSP programs within the five CMHSPs, and nine unique SUD licensed sites. A total of 758 units of service with a total of $36,832.56 evaluated. All but one line was found to be valid per this methodology. A written formal corrective action plan would be required for each provider scoring below 95%. There is no formal corrective action plan required this year. All providers scored above 95%.

Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Verification of Services – Medicaid Service Verification – Complete Medicaid Service Verification timely and address any barriers identified for services delivery and health outcomes.						
Obtain / maintain compliance with requirements for Medicaid Service Verification. Share data in appropriate committees.	CO	90%	95%	FY22 Annually Ongoing	Continue / in FY22, 331 SAL/Claims were reviewed for 100% compliance.	QAPIP

Performance Improvement Projects

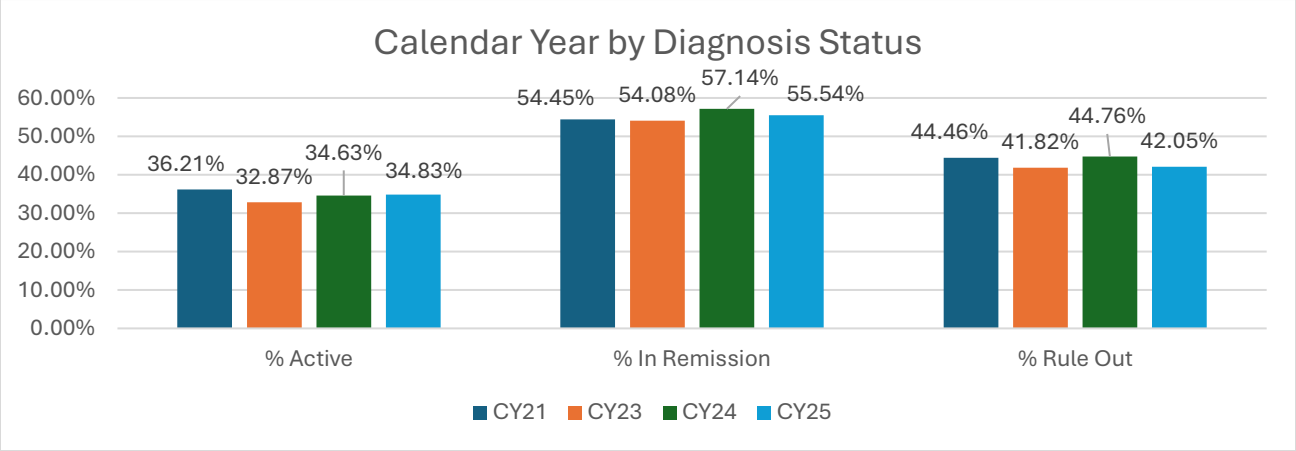
NorthCare had two Performance Improvement Projects (PIPs) in FY25. PIPs are chosen based on guidance about topic areas, identified areas of improvement based on quality review, in coordination with CMHSP and SUD provider workgroups, as applicable, and with the approval of the CEOs.

Co-Occurring Disorder Treatment PIP

The HSAG-validated, clinical PIP started in calendar year 2021 with an aim to Increase the percentage of individuals ages 12+ who are diagnosed with co-occurring disorders that are receiving cooccurring treatment.

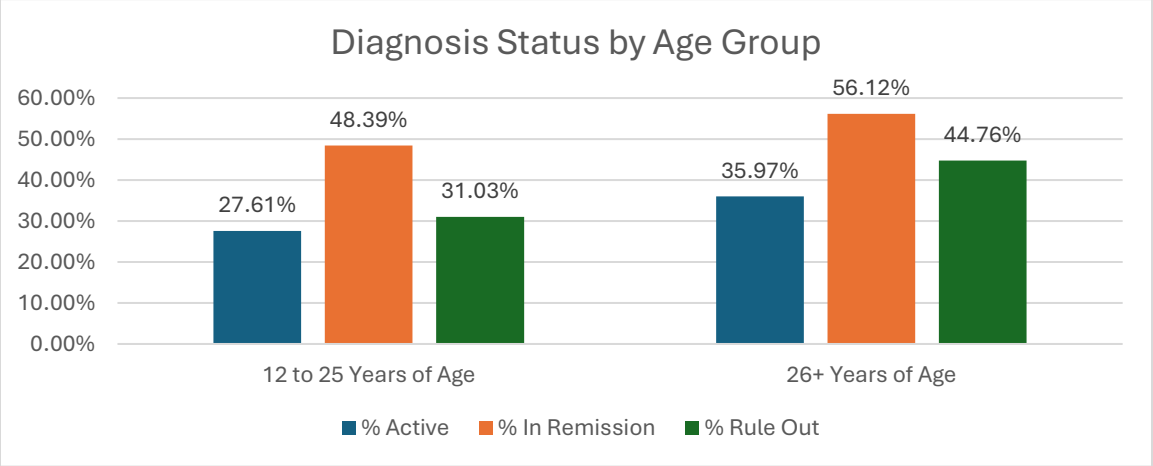
The PIP data examines individuals with both SMI and SUD diagnoses and identifies whether they are designated on the diagnostic page as receiving co-occurring integrated mental health treatment. Baseline data (CY2021) calculated for Indicator 1 show a total of 2660 individuals ages 12 and older who have co-occurring diagnoses, with 473 of these individuals received integrated treatment representing 17.78% of the denominator. However, it was later determined that these figures were not as accurate as possible. It was identified that baseline and remeasurement 1 included diagnostic specifiers such as "in remission," "active," "rule out," and "resolved." For remeasurement period 2, the diagnostic specifier of "resolved" was removed to improve accuracy. The table below represents integrated treatment data for all time periods with the diagnostic specifier removed. It is important to note that diagnosis is based on point in time data within each reporting period. Diagnostic updates may be captured if the update date falls within the measurement period. As a result, percentages for some reporting periods may exceed 100%.

	% Active	% In Remission	% Rule Out
CY21	36.21	54.45	44.46
CY23	32.87	54.08	41.82
CY24	34.63	57.14	44.76
CY25 (11.30.25)	34.83	55.54	42.05



When broken out by age, the majority of individuals included in the PIP are adults. There are 4443 adults in the denominator for 2025 (1.1.25-11.30.25) whereas there are 609 individuals age 12-25 in the denominator.

NorthCare reviewed the number of individuals served by the CMHSP system with a Mental Health or Substance Use diagnosis compared to those with a Mental Health and Substance Use diagnosis to determine the number of individuals in the CMHSP system that are COD. This data is looking at diagnoses in the active, in-remission, or rule out status at some point in the reporting period.



Review of Individuals in CMHSP services with Mental Health or SUD diagnosis vs. those with Mental Health and Substance Use Disorder diagnoses (Medicaid Eligible, 12+years old, excludes crisis and assessment only services)				
Time Period	Indicator Measurement	Mental Health OR SUD Dx only (distinct count)	Mental Health dx AND SUD dx (distinct count)	Percentage
01/01/2021 –12/31/2021	Baseline	6167	2936	47.61%
01/01/2023 –12/31/2023	Remeasurement 1	6472	3115	48.13%
01/01/2024 –12/31/2024	Remeasurement 2	6140	2947	48.00%
01/01/2025 –11/30/2025	Remeasurement 3 (partial)	5724	2744	47.94%

Around half of the consumers in CMHSP services are thereby identified as co-occurring and potentially in need of COD integrated treatment. After removing the individuals who are not identified as having co-occurring conditions and focusing only on the actionable population, the percentage of individuals with mental health and substance use disorder diagnoses—whether active, in remission, or rule-out—who are open to CMHSP services, Medicaid-eligible, and have a reportable (non-crisis or assessment-only) encounter receiving co-occurring treatment is reflected below.

- The denominator reflects open CMHSP consumers, age 12+, with Medicaid that had a reportable, non-crisis or assessment only, encounter during the measurement period with any mental health diagnosis and any substance use disorder diagnosis with the diagnoses being in either an active, in-remission, or rule-out status.
- The numerator is individuals in the denominator that received co-occurring treatment as based on the BH-TEDS field designation and/or HH modifier use.

% Active, In-Remission, and Rule-Out Co-occurring diagnoses receiving Co-occurring Treatment				
Time Period	Indicator Measurement	Numerator (distinct count)	Denominator (distinct count)	Percentage
01/01/2021 –12/31/2021	Baseline	1063	2936	36.21%
01/01/2023 –12/31/2023	Remeasurement 1	1022	3115	32.81%
01/01/2024 –12/31/2024	Remeasurement 2	1019	2947	34.58%
01/01/2025 –11/30/2025	Remeasurement 3 (Partial)	955	2743	34.82%

Broken by age, data shows a higher percentage of adults receiving treatment than youth. Both decreased during remeasurement period 1 and then rebounded slightly during remeasurement period 2, but neither are to the percent during the baseline year. Remeasurement period 3, which is 11 months of data, remains below baseline.

% Active, In-Remission, and Rule-Out Co-occurring diagnoses receiving Co-occurring Treatment 12-25 years of age				
Time Period	Indicator Measurement	Numerator (distinct count)	Denominator (distinct count)	Percentage
01/01/2021 –12/31/2021	Baseline	122	434	28.11%
01/01/2023 –12/31/2023	Remeasurement 1	118	453	26.05%
01/01/2024 –12/31/2024	Remeasurement 2	114	411	27.74%
01/01/2025 –11/30/2025	Remeasurement 3 (Partial)	103	373	27.61%

% Active, In-Remission, and Rule-Out Co-occurring diagnoses receiving Co-occurring Treatment 26+ years of age				
Time Period	Indicator Measurement	Numerator (distinct count)	Denominator (distinct count)	Percentage
01/01/2021 –12/31/2021	Baseline	941	2502	37.61%
01/01/2023 –12/31/2023	Remeasurement 1	904	2662	33.96%
01/01/2024 –12/31/2024	Remeasurement 2	905	2536	35.69%
01/01/2025 –11/30/2025	Remeasurement 3 (Partial)	852	2370	35.95%

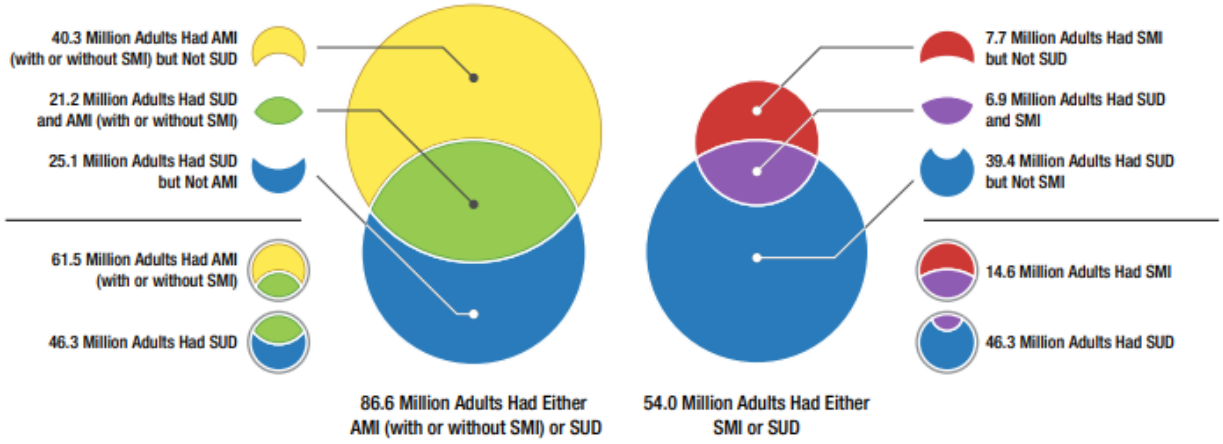
The updated data consists of a more accurate representation of the population co-occurring treatment would apply to. Percentages are higher due to the removal of the unaffected population. However, they still show a reduction from the beginning of the baseline period. This percentage is consistent with national rates. SAMHSA *Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health* indicates that 16.8% (48.4 million) people age 12+ used substances in that year. Mental illness rates remained the same.

Figure 51: Any Mental Illness: past year: Adults 18+; Percentages 2021-2024					
Age Group	2021	2022	2023	2024	Trend
18 +	23.0%	23.1%	22.8%	23.4%	No change
18-25	34.5%	36.2%	33.8%	33.2%	No change
26-49	28.5%	29.4%	29.2%	29.7%	No change
50+	15.0%	13.9%	14.1%	15.2%	No change

For adults in 2024, 33% (86.6 million people) had either any mental illness or a substance use disorder in that past year. Approximately 33% of those with mental illness had a co-occurring

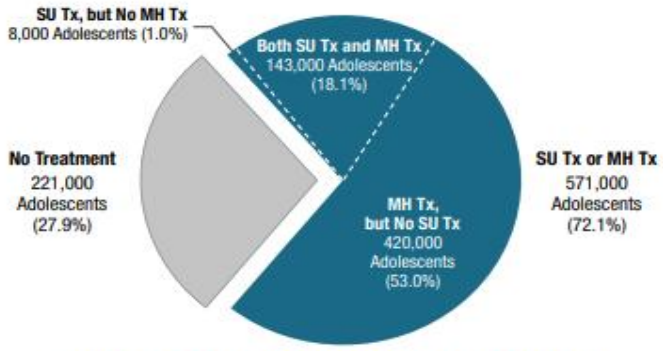
substance use disorder. Forty-six percent of those with a substance use disorder had a co-occurring mental illness.

