BAY-ARENAC BEHAVIORAL HEALTH

PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING

Thursday, April 10, 2025
1:30 p.m. - 3:30 p.m.
Teams Conference Call

MEMBERS	Present	MEMBERS	Present	AD-HOC MEMBERS	Present
Allison Gruehn, BABH ACT/CSM/Sr. Outreach Prog. Mgr.	X	Karen Amon, BABH Healthcare Accountability Director/CCC		Amanda Johnson, BABH ABA/Wraparound Team Leader	
Amy Folsom, BABH Psych/OPT Svcs. Program Manager		Kelli Wilkinson, BABH Children's IMH/HB Supervisor		Jacquelyn List, List Psychological COO	
Anne Sous, BABH EAS Supervisor		Laura Sandy, MPA Clinical Director & CSM Supervisor	X	?, Consumer Council Rep (J/A/J/O)	
Barb Goss, Saginaw Psychological COO		Lynn Blohm, BABH North Bay CLS Team Supervisor	X	Lynn Meads, BABH Medical Records Associate	
Chelsea Hewitt, Saginaw Psychological Asst. Supervisor	X	Megan Smith, List Psychological Site Supervisor	X	Michele Perry, BABH Finance Manager	
Courtney Clark, Saginaw Psychological OPT Supervisor	X	Melanie Corrion, BABH Adult ID/DD Manager		Nathalie Menendes, Saginaw Psychological COO	
Emily Gerhardt, BABH Children Services Team Leader	X	Melissa Deuel, BABH Quality & Compliance Coordinator	X	Nicole Sweet, BABH Clinical Services Manager	X
Emily Simbeck, MPA Adult OPT Supervisor	X	Melissa Prusi, BABH RR/Customer Services Manager	X	Sarah Van Paris, BABH Nursing Manager	
xxx, BABH Integrated Care Director		Moregan LaMarr, Saginaw Psychological Clinical Director		Stephanie Gunsell, BABH Contracts Manager	
Heather Friebe, BABH Arenac Program Manager		Pam VanWormer, BABH Arenac Clinical Supervisor	X	Taylor Keyes, Adult MI Team Leader	
Jaclynn Nolan, Saginaw Psychological OPT Supervisor		Sarah Holsinger (Chair), BABH Quality Manager	X	**GUESTS**	**Present**
James Spegel, BABH EAS Mobile Response Team Supervisor		Stacy Krasinski, BABH EAS Program Manager	X		
Joelin Hahn (Chair), BABH Integrated Care Director	X	Stephani Rooker, BABH ID/DD Team Leader			
Joelle Sporman (Recorder), BABH BI Secretary III	X	Tracy Hagar, MPA Child OPT Supervisor	X		

	Topic	Key Discussion Points	Action Steps/ Responsibility
1.	**a. Review of, and Additions to Agenda** **b. Presentation: None this month** **c. Approval of Meeting Notes: 03/13/25** **d. Program/Provider Updates and Concerns**	a. There were no additions to the agenda. b. No presentations this month. c. The March meeting notes were approved as written. d. **Program/Provider Updates and Concerns:** Bay-Arenac Behavioral Health: - ABA/Wraparound – No updates to report this month. - ACT/Adult MI – ACT has no changes, still down a nurse and clinical therapist. The MI Team hired a new case manager and in the process of being trained. - Arenac Center – The Children's Case Manager is moving to the ES Team. We are down an adult case manager. - Children's Services – Stacey Koin retired in March, and she was replaced with Tracey Farley. Intake worker has been on leave but will be back in a few weeks. - CLS/North Bay – Disability Network gave a notice to terminate their contract effective 05/31/25 for CLS services. We will be down a CLS provider. BHS has a cap on how many referrals they will allow for CLS services which includes children, adult, and 24-hour services. They will not have any more than 30 referrals and we are already at 28 without sending	

