HEALTHWEST

FULL BOARD MINUTES

June 26, 2026

8:00 a.m.

376 E. Apple Ave.
Muskegon, MI 49442

CALL TO ORDER

The meeting of the Full Board was called to order by Chair Thomas at 8:01a.m.

ROLL CALL

Members Present:	Janet Thomas, Cheryl Natte, Jeff Fortenbacher, Thomas Hardy, Michelle Hazekamp, Janice Hilleary, Tamara Madisson
Members Absent:	Charles Nash, Chris McGuigan, John M. Weerstra, Mary Vazquez, Remington Sprague, M.D.
Others Present:	Rich Francisco, Holly Brink, Gina Maniaci, Brandy Carlson, Christy LaDronka, Jennifer Hoeker, Carly Hysell, Melina Barrett, Casey Olson, Linda Anthony, Lea Streblow, Gary Ridley, Pam Kimble, Amber Berndt, Amber Picard, Jackie Farrar, Kim Davis, Calvin Davis, Gina Kim, Michelle Lyons, Anissa Goodno
Guests Present:	Alan Bolter, Matt Farrar, Stephanie VanDerKooi

MINUTES

HWB 94-B - It was moved by Mr. Hardy, seconded by Mr. Fortenbacher, to approve the minutes of the May 29, 2026 Full Board meeting as written.

MOTION CARRIED

COMMITTEE REPORTS

Finance Committee

HWB 86-F - It was moved by Mr. Weerstra, seconded by Mr. Hardy, to approve the Finance Committee meeting minutes from May 15, 2026 as written.

MOTION CARRIED

HWB 87-F - It was moved by Mr. Hardy, seconded by Ms. Thomas to approve expenditures for the month of May 2026, in the total amount of $5,857,280.48.

MOTION CARRIED

HWB 88-F - It was moved by Mr. Hardy, seconded by Mr. Weerstra, to authorize HealthWest to enter into a sole-source agreement with Mend at an estimated cost of $217,600 for year 1 and

estimated year 2 and 3 cost of $196,100 and authorize the HealthWest Executive Director to sign the three-year agreement.

MOTION CARRIED

HWB 89-F - It was moved by Mr. Hardy, seconded by Mr. Weerstra, to authorize the HealthWest Board to contract with Peter Chang enterprises, Inc. (PCE), for implementation and maintenance of the Crisis Residential Unit module in the Electronic Health Records (EHR) services to HealthWest, for approximately one time fee of $38,500 and annual maintenance of $24,960.

MOTION CARRIED

HWB 90-F – It was moved by Mr. Hardy, second by Mr. Weerstra, to authorize the HealthWest Executive Director to sign a contract with Inspiring Loving Hope Homes LLC, effective June 27, 2026, through September 30, 2027, to provide specialized residential services to eligible HealthWest consumers. The funding is within the HealthWest AFC Specialized Residential Budget of $24,900,000.00.

MOTION CARRIED

HWB 91-F – It was moved by Commissioner Hazekamp, seconded by Mr. Hardy, to authorize the HealthWest Executive Director to sign contract #DFA27-61001 with the State of Michigan Department of Health and Human Services for $76,400.00. This contract will fund the Eligibility Specialist at the HealthWest building from October 1, 2026, through September 30, 2027.

MOTION CARRIED

HWB 92-F – It was moved by Mr. Hardy, seconded by Ms. Thomas, to authorize the HealthWest Executive Director to sign a contract with Doctor Jawor, D.O. with a total not to exceed $288,600.00 effective June 29, 2026, through September 30, 2027.

MOTION CARRIED

HWB 93-F – It was moved by Mr. Hardy, seconded by Mr. Weerstra, to authorize the HealthWest Executive Director to sign a contract with Northern Behavioral Solutions, LLC effective June 1, 2026, through September 30, 2027, to provide Applied Behavioral Analysis Therapy to HealthWest consumers. The funding is within the approved HealthWest Autism Budget of $2,908,811.00.

MOTION CARRIED

ITEMS FOR CONSIDERATION

HWB 95-B – It was moved by Mr. Hardy, seconded by Ms. Natte, to approve the 2026 Quality Assessment and Performance Improvement Plan, effective June 26, 2026.

MOTION CARRIED

OLD BUSINESS

There was no old business.

NEW BUSINESS

There was no new business.

COMMUNICATION

Alan Bolter, Chief Executive Officer for the CMHA, provided updates from Lansing.

DIRECTOR'S COMMENTS

Mr. Francisco, Executive Director, presented his Formal Director's report.

Director's Update

MDHHS Updates:

- Leadership change at MDHHS. I forwarded the Governor's announcement, which we received from CMHA, stating that MDHHS Director Hertel will be moving on in her career and stepping down from the role as director. The Governor announced Amy Epkey will be the acting director for MDHHS effective July 1.

- RFP update: HW has not heard of any recent new RFP released by MDHHS.

LRE Level Updates:

- The June 22, 2026, LRE Executive Work Session and Board Meeting were cancelled. The next board meeting is scheduled for July 22,2026.

- The LRE Ops group did meet on June 17th after the LRE Executive Committee meeting. The major topic of conversation with the LRE Ops group was a discussion on the current FSR (Financial Status Report) that was shared with the CEOs. There was a significant increase in the Ottawa deficit. For the month of April's report there was an increased deficit showing at ~2.58M for Ottawa. N180 was at ~4.6M in deficit. In looking at projections and comparing to spending plans submitted by the CMHSPs, the region will need to resubmit a new Risk Management strategy report to MDHHS due to the deficit now at 16.5M. The LRE board will have to make this decision.

- CSU discussion: The Ops group also discussed the ongoing funding of N180 CSU and that it is part of capitation. The big question surrounding this is how much funding is in the capitation for CSU operations. There were questions asked whether this was contributing to N180 deficit as well.

CMH Level:

- HealthWest continues with various projects:
  - **Utilization Review:** I provided an update last month that HW is reviewing closely the service utilization. We are projecting a surplus in the budget for year end. I have developed a workgroup to closely monitor underutilization in various programs. The goal is to understand what factors are causing the decline in services and how we can affect change. The communication team will be sharing information related to this effort

with staff. Internally we have started to look at various reports and dashboards from the different teams and programs, and the directors of these programs are collaborating with staff to address the barriers contributing to the decline in services.

- **Strategic Plan updates** – The strategic plan process is at the KPI (Key Performance Indicator) development stage at this point. Gary and his team have been collaborating with staff from Quality and Compliance to develop an integrated approach for the reporting of the data which will be key components for staff to know where the agency is at related to these KPIs.
- **Facilities discussion**: HW is continuing to review ways to consolidate programs in various locations. We are exploring expanding our footprint at NIMS because they have availability and we already have several teams in that building.
- **SDA (Same Day Access)** – Christy LaDronka and her team continue to work rolling out same day access with the goal of improving access, timeliness to service and enhance community responsiveness. This also aligns and is best practice for CCBHC (Certified Community Behavioral Health Clinic).

AUDIENCE PARTICIPATION

There was no audience participation.

ADJOURNMENT

There being no further business to come before the board, the meeting adjourned at 8:51 a.m.

Respectfully,

Janet Thomas
Board Chair
/hb

HealthWest
Muskegon's Behavioral Wellness Connection

TO: **HealthWest Board Members**

FROM: **Janet Thomas, Board Chair, via Rich Francisco, Executive Director**

SUBJECT: **Full Board Meeting**
June 26, 2026
376 E. Apple Ave., Muskegon, MI 49442
https://healthwest.zoom.us/j/92330401570?pwd=TFNHMWhnQmF5NVAybWRQVG54Tk1GZz09
One tap mobile: (309)205-3325, *92330401570# Passcode: 428623*

AGENDA

1) Call to Order — Action

2) Approval of Agenda — Action

3) Approval of Minutes

A) Approval of the Full Board Minutes of May 29, 2026 — Action
(Attachment #1 – pg. 1-4)

4) Public Comment (on an agenda item)

5) Committee Reports

A) Finance Committee — Action
(Attachment #2 – pg. 5-8)

6) Items for Consideration

A) Authorization to Approve the 2026 Quality Assessment and Performance Improvement Plan — Action
(Attachment #3 pg. 9-39)

7) Old Business

8) New Business

9) Communication

A) CMHA Update: Alan Bolter, Chief Executive Officer — Information
(Attachment #4 pg. 40-80)

B) Consumer Advisory Update: Thomas Hardy — Information
(Attachment #5 pg. 81)

C) July Meeting Notice — Information
(Attachment #6 – pg. 82)

D) Director's Report — Information
(Attachment #7 – pg. 83-84)

10) Public Comment

11) Adjournment — Action

/hb

HEALTHWEST

FULL BOARD MINUTES

May 29, 2026

8:00 a.m.

376 E. Apple Ave.
Muskegon, MI 49442

CALL TO ORDER

The meeting of the Full Board was called to order by Chair Thomas at 8:01a.m.

ROLL CALL

Members Present: Janet Thomas, Cheryl Natte, Chris McGuigan, John M. Weerstra, Thomas Hardy, Mary Vazquez, Michelle Hazekamp, Janice Hilleary, Tamara Madisson

Members Absent: Charles Nash, Jeff Fortenbacher, Remington Sprague, M.D.

Others Present: Rich Francisco, Holly Brink, Gina Maniaci, Kristi Chittenden, Brandy Carlson, Christy LaDronka, Jennifer Hoeker, Carly Hysell, Melina Barrett, Casey Olson, Helen Dobb, Tasha Kuklewski, Mickey Wallace, Linda Anthony, Lea Streblow, Gary Ridley, Pam Kimble

Guests Present: Commissioner Sims, Matt Farrar

MINUTES

HWB 80-B - It was moved by Mr. Hardy, seconded by Mr. Weerstra, to approve the minutes of the April 17, 2026 Full Board meeting as written.

MOTION CARRIED

COMMITTEE REPORTS

Finance Committee

HWB 76-F - It was moved by Mr. Hardy, seconded by Mr. Weerstra, to approve expenditures for the month of April 2026, in the total amount of $8,511,368.74.

MOTION CARRIED

HWB 77-F - It was moved by Mr. Hardy, seconded by Ms. Thomas, to authorize the submission and acceptance, if awarded, of a grant request in the amount of up to $750,000 to the Michigan Endowment Fund Behavioral Health Fund for the project “Enhancing Behavioral Health Crisis Response & Stabilization in Muskegon County” (grant term anticipated 10/01/2027 – 09/30/2029);and further authorize the Executive Director to execute any required application materials, certifications, and if awarded grant agreements and related documents.

MOTION CARRIED

HWB 78-F - It was moved by Mr. Hardy, seconded by Mr. Weerstra, to authorize the HealthWest Board of Directors to approve the purchase of and / or reimbursement from VitalCore and / or other utilized pharmacies for FY2026.

MOTION CARRIED

HWB 79-F - It was moved by Mr. Hardy, seconded by Mr. Weerstra, to authorize the HealthWest Executive Director to continue contract with Rise ABA effective June 1, 2026, through September 30, 2027, to provide Applied Behavior Analysis Therapy to HealthWest consumers. The funding is within the approved HealthWest Autism Budget of $2,908,811.00.

MOTION CARRIED

ITEMS FOR CONSIDERATION

HWB 81-B – It was moved by Mr. Hardy, seconded by Mr. Weerstra, to approve the continued appointment of Rich Francisco as the Executive Director of HealthWest effective June 5, 2026 to June 4, 2029, and authorizes the HealthWest Board Chair Person, Janet Thomas, to sign the employment agreement.

MOTION CARRIED

OLD BUSINESS

There was no old business.

NEW BUSINESS

There was no new business.

COMMUNICATION

Gary Ridley presented the Strategic Assessment Summary.

DIRECTOR'S COMMENTS

Mr. Francisco, Executive Director, presented his Formal Director's report.

Director's Update

MDHHS Updates:

- **RFP update**. On January 8th, Judge Yates ruled that MDHHS had the legal authority to proceed with procurement but also ruled in favor of the CMHSPs that the RFP released in August 2025 violated Michigan law, which prevents CMHSPs from conducting their required statutory functions. Later, on April 13th, MDHHS requested a hearing to dismiss the case as moot because they had withdrawn the RFP altogether. Judge Yates then had to consider whether to dismiss the case with or without prejudice. The judge finally ruled to dismiss the case without prejudice. The CMHSPs have already filed an appeal of the ruling.

- An update on the **MHF (Mental Health Framework)** initiative. I have updated the board that MDHHS was rolling out a new health benefit called BH-COVER as part of the Mental Health Framework. This gives health plans access to screening individuals in crisis, partial hospitalization, and inpatient screening. This effort effectively privatizes a large segment of services that CMHSPs manage. This change would have introduced complications to crisis services coordination in a system already managed efficiently by CMHSPs. On May 15th, Kristen Morningstar (Specialty Behavioral Health Services Director) issued a delay:
    - "MDHHS will temporarily delay the MHF Coverage Responsibility policy to allow time for system-wide preparation."

- There are still many questions surrounding the “how?” and many stakeholders have pushed back on what this implementation entails. We did receive a memo update on 5/27/2026 stating that, while the delay for MHF remains in place, there is an expectation that assessments will continue, including the use of LOCUS and MichiCANS in determining the level of care for individuals seeking services.

- **CCBHC Caucus Meeting** – 5/27/2026. The group talked about the sustainability of CCBHCs in the state of Michigan. The discussion included the development of a CCBHC data warehouse at CMHA (our association). The CCBHC data warehouse will improve access to data and support advocacy efforts in demonstrating ROI. There is support from MDHHS and other partners to develop this CCBHC database. There is also an effort to centralize TA (Technical Assistance) in a Michigan hub rather than requiring organizations to gather CCBHC information from multiple resources. This effort is funded by the Balmer Group, other funding sources, and the National Council.

LRE Level Updates:

- LRE – A board work session was held on 05/27/2026, and the topic was an educational training on AI (Artificial Intelligence. The goal was to provide an understanding of AI, its use in the current landscape, and how CMHSP partners are using AI. Most CMHSPs have implemented AI to help with documentation in the Electronic Health Record (EHR).

- The LRE Ops group met on 5/20 and discussed several topics, including **the autism framework** proposed by a workgroup composed of CMHSP experts in autism services. All CMHSPs participated in creating a framework for autism service delivery and best practices for the region. This is one area where there is variation in how services are delivered. The group reviewed authorization standards, length-of-stay expectations, and discharge standards to help partners implement this service more consistently.

CMH Level:

- HealthWest continues with various projects:

  - **CSU (Crisis Stabilization Unit)** – A handful of staff along with the project management team and grants team have been busy with coordinating and responding to additional questions from the Michigan Health Endowment fund. We have requested $500,000 in funding to support the development of CSU. This is in addition to the 4M we requested in Congressional Designated Spending for the capital investment for CSU.

  - **Utilization Review:** We are seeing decrease in actual utilization as evidence in our actual expense. HW is at a 6M surplus per the FSR. I am putting together a small work group to review utilization and identify areas where we are seeing the decrease. Actual numbers on the FSR (Financial status reports) are not a final number because of claims lag but we need to understand what is occurring with utilization.

  - **Strategic Plan updates** – Per the presentation from Gary on the strategic plan, we are getting close to the final plan. I would like to give Kudos to his team for coordinating this big lift ensuring we obtained input from all stakeholders, staff, and the Board. Many thanks as well to the different strategic plan committee members for the splendid work put into the strategic plan so far.

AUDIENCE PARTICIPATION

There was no audience participation.

ADJOURNMENT

There being no further business to come before the board, the meeting adjourned at 8:41 a.m.

Respectfully,

Janet Thomas
Board Chair
/hb

PRELIMINARY MINUTES
To be approved at the Full Board Meeting on
June 26, 2026

HEALTHWEST

FINANCE COMMITTEE REPORT TO THE BOARD

via Janet Thomas, Committee Vice Chair

1. The Finance Committee met on June 12, 2026.

*2 It was recommended, and I move to approve the minutes of the May 15, 2026 meeting as written.

*3. It was recommended, and I move to approve expenditures for the month of May 2026, in the total amount of $5,857,280.48.

*4. It was recommended, and I move to approve HealthWest to enter into a sole-source agreement with Mend at an estimated cost of $217,600 for year 1 and estimated year 2 and 3 cost of $196,100 and authorize the HealthWest Executive Director to sigh the three-year agreement.

*5. It was recommended, and I move to approve the HealthWest Board to contract with Peter Chang Enterprises, Inc. (PCE), for implementation and maintenance of the Crisis Residential Unit module in the Electronic Health Records (HER) services to HealthWest, for approximately one time fee of $38,500 and annual maintenance of $24,960.

*6. It was recommended, and I move to approve the HealthWest Executive Director to sign a contract with Inspiring Loving Hope Homes LLC, effective June 27, 2026, through September 30, 2027, to provide specialized residential services to eligible HealthWest consumers. The funding is within the HealthWest AFC Specialized Residential Budget of $24,900,000.00.

*7. It was recommended, and I move to approve the HealthWest Executive Director to sign contract #DFA27-61001 with the State of Michigan Department of Health and Human Services for $76,400.00. This contract will fund the Eligibility Specialist at the HealthWest building from October 1, 2026, through September 30, 2027.