Figure 57. Any Mental Illness (AMI), Serious Mental Illness (SMI), or Substance Use Disorder (SUD) in the Past Year: Among Adults Aged 18 or Older; 2024



Approximately 18% of youth and 14.5% of adults with any mental illness to 19% of adults with serious mental illness received co-occurring treatment nationally in 2024, per SAMHSA.

Figure 79. Receipt of Substance Use Treatment or Mental Health Treatment in the Past Year: Among Adolescents Aged 12 to 17 with Past Year Substance Use Disorder and Major Depressive Episode (MDE); 2024



792,000 Adolescents with a Substance Use Disorder and MDE

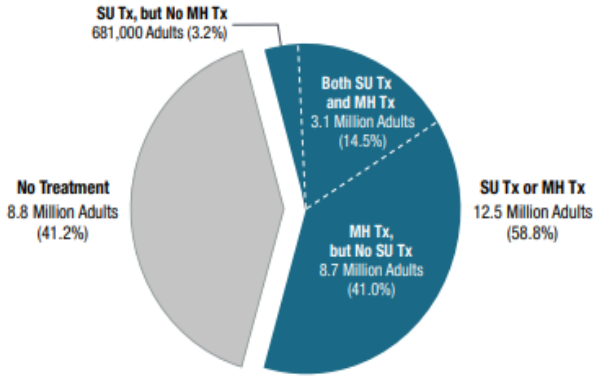
MH Tx = mental health treatment; SU Tx = substance use treatment.

Note: Adolescents with unknown past year MDE data were excluded.

Note: Substance use treatment includes treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medications for alcohol use disorder or opioid use disorder; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

Note: Mental health treatment includes treatment/counseling received as an inpatient or as an outpatient; use of prescription medication to help with mental health; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

Figure 80. Receipt of Substance Use Treatment or Mental Health Treatment in the Past Year: Among Adults Aged 18 or Older with Past Year Substance Use Disorder and Any Mental Illness; 2024



21.2 Million Adults with a Substance Use Disorder and Any Mental Illness

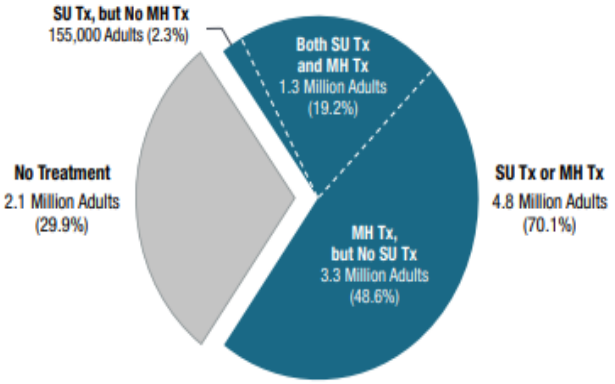
MH Tx = mental health treatment; SU Tx = substance use treatment.

Note: The numbers and percentages for the subdivisions may not add to the percentage for the whole division due to rounding.

Note: Substance use treatment includes treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medications for alcohol use disorder or opioid use disorder; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

Note: Mental health treatment includes treatment/counseling received as an inpatient or as an outpatient; use of prescription medication to help with mental health; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

Figure 81. Receipt of Substance Use Treatment or Mental Health Treatment in the Past Year: Among Adults Aged 18 or Older with Past Year Substance Use Disorder and Serious Mental Illness; 2024



6.9 Million Adults with a Substance Use Disorder and Serious Mental Illness

MH Tx = mental health treatment; SU Tx = substance use treatment.

Note: Substance use treatment includes treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medications for alcohol use disorder or opioid use disorder; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

Note: Mental health treatment includes treatment/counseling received as an inpatient or as an outpatient; use of prescription medication to help with mental health; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

As part of its monitoring efforts, NorthCare completed a targeted review of co-occurring charts to identify opportunities for improving the assessment of SUD concerns at access, during the BPS assessment, and within the IPOS. Factors such as staff turnover, limited availability of appropriately credentialed SUD clinicians, and challenges in establishing client trust with assessors may contribute to gaps in the data for this PIP.

Forty-three charts have been identified as co-occurring thus far in FY25. This information was gathered from FY26 October Chart Audits, HCBS Chart Audits, AOT Chart Audits, and hospital discharge review. A chart was included in this data set when evidence of co-occurring needs was present but not addressed in the BPS or IPOS, provided those SUD needs were not formally deferred.

Of the 43 charts identified, over half (26) were not properly identified as 42 CFR Part 2. 42 CFR Part 2 indicates that a chart should be noted as having additional confidential protections if the individual is or was engaged in SUD Treatment. 28 of these charts have an SUD diagnosis identified in our EMR. Five of these individuals were not open to CMHSPs at the time of the review.

This information highlights the need to increase awareness of co-occurring treatment and lead to the development of a "how-to" guide for assessing SUD during the BPS. The guide is designed to support new clinicians, refresh the knowledge of experienced clinicians, and assist case managers as they complete annual BPS assessments. It also provides guidance on documenting the HH modifier—specifically, when to include it on the SAL report for future tracking and how to educate staff on its purpose. The guide will be available in FY26 for distribution to the CMHSPs.

Areas of improvement include consistently identifying the need for SUD treatment, documenting when a client declines a referral by marking the need as 'deferred' and maintaining a clear golden thread of documentation throughout the record to reflect this process.

Satisfaction Survey PIP

The FY25 Satisfaction Survey PIP sought to increase the number of satisfaction survey responses that were received. The initial phase was to review and revise the satisfaction survey questions, followed by placing the survey in an electronic version found online. The survey questions were categorized into four main themes:

- A – comfort,
- B – planning,
- C - goal progress, and
- D – staff presentation / assistance.

Question 1 and 2 related to comfort and scored an average of 95.16%. Questions 3-5 are related to planning and scored an average of 94.72%. Questions 6-9 relate to goal progress and scored the lowest at 91.86%. Questions 10-14 relate to staff presentation/assistance and scored lower at 91.91%. Question 15 was an overall question of satisfaction and is not part of any theme category. This overall satisfaction response was 93.55%.

More information about the satisfaction survey PIP is detailed in the Stakeholder Input section of this review on page 41. Overall, the goal of increasing response rates was not achieved. Response rates decreased despite multiple options of methods to complete a response. Each CMHSP was provided with their information and regional aggregate data in December 2025. Phase 3 of the PIP addresses adding technology within waiting rooms to promote and provide opportunities to complete the satisfaction survey. It is speculated that this will prompt and increase response rates.

Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Performance Improvement Project - Increase the percentage of individuals ages 12+ who are diagnosed with cooccurring disorders that are receiving cooccurring treatment						
Baseline Data Calendar year 21 – 17.78%. NorthCare will review data timely and bring to appropriate meetings to discuss improvement strategies.	QI / SUD / Data	NA	Better than 23	FY23 Quarterly Ongoing	Continue / bring to CPQI, UM, PMC, and PIP workgroup	QAPIP
Offer consultative services to CMHSPs to improve co-occurring illness, via contract with psychiatrist board certified in addiction medicine.	SUD / ICT	Began June 23	Increased utilization from 23	FY23 Monthly Ongoing	Continue	QAPIP
Performance Improvement Project						
Increase the responses to the satisfaction survey	CS/ QI	FY25 start date – baseline data		FY25	Start/ Continue	QAPIP

Special Populations

Prevention

Universal, evidence-based prevention has been the primary focus of prevention programming for several years. Programs funded during the FY25 included:

- *Botvin's Life Skills*: A universal evidence-based program for middle-school students. Botvin's programming focuses on increasing life skills and life skills development has been shown to be effective in preventing early initiation of substance use and increases emotional regulation.
- *Prime for Life*: A selected/indicated program for either youth or adults with high school or college students that have substance use issues and referred by their school.
- *Social Development Strategy*: An integral part of the Communities That Care model, it helps communities provide opportunities for positive interactions that teach skills needed for success and provides for consistent recognition of effort which increases bonding and emotional connection of the youth to adults.
- *Catch My Breath*: An evidence-based youth nicotine vaping prevention program for grades 5-12 that has been proven to substantially reduce students' likelihood of vaping. Catch My Breath is designed to help youth make healthy choices and avoid risky behaviors when it comes to e-cigarettes.
- *InDepth is Intervention for Nicotine Dependence: An Education, Prevention, Tobacco and Health (INDEPTH*): An alternative to suspension or citation that helps schools and communities address the teen vaping problem in a more supportive way. Instead of solely focusing on punitive measures, INDEPTH is an interactive program that teaches students about nicotine dependence, establishing healthy alternatives, and how to kick the unhealthy addiction that got them in trouble in the first place.

Although funding has decreased, Botvin Life Skills continues to be implemented widely across the UP. Eight Coalitions across ten counties continue to promote and advocate for evidence-based services to be implemented with other funds such as Opioid Settlement funds, and partner with community organizations in order to continue providing Prevention services.

Class	2022 Total Participants	2023 Total Participants	2024 Total Participants	2025 Total Participants
Botvin's Life Skills	5611	5,991	5,562	5,635
Guiding Good Choices	60	81	17	
Prime for Life	152	123	125	401
Project Toward No Drug Abuse		50	192	
Catch My Breath		431	457	66
InDepth		178		2

In FY23, NorthCare was awarded the Partnership for Success grant, which provides the opportunity to expand current coalition capacity. The Partnership for Success grant funding has provided Region 1 with funding to employ and reestablish coalitions in Chippewa, Gogebic, Ontonagon, Baraga, and Luce Counties.

Veterans

The Veteran Navigator Team consists of two Veterans with lived experience whose purpose is to navigate Veterans through the plethora of resources available to them through both the Veterans Administration (VA) and through local charitable organizations. The Veteran Navigator and Veteran Peer Support Specialist act as advocates for Veterans and their families as they navigate life challenges. These challenges include but are not limited to substance use disorder and mental health issues, food insecurities, homelessness, loss of income, and working with the VA. They also work alongside many organizations assisting Veterans. These organizations include CMHSP's, Veterans of Foreign Wars, American Legions, Rotary Clubs, county and regional suicide prevention organizations, and local support groups. The overall goal of the Veteran Navigator team is to support and advocate for Veterans and effectively lower the rate of Veteran suicide. There were 33 Veterans and three families served in FY25.

Technology

Power BI Data Analysis

FY25 afforded NorthCare the ability to hone focus on using data to support initiatives. With the purchase of Power BI and a staff position partially devoted to increasing clinical data capabilities, NorthCare began quality initiatives on a variety of clinical topics. Some of these are complete and some are still in process of revision in FY26:

- Incident Reporting Dashboard - Built a Power BI dashboard to track critical, sentinel and other types of incidents, including timeliness, counts and trends by provider and month. Implemented DAX logic in Power BI for business-day calculations, categorization and compliance monitoring.
- LOCUS Reports - Report reflecting all the variables related to LOCUS Data

- LOCUS Power BI dashboard - Built Power BI dashboard to analyze LOCUS-recommended levels of care against actual service utilization across providers and time. Analyzed LOCUS distribution across all categories (Initial/Intake, Acute/Crisis etc.) Also added and analyzed LOCUS score variations across different time periods in a fiscal year to determine improvement/regression.
- LOCUS Timeliness Reports - Built data report to see whether a CG/Acute Crisis LOCUS assessment or other LOCUS assessments are completed prior to psychiatric inpatient hospital discharge or within seven days of follow-up. Reports are being developed in Power BI. Additionally, NorthCare is working on another timeliness report to analyze whether Initial/Intake LOCUS assessment was completed on the same day as the BPS and if there was improvement or regression in member status over time.
- MichiCANS - A data report reflecting variables like Age, Transition Age Youth, Level of Need, MichiCANS disposition etc. Also working on building this report in Power BI.
- Autism Report - Built a data report to determine supervision ratios and to see whether the staff providing autism services meets the minimum requirement of 1:10 (1 hour of case supervision for every ten hours of direct treatment). The report is in the process of being built in Power BI.
- Functional Assessment Data Report - Built a data report to determine whether functional assessments have been completed or not and analyzed this data alongside consumers having DDA Level of Care (1-4) and HAB Waiver.
- AOT Data Report - This data report has been built to determine whether open individuals on AOT are getting services by CMHSP currently. Also looking for their insurance status (Medicaid/General Fund).
- ER Data Report - Data Report in the process of being built in Power BI to determine inpatient hospitalizations and analyze other factors like hospital acceptance/denial rates, length of time in ER, recidivism rates etc.
- NorthCare intends to monitor PHQ-9 scores from measurement 1 to measurement 2 and compare it to interventions provided in FY26.