Topic	Key Discussion Points	Action Steps/ Responsibility
	DNMM referrals. Stephanie Rooker, the IDD Team Leader, is taking over as the CLS Program Manager, replacing Nicole Sweet. - Corporate Compliance – No updates to report this month. - EAS (Emergency Access Services)/Mobile Response – Hired an Arenac Center employee as 2nd shift full-time Mobile Response Team person. In the process of hiring the 2nd shift team lead position as well. - ID/DD – No updates to report this month. - IMH/HB – No updates to report this month. - Integrated Care – No updates to report this month. - Madison Clinic – No updates to report this month. - Medical Records – No updates to report this month. - Quality – MDHHS will be doing their waiver audit yearly vs. every two years. Once we go through all the documentation, BABH will get in touch with everyone. CARF will be on site 04/14 - 04/16. - Recipient Rights/Customer Services – Melissa has accepted the position of Healthcare Accountability Director replacing Karen Amon. The RR/CS Manager interviews are taking place. The transition won't take place till around June. - Self Determination – No updates to report this month. List Psychological: - IDD – We lost a provider. The intern is graduating soon and will be hired as a full time BABH provider but not for Medicare. MPA: - CSM – No updates to report this month. - OPT-A – No updates to report this month. Saginaw Psychological: - CSM – Closed to CSM referrals because we are down a case manager. There has been an interview, but she does not graduate till May. - OPT – We have a therapist on leave and another therapist that is a month on the job. Another therapist starts later this month. Closed to Medicare	

BAY-ARENAC BEHAVIORAL HEALTH

PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING

Thursday, April 10, 2025

1:30 p.m. - 3:30 p.m.

Teams Conference Call

	Topic	Key Discussion Points	Action Steps/ Responsibility
		referrals due to fully licensed staff are at capacity. LLMSW are prepared to take their tests. The two MSW Interns will be graduating and coming on as full-time therapists.	
2.	**Plans & System Assessments/Evaluations** a. QAPIP Annual Plan (Sept) b. Organizational Trauma Assessment Update	a. QAPIP Annual Plan – Nothing to report this month. b. Organizational Trauma Assessment – Nothing to report this month.	
3.	**Reports** a. QAPIP Quarterly Report (Feb, May, Aug, Nov) b. Harm Reduction, Clinical Outcomes & Stakeholder Perception Reports i. MSHN Priority Measures Report (Jan, Apr, Jul, Oct) **ii. Recipient Rights Report (Jan, Apr, Jul, Oct)** iii. Recovery Assessment Scale (RAS) Report (Mar, Jun, Sep, Dec) iv. Consumer Satisfaction Report (MHSIP/YSS) v. Provider Satisfaction Survey (Sept) c. Access to Care & Service Utilization Reports i. MMBPIS Report (Jan, Apr, Jul, Oct) ii. LOCUS (Mar, Jun, Sep, Dec) **iii. Leadership Dashboard - UM Indicators (Jan, Apr, Jul, Oct)** **iv. Customer Service Report (Jan, Apr, Jul, Oct)** v. Employment Data (Dec, Mar, Jun, Sept) d. Regulatory and Contractual Compliance Reports i. Internal Performance Improvement Report (Feb, May, Aug, Nov)	a. QAPIP Quarterly Report – Nothing to report this month. b. Harm Reduction, Clinical Outcomes & Stakeholder Perception Reports i. MSHN Priority Measures Report – Nothing to report this month. ii. **Recipient Rights** – Melissa will send out the RR Report for staff to look over. iii. RAS – Nothing to report this month. iv. MHSIP/YSS – Nothing to report this month. v. Provider Satisfaction Report – Nothing to report this month. c. Access to Care & Service Utilization Reports i. MMBPIS Report – Nothing to report this month. ii. LOCUS – Nothing to report this month. iii. **Leadership Dashboard** – Defer iv. **Customer Service Report** – Melissa will send out the Customer Service Report for staff to look over. v. Employment Data – Nothing to report this month. d. Regulatory and Contractual Compliance Reports i. PI Report – Nothing to report this month. ii. Internal MEV Report – Nothing to report this month. iii. **MSHN MEV Audit Report** – BABH received 82.57% for the MSHN MEV review that took place in February 2025. There were a total of 304 claims reviewed. There were 33 claims that did not have IPOS Training documentation. Of those 33 claims, 9 were due to there being an IPOS Training form signed after the date of service. There were 2 claims where the HO modifier should have been billed, not the HN modifier as	b.ii. **Recipient Rights Report** – Melissa will send the RR Report out to the committee for review. c.iii. **Leadership Dashboard** – Deferred c.iv. **Customer service Report** – Melissa will send the Customer Service Report out to the committee for review.