*8. It was recommended, and I move to approve the HealthWest Executive Director, to sign a contract with Doctor Jawor, D.O. with a total not to exceed $288,600.00 effective June 29, 2026, through September 30, 2027.

*9. It was recommended, and I move to approve the HealthWest Executive Director to sign a contract with Northern Behavioral Solution, LLC effective Jule 1, 2026, through September 30, 2027, to provide Applied Behavior Analysis Therapy to HealthWest consumers. The funding is within the approved HealthWest Autism Budget of $2,908,811.00.

/hb

HEALTHWEST

FINANCE COMMITTEE MEETING MINUTES

June 12, 2026
8:00 a.m.

CALL TO ORDER

The regular meeting of the Finance Committee was called to order by Committee Chair Fortenbacher at 8:00a.m.

ROLL CALL

Committee Members Present:	Jeff Fortenbacher, Janet Thomas, Thomas Hardy, Michelle Hazekamp, John M. Weerstra
Committee Members Absent:	Charles Nash, Remington Sprague, M.D.
Also Present:	Holly Brink, Gina Manaici, Brandy Carlson, Christy LaDronka, Kristi Chittenden, Brian Plumhoff, Linda Anthony, Kim Davis, Lea Streblow, Casey Olson, Mickey Wallace, Devan Peterson, Amber Berndt, Chris Yeager, Amber Picard, Gina Kim, Carly Hysell, Jackie Farrar, Tasha Kuklewski, Justin Robillard
Guests Present:	Angela Gasiewski

ITEMS FOR CONSIDERATION

A. *Approval of the Minutes of May 15, 2026*

It was moved by Mr. Weerstra, seconded by Mr. Hardy, to approve the Finance Committee meeting minutes from May 15, 2026 as written.

MOTION CARRIED

B. *Approval of Expenditures for May 2026*

It was moved by Mr. Hardy, seconded by Ms. Thomas, to approve expenditures for the month of May 2026, in the total amount of $5,857,280.48.

MOTION CARRIED

C. *Monthly Report from the Chief Financial Officer*

Ms. Carlson, Chief Financial Officer, presented the April report, noting an overall cash balance of $10,306,747.73 as of April 30, 2026.

D. *Authorization to Contract with Mend*

It was moved by Mr. Hardy, seconded by Mr. Weerstra, to authorize HealthWest to enter into a sole-source agreement with Mend at an estimated cost of $217,600 for year 1 and estimated year 2 and 3 cost of $196,100 and authorize the HealthWest Executive Director to sigh the three-year agreement.

MOTION CARRIED

E. *Authorization to Contract with Peter Chang Enterprises, Inc.*

It was moved by Mr. Hardy, seconded by Mr. Weerstra, to authorize the HealthWest Board to contract with Peter Chang Enterprises, Inc. (PCE), for implementation and maintenance of the Crisis Residential Unit module in the Electronic Health Records (HER) services to HealthWest, for approximately one time fee of $38,500 and annual maintenance of $24,960.

MOTION CARRIED

F. *Authorization to Contract with Inspiring Loving Hope Homes LLC.*

It was moved by Mr. Hardy, seconded by Mr. Weerstra, to authorize the HealthWest Executive Director to sign a contract with Inspiring Loving Hope Homes LLC, effective June 27, 2026, through September 30, 2027, to provide specialized residential services to eligible HealthWest consumers. The funding is within the HealthWest AFC Specialized Residential Budget of $24,900,000.00.

MOTION CARRIED

G. *Authorization to Contract with Michigan Department of Health and Human Services (MDHHS)*

It was moved by Commissioner Hazekamp, seconded by Mr. Hardy, to authorize the HealthWest Executive Director to sign contract #DFA27-61001 with the State of Michigan Department of Health and Human Services for $76,400.00. This contract will fund the Eligibility Specialist at the HealthWest building from October 1, 2026, through September 30, 2027.

MOTION CARRIED

H. *Authorization to Contract with Dr. Katherine Jawor, D.O.*

It was moved by Mr. Hardy, seconded by Ms. Thomas, to authorize the HealthWest Executive Director to sign a contract with Doctor Jawor, D.O. with a total not to exceed $288,600.00 effective June 29, 2026, through September 30, 2027.

MOTION CARRIED

I. *Authorization to Contract with Northern Behavioral Solutions, LLC*

It was moved by Mr. Hardy, seconded by Mr. Weerstra, to authorize the HealthWest Executive Director to sign a contract with Northern Behavioral Solution, LLC effective Jule 1, 2026, through September 30, 2027, to provide Applied Behavior Analysis Therapy to HealthWest consumers. The funding is within the approved HealthWest Autism Budget of $2,908,811.00.

MOTION CARRIED

OLD BUSINESS

There was no old business.

NEW BUSINESS

There was no new business.

COMMUNICATIONS

There was no communication.

AUDIENCE PARTICIPATION

There was no audience participation.

ADJOURNMENT

There being no further business to come before the committee, the meeting adjourned at 8:23 a.m.

Respectfully,

Jeff Fortenbacher
Committee Chair

/hb

PRELIMINARY MINUTES
To be approved at the Finance Meeting on
July 10, 2026

REQUEST FOR HEALTHWEST BOARD CONSIDERATION AND AUTHORIZATION

COMMITTEE	BUDGETED	NON-BUDGETED	PARTIALLY BUDGETED
Full Board	X		

REQUESTING DIVISION	REQUEST DATE	REQUESTOR SIGNATURE
Administration	June 26, 2026	Pamela Kimble, Director of Quality Assurance

SUMMARY OF REQUEST (GENERAL DESCRIPTION, FINANCING, OTHER OPERATIONAL IMPACT, POSSIBLE ALTERNATIVES)

HealthWest Board authorization is requested to approve the 2026 Quality Assessment and Performance Improvement Plan.

> Per Policy: 09-001, HealthWest will have a Quality Assessment and Performance Improvement Plan (QAPIP) that achieves, through ongoing measurement and intervention, improvement in aspects of clinical care, supports, recovery, and non-clinical services that can be expected to positively affect consumer health status, quality of life, and satisfaction. It is the policy that an annual QAPIP will be prepared and forwarded to the Board of Directors for Approval.

The QAPIP was last approved by the HealthWest Board on June 27, 2026, as documented in the Full Board Minutes for that date. Standard XIII Quality Assessment and Performance Improvement Program, number 13.5a states, “Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include the following: a) There is documentation that the Governing Body has approved the overall QAPIP plan.” This QAPIP is being presented as part of a motion for authorization and approval.

SUGGESTED MOTION (STATE EXACTLY AS IT SHOULD APPEAR IN THE MINUTES)

I move to authorize and approve the 2026 Quality Assessment and Performance Improvement Plan, effective June 26, 2026.

COMMITTEE DATE	COMMITTEE APPROVAL
June 26, 2026	_____ Yes _____ No _____ Other
BOARD DATE	**BOARD APPROVAL**
June 26, 2026	_____ Yes _____ No _____ Other

HWB 95-B

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN (QAPIP)

June 26, 2026

Prepared By: Pamela Kimble, Director of Quality Assurance

Last Updated: June 27, 2026

Reviewed By: Quality Improvement Committee June 10, 2026

HealthWest Leadership Team June 16, 2026

Approved By: HealthWest Board of Directors June 26, 2026

Contents

Mission Statement

To be a leader in integrated healthcare, inspiring hope and wellness in partnership with individuals, families, and the community.

Vision Statement

Building a healthier, more informed, and inclusive community through innovation and collaboration.

Quality Assessment

The systematic process used to evaluate if services meet quality standards. This includes assessment of our performance in meeting contractual requirements and other agreed upon quality standards.

Quality Improvement

A systematic approach guided by data to improve the quality, safety, and effectiveness of integrated healthcare services.

Performance Improvement

An efficient approach for improving employee and organizational performance to achieve results. It is a process that describes preferred performance, identifies causes of performance concerns, and then selects, designs, and implements interventions to fix the cause and measure change in performance.

The Goal of Quality and Performance Improvement

To improve healthcare delivery for enhanced access to care, improved consumer outcomes, and increased satisfaction with services. To recognize opportunities for enhancement in performance at the organizational, system, process, and employee levels to achieve desired organizational results of high-quality, sustainable behavioral health services that increase positive outcomes for consumers.

I. PURPOSE

The HealthWest Quality Assessment and Performance Improvement Plan (QAPIP) aims to follow a process of assessment, strategy development, stakeholder input, plan implementation, results review, and change using the cycle of continuous quality improvement (CQI). HealthWest will seek to improve outcomes for those receiving services.

The function of the QAPIP is to guide the agency-wide quality improvement activities of HealthWest and support the integration of a continuous quality improvement philosophy into the organization's everyday work.

Continuous quality improvement is based on the following assumptions:

1. Those working on behalf of the organization seek to provide high-quality services.
2. In nearly all situations, improvement can be made by analyzing processes and systems for completing work.
3. Individuals served will be involved in defining the quality of services.
4. Decisions are based on reliable data.

The QAPIP addresses the contractual requirements of the Michigan Department of Health and Human Services (MDHHS) and the Pre-Paid Inpatient Health Plans (PIHP), as well as CARF accreditation requirements. In addition, it also fulfills the requirement that each Certified Community Behavioral Health Clinic (CCBCH) have a Continuous Quality Improvement (CQI) Plan for clinical services and clinical management.

II. Policy

HealthWest will have a fully operational QAPIP that upholds industry standards for best practices in performance measurement, performance management, and performance improvement, as described in MDHHS contracts, CARF standards for behavior healthcare providers, and the Certified Community Behavioral Health Clinic (CCBHC) Handbook.

The QAPIP will be reviewed and approved on an annual basis by HealthWest Board of Directors. Through this process, the Board gives authority for the implementation of the plan and all its components. This authority is essential to the effective execution of the plan.

Consistent with the structure of HealthWest and its Board of Directors, this authority is discharged through HealthWest's Executive Director. In turn, the Executive Director discharges this authority through the Director of Quality Assurance.

III. GOALS

1. Target improvements at all levels including management, administration, and clinical programs.
2. Involve people served, and those who care for them, in assessing and improving satisfaction with outcomes and services.
3. Develop internal performance indicators in the areas of effectiveness, efficiency, access, and satisfaction.
4. Meet the Behavioral Health Core Set indicator.
5. Ensure that service providers fulfill their contractual obligations and are competent in providing services through a system of on-site facility reviews, clinical records audits, desk audits, and credentialing/training audits.
6. Ensure that HealthWest provides effective, equitable, understandable, and respectful quality care and services responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
7. Ensure that performance indicators and improvement activities impact all populations served by the agency, including but not limited to populations such as persons served over a long period of time, older adults, children, non-English speakers, and those with developmental disabilities.

IV. PLAN REQUIREMENTS

The Quality Assessment and Performance Improvement Plan will meet the following requirements:

1. Meet the Michigan Mission-Bases Performance Indicator System (MMBPIS) standards and the Behavioral Health Core Set standards. Failure to meet the standards for one quarter will result in initiating a performance improvement project and in-depth analysis.
2. Certified Community Behavioral Health Clinic (CCBHC) Continuous Quality Improvement Plan for clinical services and clinical management.
3. Develop internal standards for performance when these standards are not set by MDHHS, CARF, the LRE, federal standards, and/or awarded grant requirements.
4. Quality improvement projects will sustain improvement in significant aspects of clinical and non-clinical services.
5. Monitor and review activities to ensure systematic problems are identified and corrected.
6. Meet all MDHHS and awarded grant requirements for grievances and appeals and maintain an active member services function.
7. Maintain a record of all performance improvement projects and provide follow-up data to ensure improvements are demonstrated and maintained.
8. Quality and performance improvement activities in the clinical area will strive to improve prevention, acute, chronic, high-volume, and high-risk services, providing a whole-person approach to health care services as well as any process that may be relevant to service improvement.

9. Quality and performance improvement activities in non-clinical processes may include availability, accessibility, cultural competency, quality of providers, processes regarding billing and authorizations, appeals, grievances, and complaints.
10. Identify quality improvement initiatives through a regular process of data gathering, analysis, and prioritization, which considers prevalence, need, risks, and the interest of those served in pursuing the project.
11. Review all sentinel events and implement action items based on these reviews.
12. Implement a utilization management function that clearly identifies criteria for services with the agency, publicizes these to those individuals currently and potentially receiving services, and reviews trends in access and service utilization.
13. Carry out quality projects as required by the State, Federal and awarded grant guidelines.

The Quality Assessment and Performance Improvement Plan (QAPIP) will be reviewed on an annual basis. Review and evaluation will include:

1. A review of QAPIP goals from the previous year;
2. A review of the Quality Improvement Committee's objectives and actions from the previous year;
3. A review of the annual Quality Improvement Committee self-evaluation results;
4. A review of all quality oversight activities;
5. A review of the appropriateness and relevance of current performance indicators and quality measures (contained throughout this report);
6. An overall performance summary, including progress on improvement projects and trends within the accessibility, effectiveness, efficiency, and satisfaction of HealthWest services;
7. Identification of QAPIP goals and priorities for the coming year;
8. Recommendations and next steps.

Upon its completion, the annual QAPIP review and evaluation is provided to the HealthWest Leadership Team and Board of Directors, as well as the provider network and Consumer Advisory Committee. Additionally, the annual QAPIP review and evaluation is available to Staff, consumers, and members of the community. The QAPIP can be provided at any time upon request.

V. RESPONSIBILITIES

A. The HealthWest Board will annually approve the Quality Assessment and Performance Improvement Plan. The Board will also periodically review performance improvement data and information.

B. The Executive Director will ensure that a quality improvement (QI) system is in place. The director will review recommendations from the Leadership Team and authorize any subsequent action plans.

C. The Medical Director or designee shall provide consultation to any committee that requires medical consultation. The Medical Director or designee will serve as an ad hoc member of the Leadership Team and will ensure that psychiatric representation is available for the Pharmacology & Therapeutics/Medication Committee, Utilization Management Committee, Sentinel Event Review, Quality Improvement Committee, and the Behavior Treatment Review Committee, as needed.

D. The Director of Quality Assurance will be responsible for the implementation and ongoing functions of the QI system. The Director of Quality Assurance will serve as a member of the Leadership Team and will provide facilitation and data analysis within the QI system. This includes the ongoing development of the QAPIP and evaluation of the QI system.

E. The HealthWest Leadership Team will be responsible for reviewing performance indicators on a regular basis, developing action plans to improve performance where required, and ensuring compliance with clinical care standards. The Leadership Team has central responsibility for the implementation of the QAPIP.

F. HealthWest Staff will ensure consistent, high-quality care and services. Whether providing clinical or administrative services, staff work to support the mission, vision, and guiding values of HealthWest. Staff are responsible for identifying areas which need improvement and suggesting process and system changes by bringing quality issues to their direct supervisor or a member of the Quality Assurance team. Quality and performance initiatives may also start based on findings in process and data quality monitoring such as Medicaid Verification. Staff will serve on committees, performance improvement workgroups, and participate in the Kata process if approved by their direct supervisor.

G. Contractual agencies will be evaluated based on the performance standards stated in their contracts. They will be provided a regular means of communicating issues to HealthWest, such as the Provider Network Meeting, which meets monthly or by submitting issues to the contracts department.

VI. STRUCTURE

The structure of the quality assurance system is graphically depicted in Appendix B: Quality Assurance and Performance Improvement Structure:

The Quality Improvement Committee will regularly report to the Leadership Team with findings and recommendations. See *Appendix C: Quality Improvement Committee Members* and *Appendix E: QAPIP Data Review Schedule* for a detailed review of committee responsibility for plan development, policy, CARF standards, and performance indicators. The duties and responsibilities of Quality Improvement Committee include:

1. Receive regular outcome reports from committees and departments.
2. Review and evaluate various survey results and identify priorities for improvement.
3. Review and evaluate all employee-generated suggestions for improvement.
4. Annually review and approve the QAPIP.
5. Annually review the committee structure to ensure comprehensive improvement process.
6. Assure that plans for improving systems are in place and effectively implemented, monitored, and communicated.
7. Identify the organization's training needs related to quality assurance and performance improvement.
8. Recommend priorities for action based on data and recommendations.
9. Review and document action taken.
10. Ensure that any work group assigned by the Quality Improvement Committee understands its role and function clearly.

The Quality Assurance Team is responsible for the following:

1. Presents the Quality Assessment and Performance Improvement Plan to the Leadership Team and the CMH Board on an annual basis.
2. Provides consultation and support to departments and the Leadership Team in their role of quality assurance.
3. Reviews internal Peer Chart Review and Medicaid Event Verification audits to ensure quality standards are met and to identify areas for improvement.
4. Ensures that quality and performance improvement data is regularly presented to the Leadership Team.
5. Prepares reports for the MDHHS and PIHP performance indicators and other required quality-related reporting.
6. Coordinates the PIHP Medicaid Event Verification process.
7. Assists with state-required consumer satisfaction surveys..
8. Facilitates completion of root cause analysis for sentinel events warranting such analysis.
9. Leads preparation for Commission on Accreditation of Rehabilitation Facilities (CARF) surveys, Michigan Department of Health and Human Services (MDHHS) audits, and Lakeshore Regional Entity (LRE) site reviews.
10. Leads preparation for Michigan Fidelity Assistance Support Team (MIFAST) Reviews, including reviews for Assertive Community Treatment (ACT), Dialectical Behavior Therapy (DBT), Level of Care Utilization System (LOCUS), and Supported Employment/Individual Placement and Supports (IPS).
11. Manages the Home and Community Based Services, Waiver Programs, and Self-Directed Services to ensure requirements are met in all areas.