Contracted Providers Electronic Signature, Billing and Remittance Advices

Technology was highlighted with the addition of Docusign for electronic signature of contracts. Docusign was purchased and implemented in FY25. This allowed NorthCare to fully execute almost all contracts by the start of the fiscal year. This, in addition to standardizing templates and a contract review process, has improved the quality of contracted services. Tracking of contracts payments has been expanded to include timeliness and reporting verification before payments are sent. Additionally, when completing a Request for Proposal or Request for Quotation, the NorthCare contract manager now works closely with the Program Leads. This change enables the contract manager to focus on the administrative process while allowing the Program Lead to concentrate on programming components, a division of responsibilities that is expected to enhance overall quality.

To protect confidentiality, NorthCare no longer issues paper remittance advice that includes Protected Health Information (PHI). A process has been established to allow providers to view their remittance advice in the EMR when they receive a payment from NorthCare. For providers without EMR access, a single designated contact may receive remittance advice containing PHI via

encrypted email. Similarly, Automated Clearing House (ACH) process for direct deposit payments has been set up in the Great Plains accounting software. This enables NorthCare to issue payments to vendors and providers electronically rather than by paper check through the United States Postal Service, for those vendors who choose ACH over paper checks.

NorthCare SUD has worked towards eliminating staffing grants and moving towards fee-for-service billing in the EMR. The efficiency of electronic billing should save time and reduce error.

HIPPA Security Risk Assessment

NorthCare completed a HIPPA Security Risk Assessment. The assessment was completed by NorthCare's Chief Information Officer using the Security Risk Assessment Tool provided by the Office of the National Coordinator for Health IT.

The assessment identified a small number of vulnerabilities, including those related to insider threats, the potential for unauthorized access, and risks to business continuity.

High-risk items include sensitive data exposure or tampering by insiders, unauthorized access granted to outsiders, and falsification or destruction of records due to an untrustworthy employee or business associate. Moderate risks were found in areas such as device security, log monitoring, and contingency planning.

To mitigate these risks, a list of mitigation plans was generated based on analysis of best practice, existing capabilities and competencies, and available resources. Resources required to undertake these plans included staff time, new equipment or software, and additional vendor services. Most mitigations are targeted for completion by March 31, 2026, with more advanced measures having a goal date of September 30, 2026.

Conclusion

NorthCare's implementation of new staff, data analytic tools, and technology in FY25 allowed for the increase in monitoring and quality oversight which will continue in future years. This in and of itself is a quality improvement. Initiatives were aimed at identifying areas for improvement and training development. This has led to updates of some QI processes and ideas for FY26 to better assess and rate the provider network.

NorthCare continues to identify and address priority areas for improvement. NorthCare has identified satisfaction surveys and stakeholder input as an area to continue to improve upon and has focused on improving process related to Grievance and Appeals.

NorthCare has stressed the value of communication, relationship, and continuous quality improvement with providers. In FY26, NorthCare has offered and scheduled meetings with all contracted inpatient psychiatric providers to promote quality management. Additionally, beyond regularly scheduled committee meetings, there have been meetings offered to focus on special topics such as HCBS. Finally, NorthCare focused on updating and communicating clinical practice guidelines in FY25 via region wide committees to promote implementation and ensure contract and technical guideline requirements are achieved.

FY26 QAPIP

The following pages detail the FY26 QAPIP and associated workplan. This will be the focus area of the QM department over the fiscal year. This plan and associated workplan will adjust as indicated by results of HSAG and MDHHS audits indicate, and as NorthCare quality and utilization reviews deem necessary.

FY26

NorthCare Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN (QAPIP)

Quality Management Department
NorthCare Network
1230 Wilson Street
Marquette, MI 49855
Direct Line: 906-205-4347
Toll Free: 888-333-8030
Website: www.northcarenetwork.org
Email: bpietsch@northcarenetwork.org

Contents

Introduction....126
Purpose....127
Quality Improvement Authority and Structure....128
Accountability and Responsibility....128
NorthCare Network Governing Board....128
Designated Senior Official....128
QAPIP Committee/Teams....129
Quality Management System....130
Quality Standards....131
Quality Assessment Activities....132
Stakeholder Input....132
Ongoing Assessments of Consumer Experiences with Services and the PIHP....133
Provider Network Monitoring....134
Utilization Management and Authorizations....134
Credentialing and Qualification for Scope of Practice....135
Oversight of Vulnerable Individuals....136
Behavior Treatment Review....136
Event Reporting and Notification....136
LTSS (Long Term Supports and Services)....138
Home and Community Based Services (HCBS)....139
External Quality Reviews....139
Performance Measurement....140
Performance Indicators [Measures]....140
Outcomes Management....142
Practice Guidelines....143
Verification of the Delivery of Medicaid Services....143
Improvement Strategies....144
Performance Improvement Projects (PIP)....144
Utilization Management (UM)/Authorization strategies....145
Procedures for Adopting and Communicating Process & Outcome Improvements....146
Evaluation and Monitoring....146
References....147
Attachments....147
Approvals....148
Attachment A- Acronyms used in this document....148

Introduction

NorthCare Network (NorthCare) is a regional entity under Section 1204(b) of the Michigan Mental Health Code and is governed by a board of directors with representation from the five-member Community Mental Health Authorities. NorthCare Network continues to hold a Standard Contract with the Michigan Department of Health and Human Services (MDHHS) for the Medicaid Managed Specialty Supports and Services 1115 Demonstration Waiver, 1915 (c)/(i) Waiver Programs, the Healthy Michigan Program, the Flint 1115 Waiver and SUD Community Grant Programs and the MI Health Link Demonstration Program, which ends December 31, 2025. NorthCare is also part of the Behavioral Health Home (BHH) and SUD Health Home (SUD HH) programs.

NorthCare Network is the Prepaid Inpatient Health Plan (PIHP) for the five Community Mental Health Services Programs (CMHSP) serving the Upper Peninsula: Copper Country Community Mental Health, Gogebic County Community Mental Health, Hiawatha Behavioral Health, Northpointe Behavioral Health System, and Pathways Community Mental Health. The counties which each serve is detailed below.

- Copper Country: Baraga, Houghton, Keweenaw, Ontonagon
- Gogebic: Gogebic
- Hiawatha: Chippewa, Mackinac, Schoolcraft
- Northpointe: Dickinson, Iron, Menominee
- Pathways: Alger, Delta, Luce, Marquette

This document outlines requirements for the annual Quality Assessment and Performance Improvement Program (QAPIP) as set forth in the PIHP/MDHHS Medicaid Managed Specialty Supports and Services Program Contract Attachment. It also describes how these functions are accomplished and the organizational structure and responsibilities relative to these functions.

This QAPIP aids in supporting NorthCare's mission, "NorthCare Network ensures that every eligible recipient receives quality specialty mental health and substance use disorder services and supports through the responsible management of regional resources." This mission guides the activities of NorthCare Network. It supports our vision to ensure a full range of accessible, efficient, effective, and integrated quality behavioral health services and community-based supports for residents of Michigan's Upper Peninsula.

We achieve this by staying true to our values.

- We believe in respect, consumer empowerment, person centered care, self-determination, full community participation, recovery, and a culture of gentleness.
- We endorse effective, efficient community-based systems of care based on the ready availability of a competent workforce and evidence-based practices.
- We believe in services that are accessible, accountable, value based, and trauma informed.
- We support full compliance with state, federal and contract requirements, and responsible stewardship.
- The right care, and the right time, for the right cost, and with the right outcome.

Purpose

The QAPIP is intended to outline requirements and provide guidance for carrying out organizational functions, including but not limited to:

- Outlining the quality improvement structure for the managed care activities of the NorthCare Network.
- Evaluating and updating, as appropriate, NorthCare Network's QI processes and outcomes.
- Monitoring and evaluating the systems and processes related to the quality of clinical care and non-clinical services that can be expected to affect the health status, quality of life, and satisfaction of people served by Network Providers.
- Identifying and assigning priority to opportunities for performance improvement.
- Creating a culture that encourages stakeholder input and participation in improvement initiatives and problem solving.
- Stressing the value of employees; cooperation between employees; team building; and a partner relationship between the PIHP, Member CMHSPs, Network Providers, advocacy groups and other human service agencies within a continuous quality improvement environment.
- Promoting the basic quality management principle of prevention over remediation. It is less expensive in the long run to build quality into an organization's services than expending additional resources on rework and dissatisfied customers.
- Providing guidance for the PIHP Performance Improvement Projects.
- Ensuring verification that services reimbursed by Medicaid were provided to enrollees by Network Providers according to the plan of service and adequately documented.
- Working with the Regional Clinical Practices/Quality Improvement Committee to ensure implementation of evidence-based practices throughout the region.
- Meeting standards specified in the NorthCare Network Medicaid Managed Specialty Supports and Services Contract and QAPIP attachment, the ICO/PIHP Contract for the MI Health Link Project through December 31, 2025, quality assurance provisions of the Balanced Budget Act of 1997, as amended, Medicaid Managed Care Rules, and Accreditation Standards, as applicable.

We do this to achieve the following desired outcomes:

- Meet or exceed state performance metrics as well as improving performance for identified projects.
- Improved data analysis of critical incidents to reduce adverse effects on consumers and behavior treatment committee data to reduce the need for physical intervention.
- Ensure satisfaction of services and HCBS rules and quality clinical practice guidelines that are accessible to consumers and staff.
- Verify staff are qualified to complete their duties and there is network adequacy to provide necessary services.
- Ensure services meet Medicaid standards. Ensure appeal and grievance information is provided to members.
- Increase consistency in Utilization Management decisions across the region and assess the appropriateness of individuals' level of care and the services they are providing.

Quality Improvement Authority and Structure

The QAPIP is reviewed and approved on an annual basis by the NorthCare Network Governing Board. Through this process, the governing body gives authority for the implementation of this plan and all components.

NorthCare Network's Chief Executive Officer (CEO) provides guidance and authority to the Quality Improvement/Utilization Management (QI/UM) Director who is responsible for implementation of the QAPIP. The Performance Management Committee and Governing Board receive routine reports on the progress of the QAPIP including performance indicators, quality improvement projects, progress and actions taken, and the results of those actions. The committee structure is designed to encourage contributions from a variety of sources, facilitate accountability, and ensure follow-through on improvement efforts. NorthCare Network's Medical Director is involved in QI, UM, credentialing activities and is available for consultation to any of the regional committees, including review and consultation regarding sentinel and critical events.

The Customer Services Committee and NorthCare Network's Governing Board provide significant opportunities for involvement by primary and secondary consumers. Additionally, focus groups and surveys may be utilized to elicit consumer feedback.

Accountability and Responsibility

NorthCare Network Governing Board

Membership: NorthCare Network's 15-member Governing Board includes three representatives from each of the five Member CMHSP Boards of Directors. *Role/Function:* The NorthCare Network Governing Board retains the ultimate responsibility for review and approval of the QAPIP, policy approval and governance. Functions include, but are not limited to:

- *Oversight of the QAPIP:* This includes documented evidence that the Board has approved the overall QAPIP and QI Plan. The Board's role is to monitor, evaluate and establish policy that supports improvements to care.
- *QAPIP Progress Reports:* The NorthCare Network Governing Board routinely receives written reports from the Chief Executive Officer describing performance improvement initiatives undertaken, the actions taken, and the results of those actions.
- *Annual QAPIP Review:* The NorthCare Network Governing Board formally reviews a written report on the operation of the QAPIP, at least annually.
- *Reporting Accountability:* The NorthCare Network Governing Board reports to stakeholders via committee and Board meeting minutes. The Governing Body submits a written annual report to MDHHS following its review, due February 28th, which includes a list of members.
- *Reporting Frequency:* Quarterly

Designated Senior Official

NorthCare's QI/UM Director is responsible for coordinating activities related to the design, implementation, management and evaluation of the quality improvement and compliance programs. Quality management works collaboratively with many different functional areas. Although each position identified below is not directly assigned to the quality management function, they maintain an active role in quality related activities. The following grid provides a

representation of what percentage of total time is spent by NorthCare staff on quality related activities. Much of NorthCare's quality management work is implemented through the various committees listed below.

