QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN

FY26 Workplan

Approvals:

Quality and Compliance Oversight Committee	January 6, 2026
Internal Operations Committee	January 8, 2026
NMRE Board of Directors	January 28, 2026

INTRODUCTION

The Northern Michigan Regional Entity (**NMRE**) is the Medicaid specialty prepaid inpatient health plan (PIHP) for the five Community Mental Health Services Programs (CMHSPs) serving the northern lower peninsula of Michigan. The member Boards are:

Wellvance (WV, formerly known as AVCMH) serving Iosco, Ogemaw, and Oscoda counties,
Centra Wellness Network (CWN) serving Benzie and Manistee counties,
North Country Community Mental Health Authority (NCCMH) serving Antrim, Charlevoix, Cheboygan, Emmet, Kalkaska, and Otsego counties,
Northeast Michigan Community Mental Health Authority (NEMCMH) serving Alcona, Alpena, Montmorency, and Presque Isle counties,
Northern Lakes Community Mental Health Authority (NLCMH) serving Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, and Wexford Counties.

The managed care activities are the responsibility of the NMRE.

The QAPIP is intended to outline requirements and provide guidance for carrying out organizational functions.

AUTHORITY

The Quality Assessment and Performance Improvement Program (QAPIP) is reviewed and approved on an annual basis by the NMRE Governing Board. Through this process, the Governing Board gives authority for the implementation of the plan and all its components. This authority is essential to the effective execution of the plan. The Governing Board receives periodic updates on the QAPIP, as well as a year-end effectiveness review.

MISSION & VISION

Mission: Develop and implement sustainable, managed care structures to efficiently support, enhance, and deliver publicly funded behavioral health and substance use disorder services.

Vision: A healthier regional community living and working together.

PURPOSE

As the PIHP for the twenty-one-county region, the NMRE's mission guides quality improvement activities. The QAPIP is intended to serve several functions, including but not limited to:

- Serve as the quality improvement structure for the managed care activities of the NMRE as the PIHP for the twenty-one-county area.
- Provide oversight of the CMHSPs' quality improvement structures and ensure coordination with PIHP activities, as appropriate.
- Provide leadership and coordination for the PIHP Performance Improvement Projects (PIPs).

This written plan describes how these functions will be accomplished. It also describes the organizational structure and responsibilities relative to these functions. A Designated Senior Official (NMREs Chief Clinical Officer) is responsible for coordinating activities related to the design, implementation, management, and evaluation of the quality improvement and compliance programs. On an ongoing basis the Chief Clinical Officer works with various committees to conduct an effectiveness review of the QAPIP and the previous fiscal year's workplan. The effectiveness review includes an analysis to determine whether members experienced any improvement in their quality of healthcare and services as an outcome of QAPIP activities. The effectiveness review is shared with the NMRE Governing Board, network providers, beneficiaries, and the public (via the NMRE website). The effectiveness review is used to inform the following year's QAPIP and Workplan.

STRUCTURE

1. Provider/Beneficiary Involvement

   The involvement of provider and beneficiary representatives is essential to the effectiveness of the QAPIP; this involvement is sought, encouraged, and supported at several levels including:
   a. The NMRE Governing Board includes beneficiaries as members.
   b. The NMRE Consumer Advisory Panel (Regional Entity Partners) provides input on various managed care activities.
   c. The regional Quality and Compliance Oversight Committee (QOC) is comprised of staff from the NMRE, its member CMHSPs, with SUD representative attendance on as needed basis.
   d. Each member CMHSP operates a Consumer Advisory Committee and includes beneficiary representatives on its Governing Board and on various committees.

2. NMRE Internal Operations Committee

   The NMRE Internal Operations Committee (IOC) has the central responsibility for the implementation of the QAPIP. Committee membership consists of key NMRE staff including but not limited to:
   a. Chief Executive Officer
   b. Chief Information Officer/Operations Director
   c. Chief Financial Officer
   d. Chief Clinical Officer
   e. Executive Administrator
   f. Compliance and Customer Services Officer
   g. Provider Network Manager
   h. Human Resources Director

3. NMRE Quality and Compliance Oversight Committee

   The regional Quality and Compliance Oversight Committee (QOC) has the responsibility for ensuring that network providers have appropriate quality improvement structures and activities necessary to meet federal and state requirements. This group provides the primary link between the quality improvement structures of network providers and the NMRE. To

create this link, the CEO of each member CMHSP appoints representatives to serve as members of the committee.

4. CMHSP Quality Improvement Committees
   Each member CMHSP has a Quality Improvement process to address quality issues within its operations that meet the requirements of MDHHS and the NMRE.

5. NMRE Governing Board/Board of Directors
   The business, property, and affairs of the Northern Michigan Regional Entity are managed by its Governing Board. The Governing Board of the Northern Michigan Regional Entity is a policy Board. It does not directly operate the Northern Michigan Regional Entity; it determines policy which the CEO executes.