VII. STANDING COMMITTEES

Standing committees serve functions that are directly related to contract or accreditation requirements. They are long-standing and are responsible for monitoring and reporting specific findings identified in the Quality Assessment and Performance Improvement Plan. They may or may not be required by MDHHS, CARF, etc. Committees include HealthWest staff and may include people served by the organization or people who care about them, such as family members, guardians, and advocates. *See Appendix B: Quality Assurance and Performance Improvement Structure*

Behavior Treatment Review Committee: This committee, mandated by MDHHS contract, reviews restrictive, intrusive, or aversive behavior plans, whether developed by HealthWest clinical staff or contracted programs, and psychotropic medications prescribed for behavioral control purposes. The committee also educates Staff regarding behavior issues. Refer to *Policy and Procedure No. 06-001 Behavior Treatment Plan Review Committee* for full details. The committee provides recommendations for Staff seeking interventions for challenging cases. The committee meets monthly and reports data quarterly to the Quality Improvement Committee and to the Lakeshore Regional Entity's regional committee. This data is used to identify trends, address concerns, and guide quality improvement efforts. A Power BI dashboard is maintained for Physical Management related data to support data review and analysis.

CARF Committee: This committee reviews the CARF accreditation standards, periodically audits for compliance with CARF standards, and educates program staff in the standards. In addition, they participate in the QAPIP by monitoring the performance measures for Access, Effectiveness, Efficiency, Satisfaction, and Business Functions as they relate to CARF accredited programs and for any program which we may seek to become accredited for in the future. Over the three-year accreditation cycle, the committee meets as follows: year one the committee meets quarterly to review recommendations and implement performance improvement projects, year two the committee meets bi-monthly to step up efforts in performance improvement, year three the committee meets monthly to increase efforts in education, communication, and preparation regarding upcoming CARF survey. This committee reports quarterly to the Quality Improvement Committee.

Certified Community Behavioral Health Clinic (CCBHC) Committee: This committee works to maintain CCBHC Certification, meeting 100% of requirements. It aligns with CCBHC certification criteria to secure additional funding and position our organization for the future model of behavioral healthcare. Sub-committees include Designated Collaborative Organizations (DCOs) and Care Coordination. The committee meets bi-weekly and reports to the Quality Improvement Committee quarterly.

Clinical Operations Committee: This committee provides oversight, guidance, and direction regarding clinical operations across the organization to improve workflow and clinical communications, discover and implement efficiencies, ensure adherence to all standards and requirements, support evidence-based and best practices, and improve the overall staff and consumer experience in the delivery of clinical care. The committee collaborates with the Quality Assurance Department to ensure clinical

decisions align with the standards of governing bodies, addresses systemic level issues identified through audits and corrective action plans, reviews and supports initiatives related to implementation and sustainability of evidence-based and best practice models (*Policy and Procedure No. 06-017*), oversees clinical practices and policies, and reviews credentialing when there is ambiguity as to if the credentials are appropriate/qualify for a position. This committee regularly reviews, monitors use of, evaluates, and, at least annually, formally adopts Clinical Practice Guidelines (https://www.lsre.org/clinical-practice-guidelines) for the provision of long-term care services that are relevant to the target populations served. The committee meets monthly and reports to the Quality Improvement Committee quarterly.

Compliance Committee: This committee provides oversight of the compliance functions of the organization, reviews compliance incidents and data, and oversees policy and procedure development in privacy, security, and compliance. The committee develops a *Corporate Compliance Plan* and an annual *Risk Management Plan,* which covers a variety of risk factors such as programmatic, financial, or health and safety. This committee is responsible for the agency's Risk Management and Corporate Compliance Plans. The committee meets monthly and reports to Leadership Team quarterly.

Consumer Advisory Committee: This committee comprises HealthWest staff and current HealthWest consumers or guardians. The committee reviews satisfaction surveys, consumer experiences, and other information to make recommendations to the agency. The committee meets monthly and reports to the HealthWest Board bi-monthly.

Doctors' and Pharmacy Workgroup: This committee is chaired by the HealthWest Medical Director. The committee addresses areas related to the safety and quality of healthcare provided to individuals in services. The committee also provides an organized mechanism for evaluation and assessment of medical Staff through the Peer Review process. Refer to *Policy and Procedure No. 12-003 Medical Staff Peer Review Protocol*. It monitors the utilization of medications in HealthWest-operated and contractual programs. The workgroup reviews significant medication errors, assures compliance with internal and external standards and policies, provides assistance to programs for the purpose of developing procedures, and revises HealthWest policies and procedures regarding medication. Refer to *Policy and Procedure No. 06-010 Medication Management*. Record reviews are completed monthly by prescribers, pharmacists, and nurses, independent of the monthly committee meeting. The committee meets monthly and reports to the Quality Improvement Committee quarterly. The quarterly summary report from these findings is used to identify opportunities for performance improvement and areas for additional education. The committee meets monthly and reports to the Quality Improvement Committee quarterly.

Environment of Care Committee: This committee oversees efforts across the organization to ensure that effective safety, emergency preparedness, and security issues are addressed. The committee meets quarterly and reports to the Compliance Committee quarterly. Please refer to *Policy and Procedure No. 10-009 Environment of Care*.

Integrated Health and Care Coordination Committee: This committee recognizes integrated and holistic care is the best practice for supporting recovery of individuals with behavioral health concerns, developmental delay, and concerns with substance use. Members work to ensure HealthWest staff are accurately integrating and coordinating care, including documentation of care. The committee also focuses on external referrals, model payments, spend-downs, insurance benefit planning, housing, and other various ancillary services. The committee meets bi-weekly and reports to the Quality Improvement Committee quarterly.

Network Adequacy Committee: This committee is composed of 19 members representing a broad range of departments, including: clinical, contracts, compliance, customer service, finance, quality, training, recipient rights, and executive leadership. The committee evaluates and oversees provider-related topics such as quality performance, provider access and capacity, financial considerations, contract needs and gaps, pre-contracting assessments, and provider dispute resolution. The committee is committed to ensuring equitable access to care, high quality services, and improved outcomes for individuals served. Please refer to *Policy and Procedure No. 10-018 Provider Capacity and Services.*

Provider Contract Meeting: This is not a committee but a standing meeting that works to address any HealthWest provider network issues that may be related to contractual changes, HealthWest Latitude 43 issues, Provider Performance and Compliance issues, as well as any other HealthWest provider concerns such as billing changes. This group includes HealthWest staff and provider staff and meets monthly. Information from this meeting is used to update the Network Adequacy Plan. The plan and data related to it is presented to the Quality Improvement Committee semi-annually.

Recipient Rights Advisory Committee: This committee, mandated by MDHHS contract, helps to ensure that every individual receiving HealthWest services has certain protected rights. The committee membership is appointed by the Board and includes board members. The committee meets every other month. Refer to *Policy and Procedure No. 04-006 Safeguarding the Rights of Recipients*. It is the responsibility of the Recipient Rights Office to collect and report data to the Quality Improvement Committee quarterly.

Utilization Management Steering Committee: This committee monitors the utilization of resources to ensure that services are clinically necessary, effective, and provided in the most cost-effective manner. Regular data reports will be reviewed, and adjustments will be made in the organization based on the data. It is responsible for the agency's Utilization Plan. The committee meets monthly and reports to the Quality Improvement Committee quarterly.

VIII. ADVERSE EVENTS

Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrants a review. Subsets of these adverse events will qualify as "reportable events" according to the MDHHS Critical Event Reporting System. These include MDHHS-

defined sentinel events, critical incidents, and risk events. HealthWest has a system in place to document and monitor such events, report to the PIHP and MDHHS as required within the appropriate timeframes, ensure root cause analyses are performed as required by staff with the appropriate credentials, and that improvements and preventative measures are put in place to address safety issues and avoid future adverse events. Healthwest's policies, procedures, and reporting system for adverse events were developed to fulfill all requirements specified in the MDHHS/PIHP Medicaid Managed Care Specialty Supports Services Contract as well as the requirements established by the Lakeshore Regional Entity for its affiliate CMHSPs. For additional information, see the *HealthWest Policy and Procedure No. 04-019 Reporting Unusual Incidents*, *MDHHS QAPIP Practice Guidelines*, and the MDHHS/PIHP Contract. See also *Appendix F: Critical and Risk Event Incident Reporting Grids*.

a. Critical events that are required to be reviewed and reported include: suicide deaths, non-suicide deaths, arrests, emergency medical treatment or hospitalization due to injury or medication error, and serious challenging behaviors, 911 calls made by staff for assistance with a behavioral crisis, and physical management for required populations as defined by MDHHS., Subcategories reported for deaths include: accidental/unexpected (including suicide deaths), homicide deaths, deaths from an undiagnosed condition, accidental deaths, or deaths suspicious of abuse/neglect receiving specialty supports and services. Subcategories for emergency medical treatment and hospitalizations include those injuries from the use of physical management and/or falls. Critical incidents will be reported consistent with MDHHS contract requirements.
b. The Quality Assurance Team will analyze critical incident and risk event data. This information will be reported regularly to the Leadership Team, who will, as appropriate, review additional information needed to determine when and what actions to remediate a situation or to reduce the potential for similar events to be implemented.
c. Critical incident reporting will be submitted to Lakeshore Regional Entity by the 15th of each month. *See Appendix F* for a grid of critical incidents.
d. For some events, remediation may be required within 30 days of the reported date. HealthWest may be notified of need for remediation for the following reasons:
    i. Not reported in a timely manner,
    ii. For emergency medical treatment or hospitalizations due to medication errors,
    iii. For emergency medical treatment or hospitalizations due to a fall,
    iv. For emergency medical treatment or hospitalizations as the result of physical management, or
    v. Other reason requested by MDHHS upon their review of the incident.

2. Risk Events: Events that put an individual at risk of harm. Such an event is reported internally and analyzed to determine what action needs to be taken to remediate the problem or situation and prevent additional events and incidents. Risk events minimally include:
    a. Harm to Self: Actions taken by consumers that cause physical harm requiring emergency medical treatment or hospitalization due to an injury that is self-inflicted (e.g. pica, head banging, self-mutilation, biting, suicide attempts.)

b. Harm to Others: Actions taken by consumers that cause physical harm to others (family, friends, Staff, peers, public, etc.) that result in injuries requiring emergency medical treatment or hospitalization of the other person(s).
c. Police Calls: Police calls by Staff of specialized residential settings, general (AFC) residential homes or other provider agency staff for assistance with a consumer during a behavioral crisis situation.
d. Emergency Use of Physical Management: Techniques used as an emergency intervention to restrict the movement of an individual by continued direct physical contact despite the individual's resistance to prevent them from physically harming themselves or others. The term "physical management" does not include briefly holding an individual to comfort him or her or to demonstrate affection or holding their hand.
e. Two or more unscheduled admissions to a hospital w/in a 12-month period.
f. Risk Event reporting will be submitted to Lakeshore Regional Entity by the 15th of each month. *See Appendix F* for a grid of Risk Event incidents.

3. Sentinel Events:
    a. Critical incidents that meet the criteria as sentinel events will result in a full review and analysis, referred to as a Root Cause Analysis (RCA). This is reported semiannually by HealthWest to MDHHS and the Lakeshore Regional Entity compliance point-person. The review will meet requirements as defined by MDHHS and specified in HealthWest *Policy No. 04-021, Reporting a Review of Recipient Death*. Following completion of the RCA, any recommendations for change or corrective action plans, will be presented to the Compliance Committee and to Leadership.
    b. The Quality Assurance Team determines the necessity of an RCA and provides support during the review.
    c. The Quality Assurance Team will maintain a log of all recommendations, assuring that actions steps are completed as required.
    d. Staff involved in the review will have the proper training, expertise, and credentials for the specific event being reviewed. The Medical Director or other assigned medical professional will participate in the process and review all results when appropriate.
    e. HealthWest will report all applicable deaths to the State per *attachment C 6.5.1.1 in the State contract* and will ensure that all deaths subsequent to leaving a state facility within a 6-month period will be properly reported.
4. Immediately Reportable Events:
    a. Any death that occurs because of a suspected staff member action or inaction or any death that is the subject of a recipient rights, licensing, or police investigation is reported to LRE within 24 hours of either the death, receipt of notification of death, or receipt of notification that a rights, licensing, and/or police investigation has commenced. The LRE has 48 hours to report to MDHHS. The report must include:
        i. Name of person served
        ii. Case Number
        iii. Date, Time, and Place of Death (if a licensed foster care facility, include the license number),

iv. Preliminary cause of death
v. Contact person's name and email address

b. Relocation of a consumer's placement due to licensing suspension or revocation within five (5) business days of relocation.
c. An occurrence that requires the relocation of any CMHSP or provider panel service site, governance, or administrative operation for more than 24 hours within five (5) business days of relocation.
d. The conviction of a CMHSP or provider panel staff member for any offense related to the performance of their job duties or responsibilities which result in exclusion from participation in federal reimbursement within five (5) business days of knowledge.
e. Any changes to the composition of the provider network organizations that negatively affect access to care within seven (7) days of any change.
f. Critical incidents which may be newsworthy or represent a community crisis must be reported to LRE immediately, for reporting to MDHHS.

IX. INVOLVEMENT OF PERSONS SERVED

HealthWest will ensure that persons served will be offered input and involvement in the performance improvement system through the following mechanisms:

1. Primary consumers of mental health services serve on the CMH Board.
2. HealthWest consumers serve as full members of the Consumer Advisory Committee.
3. HealthWest consumer(s) will serve on the Quality Improvement Committee.
4. Satisfaction surveys are completed according to the following frequency:
    a. Behavior treatment - annually
    b. Persons served with mental illness or emotional disturbance – annually.
    c. Persons served with developmental disabilities (includes parents and guardians) – annually.
    d. Post-discharge satisfaction surveys – monthly.
    e. Satisfaction with contractual provider services – completed during contract review and pre-planning and treatment planning process.
    f. ACT and Home-Based satisfaction as mandated by MDHHS.
    g. Progress note completion or quarterly outcome measures in the electronic medical record as required.
5. Persons served will always be given the opportunity to contact a representative of HealthWest directly as part of the satisfaction process.
6. When specific issues are discovered, special efforts may be utilized, such as targeted consumer interviews or focus groups.
7. Involvement of persons served will be solicited to address issues relating to the quality, availability, and accessibility of services.
8. HealthWest will seek to improve the representation of people served in quality improvement participation, policy setting, employment, and volunteer opportunities.

9. HealthWest will communicate information on satisfaction, performance indicators, and needs assessment to consumers and stakeholders.
    a. The Consumer Advisory Committee will receive this information for discussion and be given the opportunity to make recommendations to the HealthWest Executive Director and HealthWest Leadership Team.
    b. Data will be provided to the CMH Board on a regular basis. Performance Indicator data will be presented at least quarterly.
    c. Findings and analysis will be made available on the HealthWest website. Periodically, information will be made available in agency lobbies and offices.

X. QUALITY IMPROVEMENT/REMEDIAL ACTIONS/TRAINING

The Leadership Team will identify issues that require additional effort to resolve and improve. In addition to standing committees, workgroups may be developed. A workgroup is not mandated by MDHHS, CARF, or any other compliance standard. It is established by the HealthWest Leadership Team to address a specific project or identified focus area within the agency. Workgroups are comprised of HealthWest staff across multiple departments and assigned on a voluntary basis. Group/project outcomes will be used by HealthWest Leadership and Board to measure growth in the identified focus area. The duration of the group is dictated by the assigned scope. A "Committee/Workgroup Charter" will be completed that specifies the scope of expectation for any group sanctioned by the Leadership Team.

The Quality Assurance Team provides support to the QI system by serving as consultants to the committees and performance improvement groups. This includes using QI tools and methods to assist in problem identification and plan development. Below are some of the most common tools that will be used in improvement efforts at HealthWest.

Customer Satisfaction Assessment: Annually, the Regional Customer Satisfaction Survey is conducted. Since Fiscal Year 2024, the survey instrument used incorporates the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Experience of Care Survey and the Youth/Family Services Survey for Families (YSS-F) as required for CCBHC Demonstration Sites.

KATA. HealthWest will use a process improvement tool called Improvement KATA. Improvement KATA accomplishes improvements through a scientific process with a goal-oriented method to meet objectives. KATA allows practitioners to evaluate existing conditions, define a work goal or objective, and work towards these goals using a Plan, Do, Check, Act (PDCA) process. KATA also works on the foundations of LEAN thinking, which aims to remove waste in processes and increase value to the consumer through an efficient and timely process. (https://www.lean.org/lexicon/kata)

Flowcharting. A process used at HealthWest to visualize a workflow or process. It gives a picture of each step within a process in the order it occurs. It is useful when analyzing how a process is done,

where there may be gaps or departmental overlaps in a process that can be improved, and when planning a new workflow or process.