Title	Department	Average percent per quarter devoted to QM
QI/UM Director	QI	50%
SUD Clinical Director	Clinical/ SUD Access	15%
Integrated Care / UM Specialist	Clinical	20%
Clinical Practices Specialist	Clinical	15%
Customer Service Specialist	Customer Service	10%
Data Analyst	Information Management	5%
Population Health Director	Integrated Care/Population Health	35%
Medical Director (Part-time)	Clinical	75%
Provider Network Specialist	Network Management	10%
QI/UM Staff (2 positions)	QI	50%
Systems Analyst	Information Management	25%
Compliance-Privacy Officer	Compliance	25%

QAPIP Committee/Teams

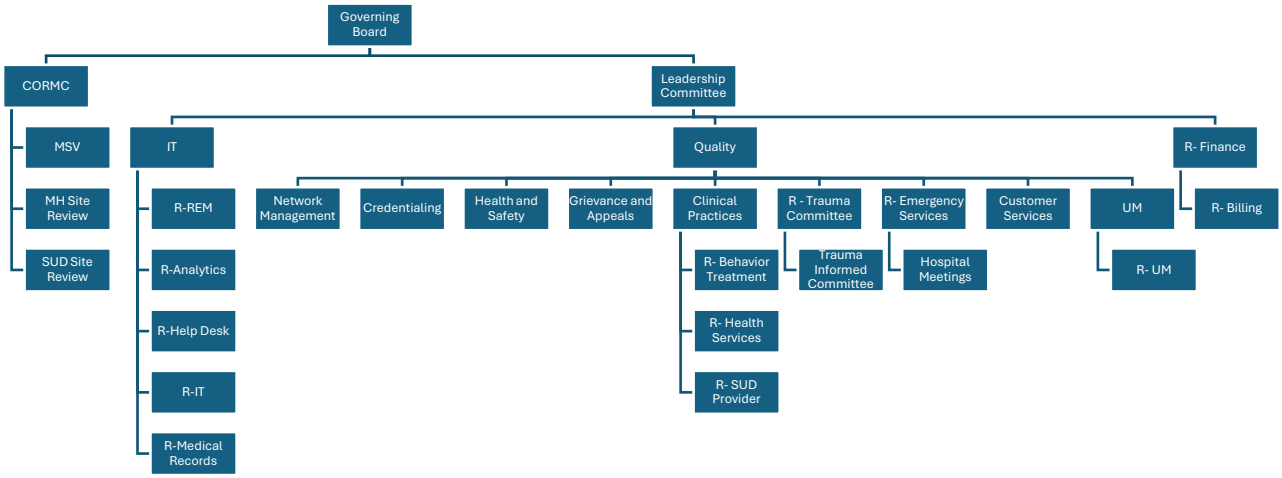
NorthCare Network's QAPIP is implemented through various PIHP and regional committees/teams as listed below. All are ultimately accountable to NorthCare Governing Board and/or NorthCare Leadership. Regional committees are denoted with an "R" on the chart.

NorthCare Governing Board of Directors

A. NorthCare Compliance Oversight and Risk Management Committee (CORMC)
    1. NorthCare Medicaid Service Verification Team (MSV)
    2. NC Site Review Team (MH)
    3. NC Site Review Team (SUD)
B. NorthCare Leadership Committee
    1. NorthCare Information/Technology Management Committee
        a) Regional Elmer Management Committee (REM)
        b) Regional Analytics Committee
        c) Regional Help Desk Committee
        d) Regional Information Technology and Security Committee
        e) Regional Medical Records Committee
    4. NorthCare Quality Management Committee
        a) NorthCare Network Management Committee
        a) NorthCare Credentialing Committee
        f) NorthCare Health and Safety Review Committee
        g) Regional Grievance & Appeal Committee
        h) Regional Clinical Practices/QI Committee
            - Regional Behavioral Treatment Committee
            - Regional Health Services Committee
            - SUD Provider Clinical Meeting
            - Regional Trauma Informed Committee
                - NorthCare Trauma Informed Committee

g) Regional Emergency Services Committee
    - Meetings with each contracted hospital
h) NorthCare Utilization Management Committee
    - Regional Utilization Management Committee
i) Regional Customer Services Committee

3. Regional Finance Committee
    a) Regional Billing Committee



Each committee has an approved "Fact Sheet" which documents the committee charge, reporting requirement(s), membership, deliverables, and meeting frequency. Project specific or time specific workgroups are established as appropriate.

Additionally, each CMHSP has a quality improvement process to address quality issues within its operations. Each CMHSP also has a customer services meeting for increased consumer involvement and voice. Regional satisfaction results are shared and reviewed by NorthCare Network. NorthCare reviews the CMHSP websites and publications annually.

Substance Use Disorder (SUD) services are delivered through a network of contracted provider organizations. No managed care functions are delegated to SUD providers. To ensure representation, SUD providers are involved in the Regional SUD Provider Clinical Meetings and concerns are brought to leadership.

Quality Management System

NorthCare Network's Quality Management System combines the traditional aspects of quality assurance and adds the elements of continuous quality improvement. The Quality Management

System helps NorthCare Network achieve its mission, realize its vision, and live its values. It protects against adverse events, and it provides mechanisms to bring about positive change while ensuring quality services. Continuous quality improvement efforts assure a proactive and systematic approach that promotes innovation, adaptability across the Network, and a passion for achieving best practices.

The *Quality Management System* includes:

- Predefined standards
- Formal and informal assessment activities
- Measurement of performance in comparison to standards
- Strategies to improve performance rates that are below standard

The various aspects of the system are not mutually exclusive. However, for descriptive purposes, the following table separates the components.

QUALITY MANAGEMENT SYSTEM			
Quality Standards	Assessment Activities	Performance Measurements	Improvement Strategies
• Federal & State Rules/Regulations • Stakeholder Expectations • MDHHS Contract • Provider Contracts • Practice Guidelines and Evidence Based Practices • Network Standards • Accreditation Standards • Network Policies and Procedures • Delegation Agreement • Clinical Documentation Standards • AFP/ARR	• Quality Monitoring Reviews • Accreditation Surveys • Credentialing • Risk Assessment/ Management • Utilization Reviews • External Quality Reviews • Stakeholder Input • Sentinel Events • Critical Incident Reports • Documentation Reviews • Medicaid Service Verification • Performance Improvement Projects • Critical Event Reporting	• Behavioral Health Quality Program (Starting FY26) • Audit Reports • External Quality Reviews (HSAG) • MDHHS Site Reviews • Outcome Reports • Benchmarking • Grievance & Appeals • MDHHS Performance Based Incentive Program • CMS Behavioral Health Core Set	• Corrective Action/Improvement Plans • Improvement Projects • Improvement Teams • Strategic Planning • Practice Guidelines • Organizational Learning • Administrative and Clinical Staff Training • Cross Functional Work Teams • Reducing Process Variation

Quality Standards

Quality Standards provide the specifications, practices, and principles by which a process may be judged or rated. NorthCare Network identifies and sets standards by reviewing, analyzing, and integrating such areas as:

- Performance expectations of network providers for both clinical services and administrative functions
- Government regulations/rules
- Practice Guidelines
- Accreditation and/or Network Standards
- External review findings
- Utilization Management and Authorizations

Quality Assessment Activities

Quality assessment consists of strategically planned activities that help to identify the actual practices, attitudes, performance, and conformance to standards that are enhance or inhibit the achievement of quality. Obtaining stakeholder input is critical to quality assessment activities.

Stakeholder Input

NorthCare Network recognizes that a vital aspect of any continuous improvement system is a means to obtain stakeholder input and satisfaction information. Stakeholders identified to provide input to NorthCare Network may include individuals who are or have received services, staff, contract service providers, families/advocates, and the local communities, representing both internal and external customers.

Input is collected to better understand how NorthCare Network is performing from the perspective of its stakeholders. The input is continually analyzed and integrated into the practices of the PIHP, as feasible. NorthCare Network's Customer Services Committee and Governing Board both provide opportunities for stakeholder input. NorthCare Network encourages stakeholder participation on other committees as appropriate. Each Member CMHSP will ensure that there is adequate input from stakeholders for local decision-making. Surveys are sent to staff periodically, as determined necessary, to identify training needs.

SUD providers are invited to provide input in the regional SUD clinical meeting. Grievance and appeals are also a valuable source of stakeholder input, as well as consumer satisfaction surveys and targeted surveys based on program (e.g., the BTC bi-annual survey).

The table below summarizes methods and sources for obtaining stakeholder input.

STAKEHOLDER INPUT METHODS AND SOURCES						
Type of Input	Consumer	Staff	Providers	Family/ Advocates	Community	MDHHS/EQRO
Interviews	MDHHS Site Reviews, Accreditation, Satisfaction Surveys, Person Centered Planning (PCP) process	Performance Evaluations, Termination/Exit Interviews	ORR Site Visit, Contract Provider Quality Review	MDHHS Site Reviews, Fidelity Reviews of Evidence Based Practices	Open Door Policy of the NorthCare Network CEO	MDHHS Site Reviews, External Quality Review Organization (EQRO)– under contract w/MDHHS

Suggestions	Ongoing opportunity through PCP process	Supervision, Suggestion box for Improvement process	Quality reviews	Ongoing opportunity through PCP process per consumer choice	Focus Groups or Public Forums	MDHHS, EQRO
Forums	Consumer advisory committees, Board meetings	Team/Dept Meetings, All staff meetings	MDHHS Review, Contract negotiations, meetings	MDHHS Review, Advisory committees	MDHHS /EQR/ Accreditation Reviews, Annual PRR forum, Public comments at Board meetings	MDHHS, EQRO
Surveys	Consumer surveys, Health Plan Survey per Accreditation	Staff surveys	Provider surveys, Accreditation surveys	Satisfaction surveys	Stakeholder Surveys	MDHHS, EQRO
Assessment of experience with services/ organization	Ongoing through PCP process, progress notes, discharge summary, Various regional committee membership	Performance evaluations	Quality review of provider, AFC licensing reports	Regional committee membership	Community Needs Assessment	MDHHS, EQRO
Due Process Grievance, Appeals, Medicaid Fair Hearings	Filing of appeals and grievances	Review dispositions with staff	Review dispositions with providers	Due Process	Comments via NorthCare Network Website	MDHHS, EQRO
Complaints	MDHHS-ORR Audit reviewed as completed Compliance Complaints	Recipient Rights Complaints as mandated reporters Compliance Complaints	Recipient Rights Complaints as mandated reporters Compliance Complaints	RR Complaint, Compliance complaint process, Customer Service compliant process	RR Complaint, Compliance complaint process	MDHHS, EQRO

Ongoing Assessments of Consumer Experiences with Services and the PIHP

NorthCare Network conducts assessments of member experiences with its services. These assessments must be representative of the individuals served, including individuals receiving long-term supports or services, and the services and supports offered. Members of services are encouraged to complete the satisfaction survey. Surveys were previously mailed to a sample of individuals monthly, and the survey is always available online via the NorthCare website. To increase consumer input, CMHSPs and SUD Providers have provided this survey link on appointment reminder cards, posted it in waiting room lobbies, and have encouraged completion at contacts. In FY25, NorthCare implemented a Satisfaction Performance Improvement Project (PIP) to increase the number of returned surveys. This will continue in FY26.

Results will be used to improve services, processes, communication, etc. Processes found to be effective and positive will be continued, while those with questionable efficacy or low consumer satisfaction will be revised by:

- Taking specific action on individual cases as appropriate.
- Identifying and investigating sources of dissatisfaction.
- Outlining systemic action steps to follow up on the findings.
- Informing practitioners, providers, recipients of service, and the NorthCare Network Governing Board of assessment results.

Just as the original processes must be evaluated, the interventions used to increase quality, availability, satisfaction, and accessibility to care and services must also be assessed. Therefore, all actions taken as a result of assessments will be evaluated periodically. Quality improvement is never static, and it is an expectation that all evaluation efforts will be examined on an ongoing basis.

Provider Network Monitoring

NorthCare Network conducts annual site reviews of organizational providers with whom we directly contract to ensure compliance with all contracted functions as well as state and federal mandates.

NorthCare Network's process is a systematic and comprehensive approach to monitor, benchmark, and make improvements in the provision of mental health and substance use services. NorthCare Network conducts annual (at minimum) site reviews to evaluate:

- Compliance with regional, state, federal and accreditation standards through annual site visits
- Compliance with delegated functions, if applicable
- Clinical documentation reviews
- Verification of Medicaid services
- Clinical Implementation of effective treatments
- The Provider Network Monitoring process provides NorthCare Network the ability to:
- Establish clinical and non-clinical priority areas for improvement
- Use a number of measures to analyze the delivery of services and quality of care
- Establish performance goals and compares findings and ratings with past performance
- Provides performance feedback with suggestions for improvement through written report
- Requires an improvement/corrective action plan from providers in areas not achieving targets or in non-compliance with accepted standards
- Ensures implementation of the improvement plan by providers

Utilization Management and Authorizations

NorthCare Network implements a Utilization Management Plan within the provisions of the Standard Contract with Michigan Department of Health and Human Services (MDHHS). NorthCare Network has oversight authority and performs utilization management functions sufficient to control costs and minimize risk while assuring quality care. The UM Plan establishes a framework for oversight and guidance of the Medicaid Programs by assuring consistent application of

program/service eligibility criteria, and in decisions involving the processing of requests for initial and continued authorization of services.