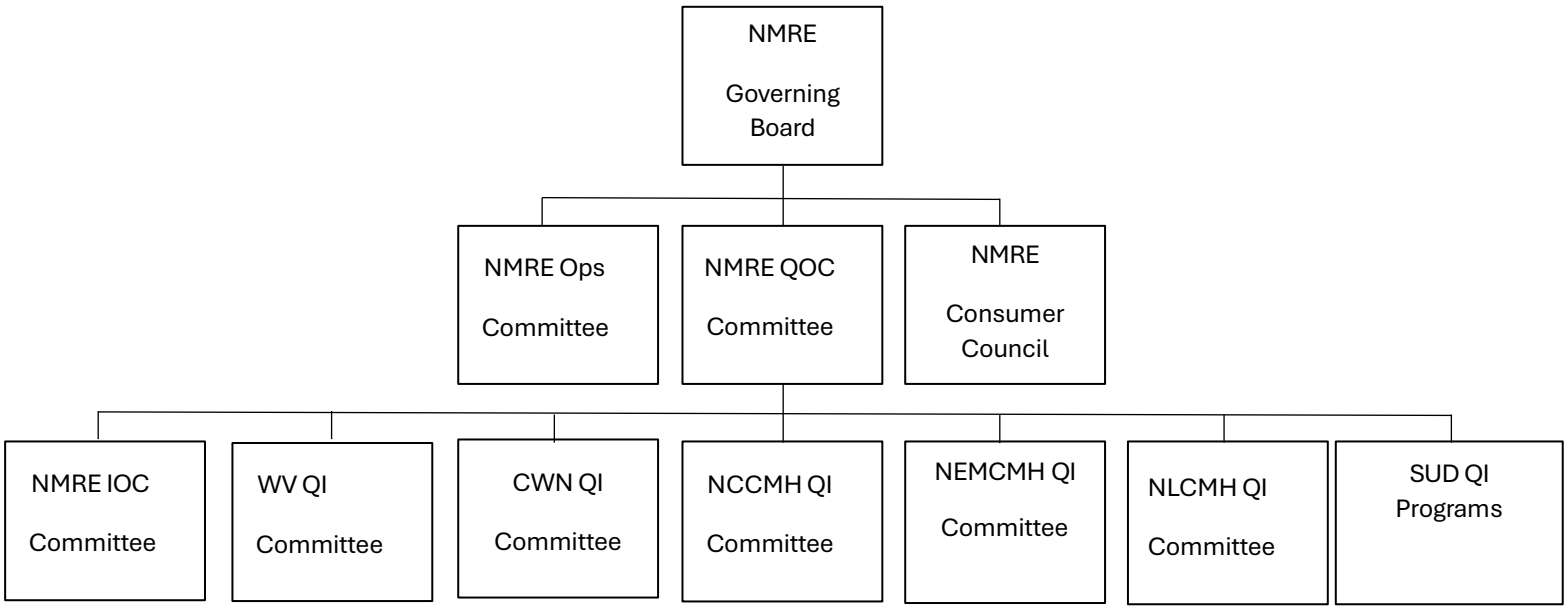
   Each of the five participating Member Community Mental Health Services Programs apponts individuals from its current Board roster to serve on the Northern Michigan Regional Entity Governing Board. At least one individual must have received mental health or substance use disorder services, as defined in the Mental Health Code and the Public Health Code, 1978 PA 368, and 2012 PA 500.

NMRE Board Members:	Robert Adrian, Dave Freedman, Ed Ginop, Karen Goodman, Ron Iseler, Dana Labar, Eric Lawson (Vice-Chair), Mary Marois, Michael Newman, Jay O'Farrell, Ruth Pilon (Secretary), Don Smeltzer, Don Tanner (Chair), Chuck Varner

6. Accountability

   Because one of the tenants of quality improvement and a key element of a successful team is accountability, the success of the NMRE's QAPIP is dependent on the success of its parts. Employees and/or agents of the NMRE and its network providers are accountable to beneficiaries, coworkers, various committees, and their primary employer for the quality and integrity of their work.

   The following table displays the reporting accountability of the various components of the quality improvement system.



NMRE Board Structure

The components of the QAPIP Structure are intended to ensure compliance with the following required activities:

1. Performance Improvement Projects

The NMRE will engage in Performance Improvement Projects (PIPs), addressing clinical as well as non-clinical aspects of care. PIPs will involve measurable and objective quality indicators, interventions leading to improvement, as well as evaluation of effectiveness. The goal of PIPs is to improve health outcomes and member satisfaction.

PIP #1 (Opioid Health Home PIP)

The NMRE Quality and Compliance Oversight Committee (QOC) will continue to collect data, conduct ongoing analysis, and coordinate with providers to improve the number of individuals enrolled in the Opioid Health Home (OHH) program as part of the broader Substance Use Health Home (SUDHH). The NMRE will collect data and conduct analysis to show evidence of improvement in enrollment from the baseline by September 30, 2026. Non-clinical/HSAG Validated

PIP #2 (Behavioral Health Home PIP)

The NMRE QOC will collect data and conduct analysis for Behavioral Health Home (BHH) enrollment. The NMRE will strive to improve the percentage of individuals who are enrolled in the Behavioral Health Home program from 6% to 7% by September 30, 2026. Non-Clinical

PIP #3 (Clinical PIP Development)

Performance Indicator 3 (PI 3) improvement goal is to increase the percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.

1. Anticipated Barriers: Staffing and lack of appointment slots due to staffing issues.
2. Anticipated Strengths/Challenges: Staffing, trained staff, automated appointment reminders, consumers cancelling, rescheduling, or requesting outside of the 14-day window due to their own schedules, no-shows, requesting in-person (not telehealth) services, which significantly reduces the number of available therapists.
3. Interventions: Ongoing review of performance indicators to learn about trends and potential process changes that may be needed, additional staff training, availability of telehealth being offered; successful strategies to be reviewed and shared with QOC members.