Root Cause Analysis (RCA). Tools and methodologies used to identify causal factors in a specific event or, more broadly, in situations where performance has dropped below standards. Common tools used to complete an RCA include but are not limited to, "The Five Whys", Fishbone diagram, Pareto Chart, and scatter plot diagrams. Events or situations that may require an RCA can come from many sources, such as incident reports, appeals/grievances, or corrective action plans. The highest priority is given to events that result in significant harm or death, followed by those that may be "near miss" events or those events that could have resulted in harm but did not.

Performance improvement opportunities can occur at any point during HealthWest's operations. Regardless of when an opportunity presents itself and whether it arises following a specific event or as the result of ongoing monitoring, corrective action must be taken to address all performance concerns. However, there may be times when improvement opportunities appear to conflict with other existing organizational priorities. The Quality Improvement Committee and Leadership Team will prioritize improvement projects within the context of the regulatory requirements and the agency's overall strategic plan goals, as well as existing improvement projects already underway. To assist in the prioritization of Performance Improvement projects a Prioritization Matrix will be used, *Appendix H: PI Project Prioritization Matrix.* Ratings will be completed as a committee/team, as opposed to one individual, to reduce the risk of bias in the process.

XI. CARF ACCREDITATION

HealthWest maintains accreditation with CARF International. The most recent CARF survey was conducted in May 2024. The agency is currently accredited in the follow programs: Assertive Community Treatment, Behavioral Consultation Services-Autism Spectrum Disorder, Case Management/Services Coordination, Community Employment Services, Community Integration, Crisis Programs, Governance, Health Home, Intensive Family-Based Services, and Outpatient Treatment *See Appendix D: CARF-HealthWest Program Crosswalk*. CARF standards 1.M.4 - 1.M.9 state that each program/service seeking accreditation will have measures for Effectiveness, Satisfaction, Efficiency, Service Access, and Business Functions.

CARF standard 1.M.10 requires that staff are provided with training and education related to their roles and responsibilities in performance measurement and management. This is an area that will require continued development, including the incorporation of performance measurement and management training during staff orientation and onboarding. A CARF Committee has been established and will be responsible for tracking adherence to CARF standards between survey windows. This committee will report to the Quality Improvement Committee.

XII. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC (CCBHC)

HealthWest is responsible for developing, implementing, and maintaining a comprehensive, data-driven Continuous Quality Improvement (CQI) Plan for clinical services and clinical management related to the CCBHC population. The CQI Plan is formally approved by leadership and reviewed at least annually, with ongoing monitoring conducted throughout the year. CQI projects are clearly defined, prioritized, implemented, and evaluated on an annual basis using established performance improvement methodologies. The number, scope, and focus of projects are determined based on identified needs of the CCBHC population and reflect the scope, complexity, utilization trends, risk areas, health disparities, and past performance outcomes of services and operations. The plan establishes measurable performance indicators aligned with CCBHC-required quality measures, including behavioral health outcomes, physical health outcomes, access to care, care coordination, client safety, and patient experience. Data sources include the electronic health record, state and federal reporting measures, incident reports, claims/utilization data, and client and staff feedback. Performance data is routinely collected, analyzed, trended over time, and stratified (e.g., by race, ethnicity, gender identity, age, and other relevant factors) to identify disparities and inform targeted improvement efforts. The plan explicitly incorporates input from key stakeholders, including individuals served, families, clinical staff, and leadership, to ensure improvement activities are person-centered and responsive to community needs. Staff are trained on CQI processes and are expected to actively participate in improvement initiatives. All CQI activities are evaluated for effectiveness, with documented evidence of interventions, outcomes achieved, and sustainability of improvements. When performance goals are not met, corrective action plans are developed, implemented, and monitored for effectiveness. Findings and progress are regularly reported to leadership, governance bodies, and appropriate committees to support organizational accountability. HealthWest ensures that CQI activities are integrated across departments and aligned with broader organizational quality, compliance, and risk management programs, as well as state and accreditation requirements. The CCBHC documents each improvement project, including the rationale for selection, baseline data, defined performance targets, interventions implemented, and measurable progress achieved. The CCBHC Project Coordinator is responsible for operationalizing and coordinating the CQI Plan, in collaboration with the Quality Assurance Department, clinical leadership, and program staff.

Required Focus Areas and Events

The CQI Plan includes ongoing monitoring, analysis, and improvement activities related to the following required focus areas:

1. **Health Disparities and Equity** – Explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities), including the use of disaggregated data from quality measures and other sources to identify, monitor, and reduce disparities in access, care, and outcomes.

2. **Suicide Prevention and Response** – Monitoring and analysis of suicide deaths and suicide attempts among individuals served, including implementation of evidence-based prevention and follow-up strategies.
3. **Substance Use Outcomes** – Tracking and response to fatal and non-fatal overdoses, including care coordination, harm reduction strategies, and post-event engagement.
4. **Mortality Review** – Review and analysis of all-cause mortality among individuals receiving CCBHC services to identify trends, risk factors, and opportunities for system improvement.
5. **Hospital Readmissions** – Monitoring 30-day hospital readmissions for psychiatric and substance use-related conditions, including coordination with hospitals and transitions of care interventions.
6. **Adverse Events and Safety** – Inclusion of critical incidents, grievances, complaints, and other safety events impacting individuals served.
7. **Access and Timeliness of Care** – Evaluation of access standards, wait times, and service availability.
8. **Care Coordination and Integration** – Monitoring effectiveness of coordination across behavioral health, physical health, and community-based services.
9. **Additional Required Areas** – Any other events, indicators, or priorities as required by the State, federal guidance, or applicable accreditation bodies.

XIII. NETWORK ADEQUACY

Providers must meet contract requirements to provide services within the HealthWest network, including standards related to licenses, educational background, credentials, and required training. The HealthWest *Policy and Procedure No. 10-003:Contracting with New Service Providers, Compliance, and Site Reviews* outlines the guidelines and responsibilities of providers for credentialing and re-credentialing staff. Providers are responsible for ensuring all staff employed in their organization are appropriately licensed, credentialed, and trained consistent with their scope of practice. Providers must also maintain and implement a credentialing policy that requires adherence to HealthWest standards. Failure to meet contractual obligations may lead to a corrective action plan, or in some cases, termination of the contract.

HealthWest has a provider contracting process in place for contracting with new providers of necessary/required services and to ensure initial and ongoing compliance with standards of care, which begins with the HealthWest Pre-Contracting Assessment (PCA). If PCA submission has advanced to the next stage and the contracting process has been completed, orientation for the new provider is scheduled within three weeks after the contract is executed. Orientation includes an overview of HealthWest systems and resources, introduction to key departments, explanation of policies and expectations, and connection to designated contact person for ongoing support (refer to the Orientation Template in HealthWest *Policy and Procedure No. 10-17*).
Once a provider is established, ongoing monitoring through audits occurs including Lakeshore Regional Entity (LRE) desk audits, Michigan Department of Health and Human Services (MDHHS) audits, and

HealthWest sample audits completed in partnership between the contracts and quality assurance departments. HealthWest sample audits include review of staff files and consumer files. This allows prepare providers for more comprehensive audits, to identify compliance gaps early, and to provide actionable feedback for improvement. It is notable that survey and antidotal feedback from providers indicates they play strong value in these audits.

In addition to support through audit, HealthWest and providers meet quarterly to address key provider network matters. Discussions include topics such as contractual changes, HealthWest Electronic Health Record concerns, provider performance and compliance concerns, and other provider-related matters, including billing updates. Information gathered during these discussions is used to inform updates to the Network Adequacy Plan. The Network Adequacy Plan, along with supporting data, is presented to the Quality Improvement Committee on a semi-annual basis.

XIV. CREDENTIALING, PRIVILEGING, AND COMPETENCY OF STAFF

Credentialing/re-credentialing, privileging, primary source verification, and qualification of CMHSP Participants (Staff who are employees of HealthWest or under an independent contract with HealthWest) are delegated by the LRE to HealthWest. Accordingly, HealthWest has established written policies and procedures for the credentialing and re-credentialing of providers in compliance with MDHHS's Credentialing and Re-Credentialing Processes Guidelines. Practices relating to these functions are explained in detail in HealthWest *Policy and Procedure No. 02-026 Credentialing and Re-Credentialing Requirements of HealthWest Employees and Licensed Independent Practitioners*. The policies and procedures ensure that each provider, employed and contracted, meets all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual requirements, including relevant work experience and, education, and cultural competence.

HealthWest maintains a complete system for credentialing and competency that includes HealthWest staff and contractual Staff. HealthWest is also responsible for the selection, orientation, training, and evaluation of the performance and competency of their own Staff and subcontractors. HealthWest conducts credentialing and privileging of all HealthWest staff who provide services, as well as licensed independent practitioners upon hire/contract initiation, and every three years thereafter. HealthWest written policies and procedures also ensure that non-licensed providers of care or support are qualified to perform their jobs.

Staff employed by external provider agencies contracted by HealthWest must also be appropriately credentialed and qualified to provide services. Credentialing, privileging, primary source verification, and qualification of Staff employed by contracted external provider agencies is conducted by the provider agency. Oversight is provided by the Provider Relations/Network Manager, integrated into contractual requirements, and verified during CMHSP and provider site reviews.

XV. HEALTH DISPARITIES

In alignment with the Lakeshore Regional Entity's Performance Improvement Plan, HealthWest will continue to evaluate access and treatment trends of ethnic/minority groups. Evaluation analyzes all current activities designed to assure equitable access and effective treatment to people with cultural barriers to receiving services. In addition, the Quality Improvement Committee will specifically track health disparities between those who identify as Black/African American and those who identify as White.

Goal: By the end of the CY 2026 measurement period, HealthWest will achieve no statistically significant difference in the FUH30 follow-up rates between African American/Black and White individuals age 6 and older following psychiatric inpatient discharge, while ensuring that the follow-up rate for White individuals is maintained or improved.

XVI. UTILIZATION MANAGEMENT SYSTEM

HealthWest ensures access to publicly funded behavioral health services in alignment with LRE contracts, MDHHS contracts, the Medicaid Provider Manual, and Michigan Mental Health Code requirements. Utilization Management activities include initial approval or denial of requested services, screening and authorization for psychiatric inpatient and partial hospitalization services, and authorization of initial and ongoing community services. All service authorizations are based on medical necessity determinations that establish eligibility for the identified services. HealthWest is responsible for communication with individuals about UM decisions, including adverse benefit determination notices, rights to a second opinion, and grievance and appeals processes.

HealthWest's Utilization Management Steering Committee is responsible for the following:

1. Strategies for evaluating medical necessity, criteria used, information sources, and the processes used to review and approve the provision of medical, clinical and support services.
2. Mechanisms to review trends in service utilization, outcomes, and costs on a regular basis.
3. Procedures for conducting prospective, concurrent, and retrospective reviews of authorizations.
4. Development and maintenance of a Utilization Management Plan.

XVII. CLAIMS VERIFICATION OF MEDICAID SERVICES

HealthWest and the PIHP will conduct an audit of internal and external programs to ensure that claims billed under Medicaid have met standards as identified by the Lakeshore Regional Entity, MDHHS, and federal standards. Data will be provided to the Lakeshore Regional Entity as requested. Findings will be presented to HealthWest's Compliance Committee. Immediate recommendations may be made to the

agency's Leadership Team. Claims found to be deficient will result in a required plan of correction. Restitution will be sought for those claims when necessary.

XVIII. Notices, Grievances, and Appeals

HealthWest is committed to ensuring that all Notices of Adverse Benefit Determination (NABDs), provider grievances, and appeals comply with MDHHS standards and policy. To meet compliance, the following standards must be met:

- Notices must be professional, grammatically correct, and error-free
- Notices must be person-centered
- Acronyms must be spelled out on first use
- NABDs must meet a 6.9 grade-level readability standard
- Documentation of guardianship must be included with the appeal packet when applicable

To ensure compliance, the Customer Services Department conducts internal audits of NABDs. Any issues identified during this audit process are followed up with education and training for the staff who completed the document. In addition to internal audits, HealthWest is audited by the LRE using a sample from the state report. The LRE will issue Corrective Action Plans (CAPs) for any deficiency. HealthWest will complete the CAP and validate remediation with proof sent to the LRE. LRE also monitors the HealthWest grievance and appeals processes through an annual CMHSP audit. These audits ensure compliance with federal and state regulations. CAPs are issued when deficiencies are identified, and remediation is monitored and validated to ensure compliance is achieved and sustained.

XIX. APPENDICES

Appendix A: Acronyms and Definitions
Appendix B: Quality Assurance and Performance Improvement Structure
Appendix C: Quality Improvement Committee Members
Appendix D: CARF-HealthWest Program Crosswalk
Appendix E: QAPIP Data Review Schedule
Appendix F: Critical and Risk Event Incident Reporting Grids
Appendix G: PI Project Prioritization Matrix

Appendix A: Acronyms and Definitions

Adverse Events: Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrants a review. Subsets of these adverse events will qualify as "reportable events" according to the MDHHS Critical Event Reporting System. These include MDHHS-defined sentinel events, critical incidents, and risk events.

Beneficiary: A person served by the publicly funded behavioral health and substance use disorder system or the person's representative.

CARF: Commission on Accreditation of Rehabilitation Facilities. An international non-profit organization that accredits health and human service programs.

CCBHC: Certified Community Behavioral Health Clinic. Designated provider organizations that have adopted a model focused on increasing access to high-quality care, integrating behavioral health with physical health care, promoting the use of evidence-based practices, and establishing standardization and consistency with a set criterion for all certified clinics to follow.

CMHSP: Community Mental Health Services Program. For the purposes of this document, refers to HealthWest.

Committee: Committees serve functions that are directly related to contract or accreditation requirements. They are long-standing and are responsible for monitoring and reporting specific findings identified in the Quality Assessment and Performance Improvement Plan. They may or may not be required by MDHHS, CARF, etc. Committee members may be assigned by the Executive Director or be voluntarily assigned as appropriate. All committees report to and are monitored by the Quality Improvement Committee/Quality Team.

Credentialing: The process of reviewing the education, experience, and background of all staff to establish their qualifications for providing services. This includes all licensed professional staff as well as non-licensed staff who provide services.

HealthWest Leadership Team: A committee comprised of staff designated by the HealthWest executive director who are responsible for strategic planning and decision-making.

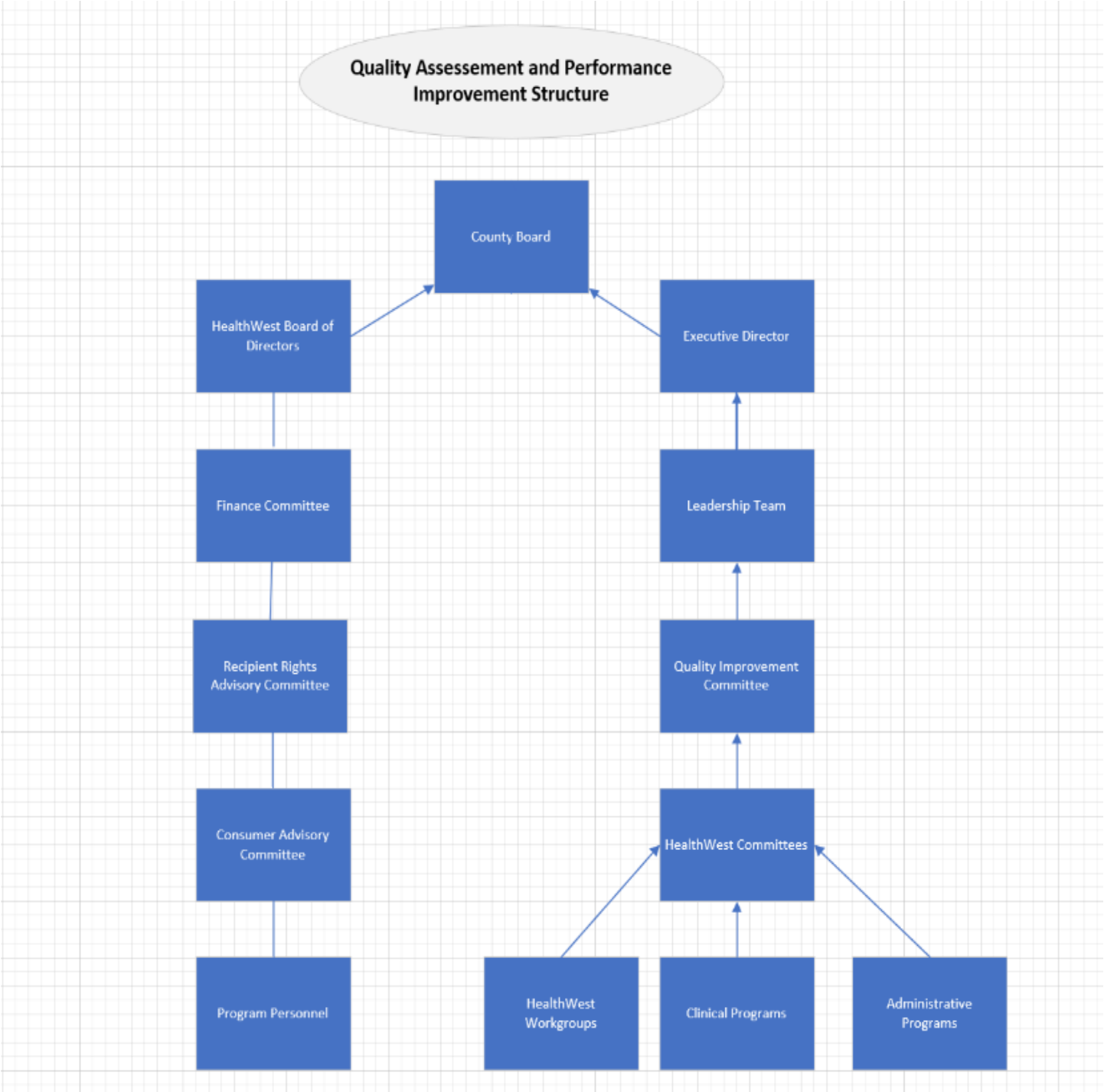
Network Provider: Any provider that receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the state's contract with the Lakeshore Regional Entity (LRE), its member CMHSPs, and the Substance Use Disorder provider panel.