Utilization Management is committed to not only reviewing practices related to resource utilization, but also to taking action to modify inappropriate, inefficient or ineffective utilization. Many of the NorthCare Network Utilization Management functions overlap or are reliant on coordination with Quality Assessment & Performance Improvement, Provider Relations, Customer Service, Regional Clinical Practices and Quality Improvement Committee, Claims/Reimbursement, Management of Information Services and other managed care functions. Successful interface among the various functions of the PIHP is essential for effective and efficient management of resources, identification of gaps in service delivery and resolution of over- and under-utilization of services and resources. Interface between Utilization Management and other PIHP functions occurs through exchange of data, information and reports, joint participation in a variety of committees and collaboration in planning, projects, and operational initiatives.

Compensation to individuals or entities that conduct utilization management activities cannot be structured to provide incentives to the individual or entity to deny, limit, or discontinue medically necessary services to any recipient.

Some UM activities overlap with other areas and may be led by various committees but be pertinent to UM, such as recidivism for inpatient psychiatric admissions. UM areas of focus include over and underutilization, appropriate level of care, eligibility criteria, and medical necessity for specific services.

Credentialing and Qualification for Scope of Practice

The NorthCare Network Credentialing Committee is responsible for applying legal, professional and ethical scrutiny to applicants seeking to be credentialed as a provider in the network and to approve the re-credentialing of existing providers. NorthCare Network retains final authority for the credentialing of individual and organizational providers as a member of the provider panel employed or under contract. The qualifications of physicians and other licensed and unlicensed behavioral healthcare practitioners/professionals employed by or under contract to the PIHP are reviewed according to the NorthCare Network Credentialing and Privileging Policies to ensure they are qualified to perform their services. Continuous monitoring of the credentialing program occurs across the network to ensure compliance and identify quality or network issues. Organizations are responsible for ensuring that individual practitioners/providers, employed or under contract, and organizational providers meet all applicable licensing, scope of practice, contractual, and payor requirements.

NorthCare Network requires professional staff in the network to have a documented review and approval of their clinical privileges to assure services provided to the network members are delivered by qualified and competent staff. Minimally, this is done as part of the initial credentialing/re-credentialing process and when duties/responsibilities change.

NorthCare Network and network providers shall train new personnel regarding their responsibilities, program policy, and operating procedures. Both NorthCare Network and network providers shall also identify staff training needs, provide in-service training, continuing education, and staff development activities according to NorthCare Network's Training – Personnel Policy and

the Training-Network Provider Policy. Training requirements are reviewed minimally on an annual basis for relevancy, changes from accepted research and specific findings associated with the results from both routine and as needed monitoring and reviews.

In FY26, credentialing will be housed in the MDHHS Customer Relationship Management (CRM) platform.

Oversight of Vulnerable Individuals

NorthCare Network utilizes the appropriate qualified clinical staff and various reporting mechanisms and data sets to identify vulnerable individuals and events that put them at risk of harm, including required health measures and health assessments. Such events and data, that are not a product of a protected peer review process, will be used to determine opportunities for improving care and outcomes and reported to the Compliance Oversight and Risk Management Committee as appropriate. Individuals with increased needs due to multiple conditions may be referred to the Behavioral Health Home (BHH), Substance Use Disorder Health Home (SUDHH), or Integrated Care Team (ICT) meetings with the Medicaid Health Plan; Upper Peninsula Health Plan (UPHP). If an issue that places an individual at imminent risk to health or welfare is identified, NorthCare will take immediate action to ensure their safety. NorthCare will invoke an immediate review and require a response by the Provider, within seven (7) calendar days.

Home and Community Based Service (HCBS) recipients, individuals on c-waivers, and individuals receiving Long-Term Services and Supports (LTSS), as well as those with various health conditions involved in Integrated Care Team meetings or the Health Homes are considered vulnerable and will be considered in data review. Some populations require the use of MDHHS developed tools or have data collected and reported via Care Connect 360.

Behavior Treatment Review

NorthCare Network's Clinical Practices Specialist will review analyses of data from Member CMHSP behavior treatment review committee(s) on a quarterly basis where intrusive or restrictive techniques have been approved for the use with beneficiaries and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis. Patterns and trends will be evaluated for possible system and/or process improvement initiatives and will be reported to NorthCare Network's Clinical Practices and Quality Improvement Committee. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plan Review Committees and that have been approved during person-centered planning by the beneficiary, and/or his/her guardian may be used with beneficiaries. Data includes numbers of interventions and length of time the interventions were used with the individual.-Additionally, the committee shall be advised of updated regulatory requirements, and work collaboratively to ensure practices are sufficiently reflecting adherence to requirements thereof.

Event Reporting and Notification

Each Network Provider will record, assess, and report critical incidents according to NorthCare Network policy. They will analyze at least quarterly the cumulative critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents and report the outcome of this analysis to NorthCare Network. NorthCare Network's Health and Safety Review Team will analyze aggregate data to identify any trends or patterns and may follow-up on individual events as

warranted. The Health and Safety Review Team will report aggregate high-risk areas and concerns to NorthCare Network's Compliance Oversight and Risk Management Committee as appropriate. Member CMHSPs utilize NorthCare Network's Incident Report Module to report all events defined below. Specialty residential providers will report incidents to the CMHSP, either via electronic or paper process. Other Network Providers, including residential SUD treatment providers, may continue to report on paper. Select incidents will be reviewed during the NorthCare Health and Safety meeting. Analysis and trend lines will be reviewed frequently.

- Critical Events: Critical Event Reporting will be uploaded nightly to MDHHS's CRM by PCE (NorthCare Network's software vendor) automatically. This Critical Incident Reporting System captures information on five specific reportable events based on varying populations as mandated by MDHHS. Detailed requirements can be found in NorthCare Network's Incident, Event & Death Reporting & Monitoring Policy and the PIHP/ MDHHS Reporting Requirements Policy.
- Event Notification: The PIHP is also required to immediately notify MDHHS of specific events as outlined in the MDHHS Reporting Requirement Policy and NorthCare Incident, Event & Death Reporting & Monitoring Policy.
- Sentinel Events, as defined in the MDHHS Reporting Requirement Policy must be reviewed and acted upon as appropriate and in accordance with NorthCare Network's Incident, Event & Death Reporting & Monitoring Policy.
- Risk Events are additional events that put individuals at risk of harm, including at minimum: actions taken by individuals that cause harm to themselves or others; two or more unscheduled admissions to a hospital within a 12-month period; emergency use of physical management by staff in response to a behavioral crisis, and police calls by staff under certain circumstances. For detailed information refer to PIHP/ MDHHS QAPIP Guideline. NorthCare Network's Health and Safety Review Team and CMHSP staff review trends and follow up as indicated.
- All unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed. Unexpected deaths include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect. Unexpected deaths are marked as either critical, sentinel, or both. Specifics for reporting are included in NorthCare's Incident, Event & Death Reporting & Monitoring Policy.

Critical Incidents are automatically uploaded into the CRM nightly via information transfer from PCE. Immediately reportable events and SUD sentinel events are manually uploaded into the CRM within the specified timeframes identified in the MDHHS guidelines. Remediation details for events, as necessary, are also submitted via the CRM.

LTSS (Long Term Supports and Services)

The following are the LTSS codes in the 1115 Pathway to Integration Waiver.

LONG TERM SERVICES & SUPPORTS 1115 Pathway to Integration Waiver (michigan.gov)	**CPT/HCPCS** MDHHS SFY 2022 Behavioral Health Code Chart
Respite	H0045 (Out-of-Home Setting) S5150 (Unskilled caregiver, "family friend") S5151 (In-Home Setting) T1005 (15 minutes)
Community Living Supports	H2015 (Unlicensed Setting) H2016 (Licensed Residential Setting)
Private Duty Nursing	S9123 (Registered Nurse, Hour) S9124 (Licensed Practical Nurse, Hour) T1000 (RN or LPN, 15 minutes)
Supported Integrated Employment	H2023
Out of Home Non Vocational Rehab	H2014
Goods & Services	T5999
Environmental Modification	S5165
Supports & Service Coordination	T1017
Enhanced Pharmacy	T1999
Personal Emergency Response (PERS)	S5160 (Installation and testing) S5161 (Service fee, per month, excludes installation and testing)
Community Transition Services	T2038
Enhanced Medical Equipment & Supplies (including vehicle modification)	E1399 (Durable Medical Equipment) S5199 (Personal Care Items) T2028 T2029 T2039 (Vehicle Mod)
Family Training	G0177 (Family Education Groups) S5110 (Family Psycho-Education Skills Workshop) S5111 (Home care training; family) T1015 (Family Psycho-Education, Joining)
Non-Family Training	S5116
Specialty Therapies (Music, Art, Massage, etc)	G0176 (Music, Art, Recreation Therapy) 97124 (Massage) 97530 (Therapeutic Activities)
Children Therapeutic Foster Care	S5140 (age 11 and older) S5145
Therapeutic Overnight Camping	T2036
Transitional Services	T2038
Fiscal Intermediary	T2025
Prevocational Services	T2015

The PIHP must have mechanisms in place to assess the quality and appropriateness of care furnished to beneficiaries using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's

treatment/service plan. Mechanisms are in place 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. This is achieved by, but not limited to review, analysis, and monitoring of person-centered planning, IPOS reviews/amendments, and standardized assessment scores that support level of care such as the Level of Care Utilization System (LOCUS). For individuals on a waiver, or attempting to be on a waiver, there is additional paperwork and approval process for waiver covered services identified above. The new 1915(i)SPA waiver also has additional process and scrutiny for identification of individuals receiving the services that are considered LTSS and qualifying for1915(i)SPA.

Home and Community Based Services (HCBS)

Under the HCBS Final Rule, the Centers for Medicare and Medicaid (CMS) established requirements for both residential and non-residential Home and Community Based Settings. These settings/services must be integrated into the community will full access to jobs, resources and services, be chosen by the individual from multiple options, ensure privacy, dignity, respect and freedom of coercion and restraint, support autonomy and independence in daily life decisions and allow individual to choose their services, supports and providers. Northcare Network monitoring activities for FY26 include the following: Ongoing review and approval of new HCBS providers through NorthCare's Provisional Approval Process and, starting 09/02/2025, following MDHHS guidance to obtain approval for any secure HCBS placement.

1. Completion of the HCBS CMS Corrective Action Plan (CAP) as required by MDHHS following the CMS audit
2. In response to the CMS HCBS CAP, NorthCare has updated and developed policies to align with the HCBS Final Rule and initiated a comprehensive review of all HCBS cases in the region.
3. Tri-Annual HCBS Reviews and annual on-site physical reviews will begin per MDHHS guidance, using their new review tool once developed.

External Quality Reviews

- MDHHS Site Reviews

Follow up activities for site reviews conducted by MDHHS are carried out and/or monitored by NorthCare Network's Network Management and/or Quality Management Committees. To best address local concerns, each Member CMHSP may be asked to draft a remedial action plan for all citations for which the Member CMHSP has been identified as being out of compliance. NorthCare Network will consider each response for inclusion in the Plan of Correction submitted to MDHHS. NorthCare Network also provides consultation for Member CMHSPs and monitors the implementation of improvement activities.

- External Quality Review Organization

The Michigan Department of Health and Human Services (MDHHS) will arrange for an annual, external independent review of the quality and outcomes, timeliness of, and access to covered services provided by the PIHP. The External Quality Review (EQR) includes an on-site review of the implementation of the QAPIP. The EQR also validates methodologies used in conducting the

required performance improvement projects (PIP) as well as validates performance measure data collection and reporting to MDHHS. The PIHP addresses the findings of the external review through its QAPIP. The PIHP develops and implements performance improvement goals, objectives and activities in response to the external review findings as part of this QAPIP. A description of the performance improvement goals, objectives and activities developed and implemented in response to the external review findings will be included in the PIHP's Quality Improvement Plan and provided to the MDHHS upon request. The MDHHS may also require separate submission of an improvement plan specific to the findings of the external review.

Performance Measurement

NorthCare Network measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data. Through monitoring and evaluation, the efforts and resources of the Network can be redirected to obtain the desired outcomes.

By using performance indicators, the variation between the target desired and the performance being measured can be identified. Indicators are used to alert NorthCare Network and the Network Providers of issues that need to be addressed immediately, to monitor trends and contractual compliance, and to provide information to consumers and the public. Performance indicators are the foundation to control and improve processes.