FY26 goal is to achieve above the 50th percentile =72.9%

2. Event Reporting and Notification

The NMRE complies with its Specialty Supports and Services Contract with the State and the Event Notification/Reporting System by providing clear guidance for the reporting and reviewing of critical incidents, sentinel events, risk events, and deaths of beneficiaries. The NMRE analyzes this data quarterly to identify improvement opportunities. The NMRE Quality and Compliance Oversight Committee (QOC), as part of the QAPIP, will continue to review and follow-up on sentinel events and other critical incidents and events that put people at risk of harm. The QOC continues to improve the data quality and timeliness in reporting events.

Information received from CMHSPs is compiled and analyzed by the NMRE. Trending of the quarterly and annual data is available via a Power BI dashboard created by the NMRE, allowing trends to be shared and reviewed regionwide or specific to a board.

a. Sentinel Events: A sentinel event is a type of critical incident that is an "unexpected occurrence" involving death or serious physical or psychological injury or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). A sentinel event does **not** include a death attributed to natural causes. Investigation of a sentinel event will be conducted by a staff with the appropriate credentials to review the event; for example, a sentinel event involving a death or serious medical condition will involve a physician or nurse.

To be a sentinel event, the incident must have occurred to a beneficiary in a reportable population and determined, through investigation, to be a sentinel event. Except for arrests/conviction and serious challenging behavior, each incident should be reviewed to determine if it meets sentinel event criteria.

i. Unexpected Death: The death of a beneficiary that is not the result of natural causes. An unexpected death includes any death that results from suicide, homicide, an undiagnosed condition, accident, or where it appears suspicious for possible abuse and/or neglect.

ii. Serious Physical Injury: Serious damage suffered by a beneficiary that a physician or nurse determines caused, or could have caused, the death of the beneficiary, the impairment of his/her bodily functions, loss of limb, or permanent disfigurement. An injury caused by actual or suspected abuse or accident must be treated at a medical facility. The treating medical facility must be noted on the incident report.

iii. Emotional Harm: Impaired psychological functioning, growth, or development that is significant in nature as evidenced by observable physical symptomatology, as determined by a mental health professional or psychiatrist.

iv. Death by Natural Causes: The death of a beneficiary that occurred as the result of a disease process from which death is an anticipated outcome. A death by natural causes is **not** a sentinel event.

v. Physical Illness Requiring Hospital Admission: The unexpected hospitalization of a beneficiary for a previously unknown or undiagnosed illness. Planned surgery, whether outpatient or inpatient, is **not** considered an unexpected occurrence and, therefore, not included in reporting under this definition. A hospital admission for an illness directly related to a beneficiary's chronic or underlying illness is also **not** reported as a sentinel event.

vi. Serious Challenging Behavior: A behavior that results in significant (over $100) property damage, an attempt at self-inflicted harm or harm to others, or an unauthorized leave of absence. A serious challenging behavior includes behaviors not previously addressed in a Behavior Treatment Plan.

vii. Medication Error: The delivery of medication to a beneficiary that is the wrong medication, wrong dosage, or double dosage, or failure to deliver medication that resulted in death or serious injury or the risk thereof. An instance where a beneficiary refused medication is **not** a medication error.

viii. Arrest/Conviction: Any arrest or conviction of a beneficiary who is in a reportable population at the time of the arrest or conviction. An arrest or conviction will be reported as a sentinel event [through the MDHHS Michigan Crisis and Access Line (MiCAL)] but does not require a root cause analysis.

b. Substance Use Disorder (SUD) Sentinel Event Reporting: Specific sentinel events that occurred to beneficiaries who were living in a 24-hour specialized residential substance abuse treatment settings at the time of the event are required to be reported to MDHHS. The specific categories are:

i. Death
ii. Accident that requires an emergency room visit and/or hospital admission
iii. Physical illness that required a hospital admission
iv. Arrest or conviction
v. Serious Challenging Behavior
vi. Medication error

Information and trends will be analyzed and reviewed quarterly during NMREs SUD Provider meeting.

c. **Risk Events:** An event that puts a beneficiary who is in a reportable population at risk of harm is categorized as a "risk event." A risk event is reported for internal analysis to determine what actions are needed to remediate the problem or situation and to prevent reoccurrence.

i. Harm to Self: An action taken by a beneficiary that causes them physical harm that requires emergency medical treatment or hospitalization (e.g., pica, head banging, self-mutilation, biting, suicide attempt).

ii. Harm to Others: An action taken by a beneficiary that causes physical harm to an individual(s) (family, friend, staff, peer, public, etc.) that requires emergency medical treatment or hospitalization of the injured person(s).

iii. Unscheduled Hospitalizations: Two or more unscheduled admissions of a beneficiary to a medical hospital within a 12-month period not due to planned surgery or the natural course of a chronic illness. The use of an emergency room or emergency department is **not** considered a hospital admission.