Prepaid Inpatient Health Plan (PIHP): One of ten entities in Michigan responsible for managing Medicaid services related to behavioral health, intellectual/development disabilities, and substance use.

Quality Improvement Committee: The CMHSP committee comprised of HealthWest staff and persons served; responsible for oversight and implementation of the agency's QAPIP.

Workgroup: Workgroups are established by the HealthWest leadership team to address a specific project or identified focus area within the agency. They are not mandated by MDHHS, CARF, or any other compliance standard. They are comprised of HealthWest staff across multiple departments and assigned on a voluntary basis. Group/project outcomes will be used by HealthWest leadership and Board to measure growth in the identified focus area. The duration of the group is dictated by the assigned scope.

Appendix B: Quality Assurance and Performance Improvement Structure



Appendix C: Quality Improvement Committee Members

Voting Members *Voting members make decisions and direct actions*	
Chief Clinical Officer	Christy LaDronka
Clinical Services Manager	Carrie Crummett
Communications and Training Manager	Gary Ridley
Consumer Advisory Committee Representative	David Scholtens
Compliance Manager	Helen Dobb
Director of Adult Clinical Services	Amie Bakos
Director of Children's Clinical Services	Ann Gatt
Director of Data Architecture and Analytics	Natalie Walther
Director of Engagement	Mickey Wallace
Director of Finance	Carly Hysell
Director of Information Systems	Randi Bennett
Director of Quality Assurance	Pamela Kimble
Human Resources Manager	Susan Plotts
Manager of Procurement and Provider Network	Jackie Farrar
Recipient Rights Officer – Recipient Rights Advisory Committee	Casey Olson
Non-Voting Members *Non-voting members report data, offer information, and participate in discussions*	
Behavior Treatment Plan Committee Chairperson	Aimee Howard
Customer Services Specialist	Kelly Betts
Evaluation and Innovation Specialist – Peer Chart Review/CIRE/HCBS	Shawna Curran
Manager of Performance Improvement and Accreditation	Bennie Chambers
Quality Improvement Specialist	Calvin Davis
Director of SUD Prevention and Treatment	Jennifer Stewart
Waiver Coordinator – CWP,HSW,SEDW, iSPA	Melissa Vanas Pfenning
Self-Directed Services Coordinator	Mackenzie Curtis

Appendix D: CARF-HealthWest Program Crosswalk

	CARF Program Standard	HW Program/Team
BEHAVIORAL HEALTH	Assertive Community Treatment: Integrated: SUD/MH (Adults)	- Assertive Community Treatment (ACT)
	Case Management: Integrated IDD/MH (Adults)	- Adult DD Community Based - Medically Complex
	Case Management: Integrated IDD/MH (Children & Adolescents)	- Youth DD - Youth Behavioral Support
	Case Management: Integrated SUD/MH (Adults)	- HW Integrated SUD Team
	Case Management: MH (Adults)	- MI Adult Community-Based
	Case Management: MH (Children and Adolescents)	- Youth SED Outpatient 1 & 2 - Youth Juvenile Justice - Transition-Age Team
	Community Integration: MH (Adults)	- Clubhouse
	Crisis Intervention: MH (Adults)	- Access - Intensive Crisis Stabilization
	Crisis Intervention: MH (Children & Adolescents)	- Access - Intensive Crisis Stabilization
	Crisis Stabilization: MH (Adults)	- Crisis Residential Unit
	Health Home: Comprehensive Care (Adults)	- Integrated Health Clinic (IHC) - All HealthWest Treatment Teams
	Intensive Family-Based Services: MH (Children & Adolescents)	- Home-Based Services - Wraparound - Infant Mental Health (IMH)
	Outpatient Treatment: MH Adults	- Outpatient Clinic
COMMUNITY & EMPLOYMENT	**CARF Program Standard**	**HW Program/Team**
	Community Employment Services: Employment Supports	- Supported Employment/IPS
	Community Employment Services: Job Development	- Supported Employment/IPS
	Behavioral Consultation Services (ASD – Children and Adolescents)	- Autism - Behavior Treatment Plan Review Committee

Appendix E: QAPIP Data Review Schedule

HealthWest

Quality Assessment and Performance Improvement Plan

		Q1			Q2			Q3			Q4		
Committee/Department	**Reporting Topic/Description**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
QAPIP Evaluation and Review	*Performance Data, QAPIP Updates, Kata Updates*		x		x		x		x		x		x
Recipient Rights	*Semi-Annual Report on Rights Complaints*				x						x		
Audits/MIFAST Fidelity	*Audit CAP updates, MIFAST Program bi-annual report outs on program outcomes*	x		x		x		x		x		x	
SUD Quality Measures/Grant Reporting	*SUD data, service/provider updates, Audit and CAP updates, QI Projects*			x						x			
Clinical Operations Committee	*Integrated Health Committee, Doctor/Pharmacy Workgroup, Clinical Quality Improvement Efforts, QI Projects*	x			x			x			x		
Behavior Treatment Plan Review Committee	*#Restrictive BPs, Types of Restrictions, Progress, HCBS Final Rule Compliance, BTPRC Survey Results, PI Use/911 Calls, QI Projects*	x			x			x			x		
Quality Measures	*Behavioral Health Quality Indicator Data, CAP updates, QI Projects, CCBHC Quality Data, QBP Measures*	x			x			x			x		
Motivational Interviewing	*MI training status, QI Projects, Data related to use of MI.*	x			x			x			x		
Organizational Development Department	*Staff Resource Groups, Supervision Data, Engagement Efforts, QI Projects*	x			x			x			x		
Trauma Informed Care Committee	*MI, PFA, Suicide Safter Care, Survey results including recommendations, actions, and updates to related QI projects.*	x			x			x			x		
Adverse Events/Root Cause Analysis	*Critical Incidents, Risk Events, Sentinel Events, RCA data/recommendations, QI Projects*		x			x			x			x	
Utilization Management Steering Committee	*Committee Update – GF Use, Rates, Utilization Review, Retro Reviews, QI Projects*		x			x			x			x	
Human Resources	*Credentialling, Staff Support, QI Projects*		x			x			x			x	
Finance	*Financial reports update, Areas of improvement needed, QI Projects*		x			x			x			x	
Peer Chart Review/Medicaid Claims Verification	*Results, QI Data, Areas of need, Areas of improvement, QI Projects*		x			x			x			x	
Provider Network	*Provider audit results, provider adequacy, QI Projects*		x			x			x			x	
CARF Committee	*QIP updates, CARF Outcomes Data, Status on next survey*			x			x			x			x
Compliance Committee	*Provider network, Recipient Rights, Provider Network, Environment of Care*			x			x			x			x
IT Committee	*IT Tech Plan, systems testing results, QI projects*			x			x			x			x
Customer Services/Consumer Advisory Committee	*Grievance and Appeal Data, Consumer Survey Results, Training Needs and Data, Outreach, CAC Updates, QI Projects*			x			x			x			x
Waiver/HCBS/Self-Direction	*#waiver slots, review of utilization, compliance concerns/improvements, policy updates, QI Projects*			x			x			x			x

Appendix F: Critical and Risk Event Incident Reporting Grids

Critical Incidents are submitted to the LRE by the 15th of each month. They must be reported by LRE to MDHHS within sixty (60) days after the end of the month, except for suicides which are reported within thirty (30) days in which the incident occurred for individuals who, at the time of the incident, were actively receiving services:

Service	Suicide (01)	Death (02)	EMT (03)	Hospital (04)	Arrest (05)	Death of Unknown Cause (06)	PM w/out Injury	Emergency Response	Use of Restraint
ACT	●	●				●			
CLS	●	●				●			
Case Management	●	●				●			
Homebased	●	●				●			
Wraparound	●	●				●			
Any Other Service	●	●				●			
1915 iSPA	●	●	●	●		●			
HAB Waiver	●	●	●	●	●	●			
SED Waiver	●	●	●	●	●	●			
Child Waiver	●	●	●	●	●	●			
Living Situation									
Specialized Residential	●	●	●	●	●	●			
Child Caring Institution	●	●				●			
Crisis Stabilization Unit	●	●				●	●	●	●

In additional to the reporting of critical incidents, as cited above, all SUD critical and sentinel events are also reported to LRE:

Service	Suicide (01)	Death (02)	EMT-Injury/Med Error (03)	Hospital – Injury/Med Error (04)	Arrest (05)	Death of Unknown Cause (06)	MAT Med Error (07)	SUD Med Error (08)	Serious Challenging Behaviors (09)
SUD Services	●	●				●	●		

Service	MAT Med Error (07)	SUD Med Error (08)	Serious Challenging Behaviors (09)	Conviction	Serious Illness Requiring Hospitalization	Accident EMT or Hospital	Alleged Cause of Abuse or Neglect
SUD 24-Hr Specialized Residential	●	●	●	●	●	●	●

Risk Events are submitted to the LRE by the 15th of each month, and must be reported by LRE to MDHHS within sixty (60) days after the end of the month in which the event occurred for individuals who, at the time of the event, were actively receiving services:

Service	Harm to Self	Harm to Others	Police Calls	Physical Management	Hospitalization 2+ w/in 12 Months
Case Management	●	●	●	●	●
ACT	●	●	●	●	●
Home-Based	●	●	●	●	●
CLS	●	●	●	●	●
Wraparound	●	●	●	●	●
HAB Waiver	●	●	●	●	●
SED Waiver	●	●	●	●	●
Child Waiver	●	●	●	●	●
1915 iSPA	●	●	●	●	●
Living Situation					
Specialized Residential	●	●	●	●	●
Child Caring Institution	●	●	●	●	●
Crisis Stabilization Unit	●	●	●	●	●
SUD 24-Hr Specialized Residential			●	●	

Appendix G: PI Project Prioritization Matrix

			Performance Improvement Requests							
Criteria	Weight	Scoring Values		Enter Scoring Value		Enter Scoring Value		Enter Scoring Value		Enter Scoring Value
- Regulatory Requirement (MDHHS, LRE, CARF, CCBHC, etc.) - Strategic Plan Requirement - Other services/departments depend on it	5	0: None are true 3: One is true 6: Two are true 9: All are true	0		0		0		0	
Risk Mitigation - Are consumers at risk if improvement is not made? - Is the agency at risk if improvement is not made?	4	0: Little risk if not made 3: Some risk if not made 6: Much risk if not made 9: High risk if not	0		0		0		0	
Value to Stakeholders - How much value does the PI project provide to consumers, staff, community?	3	0: Little value to stakeholders 3: Some value to stakeholders 6: A lot of value to stakeholders 9: Essential/Critical to stakeholders	0		0		0		0	
Cost - Includes implementation and maintenance costs - Includes financial costs, staff time/capacity, and other resources.	2	0: Lots of unknow or hidden costs 3: Some costs are known 6: Many costs are known 9: All costs, direct & indirect, are known, tabulated and approved.	0		0		0		0	
Total Score			0		0		0		0	

CMHA Spring 2026 Updates

What's in Store for 2026

2026 Election in Michigan will be historic

What is at stake?

- First time since direct US Senate elections began in 1916 that both an open U.S. Senate seat and an open Governor's race (with no incumbent) will appear on the same ballot.
    - Governor & Lt Governor (open)
    - U.S. Senate (open)
    - U.S. House
    - Secretary of State (open)
    - Attorney General (open)
    - Michigan Senate (all 38 seats)
    - Michigan House (all 110 seats)
- Constitutional Convention question, which appears every 16 years will be on the ballot
- The entire state legislature (Senate and House) is up for re-election
    - Dems hold a 20-18 majority in Senate
        - **Special election for 35th district – held on May 5 (Dems won 60%-40%)**
    - Republicans hold a 58-52 majority in House

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What's in Store for 2026

- **More inaction and gridlock in Lansing – Divided Legislature**
    - **Only 16 PAs in 2026**
- **2025 Lowlights**
- **FY26 Budget Misses BOTH Deadlines**
    - PA 160 of 2019, effective July 2021) mandates the Legislature must pass and present appropriation/budget bills to the governor **by July 1** each year.
    - Budget finally completed after a continuation budget was passed on October 1 (funding the state through 10/8) – FY26 budget was finalized on October 3rd.
- **Record Low Public Acts in 2025**
    - At the very end of December, Governor Gretchen Whitmer signed 36 bills into law, bringing the total number of public acts enacted in 2025 to 74.
        - Governor Whitmer has signed 1502 bills into law during her first 6 years as governor = 250.3 bills/per
        - The average number of new laws signed per year over the two prior decades was 383. The 74 tally from this year is an 81% drop from that average.

FY27 Budget Forecast

- **State revenues remain stable but growth is modest.** Michigan's May 2026 Consensus Revenue Estimating Conference (CREC) increased revenue projections compared with January estimates, indicating a somewhat stronger outlook heading into FY27.
- **Combined General Fund and School Aid Fund revenues are projected to be roughly $174 million higher** than previously estimated for FY27.
- **State Budget Office projects roughly $1.2 billion less in FY27 compared to FY26.**
- **Inflation and federal policy uncertainty remain major risks** to the forecast, particularly regarding federal budget decisions, Medicaid funding, trade policy, and potential economic slowdowns.
- Michigan enters FY27 in a **better position than anticipated earlier in 2026**, with modest upward revenue revisions and no immediate fiscal crisis. However, the forecast remains cautious because of **federal funding uncertainty, inflationary pressures, and slower economic growth**, which could affect revenues and spending demands over the next several years.

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FY27 Budget Forecast

H.R. 1

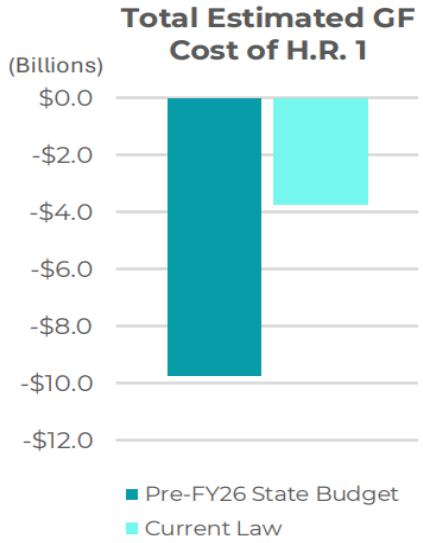
SBO State Budget Office

As health care costs are rising across the country, the federal government is passing the tab to states:

- Last July, Congress passed H.R. 1, which cut federal funding and shifted significant costs to states across the country
- When H.R. 1 passed, it immediately blew a $1B hole in our budget
- While Michiganders continue to pay federal taxes, we all get less back in federal support, and the state pays more

We took steps to mitigate some of the impacts in FY26:

- Decoupled from federal tax provisions
- Protected $2.7B in annual Medicaid funding
- Invested $30M for SNAP error rate reduction
- Accomplished this while maintaining investments in priorities and passing a $2B roads plan



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FY27 Exec Budget Recommendation

- The proposed FY27 spending plan is $88.1 billion, including a general fund total of $13.6 billion and a school aid budget totaling $21.4 billion. **The budget is based on roughly $800 million in tax increases, $630 million in cuts and $400 million from the rainy day fund.**

- **Biggest Spending Areas**
  - **Education (Higher Ed & K-12):** Expanded funding, especially literacy and per-pupil increases.
  - **Health & Human Services:** State increases to offset federal changes and strengthen Medicaid administration.
  - **Tax Relief Programs:** New/expanded credits that effectively increase net budgetary commitments (senior property tax credit & working families tax credit)
  - **Infrastructure/Transportation:** Continued and substantial road funding commitments.
  - **Other Department Growth:** Small but numerous increases in other state functions and initiatives.
  - **General Growth/Inflation:** Baseline increases due to inflation, caseload adjustments, and service expansions.