Performance indicator results are used to guide management decision-making related to:

- Strategic planning
- Resource allocation
- Modification of service delivery
- Administrative process changes
- Staff training, credentialing and privileging
- Other activities identified by our various stakeholders

Performance Indicators [Measures]

NorthCare Network's Quality Oversight Committee monitors performance indicators for individual Member CMHSPs and collectively for the region. The QAPIP is utilized to ensure that at least the minimum performance level on each indicator is achieved. A plan of correction that includes a review of possible causes for outliers is required from any Member CMHSP for each Performance Indicator out of compliance for two consecutive quarters. NorthCare Network's Quality Oversight Committee and/or QI/UM Specialist will monitor any plans of correction. Performance data is reviewed and discussed with the various QAPIP committees.

- Michigan Mission Based Performance Indicator System (MMBPIS)

NorthCare Network utilizes performance measures established by MDHHS In FY26, PI2a will continue. The other PI measurements from FY25 are to be discontinued. The Quality Oversight Committee will review MMBPIS results. Member CMHSPs who are out of compliance with MDHHS and/or NorthCare standards will work with NorthCare Network QI/UM Specialist and the Quality Oversight Committee to ensure the implementation of effective improvement plans.

- HEDIS Measures

NorthCare has previously had access to HEDIS Measures and was reviewing some under the Performance Bonus Incentive Program (PBIP). Other measures have not been previously reviewed. In FY25, the HEDIS measures were collected alongside MMBPIS. In FY26, the HEDIS measures are replacing the previous performance indicators. MDHHS is focusing on the measures across a three-year period.

1. ADD: Follow up care for children prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication. This standard assesses the percentage of children aged 6-12 who receive adequate follow-up care after being newly prescribed medication for ADHD.
2. FUH: Follow up after hospitalization for mental illness. This standard assesses the percentage of members six years and older who were hospitalized for mental health or intentional self-harm diagnoses and had a follow-up mental health visit within seven and 30 days after discharge. It checks to see if there is an appointment within seven days and/or 30 days post discharge from a psychiatric unit, as care post hospitalization is important to recovery. Previously FUH was measured alongside the MMBPIS measurement for seven-day follow-up. CMH staff are accustomed to scheduling appointments for individuals within seven days when the individual is following up with CMH. The biggest change with the HEDIS measurement is that the follow up appointment can be anywhere. Staff may need to increase coordination of care with alternative providers for those choosing not to follow up at CMH.
3. APM: Metabolic monitoring for children and adolescents on antipsychotics. This measure looks at the percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had **both of the following** in the measurement year:
    a. At least one test for blood glucose (blood glucose test or HBA1c test); and
    b. At least one cholesterol test
4. APP: Use of First Line psychosocial care for children and adolescents on antipsychotics. This measure assesses the percentage of children and adolescents newly started on antipsychotic medications without a clinical indication who had documentation of psychosocial care as first-line treatment. Two age groups are reported for this measure:
    a. Ages 1-11
    b. Ages 12-17
5. FUA: Follow up after emergency department visit for substance use. This measure looks at the percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, who had a follow-up visit. Two rates are reported:
    a. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
    b. The percentage of ED visits for which the member received follow-up within seven days of the ED visit (8 total days).
6. FUM: Follow up after emergency department visit for mental illness. This measure represents the percentage of emergency department (ED) visits for members six years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

    a. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
    b. The percentage of ED visits for which the member received follow-up within seven days of the ED visit (8 total days).
7. IET: Initiation and Engagement into substance use disorder treatment. This measure looks at the rate of initial engagement in substance use disorder (SUD) treatment. It measures the percentage of adolescent (13-17 years) and adult (18+ years) patients with a new diagnosis of alcohol or other drug (AOD) abuse or dependence who initiated treatment or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis and who engaged in ongoing AOD treatment within 34 days of the initiation visit.

In year two, there will be additional measures of:

1. SSD: Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications
2. HPCMI: Diabetes Care for People with SMI and Hemoglobin A1c Poor Control
3. OUD: Use of Pharmacotherapy for Opioid Use Disorder
4. SAA: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

In year three, there will be additional measures of:

1. MSC: Medical Assistance with Smoking and Tobacco use cessation
2. CDF: Screening for Depression and Follow-up Plan

Additionally, in year three there will be performance measures related to Medicaid Managed Long-Term Services and Supports assessment and care plan, and patient experience.

- Regional Measures

NorthCare Network may establish and monitor additional performance indicators specific to an individual program for the purpose of identifying process improvement projects. Performance indicators employed should be objective, measurable, and based on *current* knowledge and experience to monitor and evaluate key aspects of care and service. Performance goals and/or a benchmarking process are utilized for the development of each indicator.

NorthCare Network will ensure compliance with and sustainability to meet performance measures as outlined in the contract between the State of Michigan - Michigan Department of Health and Human Services with NorthCare Network and the Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans.

NorthCare Network will participate and collaborate with the ICO/Medicaid Health Plan (MHP) in regular and ongoing initiatives that address methods of improved clinical management of chronic health conditions and methods for achieving improved health outcomes for Members enrolled in any Medicaid program with the ICO/MHP.

Outcomes Management

NorthCare Network's Clinical Practices and Quality Improvement Committee will establish outcome measures and conduct quality improvement efforts to ensure effective clinical practices

based on a recovery and trauma informed system of care that are consistent with utilization management principles.

Practice Guidelines

NorthCare Network's Clinical Practices Specialist is charged with the task of overseeing the adoption, development, implementation and continuous monitoring and evaluation of Practice Guidelines when there are nationally accepted or mutually agreed upon (by MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices, and promising practices that are relevant to the individuals served. Working with the regional Clinical Practices/Quality Improvement Committee, NorthCare's Quality Management Committee, and the regional UM Committee newly implemented treatment practices required by MDHHS are monitored. The NorthCare Network Practices Guideline Manual provides information regarding the process for the adoption, development, implementation, monitoring, and evaluation of the guidelines. This manual can be found on the NorthCare website.

NorthCare must disseminate all practice guidelines it uses to all affected providers and, upon request, to beneficiaries. Beneficiaries are informed of the guidelines in the member handbook. Members may access the electronic guidelines via a link to the NorthCare Network's Clinical Practice Guidelines webpage. Members may also request hard copies of Clinical Practice Guidelines free of charge by contacting NorthCare Network. CMHSP staff attest to having access to the guidelines annually. SUD provider staff attest to having access to the guidelines and, more importantly, the SUD operations manual- which is an SUD focused guide. NorthCare must ensure decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. NorthCare must ensure services are planned and delivered in a manner that reflects the values and expectations contained in practice guidelines adopted.

The MDHHS guidelines and expectations also identify mandatory assessment tools to utilize for services. These include the Level of Care Utilization System (LOCUS) for adults with Serious Mental Illness, MichiCANS for children with Serious Emotional Disturbance and/or Intellectual/Developmental Disability, and, new in late FY26 -FY27 the WHODAS-2.0 for Adults with Intellectual/Developmental Disability.

Additionally, for emergency services, NorthCare Network member CMHSPs use the MCG Indicia tool embedded into the regional preadmission screening form to assist in determining medical necessity for inpatient psychiatric admission. Staff that are determined to be administering preadmission screenings are required to periodically complete MCG Indicia interrater reliability activities to maintain adherence to the assessment.

To ensure fidelity to practice, NorthCare and the affiliate CMHSPs will participate in Michigan Fidelity Assistance Support Team (MiFAST) reviews, as required by MDHHS. MIFAST is required prior to implementation or use of specific Medicaid codes or modifiers and is available ongoing.

Verification of the Delivery of Medicaid Services

Verification of Medicaid services is conducted in accordance with NorthCare Network's Medicaid Service Verification Policy. This process is to ensure Medicaid services were furnished to enrollees by member CMHSPs, providers, and subcontractors with corrective action taken as warranted.

Improvement Strategies

Establishing and successfully carrying out strategies to eliminate outliers, incorporate best practices, and optimize consumer outcomes is key to continuous quality improvement. The particular strategy or sets of strategies used vary according to the situation and the kind of improvement that is desired. The following provides a brief description of some of the improvement strategies utilized.

Performance Improvement Projects (PIP)

Standards published by the Centers for Medicare and Medicaid Services (CMS) require that the PIHP (Prepaid Inpatient Health Plan) conduct, "performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction."

NorthCare Network must engage in at least two affiliation-wide projects during each waiver period, which must address clinical and non-clinical aspects of care. Project topics are either mandated by MDHHS or selected by the PIHP in a manner that takes into account the prevalence of a condition among, or need for a specific service by, the organizations' consumers, consumer demographic characteristics and health risks, and the interest of consumers in the aspect of service to be addressed. Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care; while non-clinical areas would include, but not be limited to, appeals, grievances, trends and patterns of incident reports as well as access to, and availability of, services.

Projects selected may fulfill both MDHHS/HSAG and applicable accreditation requirements. The Performance improvement projects must be included in the QAPIP and must include the following elements:

1. Measurement of performance using objective quality indicators.
2. Implementation of interventions to achieve improvement in the access to and quality of care.
3. Evaluation of the effectiveness of the interventions based on the performance of measures.
4. Planning and initiation of activities for increasing or sustaining improvement.

PIP's are selected based on requirements of the PIP structure when possible. The HSAG validated co-occurring disorder treatment PIP was selected and modified as there is not enough ethnic variation in the UP to create a PIP centered around racial disparity.

When determining a PIP, NorthCare meets with the region via regional committee to discuss possible PIP topics. A topic is picked if it has the most regional support and the initial data review supports the need for a PIP that meets any of the criteria of the PIP structure. NorthCare then continues PIPs until improvement is shown that allows for sunsetting of the PIP. At times, a PIP will need to be modified based on additional discovery found in the data or review of literature.

Oversight of the PIPs is achieved through collaboration with regional committees and workgroups. Improvement is tracked on an ongoing basis through reviewing and updating the workplan, data

collection reports, and analysis of the data. Results are communicated to appropriate committees and stakeholders.

NorthCare PIPs include:

1. To Increase the Percentage of Individuals Ages 12 and Older Who Are Diagnosed With a Co-Occurring Disorder That Are Receiving Co-Occurring Treatment.

This HSAG validated PIP started in FY22, with the goal of increasing the percentage of individuals who are diagnosed with a Co-occurring disorder (COD) for children ages twelve to twenty-five and adults ages twenty-six and older who are receiving integrated COD treatment. Co-occurring is defined as having both a mental health and substance use diagnosis. The hope is that both populations will improve in their respective percentages of individuals with co-occurring needs being treated co-occurring treatment.

Thus far this PIP has not shown improvement. Further there has been concern with the data source used for measurement. Data has been remeasured but still no improvement has been shown from baseline to the most recent measurement period.

This PIP will be discontinued when a new PIP is allowed.

2. To increase the number of satisfaction survey responses received.

This PIP will increase options for responses by increasing the number of formats and methods. The survey will be available to consumers utilizing SUD providers as well; although the methods will be limited. There will be increased data collection and analysis from the additional data obtained. Responses will be used to improve the network.

Utilization Management (UM)/Authorization strategies

NorthCare Network UM activities are specifically designed to ensure only eligible beneficiaries receive plan benefits; that services received meet medical necessity criteria and are linked to other services when needed. To achieve these goals, various methods are used that focus on eliminating outliers, incorporate best practices, and optimize consumer outcomes. To improve overall quality of consumer outcomes and consistency in the amount, scope, and duration of services, clinicians use the NorthCare Network level of care placement protocols to guide level of care determinations. This clinical decision-support tool allows for greater consistency in level of care assignments and aimed at reducing variances in service delivery. Staff also use MDHHS required tools to assess the appropriateness of care given the individuals population status, including: the ASAM Continuum, LOCUS, DECA, and MichiCANS, and, once available, the WHODAS-2. Finally, utilization review activities are employed which include monitoring of individual consumer records, specific provider practices and system trends. Review and monitoring activities are used to determine appropriate application of guidelines and criteria for decision involving level of care assignments, service selection, authorization, and best practices. Tracking consumer outcomes, detecting over utilization/underutilization and reviews of outliers are also the subject of utilization review efforts. In FY25, a dashboard for over/underutilization was created using the PowerBI program. Other Power BI dashboards are being created. This platform significantly increases the data analysis capabilities associated with utilization management and allows for increased qualitative and quantitative review.

Procedures for Adopting and Communicating Process & Outcome Improvements

NorthCare Network will incorporate the Home and Community-Based Services (HCBS) Quality Framework developed for the Centers for Medicare and Medicaid (CMS) into its Quality Management Program. This Quality Framework is intended to serve as a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of services and supports provided by NorthCare Network's provider network. The Framework focuses attention on critical dimensions of service delivery and the desired outcomes of the four functions of quality management: design, discovery, remedy and improvement. Further, definitions of the functions of quality are:

- Design: Designing quality assurance and improvement strategies for a program at the initiation of the program.
- Discovery: Engaging in a process of discovery to collect data and direct participant experiences to assess the ongoing implementation of the program, identifying both concerns as well as other opportunities for improvement.
- Remedy: Taking actions to remedy specific problems or concerns that arise.
- Continuous Improvement: Utilizing data and quality information to engage in actions that assure continuous improvement in the program.