The NMRE collects this information from its member CMHSPs and trends it and reviews quarterly during QOC.

d. **Critical Incidents:** The NMRE requires all network providers (both CMHSPs and SUD providers) to report critical incidents to the NMRE monthly. Critical incidents include:

i. Suicide
ii. Non-suicide death
iii. Death of unknown cause
iv. MAT medication error
v. SUD medication error
vi. Seriously challenging behavior

Any unexpected death of a beneficiary who, at the time of their death, was receiving specialty supports and services will be reviewed. The review will include:

i. Confirmation of beneficiary's death (e.g., coroner's reports and/or death certificate)

ii. Involvement of medical personnel in the mortality review
iii. Documentation of the mortality review process, findings, and recommendations
iv. Use of mortality information to review quality of care
v. Aggregate mortality data to identify possible trends over time

The review will be a "formal process" and include areas of clinical risk. The review team will include individuals with appropriate credentials to review the scope of care, individuals who were not involved in the treatment of the beneficiary, and any additional individuals who may contribute to a thorough review process.

e. **Root-Cause Analysis (RCA):** A root cause analysis is a process for identifying the basic or causal factors that underline variations in performance, including the occurrence or possible occurrence of a sentinel event or other serious event. A root cause analysis should result in an action plan designed to reduce or attempt to reduce future incidents. Within three (3) days of a critical incident, network provider staff will determine whether it meets sentinel event standards; if it does meet that standard network provider staff will initiate a root cause analysis within two (2) days of the determination. A request for additional information, such as a coroner's report or death certificate, constitutes the start of a root cause analysis.

f. **Unexpected Death Reporting:** All unexpected deaths of Medicaid beneficiaries who, at the time of their death, were receiving specialty supports and services will be reviewed in accordance with the NMRE Critical Incident, Risk Event, Sentinel Event, and Death Reporting Policy and Procedure and the NMRE's Specialty Supports and Services Contract with the State. This reporting will include suicide, non-suicide death, homicide, undiagnosed conditions, accidental death, suspicious death, or abuse/neglect.

The NMRE and/or the network provider will immediately report to MDHHS:

i. Any death of a beneficiary who was discharged from a State Facility within 12 months preceding the date of death
ii. Any death that occurs as the result of suspected NMRE or network provider staff action or inaction, or
iii. Any death that is the subject of a Recipient Rights, licensing, or police investigation.

The report will be submitted electronically, utilizing NMRE's EMR, within 24 hours of either the death or the responsible network provider staff's receipt of the death notification, or the responsible network provider staff's receipt of notification that a Recipient Rights, licensing, and/or police investigation has commenced to the NMRE Compliance and Customer Services Officer. The report will include:

i. Name of beneficiary
ii. Beneficiary ID Number (Medicaid or Healthy Michigan Plan)

iii. Consumer ID if there is no beneficiary ID number
iv. Date, time, and place of death (if a licensed foster care facility, include the license #)
v. Preliminary cause of death
vi. Contact person's name and email address

In addition, the network provider will submit a written report of its review/analysis of the death to the NMRE within 45 days from the month in which the death occurred. The NMRE will notify MDHHS within 60 days after the month in which the death occurred.

The NMRE will monitor its network providers for compliance annually, or as needed. All incidents not related to beneficiaries (i.e., staff, volunteers, interns, and visitors) will be reported according to the appropriate NMRE or network provider policy. It is the policy of the NMRE that its network providers will have and implement a process to:

A. Review, investigate, analyze, act upon, internally report, and track critical incidents, sentinel events, and risk events, in an accurate and timely manner.

B. Review, investigate, analyze, act upon, and report critical incidents, risk events and sentinel events to the NMRE in an accurate and timely manner.

C. Identify system factors associated with critical corrective action plans to prevent recurrence of critical incidents, sentinel events, and risk events.

D. Develop and implement effective corrective action plans to prevent recurrence of critical incidents, sentinel events, and risk events. The NMRE will review, analyze, act upon when necessary, and report critical incidents and sentinel events to MDHHS in an accurate timely manner.

Training and information

The NMRE will continue to provide training to providers on the type of data to collect, the population involved in this data collection, and timeliness in reporting. The expectation is that providers will continue to train and remind their staff about this process.

Changes to Reporting Platforms

The NMRE has an established electronic process for the submission of sentinel events/immediate notification, remediation documentation including written analysis for those deaths that occurred within one year of discharge from state operated services. The NMRE maintains updates to the reporting system within PCE/EMR to better meet reporting needs and ensure timely and accurate reporting of these events to PIHP/MDHHS.

Data Collection and Review goal:

The NMRE will continue to collect events data on a regular basis (monthly, quarterly, as needed) and analyze trends, and implement necessary interventions related to critical incidents, sentinel events, unexpected deaths, as well as risk events. Reporting to MDHHS will be completed within the designated timelines listed above; 90% of events will be submitted

timely (date of notification to submission to MDHHS CRM).

3. Consumer Experience Assessments

The NMRE will conduct ongoing quantitative and qualitative assessments (such as surveys, focus groups, phone interviews) of members' experiences with services. These assessments will be representative of persons served, including long-term supports (LTSS) and services (i.e., individuals receiving case management, respite services, or supports coordination) and the services covered by the NMRE's Specialty Supports and Services Contract with the State. Assessment results will be used to improve services, processes, and communication. Outcomes will be shared in the NMRE's annual mailing. The NMRE will identify and provide possible recommendations to resolve areas of dissatisfaction on an ongoing basis.

Beneficiary satisfaction surveys are conducted annually for both CMHSP and SUD services. Each survey includes a question about beneficiary experience, requesting that any beneficiary who would like a follow up from the provider regarding the beneficiary comment can leave their name and/or telephone number to be contacted. All CMHSP and SUD providers are then given a copy of the comments received during satisfaction survey collection. The provider is then expected to follow up with beneficiaries requesting to speak to someone. In some cases, NMRE has reported information collected from satisfaction surveys to the provider's Office of Recipient Rights, Licensing and Regulatory Affairs, if appropriate, and the NMRE has opened grievances on behalf of beneficiaries.