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FY27 Budget Recommendations

Specific Mental Health/Substance Abuse Services Line items

	FY'26 (Final)	FY'27 (Exec Rec)	FY'27 (House)	FY'27 (Senate)
-CMH Non-Medicaid services	$125,578,200	$125,578,200	$125,578,200	$125,578,200
-Medicaid Mental Health Services	$3,188,847,900	$3,667,513,800	$3,329,969,700	$3,663,869,500
-Medicaid Substance Abuse services	$96,323,300	$84,902,600	$84,902,600	$84,902,600
-State disability assistance program	$2,018,800	$2,018,800	$1,922,000	$2,018,800
-Community substance abuse (Prevention, education, and treatment programs)	$79,207,900	$79,221,100	$79,207,900	$78,186,700
-Health Homes Program	$50,239,800	$50,239,800	$50,239,800	$50,239,800
-Autism services	$467,644,200	$560,716,600	$560,716,600	$560,716,600
-Healthy MI Plan (Behavioral health)	$438,267,500	$525,256,200	$375,780,500	$518,153,900
-CCBHC	$916,062,700	$916,062,700	$916,062,700	$916,062,700
-Total Local Dollars	$9,943,600	$9,943,600	$9,943,600	$9,943,600

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FY27 Budget Recommendations

H.R. 1 Implementation

- Senate reduces executive budget on HR 1 staffing costs to **$51.5 million for 485 FTEs**. Governor's budget proposed $80.3 million for additional full-time employees ($54.2 million general fund) to meet workload increases resulting from new requirements within H.R. 1. This investment includes an additional 589.0 FTEs for assistance payment workers, Office of Inspector General agents, departmental analysts, supervisors, and administrative assistants. **House does not specifically address.**

- Senate reduces executive budget on HR 1 **beneficiary support to $7.4 million**. Governor's budget proposed $16.7 million to expand beneficiary support ($6.1 million general fund) by increasing access to beneficiary help-line services and providing educational support on H.R. 1 changes. This includes a $5 million federal grant from the Centers for Medicare and Medicaid Services (CMS), included in the FY26 supplemental proposal, to support costs related to Medicaid community engagement requirements. **House does not specifically address.**

- Senate concurs with Governor's budget and includes $94.3 million (general fund), offset with a like reduction in federal revenue (net zero total) for SNAP administrative costs due to the state's required cost share increasing from 50% to 75% beginning in fiscal year 2027. **House does not specifically address.**

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FY27 Budget Recommendations

Medicaid Sustainability

The Governor's budget seeks to use the following funding streams and strategies to support the Michigan Medicaid program in the coming years:

- Tobacco Tax: forecast to generate $232 million in FY27.
- Vape Tax: forecast to generate $95 million in FY27 to be used for cancer prevention, smoking prevention, children's coordinated health care, and for the Medicaid Benefits Trust Fund.
- New internet tax rate on largest casinos: forecast to generate $135.5 million in new tax revenue in FY27, with the majority going directly to the Medicaid Benefits Trust Fund.
- Per-Wager Sports Betting Tax: forecast to generate $38.8 million for the Medicaid Benefits Trust Fund in FY27.
- Elimination of Free Play Deduction: eliminating this deduction is forecast to generate $21.1 million for the Medicaid Benefits Trust Fund in FY27.
- 4.7 % Digital Advertising tax: the tax is forecast to generate $282 million in FY27.

Governor's budget calls for $150 million in efficiency savings identified in collaboration with stakeholders to address costs, accountability and resource effectiveness while maintaining sustainability of services.

- **House and Senate budget recommendations do NOT include the $800 in revenue increases**
- House budget calls for $300 million in efficiency savings identified in collaboration with stakeholders to address costs, accountability and resource effectiveness
- Senate budget will include $350 million withdrawal from the state's emergency savings account will be used exclusively to address the Medicaid caseload and the impacts of H.R. 1.

FY27 – Proposed Medicaid Efficiencies

Medicaid Efficiencies Recommendations

The workgroup was convened by the State Budget Director and was tasked with identifying at least **$150 million in Medicaid-related general fund savings** while:

- Protecting access to care
- Avoiding cost shifts to providers or patients
- Prioritizing administrative efficiencies
- Using data-driven approaches
- Focusing on changes implementable within FY 2027

The group ultimately identified approximately **$124.9 million in potential savings**, though several estimates remain uncertain.

1. Pharmacy Savings (Estimated: $0–$96 million)

Proposed Actions

- Increase pharmaceutical supplemental rebates through federal "most-favored-nation" pricing models such as the GENEROUS Model
- Increase use of biosimilars and generic drugs via changes to the preferred drug list
- Eliminate Medicaid coverage of GLP-1 drugs when prescribed solely for obesity treatment
- Tighten the definition of "independent pharmacy" to better target enhanced dispensing fees

Important Caveats

MDHHS technical analysis warned that:

- Greater use of generics/biosimilars could actually **increase costs**
- Michigan currently benefits from substantial rebates tied to brand-name drugs
- Switching broadly to generics could raise costs by an estimated **$18.7 million GF / $85 million gross**

FY27 – Proposed Medicaid Efficiencies

2. Administrative Savings in MDHHS (Estimated: $15 million)

Proposed Actions

Expand the Estate Recovery Program by:

- Broadening estate definitions
- Allowing recovery from trusts and non-probate assets
- Removing the 3-year filing limitation

- Reduce MDHHS consulting contracts and renegotiate contract costs
- Seek lower-cost nonemergency medical transportation contracts without reducing access

Some stakeholder groups opposed or abstained from estate recovery expansion proposals.

3. Managed Care Administrative Savings (Estimated: $3.8 million)

Proposed Actions

- Require MDHHS and Medicaid managed care organizations to jointly streamline administrative requirements and achieve at least 1% savings
- Eliminate duplicative audits and redundant reporting requirements

These recommendations focused on operational efficiencies rather than benefit reductions.

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FY27 – Proposed Medicaid Efficiencies

4. Benefit Modifications (Estimated: $9.8 million)

Proposed Action

- Tighten oversight of Applied Behavioral Analysis (ABA) services to ensure clinical appropriateness and adherence to existing contract standards

The savings estimate assumes reducing average ABA service utilization by approximately one hour per week statewide without reducing access.

Other Policy Ideas Discussed (No FY 2027 Savings Estimate)

The workgroup also discussed longer-term policy concepts that were not formally voted on, including:

- Expanding cross-departmental data sharing to reduce Medicaid enrollment churn
- Expanding Certified Community Behavioral Health Clinics
- Reviewing aging technology systems
- Evaluating the structure of Michigan's behavioral health system
- Improving pharmacy pricing transparency

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FY27 Budget Recommendations

Health Care Workforce

House and Senate concur with the Executive adds $258.4 million to support 2025 and 2026 direct care worker minimum wage increases ($87.3 million general fund), which preserves $3.40 per hour in increased wages received by workers over the past two years. Currently, federal American Rescue Plan (ARP) funds that expire at the end of FY26 support these increases. This investment backfills the lost ARP funds with general fund to continue drawing down federal Medicaid match dollars.

- Senate concurs with the Executive and includes $69.5 million to support the 2027 direct care worker minimum wage increase of $1.27 per hour ($23.5 million general fund). **House budget does NOT include funding.**

- Senate concurs with the Executive and includes $24 million to provide sick leave for direct care workers consistent with Public Acts 338 and 369 of 2018 ($8.1 million general fund). Nearly all employers, such as those employing members of the direct care workforce, are required to provide paid sick leave to eligible employees. This investment transitions the cost to general fund and Medicaid matching dollars, as time limited ARP funds currently support this requirement. **House budget does NOT include funding.**

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The Direct Care Worker Wage Math Problem

The Governor's FY27 budget proposes $258.4 million to preserve a mandatory $3.40/hour wage passthrough for DCWs. Based upon previous appropriations, the actual cost is $563.4 million. **That means the Michigan providers and families who employ DCWs will be shouldering 54% of the cost in FY27.**

The gap is real, and providers/families are already at a breaking point.

Here's how we got here.

The $3.40/hour direct care worker wage passthrough is not a single line item. It is the cumulative result of three separate, bipartisan legislative appropriations made over four fiscal years. Each appropriation carries an ongoing annual cost that does not disappear when the original funding source expires.

Fiscal Year	Wage Increase	Total Gross Cost	General Fund / GP
FY22	+$2.35 / hour	$414.5 million	$146.1 million
FY24	+$0.85 / hour	$120.2 million	$42.7 million
FY25	+$0.20 / hour	$28.7 million	$10.0 million
TOTAL COMMITTED	**$3.40 / hour**	**$563.4 million**	**$198.8 million**
FY27 Gov. Rec.	Claims to preserve $3.40/hr	$258.4 million	$87.3 million GF
THE GAP	**Unaccounted for in the Gov. Rec.**	**$305.0 million**	**$111.5 million GF**

The Governor's budget describes the $258.4 million as backfilling expiring American Rescue Plan (ARP) funds. That framing is technically accurate but materially misleading. The ARP funds supported a portion of these wages; they did not represent the full cost. The full ongoing cost of the wages the state has committed to paying is $563.4 million gross. The proposed budget funds less than half of that.

FY26 Funding Situation	Behavioral Health Sector*	Total Amount
Gross funding needed to cover $1.25/hr FY26 increase	$89.7 million	$179.4 million
Gross funding MDHHS has sent to PIHPs to cover it	$51.9 million	
Additional funding passed through by most CMHSPs to providers	**$0**	
CURRENT UNFUNDED SHORTFALL	**$37.8 million**	

Our Ask

- **Reflect the true cost of the $3.40/hour passthrough.** The FY27 budget should account for the full $563.4 million gross ongoing cost of cumulative wage commitments, not just the $258.4 million partial backfill of expired ARP funds. The gap of $305.0 million gross must be addressed.
- **Fund the FY26 shortfall.** The Legislature should direct a sufficient appropriation to cover the $179.4 million gross cost of the $1.25/hour FY26 wage increase for behavioral health and aging services that providers are currently absorbing without compensation.
- **Fund the FY27 wage increase.** Provide $182.2 million gross to cover the anticipated $1.27/hour wage increase effective January 1, 2027, so the mandate does not arrive without the means to meet it.
- **Require the passthrough to actually pass through.** Include explicit boilerplate language requiring MDHHS, PIHPs and CMHSPs to distribute DCW wage funding to providers and families within a defined timeframe, with accountability and reporting requirements for compliance. Right now, most CMHSPs haven't provided any funding to providers during the current fiscal year, despite the fact we are more than six months into it.

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FY27 Budget Recommendations

Major Boilerplate Additions (House Budget)

- **REVISED: Sec. 264.** Direct Care Worker Wage Increase and Report – Revises by removing the specific direct care wage increase amount and replaces with the requirement to comply with expressly defined network adequacy standards for direct care workers and revises the report to include compliance with network adequacy standers and aggregated rates paid. **(moving away from requiring a specific wage increase for direct care workers and instead is holding providers accountable for staffing levels and workforce adequacy outcomes.)**

- **REVISED: Sec. 924.** Autism Services Fee Schedule – Requires DHHS to maintain a fee schedule for autism services by not allowing expenditures used for actuarially sound rate certification to exceed the identified fee schedule, also sets behavioral technician fee schedule at not less than $66.00 per hour. **House revises so that behavioral technicians receive not more than $66.00 per hour.**

- **NEW: Sec. 925.** Autism Services Quality Control – House requires DHHS to dedicate up to $1.0% from the autism line to contract with an independent agency to identify fraud, institute quality control measures, and provide technical assistance to improve outcomes and accountability.

- **RETAINTED: Sec. 994.** National Accreditation Review Criteria for Behavioral Health Services (**House and Senate KEEP**)

- **NEW: Sec. 1020. PIHP Request for Proposal –** House prohibits DHHS from issuing, implementing, or proceeding with any request for proposal, rebid, or procurement process related to the administration of public behavioral health services unless the request for proposal fully complies with the Mental Health Code, has received legislative enactment, and DHHS has returned to the legislature an implementation plan for approval.

- **NEW: Sec. 1021. "Mental Health Framework" Prohibition –** House prohibits DHHS expending funds to advance the "Mental Health Framework", or similar, proposal that alters the current responsibilities for behavioral health services between PIHPs, CMHSPs, or Medicaid health plans; prohibits DHHS from modifying psychiatric inpatient admissions management and responsibilities; prohibits DHHS from implementing policies that shift psychiatric inpatient benefits or related services to Medicaid health plans; and requires DHHS to maintain the current structure of responsibility for behavioral health services unless otherwise directed by law.

- **NEW: Sec. 1022. Waskul Cost Reimbursements –** House requires DHHS to reimburse CMHSPs that are a member of a PIHP that was a defendant in the Waskul settlement agreement and requires a report.

CMHA FY27 Budget Priorities

- **FY26 MEDICAID RATES MUST BE ADJUSTED**
  - **CMHA members face over a $100 million Medicaid shortfall for FY26 due to a drop in Medicaid enrollment**
- **SUPPORT REVENUE INCREASES TO MAINTAIN MEDICAID FUNDING LEVELS**
- **REDUCE ADMINISTRATIVE BURDENS**
  - Require MDHHS to comply with section 994 from the FY26 budget
- **CMHA OPPOSES ANY NEW LEGISLATIVE MANDATED RATE INCREASE FOR A SPECIFIC SERVICE THAT INTERFERES WITH PIHPS AND CMHSPS REQUIREMENT TO ESTABLISH FAIR MARKET RATES**

BOILERPLATE SUGGESTIONS

- **PROHIBIT MDHHS FOR SPENDING ADDITIONAL DOLLARS ON PIHP RFP PROCESS**
- **PROHIBIT MDHHS FOR MOVING FORWARD WITH MENTAL HEALTH FRAMEWORK**
- **STRIKE CCBHC LANGUAGE PROHIBITING EXPANSION – REPLACE WITH CONTUNUED FUNDING**
- **CREATE STANDARD DEFINITION OF RURAL**

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Rural Health Transformation Program (RHTP)

The **Rural Health Transformation Program** (RHTP) is part of the federal budget bill, H.R. 1. RHTP is a $50 billion grant program runs from Fiscal Year (FY) 2026 through FY 2030, with $10 billion allocated per year across 50 states. The goal is to increase access to rural health providers while improving outcomes for individuals living in rural communities.

RHTP Funding Details

- $50 billion dollars nationwide over five years.
- Cannot supplant any federal, state or local funding.
- New, innovative projects aimed at five policy priorities.
- Must transform rural healthcare in sustainable ways.
- Can expand or enhance services but not duplicate current programs.
- Initiatives may be directly implemented by state government or may be implemented by subcontracted funding with strong state oversight.
- Funding over the five years will change each year based on the state's progress and rate of expenditures.

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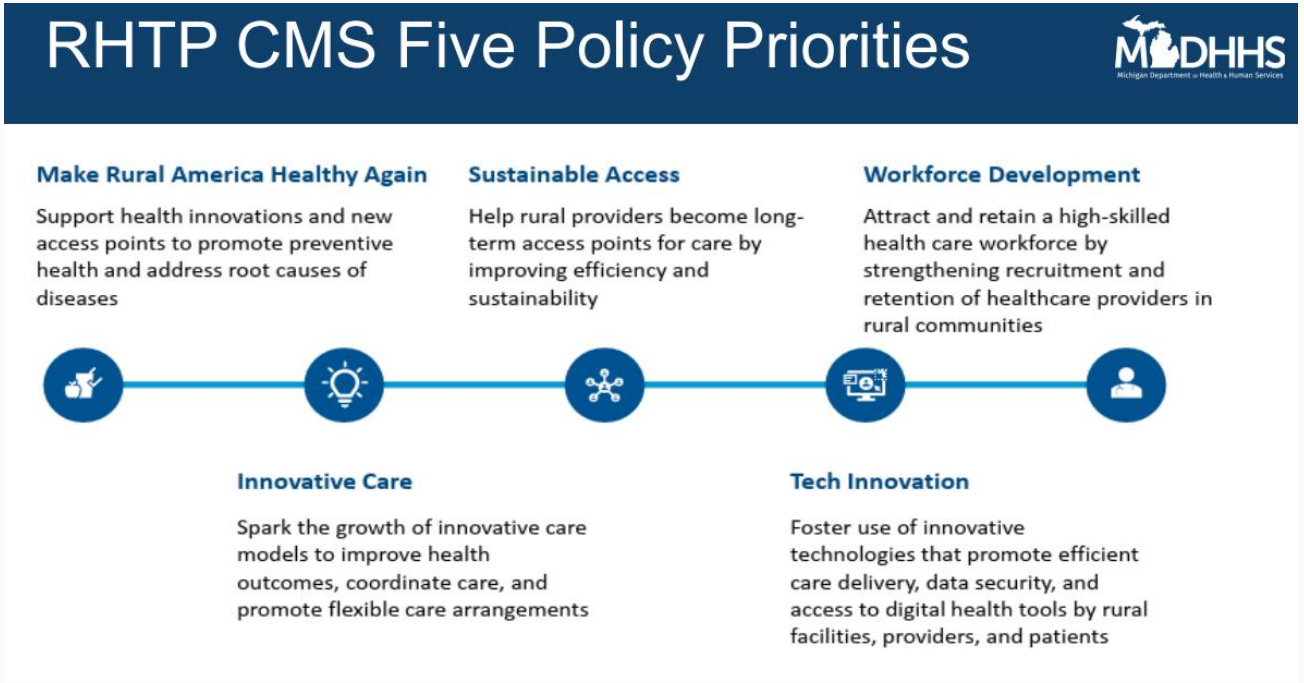
Rural Health Transformation Program (RHTP)