Focus will be on the following seven broad categories as outlined by CMS:

- Participant access
- Person-centered planning and service delivery
- Provider capacity and capabilities
- Participant safeguard
- Participant rights and responsibilities
- Participant outcomes and satisfaction
- System performance

Suggestions for improvement can come from a variety of sources. Feedback from consumers, advocates, stakeholders, network providers, MDHHS, and NorthCare Network Personnel is incorporated into the QI Plan's components and activities. NorthCare Network's QI Work Plan will identify measurable objectives, as well as the individuals and/or departments responsible for each objective. Also included will be a timeline for completion of tasks and schedule for ongoing monitoring as appropriate. This document details the specific actions NorthCare is completing related to quality improvement and is a working document. The document will be reviewed and updated intermittently at Quality Management meetings.

Evaluation and Monitoring

A meeting is convened if NorthCare becomes aware of any significant provider-related issues of quality concern. Issues would be added to the Quality Improvement Workplan. The Quality Improvement Workplan is a document that summarizes areas of quality concern, the intervention plan in place for

improvement, and the staff responsible for the implementation and target resolution dates. The Quality Improvement Workplan considers severity, duration, frequency, and if the concern is clinical or not. Items in the workplan will be monitored quarterly unless otherwise specified. The workplan is a living document, updated throughout the year.

NorthCare Network's QAPIP is reviewed and updated at least annually with input from various stakeholders and approved by the Governing Board. The NorthCare Network Governing Board and NorthCare Network Quality Management Committee are responsible for the evaluation of the effectiveness of the QAPIP. This Annual Effectiveness Review includes analysis of whether there have been improvements in the quality of health care and services for recipients because of quality assessment and improvement activities and interventions carried out by the PIHP. The analysis considers trends in service delivery and health outcomes over time and includes monitoring of progress on performance goals and objectives. Information on the effectiveness of the QAPIP must be provided annually to network providers and to recipients upon request. This annual analysis will be provided to the MDHHS annually and no later than February 28.

NorthCare Network publishes an Annual Performance Management Report that provides a summary of accomplishments and highlights from the previous Fiscal Year as well as key information that will identify whether current systems and processes are providing the desired outcomes. This report will be posted at www.northcarenetwork.org, posted at NorthCare Network's main office, a copy sent to all Network Providers and members of NorthCare Network Governing Board and copies provided to stakeholders as requested.

Additionally, the Network Adequacy standards are also completed annually, and this information is provided to MDHHS by February 28th each year. Identified concerns are brought to the attention of leadership, provider network management, and contract committees.

References

- The Balanced Budget Act of 1997 (BBA)
- MDHHS /PIHP Master Contract
- MDHHS Michigan Mission Based Performance Indicator System V6.0 Codebook
- ICO/PIHP Contract for the MI Health Link Demonstration Program
- NorthCare Network Policies -- www.northcarenetwork.org

Attachments

A - Acronyms Used in this Document

B – Work Plan

Approvals

Reviewed/Revised Date: 7/29/25

Quality Management Committee Approval: 8/28/25

Policy Committee/CEO Approval: 8/5/25

Board of Directors Approval: 9/10/25

Attachment A- Acronyms used in this document

BBA – Balanced Budget Act
BHH – Behavioral Health Home
BTC – Behavior Treatment Committee
CEO – Chief Executive Officer
CMH – Community Mental Health
CMHSP – Community Mental Health Service Program
CMS – Centers for Medicare and Medicaid Services
COD – Cooccurring Disorder
EBP – Evidence Based Practices
EQR/EQRO – External Quality Review / External Quality Review Organization
HSAG – Health Services Advisory Group (External Quality Review Organization contracted by MDHHS to conduct annual reviews of each PIHP.)
HCBS – Home and Community-Based Services
HIPAA – Health Insurance Portability and Accountability Act
HMP – Healthy Michigan Plan
ICO – Integrated Care Organization
I/DD – Intellectual/Developmental Disability
LTSS – Long Term Supports and Services
MDHHS – Michigan Department of Health and Human Services
MI – Mental Illness
MHP – Medicaid Health Plan
PIHP – Prepaid Inpatient Health Plan
PIP – Performance Improvement Project
PMC – Performance Management Committee (A NorthCare Network Committee represented by Directors of each Member CMHSP and NorthCare Network's CEO)
QAPIP – Quality Assessment and Performance Improvement Plan
QC – Quality Council
QI – Quality Improvement
QIP – QI (Quality Improvement) Plan
SUD – Substance Use Disorder
SUDHH- Substance Use Disorder Health Home
UM – Utilization Management

FY26 QAPIP Workplan

Objective/Activities	Lead / Population	Previous Measure	Goal Measure	Start/ Frequency/ Due Dates	Status / Recommendation	Guiding Criteria (CFR, contract, C-waiver)
Performance Indicators and Measures						
PI2a: BPS within 14 days: Given FY24 new measurement goals, NorthCare will seek to improve this measure beyond the 75th percentile of 62%. PI will be reviewed with each CMH and data presented to appropriate regional meetings.	QI / MH	56% (based on average of Q1-2)	62%	FY23 (mid) Quarterly FY24Q2 and Ongoing	Continue / bring to CPQI, QM, and PMC	Contract MMBPIS Standards
Identify trends in recidivism and 7-day follow up; their relationship to inpatient ALOS, and correlations between the 3. Address trends with appropriate providers.	QI / MH	NA		FY24 Quarterly Ongoing	Continue / bring to CPQI, UM, PMC, and hospital specific information to contracted hospital meetings.	
Improve timeliness of priority population admissions for SUD populations by developing a monitoring method and monitoring frequently. Overall decrease in number of out of compliance priority population admissions.	QI / SUD	NA	80%	FY24 Quarterly Ongoing	Continue / bring to SUD regional meeting, QM, and PMC	
P.1. Implement data driven outcomes measurement to address social determinants of health. Focus Area: Compare with PBIP data to better impact employment and housing related concerns.	QI / MH	NA		FY24 Quarterly 10.1.24	Continue	PBIP FY25 Pay for Performance (P4P) Measures reporting
Ensure Assessment within three days of Residential SUD admission	QI / SUD	NA	80%	FY26	Start	
Ensure continuation in treatment following assessment for SUD services	QI / SUD	NA	70%	FY26	Start	
Objective/Activities	**Lead / Population**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Performance Improvement Project - Increase the percentage of individuals ages 12+ who are diagnosed with cooccurring disorders that are receiving cooccurring treatment						
Baseline Data Calendar year 21 – 17.78%. NorthCare will review data timely and bring to appropriate meetings to discuss improvement strategies.	QI & Data / SUD	NA	Better than 23	FY23 Quarterly Ongoing	Continue / bring to CPQI, UM, PMC, and PIP workgroup	QAPIP
Offer consultative services to CMHSPs to improve co-occurring illness, via contract with psychiatrist board certified in addiction medicine.	ICT / SUD	Began June 23	Increased utilization from 23	FY23 Monthly Ongoing	Continue	QAPIP
Non-PIP - Develop the ability to offer consultative services to	SUD Director /	NA	Creation of a contract to	FY26	Start	

SUD providers contracted with NorthCare to improve treatment for individuals with co-occurring needs while in SUD treatment.	SUD		offer this service			
Performance Improvement Project: Increase the number of satisfaction survey responses.						
Increase the responses to the satisfaction survey	CS & QI / MH & SUD	FY25 start date – baseline data	Increase – numbers very low	FY25	Start/ Continue	QAPIP
Objective/Activities	**Lead / Population**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Event Reporting – Increase data reporting capability by building better reports and using the data to analyze improvements in the quality of healthcare and services for members.						
Utilize Power BI for better data analysis and review data during the Health and Safety Committee (internal) and Regional Incident Reporting (regional) meetings.	QI / MH & SUD	NA	Begin use	FY23 Quarterly Ongoing	Continue	QAPIP
Increase timely categorization of incidents as being critical, sentinel, risk, immediately reportable to 95% within three business days of incident.	QI / MH & SUD	NA	95%	FY23 Quarterly Ongoing	Continue	QAPIP
Ensure individuals living in residential living arrangements are in the correct level of care; ensuring discussion of transition for any found to be in an inappropriate level of care.	QI & CP / MH	Completion of quarterly review	Completion of quarterly review	FY23 Quarterly Ongoing	Continue / recommend setting a schedule for this activity	QAPIP
Ensure individuals receiving SUD residential services are in the correct level of care	QI / SUD	NA	80%	FY26	Start	
Ensure individuals meeting Priority Population criteria that are discharged are connected to the NorthCare Priority Population Care Manager	Priority Pop. Manager / SUD	NA	80%	FY26	Start	
Review RCA Outcomes data to assess common causal factors for possible improvement project.	QI & CP / MH & SUD	NA	Annual review	FY23 Annually Ongoing	Continue / determine if completion during site review makes most sense or mid-year review	QAPIP
Review all untimely deaths with NorthCare Medical Director and trend data over time.	QI & CP / MH & SUD	NA	Monthly	FY24 Monthly Ongoing	Continue	QAPIP
Objective/Activities	**Lead / Population**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Behavior Treatment Plan Review – NorthCare will complete analysis of BTC data and implement systemic change related to data findings as necessary.						
NorthCare will collect quarterly data from the CMH's and present data at the regional BTC meeting and internal health and	QI & CP / MH	Completion of quarterly review	Completion of quarterly review	FY23 Quarterly Ongoing	Continue / bring data and specific consumer	42 CFR 438.100 (b)(2)(v). Balanced Budget Act of 1997

safety committee meeting. Determine the "why" of the incident.					concerns to each CMH.	
NorthCare will utilize data to determine improvements/ changes in care due to BTC both on select individuals and programmatically. Review interventions and incidents; specifically 911 use and physical management.	QI & CP / MH	Reduction in use of physical management (325 events)	Reduction in use of physical management	FY23 Quarterly Ongoing	Continue / bring data and specific consumer concerns to each CMH.	42 CFR 438.100 (b)(2)(v). QAPIP
Analysis of BTC survey data to determine any concerns related to the program. Additionally, the BTC regional committee will review relevant data to identify statistically significant trends for additional improvement plans.	QI & CP / MH	Completion of survey (311 responses)	NA – biannual	FY24 Biannual Ongoing	Continue	42 CFR 438.100 (b)(2)(v).
HCBS Modifications – Modifications of HCBS conditions will be supported by an assessed need that is justified in the person-centered plan.						
Review a random sample of HCBS cases at annual site reviews.	HCBS Lead / MH	NA	Begin review	FY22 Annually Ongoing	Was to discontinue and follow MDHHS HCBS Monitoring Technical Requirement for FY26. However, per MDHHS/CMS HCBS CAP requirements additional monitoring is to occur and this review will remain a standard on our annual CMHSP site review.	42 CFR §441.301 (c)(4)(vi)(A-D)
Comprehensive review of all HCBS cases per CMS HCBS CAP.	QI & UM / MH	NA	Begin review	One-Time	HCBS cases with identity BTP will be reviewed and compliant by 12/30/2025. All remaining HCBS cases will be reviewed and compliant by 07/2026.	HCBS CMS CAP
Tri-Annual HCBS Comprehensive Reviews Every HCBS case will require a comprehensive review every three years. Review tool to be developed by MDHHS.	HCBS Lead / MH	NA	Begin Review	Tri-Annually	This will begin once direction/review tool is provided by MDHHS.	Contract
Objective/Activities	**Lead / Population**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)