Moving forward, the NMRE will monitor service providers' follow up with beneficiaries to measure if the follow up resolves issues and increases overall satisfaction. The NMRE will furnish the providers with the name and contact information of each person wishing to be contacted in a report. The report will include date of outreach (within 5 business days of receipt of report), resolution of outreach (within 60 days of outreach), and a space for a 6-month follow-up (within 6 months of resolution) to measure if satisfaction has been improved. The NMRE will complete the 6-month follow-up to ensure goals and objectives are being met.

Outcomes

The NMRE will expand its process of collecting members' experiences with services to identify and investigate sources of dissatisfaction. Processes found to be effective will be continued while those less effective or not satisfactory will be revised and followed up with.

Substance Use Disorder (SUD)

The NMRE will conduct separate SUD surveys, including Withdrawal Management/Detox and Methadone surveys, to identify specific member experiences.

Evaluation Efforts

The NMRE will outline systemic action steps to follow-up on the findings from survey results on an ongoing basis.

The NMRE will share survey results with providers, the regional Quality and Compliance Oversight Committee (QOC), the Internal Operation Committee (IOC), Board of Directors, and the Regional Consumer Council (Regional Entity Partners), and post a copy to the NMRE.org website. The NMRE's annual mailer will include instructions to direct consumers to locate the information on the NMRE.org website.

4. Provider Network Monitoring

To ensure compliance, the NMRE conducts annual (at minimum) monitoring for all directly contracted providers in the region, and out of region as needed and appropriate, utilizing reciprocity when necessary.

Monitoring

The NMRE will conduct site reviews annually for all contracted service providers by 9/30/2026. The NMRE will monitor and follow-up on corrective action plans to ensure corrective action plans (CAPs) are being implemented as stated by network providers. The NMRE QOC will request, on a regular basis, updates from providers regarding the progress of their Quality Improvement Workplans and CAPs.

The NMRE will enhance its SUD monitoring tool to specifically review a sample of treatment case files to ensure that both the PCP's name and address are documented in the member's treatment plan. Additionally, education will be provided to contracted SUD treatment providers informing them that the treatment case files must specifically include the PCP's name and address, in addition to having the copy of the signed release of information in the treatment case file.

The NMRE will ensure that its provider directory, and any delegated CMHSPs' provider directories, include all the required information from 42 CFR 438.10 as listed on the (HSAG) Provider Directory Checklist, and will make its provider directory available on the NMRE's website in a machine-readable file and format as specified by the Secretary.

The NMRE will develop new auditing tools utilizing *PCE Auditing* to increase efficacy and allow for trending and monitoring of outcomes and progress.

LTSS (Long Term Supports and Services)

The NMRE will incorporate consumers receiving long-term supports or services (LTSS) into the review and analysis of the information obtained from quantitative and qualitative methods.

LTSS programs provide service needs from complex-care to assistance with everyday activities of daily living.

Long-Term Services and Supports	CPT/HCPCS Codes
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 Modification)
Family Training	G0177 (Family Education Groups) S5110 (Family Psycho-Education Skills Workshop) S5111 (Home care training; family) T1015 (Family Psychoeducation, 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 NMRE has mechanisms in place to assess the quality and appropriateness of case furnished to beneficiaries receiving LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's individualized plan of service. This is accomplished by completing regular and ongoing monitoring of completed standardized assessments, completed IPOS and updates/changes, level of care determination tools, person centered planning requirements etc. All required paperwork for waiver beneficiaries is approved by NMRE prior to enrollment, and monthly monitoring of authorized services is done to ensure the provision of agreed upon services that support community integration of beneficiaries. The NMRE will review all efforts for community integration during scheduled site reviews.

MCPAR outcomes will be monitored as well as a source of feedback for LTSS population and shared with appropriate parties.

The NMRE will obtain a qualitative and quantitative assessment of member experience for this population, utilizing electronic version of the tool annually. Member Experience of Care outcomes are available on the NMRE.org website.

Verification of Medicaid Services

The NMRE will perform quarterly audits to verify Medicaid claims/encounters to ensure Medicaid services were furnished to beneficiaries by CMHSPs, SUD providers, providers, and/or subcontractors. This will include verifying data elements from individual claims/encounters to ensure proper service codes are used and proper documentation is in place. CAPs will be developed where appropriate per NMREs MEV policy.

The NMRE established consistent methodology for the development and implementation of responsibilities for verification of the claims/encounters submitted within the Provider Network to ensure compliance with federal and state regulations and to provide direction to NMRE Network Providers. It is the policy of the NMRE to ensure that all claims for services are properly documented, and services were provided prior to payment.

The NMRE verification methodology will include testing data elements from individual encounters against EHR and the use of data analytics, as defined within the MDHHS Technical Requirement. Additional elements may be included to support the NMRE quality improvement efforts around encounter data. Statistically representative sample requirements will meet OIG standards. The NMRE sampling process uses Microsoft SQL and Excel.

If an audited sample yields less than 95% accuracy, a Plan of Correction is required. If an audited population falls below 90% accuracy during a 12-month period, a stratified sample will be pulled, and a Plan of Correction is required.

The NMRE will work with its provider network on reaching 95% or higher accuracy during each quarterly review.

FY26 goal is to increase compliance rate from 91% (FY25) to 95% by the second quarter of FY26.

Training and technical support will be provided. Training regarding Documentation Standards and Clinical Compliance will be provided in February of 2026.