	Topic	Key Discussion Points	Action Steps/ Responsibility
	ii. Internal MEV Report **iii. MSHN MEV Audit Report (Apr)** **- MSHN MEV Final Results** iv. MSHN DMC Audit Report (Sept) v. MDHHS Waiver Audit Report (Oct when applicable e. Ability to Pay Report f. Review of Referral Status Report	the staff was an LLMSW at time of service. There were 2 claims where the H0036 and the H2022 codes were billed for the same time for the same consumer. There was one claim where the documentation had the UN modifier, but it was missing in the billing. There were 16 claims where the auditor was unable to locate consumer/parent /guardian signature on IPOS Addendum. MDHHS requires that the individual must agree to the IPOS in writing per the Person-Centered Planning Policy. • Remind staff they need to make every attempt to get the IPOS or addendum signed. If you cannot get it signed, it needs to be documented to show proof you attempted. iv. MSHN DMC Audit Report – Nothing to report this month. v. MDHHS Waiver Audit Report – Nothing to report. e. Ability to Pay Report – Nothing to report this month. f. Review of the Referral Status Report – Nothing to report this month.	
4.	**Discussions/Population Committees/ Work Groups** a. <u>Harm Reduction, Clinical Outcomes and Stakeholder Perceptions</u> i. Consumer Council Recommendations (as warranted) b. <u>Access to Care and Service Utilization</u> i. Services Provided during a Gap in IPOS ii. Repeated Use of Interim Plans c. <u>Regulatory Compliance & Electronic Health Record</u> i. 1915 iSPA Benefit Enrollment Form ii. Management of Diagnostics **d. BABH - Policy/Procedure Updates**	a. <u>Harm Reduction, Clinical Outcomes and Stakeholder Perceptions</u> i. Consumer Council Recommendations – Nothing to report this month. b. <u>Access to Care and Service Utilization</u> i. Services Provided during a Gap in IPOS – Nothing to report this month. ii. Repeated Use of Interim Plans – Nothing to report this month. c. <u>Regulatory Compliance & Electronic Health Record</u> i. 1915 iSPA Benefit Enrollment Form – Nothing to report this month. ii. Management of Diagnostics – Nothing to report this month. d. **<u>BABH - Policy/Procedure Updates</u>** – Nothing to report this month. **e. <u>Clinical Capacity Issues Status</u>** i. **Referral Status Report** – Nothing to report this month. ii. **OPT Group Therapy** – Nothing to report this month. iii. **Capacity Issue Discussion** – Nothing to report this month.	

BAY-ARENAC BEHAVIORAL HEALTH

PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING

Thursday, April 10, 2025

1:30 p.m. - 3:30 p.m.