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Rural Health Transformation Program (RHTP)

Rank	State	Award Amount (FY 26)	Population (2024 est.)
1	**Kansas**	$221,898,008	~2,970,606
2	**Nebraska**	$218,529,075	~2,005,465
3	**Missouri**	$216,276,818	~6,245,466
4	**Iowa**	$209,040,064	~3,241,488
5	**Indiana**	$206,927,897	~6,924,275
6	**Wisconsin**	$203,670,005	~5,960,975
7	**Ohio**	$202,030,262	~11,883,304
8	**North Dakota**	$198,936,970	~796,568
9	**Minnesota**	$193,090,618	~5,793,151
10	**Illinois**	$193,418,216	~12,710,158
11	**South Dakota**	$189,477,607	~924,669
12	**Michigan**	$173,128,201	~10,140,459

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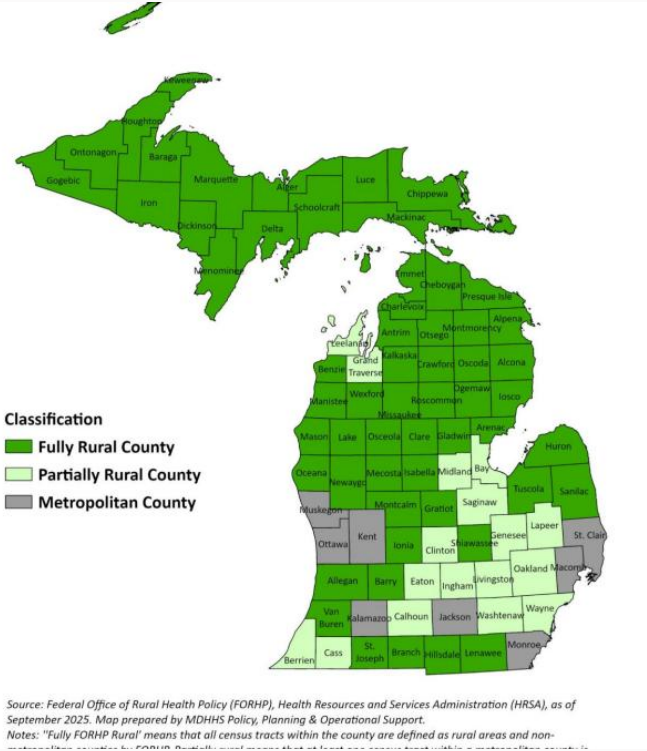
Rural Health Transformation Program (RHTP)

Michigan's RHT
Program proposal includes 75 counties that are either fully rural or partially rural counites as identified by the Federal Office of the Rural Health Policy within Health Resources and Services Administration (HRSA).



Source: Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), as of September 2025. Map prepared by MDHHS Policy, Planning & Operational Support.
Notes: "Fully FORHP Rural" means that all census tracts within the county are defined as rural areas and non-

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Rural Health Transformation Program (RHTP)

Workforce Development and Retention is a Key Priority

Rural communities face distinct challenges—including geographic isolation, lower compensation, limited training and career pathways, and elevated burnout—that make recruiting and retaining mental health professionals difficult at every level of care, from direct support staff and clinicians to crisis and specialty providers. These workforce gaps increase pressure on remaining staff, disrupt continuity of care, and leave individuals and families without essential services.

- The **Bachelor of Social Work (BSW) to Clinical Master of Social Work (MSW) Stipend Program** is designed to help bridge the mental health provider gap in rural communities by offering educational stipends to social work students. In exchange, stipend recipients would commit to working in a rural Michigan community for five years following graduation.

- The **University-Led MSW Scholarship Program** seeks to expand the pipeline of mental health professionals by providing scholarships to MSW students. Through partnerships with at least two universities, this program would offer scholarship opportunities to students who commit to serving rural communities for five years after graduation, strengthening long-term workforce capacity where it is most needed.

Rural Health Transformation Program (RHTP)

Other Key Priorities for CMHA Members

- **Recognize CMHSPs as Core Rural Healthcare Providers**
  In every rural county in Michigan, CMHSPs are the largest and most comprehensive behavioral healthcare providers—and in many counties, the only behavioral health provider. Michigan's RHTP must fully recognize CMHSPs as essential components of the rural healthcare safety net.

- **Treat Mental Health Conditions as Chronic Health Conditions**
  A wide range of mental health and substance use disorders—including schizophrenia, bipolar disorder, clinical depression, ADHD, attachment disorders, and substance use disorders—should be recognized as chronic health conditions. These conditions require the same long-term supports and attention to health-related social needs, such as housing, income stability, and transportation, as chronic physical health conditions.

- **Preserve and Expand Behavioral Telehealth**
  Rural Michiganders benefit greatly from telehealth services delivered directly into their homes, including audio-only services. These modalities proved essential during and after the pandemic and remain critical for individuals who otherwise cannot access behavioral healthcare due to geography, transportation barriers, or workforce shortages.

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Rural Health Transformation Program (RHTP)

- **Invest in Smart Home Technologies**
  Smart home technologies can enable individuals with mental health disabilities to live independently, even amid a severe and prolonged direct care workforce shortage. Providers such as MOKA demonstrate the real-world value of these technologies within Michigan's public mental health system.

- **AI Tool Purchase and Training for Clinical Use**
  Over the past year, a number of advanced AI tools have entered the market that enable behavioral health clinicians to significantly reduce the time spent on clinical documentation while also helping to identify potential risks, concerns, and treatment needs expressed during clinical interviews. Investing in the adoption of these AI tools—along with appropriate training for clinicians—would reduce administrative burden, improve clinical efficiency, and increase the amount of time clinicians can devote to direct patient care.

- **Expand the Definition of Lived Experience Providers**
  CMHA urges Michigan to expand its recognition of lived-experience providers beyond community health workers to include the full range of mental health peer providers. Michigan currently has more than 4,000 Medicaid-funded peer providers across the state, with a clear need for many more. These individuals are core members of the healthcare workforce.

- **Include Behavioral Health in Emergency Department Diversion Efforts**
  A significant share of inappropriate emergency department utilization is driven by unmet mental health and substance use needs. RHTP initiatives aimed at reducing unnecessary ED use must include behavioral health interventions such as rural CSUs, mobile crisis teams, co-responder models, and technology-supported mobile services.

Rural Health Transformation Program (RHTP)

Next Steps for the RHTP

- The RHTP is supported by a multilayered governance structure that brings together leadership from the Michigan Department of Health and Human Services (MDHHS), cross-department collaboration and community input to guide implementation and ensure investments respond to the needs of rural Michigan communities.
- **RHTP Advisory Council:** A group of external partners and community representatives who provide insight on rural health priorities, review program progress and offer recommendations to MDHHS leadership.
- **Annual Summit and Broader Engagement:** Creates opportunities for partners across Michigan to share feedback, highlight best practices and identify emerging needs. The Annual Summit will serve as a statewide convening to discuss progress and inform future RHTP priorities.
- **Cross-Departmental Coordination Team (CDCT):** Aligns work across MDHHS divisions to coordinate implementation activities, share information and ensure program efforts are integrated across departments.
- **MDHHS Executive Team:** Provides overall strategic direction and final decision-making for the program, including approvals related to policy, funding and major program initiatives.

Funds directed through Grant Funded Opportunities (GFO) or Letters of Intent (directed payments LOI)

- $95 million will be distributed through LOIs and $66.6 million through GFO

CMHA Community Mental Health Association of Michigan

Rural Health Transformation Program (RHTP)

RHTP Advisory Council Members

- **Alan Bolter**
  Community Mental Health Association
- **Andrea Wendling, M.D.**
  Michigan State University College of Human Medicine
- **Andrew Chosa**
  Upper Peninsula Health Care Solutions
- **Angela Madden**
  Michigan Association of Ambulance Services
- **April Kay Osburn**
  Central & Western Area Health Education Center / Central Michigan University
- **Catherine A. Macomber**
  Saginaw Valley State University
- **Crystal Barter**
  Michigan Center for Rural Health
- **Elise Marie Bur**
  Northern Michigan University
- **Heidi Britton**
  Northwest Michigan Health Services, Inc.
- **Jeremy Cannon**
  Kalkaska Memorial Health Center
- **Julie Kay Yaroch, D.O.**
  ProMedica
- **Kim Bachelder**
  Michigan Health Information Network (MiHIN)
- **Lauren LaPine**
  Michigan Hospital Association
- **Megan Murphy**
  Superior Health Foundation
- **Nicholas Cushman**
  Indian Health Service / University of Michigan College of Pharmacy
- **Phillip Berquest**
  Michigan Primary Care Association
- **Robert Walter Mach**
  Schoolcraft Memorial Hospital
- **Sarah Oleniczak**
  Northern Michigan Community Health Innovation Region / District Health Department #10
- **Stephanie Winslow**
  PACE Association of Michigan
- **Wilbert Morris**
  Sanilac County Community Mental Health Authority

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Mental Health Framework

What is the Michigan Medicaid "Mental Health Framework"?

The Michigan Department of Health and Human Services (MDHHS) is shifting to a **more person-centered approach to serving Michiganders with mental health needs**. As part of MIHealthyLifeExternal Link, an initiative that began in 2022 to strengthen the Comprehensive Health Care Program (CHCP), MDHHS is partnering with Medicaid Health Plans (MHPs), Prepaid Inpatient Health Plans (PIHPs),External Link and providers to improve access to and coordination of mental health care across the Medicaid program.

Under the Mental Health Framework, an enrollee's level of mental health need, as determined through a State-identified standardized assessment tool, will more clearly determine which payer—the enrollee's MHP or PIHP—is responsible for their mental health coverage and care. Also, MHPs will begin covering some additional mental health services for enrollees with lower levels of mental health need, so MHPs are accountable for more of these enrollees' continuum of care. Beginning in October 2026:

- MHPs will cover most mental health services for CHCP enrollees with lower levels of mental health need, and
- PIHPs will cover all mental health services for CHCP enrollees with higher levels of mental health need.

Referrals for mental health care, including those across MHP and PIHP systems, will be standardized to facilitate enrollee access to needed care.

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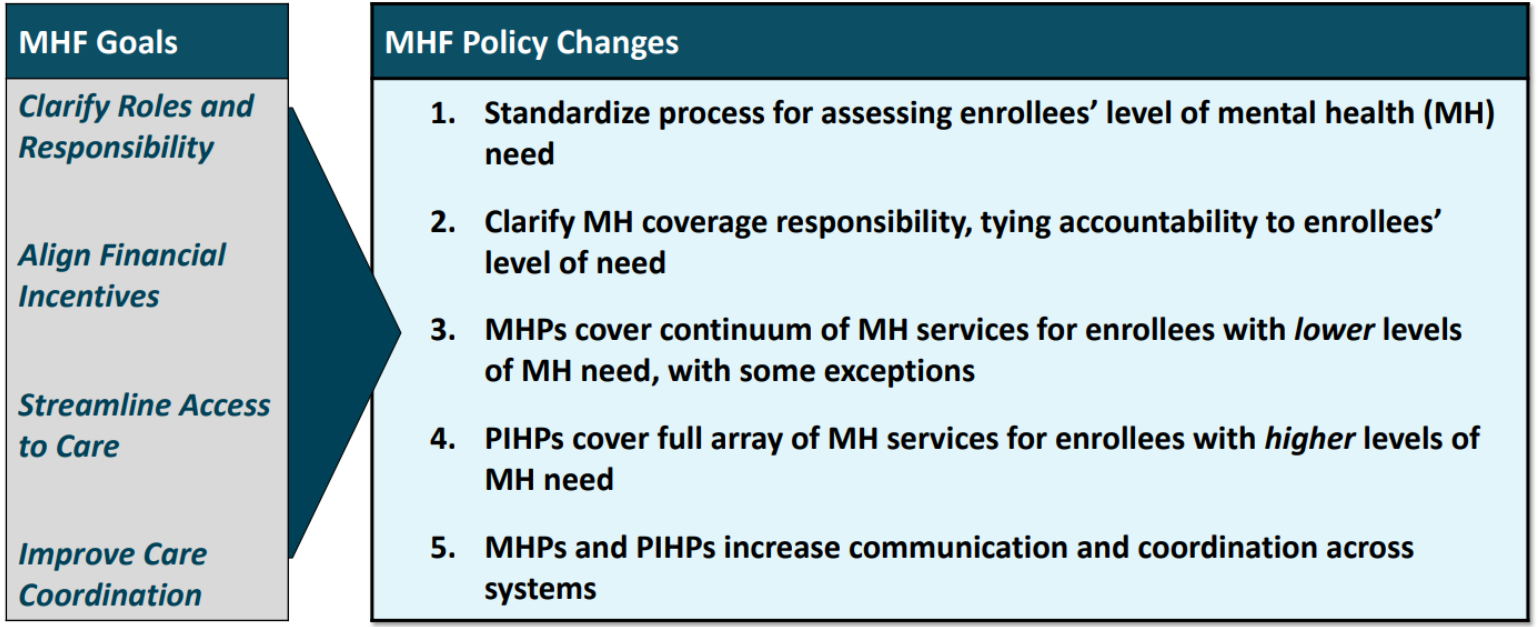
Mental Health Framework



Mental Health Framework

What the MHF Is:

- ✓ **Standardized and transparent process for determining an enrollee's level of MH need and MH coverage responsibility**
- ✓ **Greater alignment of a Medicaid managed care enrollee's MH care under one plan***
  - PIHP responsible for MH care for enrollees with higher level of MH needs
  - MHP responsible for MH care for enrollees with more mild-to-moderate MH needs
- ✓ **More robust information sharing and care coordination between PIHP and MHP delivery systems**

** Note that the payer may change over time should the enrollee's MH needs changes*

What the MHF is Not:

- × **An end to the behavioral health carve-out**
- × **Changes to who is providing MH services**
- × **Changes to coverage or delivery of waiver services or specialty services for enrollees with intellectual and developmental disabilities (I/DD)**

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Mental Health Framework

Policy Changes

- **Effective October 2026, MHPs cover *new* mental health services for enrollees with lower mental health needs, in addition to routine outpatient mental health care (which they currently cover):**
  - Inpatient psychiatric care
  - Crisis residential services
  - Partial hospitalization services
  - Targeted case management
- **PIHPs cover *all* mental health services for enrollees with higher levels of mental health need,** regardless of setting
- **MHPs and PIHPs cover ongoing mental health care, even if out-of-network, for extended period following transition to or from "PIHP-COVER"**

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Mental Health Framework

Concerns w/ MHF

- Purpose and how its components align with that **purpose are unclear, and the rationale or triggering trends behind the proposal are not explained**.
- The proposal shifts management of services for **people with complex mental health needs**—services that CMHSPs, PIHPs, and their provider networks have decades of expertise delivering—**into private Medicaid Health Plans.**
- **The design expands private Medicaid Health Plan control despite their long-standing poor performance in ensuring access to basic mental health services for people with mild to moderate needs.**
- Splitting responsibility for inpatient and community-based behavioral health services further fragments an already complex system and undermines the current, highly coordinated public mental health model.
- Moving management of psychiatric inpatient, crisis residential, partial hospitalization, and targeted case management services to private plans breaks continuity with the **CMHSP-led system that is legally responsible for these services under the Michigan Mental Health Code.**
- Effective clinical decision-making for these services requires full knowledge of and access to the entire CMHSP service array, including alternatives to higher levels of care, which private plans lack.
- The framework would **significantly increase administrative burden for public mental health agencies, hospitals, emergency departments, providers**, and—most critically—people receiving services.
- **Key stakeholders**, including PIHPs, CMHSPs, providers, people served, and advocates, **were excluded from the framework's development.**

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Mental Health Framework

Michigan Hospital Association Concerns:

- Hospitals question the rationale and validation of the modified MichiCANS and LOCUS tools. Assessments reportedly take **40+ minutes**, increasing visit length and reducing patient throughput without demonstrated benefit.
- Hospitals are concerned about conflicting coverage responsibility between MHPs and PIHPs and increased prior authorization requirements that could delay or deny care.
- Hospitals believe the framework will further fragment Michigan's behavioral health system, increase administrative burden, and push providers to reduce or eliminate Medicaid participation—ultimately harming patient access during an already strained period. The MHA urges MDHHS to reconsider the policy and engage hospitals in redesigning it.

IMPACT OF Judge Yates Decision – preadmission screening & authorization of inpatient psychiatric hospitalization

Health Plans are actively lobbying legislators:

House Bill 6022 – Allows MHP (Medicaid Health Plans) to perform preadmission screenings for their enrollees when they are financially responsible and required to do so under the MHF -Permit MHPs to use nationally recognized medical necessity criteria for preadmission screenings in meeting the requirements of the MHF - Apply the same voluntary, emergency, and court-appointed standards to MHPs when conducting preadmission screenings, as well as good-faith immunity protections that are afforded to PIHP's

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Mental Health Framework

April 13 email from MDHHS issued confidential drafts:

MDHHS is developing a new Medicaid mental health benefit plan called BH-COVER for beneficiaries in Medicaid Health Plans who meet certain clinical criteria. Those enrolled in BH-COVER will receive all medically necessary mental health services through their PIHP, including services outside the CMHSP network. The plan also shifts responsibility to MHPs for covering certain services—like inpatient psychiatric care, partial hospitalization, and crisis residential services—for beneficiaries not in BH-COVER. **The proposed start date is October 1, 2026**.