Home and Community Based Services (HCBS)

The NMRE and its CMHSPs monitor Home and Community Based Services (HCBS) Under the HCBS Final Rule, the Centers for Medicare and Medicaid (CMS) requirements for both residential and non-residential Home and Community Based Settings. HCBS settings and services must be integrated into the community with full access to jobs, resources and services, to 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 individuals to choose their services, supports, and providers.
In response to MDHHS CMH CAP, following a site visit, NMRE developed and updated HCBS, HCBS Monitoring, and Conflict Free policies.

The NMRE continues to host HCBS Trainings with the goal of moving this activity to CMHSPs in April of 2026. A new Site Visit Tool addressing all the areas of HCBS monitoring needs will be developed by March of 2026.

Behavioral Treatment Review

The Regional Behavioral Treatment Plan Committee (BTRC) will conduct quarterly reviews and data analyses from the CMHSP providers where intrusive, or restrictive techniques were approved for use with members and where physical management or 911 calls to law enforcement were used in an emergency behavioral crisis. Trends and patterns will be reviewed to determine if systems and process improvement initiatives are necessary.

BTP Data

Data will include the numbers of interventions and length of time the interventions were used with the individual(s). The NMRE's regional BTRC will be tasked with reviewing data to ensure that only techniques permitted by the MDHHS Technical Requirements for Behavior Treatment Plans and that were approved by the members or their guardians during person-centered planning have been used. By asking the behavior treatment committees to track this data, it provides important oversight to the protection and safeguard of vulnerable individuals including those receiving long-term supports and services.

The quarterly reviews of data from the Behavior Treatment Review Committee is completed in QOC meetings with all member boards identifying trends, barriers, and developing improvement strategies.

5. Quality Measures (HEDIS measures)

The NMRE will review the following HEDIS and other measures to demonstrate and ensure quality care. The NMRE will provide and analyze HEDIS measure reports to the NMRE QOC on a quarterly basis. Upon review, QOC will identify interventions to improve outcomes where necessary. The NMRE will review raw data, used for these metrics, on as needed basis to determine areas of improvement

Measures

The NMRE will collect and review data for the HEDIS measures tied to the Performance Bonus Incentive Pool:

Measure	NMRE PIHP goals for FY26:
P.1. Implement data driven outcomes measurement to address social determinants of health (40 points)	NMRE will conduct an analysis and submit a narrative report of findings and project plans aimed at improving outcomes, no longer than two pages, by July 31.
P.2. Adherence to antipsychotic medications for individuals with schizophrenia **(SAA-AD)** (20 points)	NMRE will meet or exceed a minimum standard of 62% for this metric.
P.3. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment **(IET)** (40 points)	The NMRE will meet or exceed a minimum of 40% at initiation and 14% at engagement.
P.4. PA 107 of 2013 Sec. 105d (18): Increased participation in patient-centered medical homes (25% of total withhold)	The NMRE will submit a narrative report of no more than 10 pages by November 15th summarizing prior FY efforts, activities, and achievements regarding increased participation in patient-centered medical homes. The specific information to be addressed in the narrative are: 1. Comprehensive Care 2. Patient-Centered 3. Coordinated Care 4. Accessible Services 5. Quality & Safety

Category	NMRE PIHP goals for FY26
J.1. Implementation of Joint Care Management Processes (30 points)	Each paneled MHP and NMRE will continue to document joint care plans in CC360 for beneficiaries with appropriate severity/risk, who have been identified as receiving services from both entities. The NMRE will document joint care plans in CC360 for at least 25% of qualified adult Enrollees. The NMRE will work on increase in enrollment of children.

J.2 Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days using HEDIS descriptions (30 points)	The NMRE will meet and exceed set standards for follow-up within 30 Days for each rate (ages 6-17 and ages 18 and older) of 58% for adult and 79% for child population.
J.3 Initiation and Engagement of Alcohol and Other Drug Dependence	The NMRE will meet and exceed (IET 14) minimum standard of 40% and (IET 34) minimum standard of 14%.

As part of the *Behavioral Health Quality Program Overhaul- Year 1* NMRE will meet benchmarks on the metrics below (some overall with the list above is noted):

Code	Measure	Benchmark
ADD	Follow-up care for children prescribed Attention Deficit Hyperactivity Disorder (ADHD) medication – initiation phase	52.6%
	Follow-up care for children prescribed Attention Deficit Hyperactivity Disorder (ADHD) medication – continuation phase	61.2%
FUH	Follow-up After Hospitalization for Mental Illness – within 30 days after discharge, between the ages of 6 and 17 years old (FUH-30 CH)	79%
	Follow-up After Hospitalization for Mental Illness – within 30 days after discharge, between the ages of 18 and 64 years old (FUH-30 AD)	58%
	Follow-up After Hospitalization for Mental Illness – within 30 days after discharge, age 6 years or older (FUH-30)	
APM	Metabolic monitoring for Children and Adolescents on Antipsychotics – Blood Glucose and Cholesterol Testing (TOTGC)	27.6%
APP	Use of first line Psychosocial Care for Children and Adolescents on Antipsychotics.	65.6%
FUA	Follow-up After Emergency Department Visit for Substance Use – within 30 days, between the ages of 13 and 17 years old (FUA-30CH)	35.6%
	Follow-up After Emergency Department Visit for Substance Use – within 30 days, 18 years or older (FUA-30AD)	36.3%
	Follow-up After Emergency Department Visit for Substance Use – within 30 days, between the ages 13 years or older (FUA-30)	
FUM	Follow-up After Emergency Department Visit for Mental Illness – within 30 days, age 6 years or older (NCQU) or age 18 or older (CMS)	60.8%
IET	Initiation and Engagement into Substance Use Disorder Treatment – Initiation total within 14 days of diagnosis (IET 14-TOT)	40%
	Initiation and Engagement into Substance Use Disorder Treatment – Engagement total within 34 days, age 13 years or older (NCQA) or age 18 years or older (CMS) (IET 34-TOT)	14%

Red numbers indicate that this benchmark is the median calculated using 2023 PIHP data.
Blue numbers indicate CY2023 statewide average.