Member Experience with Services – Use of an annual assessment addressing member experience, national data, LTSS, focus areas, and NCI results to address dissatisfaction and improve overall consumer satisfaction.						
Update the electronic process to achieve higher response rates to customer satisfaction survey.	CS / MH & SUD	Low	25%	FY23 Annually 9.1.24	Continue	
Analyze satisfaction survey data, address areas of dissatisfaction, and publish associated interventions in annual QAPIP effectiveness review.	CS / MH & SUD	NA		FY23 Annually 2.28.25	Continue	
Evaluate program satisfaction rate for all, including those receiving LTSS services.	CS / MH & SUD	NA		FY24 Annually 2.28.25	Continue	42CFR438.10e.2.x
Grievance and Appeals – ensure grievance and appeals are completed timely, provide appropriate						
Pull a random sample, by provider, of ABD notices to ensure ABDs have all necessary elements, are written at an appropriate readability, and are completed timely.	CS & QI / MH & SUD	80%	90%	FY22 Quarterly Ongoing	Continue	42 CFR 438.400, 42 CFR 438.210, 42 CFR 438.408
Ensure grievance letters are written to the member, error free, and written at an appropriate readability via quarterly reviews.	CS / MH & SUD		90%	FY22 Quarterly Ongoing	Continue	42 CFR 438.400
Review grievance extension letters to ensure they are error free and completed on the developed template.	CS / MH & SUD			FY23 Quarterly Ongoing	Continue	42 CFR 438.400
Acknowledge receipt of each member appeal timely.	CS / MH & SUD		100%	FY22 Quarterly Ongoing	Continue	42 CFR 438.406
Provide training regarding the difference between an extension request and ABD delay.	CS & QI / MH & SUD			FY24 Once	Commence in FY25 Q4	
Review targeted scenarios to ensure ABD completion – decision delays and commencement date of services	CS & QI / MH & SUD			FY25 Quarterly	Start	
Application Programming Interface – API – NorthCare will implement a patient access API and provider directory API.						
Update the website to be more user friendly and accessible to multiple stakeholders and developers.	IT / MH & SUD			FY24 Once 10.1.24	Continue improving accessibility	
Objective/Activities	**Lead / Population**	**Previous Measure**	**Goal Measure**	**Start/ Frequency / Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Practice Guidelines – Ensure development of requested CPGs, adoption of updated MDHHS CPGs, and dissemination of all CPGs to regional providers.						
Ensure review and updates to CPG's annually. Providers to acknowledge updates.	CP / MH & SUD	Annual	Attestation from each CMH LMS user and SUD providers	FY23 Annually 1.25.24	Continue / make part of annual training requirements	QAPIP
Ensure that screening tools recommendations are followed or adequately adjusted to ensure	CP / MH	Annual review	Annual review	FY23 Annually Ongoing	Continue with modifications	

validity to the CPG (e.g. LOCUS overrides, MichiCANs recommendations).						
Develop SUD guidelines as necessary that are not currently spelled out in the SUD Operations Manual or other SUD source documents	SUD clinical / SUD	NA	Development of guidelines for services currently without	FY26	Start	
Objective/Activities	**Lead / Population**	**Previous Measure**	**Goal Measure**	**Start/ Frequency / Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Credentialing and Re-credentialing – Ensure consistent factors considered during credentialing and recredentialing (grievances, PI, utilization, appeals, member satisfaction, and provider reviews) and that MDHHS requirements are met.						
Develop and implement detailed credentialing/recredentialing file auditing plan addressing credentialing/ recredentialing requirements, citations, and recommendations made in HSAG review. Developing an area in ELMER for region to utilize for credentialing/recredentialing of staff that will capture all required information of the staff as well as timeframes effective.	PNM / MH	Annual audit	Decreased number of charts out of compliance.	FY22 Annually September	Continue	42CFR438.214
Ensure non-licensed providers meet all Medicaid requirements.	PNM / MH & SUD	Annual audit	Decreased number of files out of compliance.	FY22 Annually September	Continue	
Conduct annual audit of all delegates performing credentialing activities according to audit plan.	PNM / MH & SUD	Annual audit	Decreased number of files out of compliance.	FY22 Annually September	Continue	
Ensure all SUD providers meet requirements for providing SUD services.	PNM / SUD	Annual audit		FY26	Start	
Objective/Activities	**Lead / Population**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Verification of Services – Medicaid Service Verification – Complete Medicaid Service Verification timely and address any barriers identified for services delivery and health outcomes.						
Obtain / maintain compliance with requirements for Medicaid Service Verification. Share data in appropriate committees.	CO / MH & SUD	90%	95%	FY22 Annually Ongoing	Continue	QAPIP
Objective/Activities	**Lead / Population**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Utilization Management – Improve consistency in UM decisions across various areas of need, such as: residential level of care, eligibility criteria, medical necessity criteria for specific services.						
Review underutilization and denoted reasons for underutilization in progress notes, periodic reviews, and other sources.	UM / MH & SUD	NA	Identify areas of concern and take steps to remediate them	FY23 Biannual Ongoing	Continue	

Review overutilization of services as indicated by additional authorization requests.	UM / MH & SUD	NA	Identify areas of concern and take steps to remediate them	FY23 Biannual Ongoing	Continue	
Discuss Interrater reliability (IRR) in the state PIHP workgroup for statewide consistency.	UM / MH	Use of IRR for pre-admission screenings	Continued use and better performance (e.g. less staff needing multiple vignettes to pass)	FY23 Annually Ongoing	Continue	Parity
Complete a sample of chart reviews to ensure accuracy and completeness of charts and compliance with C waiver requirements and CFR.	UM / MH	77%	80%	FY24 Biannual Ongoing	Continue	MDHHS C-Waiver Code of Federal Regulations (HSAG)
Determine the utilization and authorization mean and median for all services during a given time period to analyze the variance and determine appropriate benefit plans	UM / MH	NA	Calculate data	FY25	Start	
Compare "like" services for areas that are lacking a service	UM / MH & SUD	NA	Begin comparison	FY25	Start	
Complete targeted reviews as necessary in areas necessary such as % of the population in each LOC	UM / MH	NA	Begin reviews	FY25	Start	UM plan
Review penetration rates, by CMH, by program	UM / MH	NA	Calculate data	FY25	Start	UM plan
Complete LOCUS reviews on a quarterly basis to identify pain points associated with resulting inaccurate level of care determinations.	UM / MH	NA	Completion of reviews and data disseminated	FY25	Start	
Access to Services – Improve consistent access to services across the region						
Review a random selection of screenings for screener approval rate, determination at BPS, and other factors to identify trends and address any concerns. (second opinions, calls by agency, duplicate screenings, crisis and access interaction, etc.)	UM / MH	NA	Data brought to regional committees	FY24 Quarterly Ongoing	Continue	
Review data related to Emergency Services (ES) such as Average Length of stay, recidivism, 7-day follow up, IPOS amendments post hospitalization (change in need), hospital denials, ER boarding, diversion rates, denial trends)	UM / MH	NA	Data brought to regional committees	FY25	Start	
Increase the number of individuals admitted to	UM / SUD	NA	Determine baseline	FY26	Start	

treatment following an approved screening and referral for treatment from NorthCare Access.						
Objective/Activities	**Lead / Population**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Provider Network Management – Ensure there is an adequate provider network.						
Review the service array and address areas of deficiency.	PNM & QI / MH &SUD	Areas identified	Decreased the number of deficient areas	FY23 Annually Ongoing	Continue	42CFR438.207
Continued review of ABD capacity related denials and address areas of deficiency.	PNM & QI / MH &SUD	3% of FY23 denials were due to capacity	1%	FY23 Quarterly Ongoing	Continue	
Expansion of Behavioral Health Home (BHH) providers; specifically CSS in FY25.	HH Lead / MH	NA	Recruitment of additional providers. GLRC joined the BHH panel in FY24	FY23 Monthly Ongoing	Continue	BHH Handbook
Create and run report to assess significant changes in provider network or membership, including location of providers to members.	PNM & QI / MH &SUD	NA	Add services in identified deficient areas, or increase contracts	FY24 Annually Ongoing	Continue	HSAG Standard 4 / Element 4
Objective/Activities	**Lead / Population**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, C-waiver)
Long Term Services and Supports – LTSS – Compare services received by LTSS consumers vs what was authorized in their plan (over/under utilization of LTSS services).						
Review individuals in AFC level of care that do not have a matching LOC in the system to determine if AFC level of care appears appropriate	QI & CP & UM / MH	Review five cases per quarter	Review five cases per quarter	FY23 Quarterly Ongoing	Continue	
Review underutilization of authorized LTSS services.	QI & UM / MH	Review ten cases per quarter	Review ten cases per quarter	FY23 Quarterly Ongoing	Continue	
Oversight of Vulnerable Individuals –Integrated/Coordinated Care - Care coordination between the behavioral health and physical health providers will occur.						
Individuals receiving specialty care will have the recommendations of those providers incorporated into their behavioral health IPOS and a consent to share information. This will be reviewed via annual site reviews.	ICT / MH	92.6%	95%	FY22 Annually Ongoing	Continue	
Behavioral Health Home (BHH) services will expand for individuals with at least one co-morbid physical health condition at the CMHSPs.	PHS / MH	154 enrollees, six HHP's (Aug 2024)	175 enrollees	FY23 Monthly Ongoing	Continue	
Use health home data to create quality improvements within the	PHS / MH					

programs and expand the programs appropriately.						
CMHSP's will expand the provision of H0034 – Medication Training and Supports, S9445 Patient Education individual, T1001 and T1002 RN/Nursing Services.	PHS / MH			FY23 Annual Ongoing	Continue	Health Services Committee
NorthCare and UPHP will have bi-monthly data collaboration workgroup meetings to address shared member health care outcomes and gaps.	ICT / MH	7603 unduplicated shared members (FY24Q1-3)		FY23 Bi-monthly Ongoing	Continue	
Transition of Care – Care will be coordinated when transitions are occurring.						
The Medicaid Health Plan (UPHP) will be notified of all psychiatric hospitalizations and discharges for shared members.	UM / MH	100%	100%	FY23 Weekly Ongoing	Continue	PIHP-MHP Joint Care Protocol Workgroup
Waiver transitions to another PIHP area will be coordinated as they occur.	WC / MH			FY24 PRN Ongoing	Continue	
Individuals discharging from the psychiatric unit will have a completed assessment, BPS, periodic review, or IPOS amendment within 30 days of discharge.	UM / MH	NA	95%	FY26	Start	
Coordination of Care will occur when an individual is discharged from SUD services	UM / SUD	NA	80%	FY26	Start	
Waiver Services – Ensure timely HSW recertifications and pended cases.						
NorthCare will provide ongoing monitoring to the CMH's about expiring cases.	WC / MH	Notification to CMH leads at least quarterly	Notification to CMH leads quarterly	FY24 Monthly Ongoing	Continue	Result of performance issue
NorthCare will notify the CMH CEOs of data and data will also be shared in regional meetings.	WC / MH	Notification to CEOs occurred quarterly	CEO notification quarterly	FY24 Monthly Ongoing	Continue	Result of performance issue
Review of service utilization specific for waiver services/waiver individuals	WC / MH	NA		FY26	Start	

FY26 Ongoing Satisfaction Survey Performance Improvement Project (PIP)

The FY25 non-HSAG validated, non-clinical Satisfaction Survey PIP is detailed below and on the following page.

The PIP continues in FY26 and reflects updates. The workgroup, comprised of CMHSP staff and NorthCare staff, has worked to develop an updated survey questionnaire and format. The survey is available electronically here: https://forms.microsoft.com/r/aE7sDR8GtL. Paper versions of the survey are still available, although electronic completion is encouraged. The standard operating procedure was updated to reflect the changes in the survey and process on 10.1.24. Use of the new survey began 10.7.24. More information about the PIP can be found in the effectiveness review portion of this document, starting on page 118. The survey form, with indication of the question categories, is on the next page.

AGENCY NAME ON HEADER

Satisfaction Questions

Hello! We want to ensure we are providing you with quality services. Your responses will help shape our improvement efforts. Please complete this brief form. Thank you for your response.

If you need help completing this form, please contact Customer Service at 906-225-7254 or 1-888-333-8030.

Where did you hear about this questionnaire?

☐ Website/Social ☐ Agency Staff ☐ Waiting Room ☐ Poster ☐ Text Message ☐ Other: _____

Please indicate your relationship to the person receiving services.

☐ Myself ☐ Parent/Guardian of a minor (under 18) ☐ Guardian of an adult

I am reporting satisfaction on (*please complete a and b*)**:**

a. ☐ Adult Services **or** ☐ Child/Youth Services

b. ☐ Mental Illness **or** ☐ Intellectual / Developmental Disability

Service / Staff I am reporting satisfaction on: _____

	Check the box that best reflects your level of satisfaction.	**Strongly Agree** ★★★★	**Agree** ★★★	**Disagree** ★★	**Strongly Disagree** ★
1	I know where to voice concerns about services and feel safe doing so.	A			
2	Appointments and services are available at times that work well for me.	A			
3	Staff included me in making decisions and let me pick my goals.	B			
4	I chose who was involved in developing my plan with me.	B			
5	I had a chance to review and make changes to my plan.	B			
6	I know what to do if I am in crisis.	C			
7	Services have helped me.	C			
8	I am better able to do the things I want to do because of services I have received.	C			
9	I have learned skills to handle difficult times.	C			
10	Staff are welcoming and make me feel comfortable.	D			
11	Staff have helped me reach my goals and/or work towards reaching them.	D			
12	I was told about services that are available.	D			
13	Staff coordinate care with my doctors and agencies I use.	D			
14	Staff helped me find supports outside of my current services when needed.	D			
15	I am satisfied with the services I receive here.				

Additional Comments:

THEME: A – COMFORT; B – PLANNING; C – GOAL PROGRESS; D – STAFF PRESENTATION / ASSISTANCE

_____

_____

If you would like to be contacted about this survey, please indicate your name and phone number below.

Name: _____ Phone: _____