The Mental Health Framework DOES

- MHF DOES create fragmentation in care, instead of one coordinated public system, responsibility is split between CMH, Medicaid Health Plans (MHPs), and PIHPs depending on a person's classification. That means more handoffs, more confusion about who pays, and more time spent navigating the system rather than receiving care – this will slow down admissions, approvals, and treatment initiation
- MHF DOES add additional barriers to care by requiring providers to become certified in new lengthy assessment tools for Medicaid recipients and creating complex billing structures that will make it harder for individuals to access services.
- MHF DOES increase the cost of providing Medicaid services by turning over control of large portions of Michigan's Medicaid behavioral health system to private health plans that have higher administrative costs and profit. Hospitals, CMHs, and providers have raised serious concerns about the operational strain this framework would create—requiring new contracts, duplicative processes, and shifting payment responsibilities.
- MHF DOES circumvent the Michigan legislature by making significant policy changes through administrative rules as the proposal appears to conflict with Michigan's Mental Health Code and recent Court of Claims rulings.

The Mental Health Framework DOES NOT

- MHF DOES NOT offer better access to care
- MHF DOES NOT identify a clear problem that is attempting to be solved
- MHF DOES NOT better clarify roles and responsibilities
- MHF DOES NOT speak for thousands of persons served across Michigan as MDHHS has stated – they do NOT want this change

CMHA Community Mental Health Association of Michigan

PIHP Procurement

Timeline of procurement process

- **Feb 28, 2025 — MDHHS announces initiative & opens public survey.**
  MDHHS launches an initiative to "strengthen behavioral health care access, quality, and choice" and opens an **online survey** to inform a competitive procurement for PIHP contracts.
- **Mar 31, 2025 — Survey window closes.**

- **May 23, 2025 — Survey results released; procurement pillars & pre-RFP info posted.**
  MDHHS publishes survey findings (noting **2,600+ responses**) and outlines four strategic pillars to shape the procurement. It also posts **anticipated contract requirements** and a **recorded webinar** with additional details; the release states the RFP is targeted for **summer 2025** with a **service start date of Oct 1, 2026**.

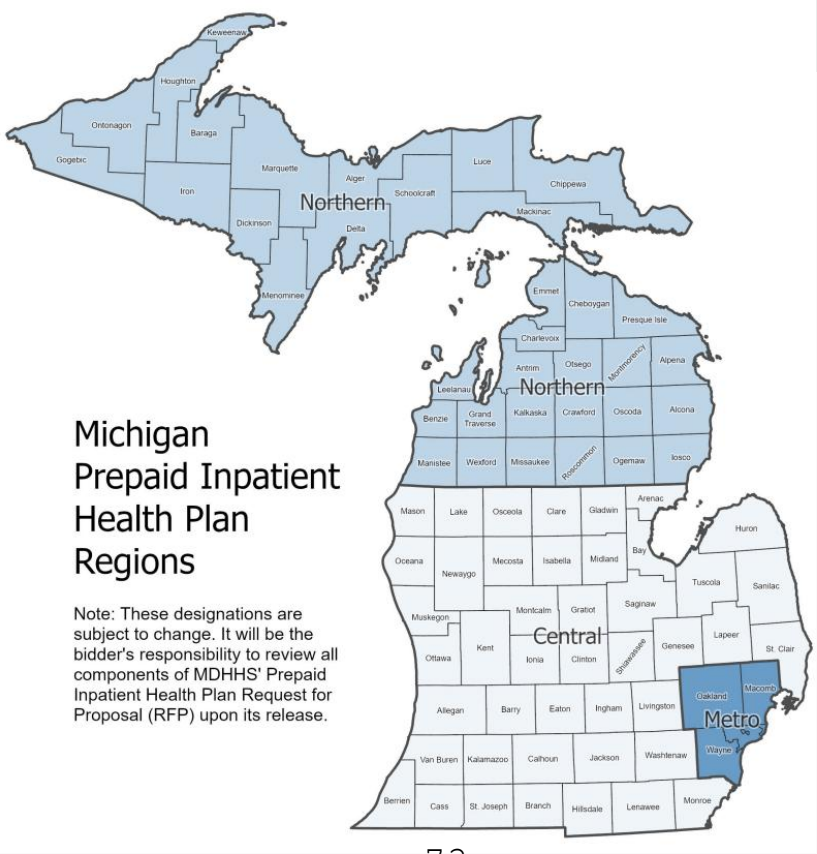
- **Aug 4, 2025 — RFP released; press release seeks proposals.**

  · **Aug 11:** Optional **Rate Setting Meeting** and **Bidder's Conference**
  · **Aug 20 (noon ET): Vendor questions due**
  · **Aug 29 (5:00 p.m. ET): State posts Q&A** on SIGMA VSS – DELAYED TWICE NOW 9/12
  · **Sept 29 (11:50 a.m. ET): Proposals due – PUSHED BACK TO 10/6 – PUSHED BACK TO 10/13**
    - ***Bids to be awarded mid-December***

- **Feb 24, 2026 — Anticipated contract signature & transition start.**
  The Proposal Instructions identify this as the **anticipated** date to sign contracts and begin transition.

- **Oct 1, 2026 — Contract effective date (services begin).**
  Target **go-live** for the new PIHP contracts.

PIHP Procurement



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PIHP Procurement

OCTOBER Court of Claims Opinion

Tuesday, October 14 Judge Christopher Yates issued a decision relating to the RFP. The Court determined that:

(1) MDHHS has the unilateral authority to shift to a competitive procurement model for Medicaid behavioral health services; and
(2) MDHHS can reduce the number of regions.

"The court concludes that a competitive procurement system is not only compatible with state law but also regarded as the preferred nationwide model. The federal preference for competitive procurement is so strong that, for years, the MDHHS has had to obtain federal authorization in the form of a waiver of governing provisions in the Social Security Act," he wrote. "The MDHHS is simply taking proactive steps to bring Michigan into compliance with the federal mandate of competitive procurement."

The Court also said that it could not issue a final decision in the case because the RFP may violate Michigan law:

- in assigning functions to PIHPs that belong to local CMHs
- in not funding CMHs so that they can fulfill their statutory obligations. The lawsuit will continue and will likely focus on these areas.

Michigan law does not empower DHHS to change the Mental Health Code by permitting a PIHP to directly provide or contract out services that a mental health agency is legally required to provide. The RFP states PIHPs are expected to provide managed care functions to beneficiaries and those functions cannot be delegated.

- Yates wrote that declaring functions non-delegable appears to conflict with the Mental Health Code, which assigns those functions to the mental health agencies, not the PIHPs. Further the RFP does not require a PIHP to provide Medicaid funds to a mental health agency.

PIHP Procurement

January Court of Claims Opinion

Thursday, January 8 the Michigan Court of Claims, Judge Christopher Yates issued an opinion that the request for proposals issued by the Department of Health and Human Services in 2025 to rebid public coverage of behavioral and mental health services conflicts with the law by violating the Michigan Mental Health Code and the statutory framework governing Michigan's public behavioral health system.

The judge's conclusion, at the end of the document, provides the most succinct summation of his analysis and opinion. The key excerpts of that opinion are provided below:

"... the Court hereby issues a declaratory pronouncement that the RFP, ***as drafted, impermissibly conflicts with Michigan law in numerous respects****, especially insofar as the RFP restricts CMHSPs from entering into financial contracts for the purpose of funding CMHSPs' managed-care functions. However,* ***the Court will not yet issue injunctive relief that directs defendants to amend or pull back the RFP. Defendants must decide, in the first instance, how to address the conflicts between Michigan law and the RFP that the Court has identified."***

PIHP Procurement

The opinion makes clear that CMHSPs are **legally mandated system stewards**, responsible for access, coordination, rights protection, crisis response, and service delivery across Michigan's public mental health system. Any framework or procurement model that restricts CMHSPs' ability to carry out these duties conflicts with Michigan law, according to the court.

CMHSPs are governmental entities created by counties, governed by local boards, and accountable for fulfilling Mental Health Code mandates. The court underscores that **their duties cannot be overridden by procurement mechanisms or transferred wholesale to managed care entities**

COURT OUTLINES KEY ROLES AND RESPONSIBILITIES

Primary system manager for public mental health services

CMHSPs are responsible for **planning, managing, coordinating, and delivering** a comprehensive array of mental health services within their geographic regions, for both Medicaid and non-Medicaid recipients. They are more than service providers; they function as **system managers** .

Universal access, regardless of ability to pay

CMHSPs must provide services **regardless of an individual's financial status** and may not deny care due to inability to pay. They are statutorily authorized to bill Medicaid or other payers after services are delivered .

Comprehensive service array

CMHSPs are required to ensure availability of a full continuum of services, including:

- Crisis stabilization and 24/7 emergency response
- Screening, assessment, and diagnosis
- Care planning, coordination, and case management
- Psychiatric treatment, rehabilitation, and supports
- Mental health advocacy and prevention services
- Any additional services approved by MDHHS

PIHP Procurement

Pre-admission screening authority

CMHSPs hold exclusive statutory responsibility for **pre-admission screening** for psychiatric hospitalization. This includes:
Determining clinical appropriateness for inpatient admission
Authorizing voluntary admissions
Ensuring follow-up, referral, and alternatives when hospitalization is not indicated
This duty applies **24/7** and cannot be shifted away from CMHSPs under state law .

Network development and provider contracting

CMHSPs must **build, maintain, and oversee provider networks**, contracting with hospitals and other providers as necessary to meet statutory obligations. These contracts enable crisis response, inpatient coordination, discharge planning, and community placement .

Care coordination across systems

CMHSPs are responsible for coordinating care across hospitals, CMHs, courts, corrections, and other systems, including:

Recipient rights protection and enforcement

Discharge and community placement planning

SUD Services

SUD services are governed by the Michigan Mental Health Code, not optional or ancillary programs. The court notes that SUD treatment must be provided by CMHSPs or regional entities created under the Code (CMHE), and cannot be freely reassigned to unrelated managed care contractors

PIHP Procurement

Status of 5 PIHP contracts

- April 9 – Hearing on Patel lawsuit (no ruling from bench)
- April 29 – Patel Opinion

- **FY25 claims dismissed:**
  The court ruled the plaintiffs can't challenge the 2025 contract or demand future contracts, because no valid FY25 contract ever existed.
  - **Dismissed with prejudice:** Those FY25-related claims are permanently thrown out—they cannot be brought back later.

- **FY24 claims survive:** Disputes tied to the existing FY24 contract (still operating during transition) are allowed to continue.
  - **Key issues still alive:** Arguments about ISF funding limits, Waskul settlement rules, due process, and funding obligations will be decided later (after more evidence).

- **Discovery resumes:** Both sides can now collect documents, take depositions, and build evidence.

- **Injunction + case status:** The court keeps the temporary order requiring SUDHH funding in place, and the case is not finished yet.

Timing of next hearing? Judge Patel is sensitive to the tight timeframe and did reference that several times during the April 9 hearing.

- How does the state solve this problem? Can they change before a final ruling by Judge Patel? Those contracts expire on September 30, 2026.

PIHP Procurement

What's Next?

- January 29 – state pulled the RFP
- April 8 – Yates denied the plaintiffs motion to reconsider the state's ability to reduce the number of regions from 10-3
  - **Plaintiffs filed an appeal to this issue on May 13**
- April 13 – Yates heard arguments to dismiss the Region 10 PIHP vs State lawsuit
  - April 13 – Assistant AGs mention that the state is developing a new RFP (but no details yet)
  - April 23 – Yates issues a dismissal of Region 10 PIHP vs State lawsuit **without prejudice**
- May 1 – Judge Yates retired

- Reached out to MDHHS numerous times – offered to work together on reforms

- Outside of MDHHS involvement MUST look to reforms – status quo is not politically viable
  - Work with allies on reforms
  - CMHA with its members developed a core concepts document regarding the future of the system

Contact Information

Community Mental Health Association of Michigan

Alan Bolter
Chief Executive Officer
abolter@cmham.org

CMHA Community Mental Health Association of Michigan

HealthWest
Muskegon's Behavioral Wellness Connection

Consumer Advisory Committee Update:

- ***Consumer Advisory Committee met on 6/10/2026.***
  - ✓ The Consumer Advisory Packet is posted on the HealthWest website on the Consumer Advisory page.
- ***Advocacy Events:***
  - ✓ September 23 – Walk a Mile Rally
- ***Walk a Mile (WAM) Updates:***
  - ✓ A coach bus cannot be booked this year.
  - ✓ County vehicles will be used instead. These can carry up to 30 people (staff and clients).
  - ✓ Clients can submit artwork for WAM buttons. The deadline is the end of June.
- ***The Center for Health and Research Transformation (CHRT) will hold a focus group during the August meeting.***
  - ✓ This is for the Certified Community Behavioral Health Clinics (CCBHC).
  - ✓ The goal is to learn about the experiences of people who receive services from these clinics in Michigan.
- ***Community Relations / Jennifer discussed:***
  - ✓ Talked about HealthWest Way programs, improvements, and the HealthWest Yay's with the codes of conduct.
- ***Community Relations – Gary discussed:***
  - ✓ Shared updates about the Strategic Planning Efforts.
  - ✓ Provided updates on discussion on services, improvements, and operations.
  - ✓ More details will be shared at the August meeting.
- ***Presentation:***
  - ✓ Elizabeth Anderson presented training about boundaries.
- ***Future Meetings:***
  - ✓ August: CCBHC focus group and Strategic Planning review
  - ✓ October (suggested): Quality Improvement with Pam Kimble

June 26, 2026

MEETING NOTICE JULY 2026

The HealthWest Board will meet in the following sessions during the month of July 2026. Please remember we must have a quorum in person for these meetings. If you participate remotely, your vote will not count. If you have any questions, please let me know.

Finance Committee	Friday, July 10, 2026
Full Board Meeting	Friday, July 31, 2026

****PLEASE NOTE THIS IS A DATE CHANGE PER EMAIL MEMO SENT ON 6/1. CALENDAR INVITE HAS BEEN UPDATED****

The administrative office will contact you via email to remind you of these meetings.

The complete schedule of committee and board meetings for 2026 can be found online at https://healthwest.net/about-us/healthwest-board-agendas-minutes/2023-board-of-directors-schedule/

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cc: HealthWest Board Members

HealthWest
Muskegon's Behavioral Wellness Connection

MEMORANDUM

Date: 06/26/2026

To: HealthWest Board of Directors

CC: Mark Eisenbarth, Muskegon County Administrator
Matt Farrar, Muskegon County Deputy Administrator
Angie Gasiewski, Muskegon County Finance Director

From: Rich Francisco, Executive Director

Subject: **Director's Update**

MDHHS Updates:

- Leadership change at MDHHS. I forwarded the Governor's announcement, which we received from CMHA, stating that MDHHS Director Hertel will be moving on in her career and stepping down from the role as director. The Governor announced Amy Epkey will be the acting director for MDHHS effective July 1.

- RFP update: HW has not heard of any recent new RFP released by MDHHS.

LRE Level Updates:

- The June 22, 2026, LRE Executive Work Session and Board Meeting were cancelled. The next board meeting is scheduled for July 22,2026.

- The LRE Ops group did meet on June 17th after the LRE Executive Committee meeting. The major topic of conversation with the LRE Ops group was a discussion on the current FSR (Financial Status Report) that was shared with the CEOs. There was a significant increase in the Ottawa deficit. For the month of April's report there was an increased deficit showing at ~2.58M for Ottawa. N180 was at ~4.6M in deficit. In looking at projections and comparing to spending plans submitted by the CMHSPs, the region will need to resubmit a new Risk Management strategy report to MDHHS due to the deficit now at 16.5M. The LRE board will have to make this decision.

- CSU discussion: The Ops group also discussed the ongoing funding of N180 CSU and that it is part of capitation. The big question surrounding this is how much funding is in the capitation for CSU operations. There were questions asked whether this was contributing to N180 deficit as well.

CMH Level:

- HealthWest continues with various projects:
  - **Utilization Review:** I provided an update last month that HW is reviewing closely the service utilization. We are projecting a surplus in the budget for year end. I have developed a workgroup to closely monitor underutilization in various programs. The goal is to understand what factors are

causing the decline in services and how we can affect change. The communication team will be sharing information related to this effort with staff. Internally we have started to look at various reports and dashboards from the different teams and programs, and the directors of these programs are collaborating with staff to address the barriers contributing to the decline in services.

- **Strategic Plan updates** – The strategic plan process is at the KPI (Key Performance Indicator) development stage at this point. Gary and his team have been collaborating with staff from Quality and Compliance to develop an integrated approach for the reporting of the data which will be key components for staff to know where the agency is at related to these KPIs.
- **Facilities discussion**: HW is continuing to review ways to consolidate programs in various locations. We are exploring expanding our footprint at NIMS because they have availability and we already have several teams in that building.
- **SDA (Same Day Access)** – Christy LaDronka and her team continue to work rolling out same day access with the goal of improving access, timeliness to service and enhance community responsiveness. This also aligns and is best practice for CCBHC (Certified Community Behavioral Health Clinic).