6. Performance Indicators

The NMRE will monitor the performance indicator for the NMRE CMHSP network as well as individually. Performance data will be reviewed and discussed by QOC on a quarterly basis. The Michigan Mission Based Performance Indicator System (MMBPIS) will be utilized by the NMRE to address areas of access, efficiency, and outcomes, and to report to the State as established in the PIHP contract. The NMRE will require corrective action from CMHSPs and providers for each indicator not met twice in a row.

Indicator #2

Access: Mental Health and Intellectual and Developmental Disabilities Indicator #2 The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, I/DD-adults, I/DD-children)

The NMREs FY26 goal is to reach the 75th percentile for this Indicator and maintain that performance, by reaching or exceeding 62%.

The NMRE will educate providers during the transition process from MMBPIS to the HEDIS measures listed above. Ongoing update and review of metrics, and/or areas of improvement, will be provided during QOC meetings.

7. Monitoring and Evaluation

The NMRE will continue to provide updates to QOC, network providers, the Governing Board, and other stakeholders regarding routine QAPIP activities. QAPIP activities will be reviewed and evaluated by QOC. The QAPIP is reviewed and updated at least annually with input from CMHSPs, providers, stakeholders, and approved by the Governing Board. Update reports will be shared with the Governing Board periodically, but at least annually. This workplan is a living document that may be updated throughout the year.

QAPIP activities will be shared with consumers through the regional Consumer Council (Regional Entity partners) and other stakeholders through committees, mailers, and posting to the NMRE.org website.

The NMRE will maintain QOC meetings with a goal of meeting monthly.

8. Practice Guidelines

The NMRE and its network providers implemented a process to adopt and adhere to practice guidelines established by American Psychiatric Association (APA) and the Michigan Department of Health and Human Services (MDHHS).

The NMRE' Chief Clinical Officer, in collaboration with QOC members, network providers (including SUD providers) will review and adopt practice guidelines established by APA and MDHHS annually, every March. The NMRE will disseminate adopted practice guidelines to all affected providers, members, stakeholders, and potential members as needed via the NMRE.org website, annual mailer, and/or annual newsletter.

A. Adoption of Practice Guidelines

1. The NMRE has adopted practice guidelines that are based on valid and reliable clinical evidence, or a consensus of providers of mental health, intellectual/developmental disabilities, and/or substance use disorder services.
2. The NMRE has adopted practice guidelines from the American Psychiatric Association (APA), other practice guidelines reviewed and made available by the APA (e.g., VA/DoD, ASAM, American Academy of Child and Adolescent Psychiatry - AACAP), and MDHHS practice guidelines, and region-specific practice guidelines.
3. The NMRE has adopted practice guidelines that consider the needs of its members.
4. The NMRE has adopted practice guidelines in consultation with its network providers.
5. The NMRE has adopted practice guidelines that are reviewed and updated annually, or as updated by the APA and MDHHS.

B. Dissemination of Guidelines

The NMRE will disseminate practice guidelines to:

- All affected providers.
- Members and potential members by an annual mailing which will direct them to the NMRE.org website.
- The public by posting to the NMRE website.

C. Annual Monitoring of Practice Guidelines

1. Practice Guidelines will be distributed to the regional Clinical Leadership Committee, the regional Quality and Compliance Oversight Committee, the regional Provider Network Managers Committee and the Substance Use Disorder Directors one month prior to the meeting during which practice guidelines are scheduled for review (e.g., February).
2. The stated committee members will be asked to provide feedback to the NMRE regarding any changes or recommendations to currently adopted practice guidelines.
3. The stated committees will approve the adoption of new practice guidelines and/or recommend that current practice guidelines be continued during the month in which the guidelines are scheduled for review (e.g., March).
4. Approval of practice guidelines will be recorded in the stated committee's meeting minutes.

5. The NMRE will review and update (if necessary) the practice guidelines posted to its website.
6. The NMRE will review its provider network as necessary, but at least annually, to ensure practice guidelines are followed appropriately.

D. Application of Guidelines

- Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply will be consistent with the guidelines.
- The NMRE will ensure services are planned and delivered in a manner that reflects the values and expectations contained in practice guidelines.
- Practice guidelines will be used to guide but not replace clinical judgment.

9. Contracting

The NMRE updated Sub-contractual Relationships and Delegation Agreements to include the language: "the right to audit records for the past 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later".

New Contracts

The NMRE will ensure that in future agreements there is a specific language referencing Sub-contractual Relationships and Delegation Agreements.

10. Credentialing and Recredentialing

FY2026 will see the NMRE continuing its collaboration with the MDHHS to implement the universal credentialing module in their CRM platform, continue monitoring on credentialing and recredentialing, and continued regional educational/training sessions.

Implementation of Credentialing CRM

The NMREs five CMHSPs have all completed implementation of Universal Credentialing CRM, with the only limitation being the extent that their normal operations have delayed the transition. Priority has been placed on ensuring the provider network is comprised of providers qualified to perform their services. Four of the NMRE's five CMHSPs have integrated the CRM into their day-to-day operations for practitioners, and three of the CMHs have added both their own providers and subscribed to others in the CRM; the other two of the NMRE's CMHSPs have subscribed to other CMHSPs shared providers. The main challenges have been transitioning from current processes, which many downstream internal operations depend on, while simultaneously ensuring credentialing is completed timely. The CMHSPs have essentially been forced to abandon the ways they have been doing tasks, and the change has not been as easy as anticipated.

The NMRE's goal will be to have all 5 of the regional CMHSPs using the CRM for all their credentialing for day-to-day operations, for both their practitioners and organizations, by April 1, 2026.

Regional Education/Training

The PIHP will continue to host training for provider network management staff.

For FY2026, the goal of the NMRE will be to host an additional 3 training days during the fiscal year, onsite with weather permitting, to further ensure that credentialing citations, credentialing operations, and contract processes are compliant.

11. Exclusion Checks

The NMRE conducted its first annual review of SUD Treatment providers having run their own staff's monthly exclusion checks during FY2025. The review found six provider organizations to be running each of the three required checks monthly and receive fully compliant scores. Three organizations did not receive a perfect score, with the trending issue being that they were not running all three of the required exclusion databases. One provider had been running all three databases but had missed some months.

The three providers that did not receive fully compliant scores were required to submit corrective action plans. For FY26, the NMRE's goal will be to have reviewed the progress made toward corrective action by all three providers by July 1, 2026, pull additional samples for review of the corrective action, and issue new CAPs as necessary

12. Utilization Management and Authorization of Services

The NMRE will continue to develop standardized utilization management protocols & functions across the region to identify areas of underutilization and overutilization of services. This will ensure access to public behavioral health services in the region is in accordance with the PIHP's contract with MDHHS, relevant Michigan Medicaid Provider Manual (MMPM) sections, and Michigan Mental Health Code (MMHC) requirements.

To incorporate best practices and optimize level of care placement protocols member CMHSPs utilize MCG Indicia as a guide alongside other standardized assessments, such as LOCUS, MichiCANS, ASAM Continuum etc.

The goal is to improve the overall quality of consumer outcomes, as well consistency in the amount, scope, and duration of services. A monitoring tool will be created in PCE by March of 2026, to allow for adequate monitoring and trending by service, provider, and standard.

Training on Quality Oversight and Utilization Alignment is scheduled for 3/2026. New ASAM IV edition implementation is scheduled to start in calendar year 2026.

Trending

NMRE developed reports to monitor, trend, and review SUD admissions, level of care, and service utilization by county and provider in the NMRE region. These reports are provided to the NMRE SUD Oversight Committee on a regular basis and are available on NMRE.org website at County Admission Reports | NMRE .

HSW Monthly service utilization reports are generated and shared with CMHSPs on a monthly basis, in order to monitor the provision of services agreed upon in the IPOS. The NMRE is also utilizing Power BI reporting for 1915(i) SPA Potential Enrollees, making sure beneficiaries with certain service codes are properly enrolled into waivers.

Additional analyses will be conducted for areas with significant variation in utilization patterns to identify root causes and opportunities for improvement. The NMRE will develop an internal process for timely authorization denials, as well es exceptions and extensions.

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

13. Regional Trainings

The NMRE continues to collect feedback from its member CMHSPs and SUD Providers, as well as record areas of improvement during site visits, and continues to conduct or fund a series of trainings to aid in process improvement as well as overall compliance.

SUD providers are supported in Co-occurring and Women Specialty Services training needs, while CMHSPs are offered Documentation Standards and Clinical Compliance, Person Centered Planning, and Quality Oversight and Utilization Alignment, all based on documented and reported needs.

14. Maintaining the Handbook

The NMRE will obtain MDHHS approval, in writing, prior to publishing the original and revised editions of its member handbook. The NMRE will use MDHHS-developed model member handbooks and member notices and ensure that its member handbook and member notices include all MDHHS-developed template language. The NMRE, and any delegates performing activities on behalf of the NMRE, will ensure that all written materials available for potential members and members use a font size at least 12-point bold font (conspicuously visible), and are written at or below the 6.9 grade reading level based on Flesch-Kincaid score.

15. Adverse Benefit Determination

The NMRE will ensure that each ABD notice meets federal and state-specific requirements, as well as content requirement, and is written at or below the 6.9 reading grade level. The NMRE will conduct training and quarterly monitoring of its provider network to measure compliance. Additionally, scheduled annual on-site monitoring will continue to include ABD review and monitoring.

To strengthen compliance and optimize level of care decision making with best practices and care guidelines, NMRE implemented MCG Indicia in December of 2025 across all five member CMHSPs. Indicia will be utilized in the ABD process as well.

Improvements made to the ABD Form in PCE EHR have been implemented and are expected to contribute to further compliance with the rules.

16. Stakeholder Engagement and Input

Stakeholder input is of high importance for continued improvement and guides change processes. The NMRE continuously analyzes feedback received from those who currently receive services, who received services in the past, families and support systems, advocates, contracted providers, community partners, coalitions etc.

Grievance and appeals as well as consumer satisfaction surveys are utilized as a source of stakeholder input. Frequent meetings and committees are another platform for feedback to be collected.

NMRE also hosts a Day of Education for its beneficiaries and interested parties. The Day of Education is an annual conference that provides behavioral health beneficiaries with education on relevant topics to their well-being. Topics are selected with beneficiary input.