Teams Conference Call

Topic	Key Discussion Points	Action Steps/ Responsibility
e. <u>Clinical Capacity Issues Status</u> **i. Review of Referral Status Report** **ii. OPT Group Therapy** **iii. Capacity Issue Discussion** f. Medicaid/Medicare Updates i. Medicare Open Enrollment: Verify Insurance ii. Medicaid Reenrollment: Encourage /assist as needed with process g. General Fund for FY2025 - General Fund/Loss of Insurance Reports h. Conflict Free Case Management i. LOCUS Competency Monitoring j. Periodic Review Updates k. Date on Discharge Summary l. AOT 30-Day IPOS Addendum **m. Staff Credentials and Qualifications** - **MSHN Finding** **n. Mid-State Care Coordination** **o. Coordination of Care Letter for Consumers with no PHCP** **p. Service Ranges Not Allowed (Power Point)** **q. 8/10 Elements for HCBS** **r. Transition of Care and Coordination TR** **s. Assessments** **t. Authorizations** **u. Outpatient Only Services** **v. Opportunity Center** **w. PNOQMC Note Review with Department Staff**	f. <u>Medicaid/Medicare Updates</u> i. Medicare Open Enrollment – Nothing to report this month. ii. Medicaid Reenrollment – Nothing to report this month. g. <u>General Fund for FY2025</u> – Nothing to report this month. h. <u>Conflict Free Case Management</u> – Nothing to report this month. i. <u>LOCUS Competency Monitoring</u> – Nothing to report this month. j. <u>Periodic Review Updates</u> – Nothing to report this month. k. <u>Date on Discharge Summary</u> – Nothing to report this month. l. <u>AOT 30-Day IPOS Addendum</u> – Nothing to report this month. m. **<u>Staff Credentials and Qualifications/MSHN Finding</u>** – During the MSHN audit, we almost had a finding because staff did not have their appropriate qualifications listed in PCE. When staff are designated as a QMHP, QIDP, CMHP, if it is not getting updated in PCE and just signing their name, when MSHN completes the audit and just sees the name, they will want to verify their credentials in PCE. At the last audit there were two staff who did not have their credentials listed and were required to prove they met the qualifications. The resume was submitted but did not support those credentials because it was vague. We can verify that the supervisor is a QMHP supervising those staff that did not meet the qualifications. BABH is MANDATING that the form created needs to be used internally and for all agencies. Once the form is filled out it will be put in each staff's HR folder. n. **<u>Mid-State Care Coordination</u>** – Defer o. **<u>Coordination of Care Letter for Consumers with no PHCP</u>** – Process discussion. Recommendation was made to add "None" for the primary care provider on the	m. **<u>Staff Credentials and Qualifications</u>** – The 'Verification of Staff Credentials, Qualifications, and Specialty Designations' form will be sent out to the committee for their use as this is mandatory. The BABH logo will be removed along with the CEO's signature. n. <u>Mid-State Care Coordination</u> – Deferred o. **<u>Coordination of Care Letter</u>** – Sarah to follow-up with IT. Sarah to follow-up with Karen.

Topic	Key Discussion Points	Action Steps/ Responsibility
	MDHHS consent form, however, modifications cannot be made to this form, because it is not a BABH form. BABH staff did ask if the administrative staff should enter in a coordination of care form that shows there is no primary care physician to remove 'overdue' notifications on the Supervisor Dashboard (internal process). Sarah H. will check with BI on this and discuss with leadership as this would be a system change. Providers indicate they rarely (if ever) receive a response from the primary care office. p. **Service Ranges Not Allowed** – Due to a recent interpretation from MDHHS site review staff, the use of a service 'Range' in the IPOS is no longer acceptable. Effective June 1, 2025, staff should not use "ranges" when documenting services in the IPOS or in authorizations. Sarah H. reviewed a Power Point training '**Guidance for Writing Plans of Service'**. The training will be sent to all primary care providers with the expectation that program/provider leaders will review the training with all staff providing BABH services, and they will submit evidence of the training to Sarah H. (meeting notes and a copy of the meeting sign-in sheet). Examples of "ranges" no longer allowed; 'targeted case management 1-4 times per month' and 'medication reviews 1-2 times per quarter.' BABH has requested changes in Phoenix to remove the option for ranges in authorizations. The units authorized for each service in the IPOS will be based on how frequently the program completes periodic reviews. For example, ACT and Homebased programs are required to complete periodic reviews on a quarterly basis. All authorizations for services under those programs will be authorized on a quarterly basis. This is still a year plan, but the units are based on a quarter. If you are doing a medication review and are saying the consumer will get 2 per quarter, that means the total units requested is 6. For programs that are required to complete periodic reviews on a bi-annual (every 6 month) basis, all authorizations for services under those programs will be authorized on a bi-annual basis. Over the course of the year, you have 4 units bi-annually or 8 units annually.	p. **Ranges** – Sarah will look at examples of the BT and CLS services configurations and other programs.

	Topic	Key Discussion Points	Action Steps/ Responsibility
		All authorizations in the IPOS need to be written in the 'My objective will be completed through…' section. Do not include services in the goals or objectives sections. EVERY authorization should be listed with specific amount, scope, duration, and frequency. Do not use phrases such as 'on average, at least, as needed, PRN, etc.' The authorizations and narratives should match. Here are some examples: - Targeted Case Management (T1017) 6 times bi-annually for 2 units each visit to assist with XXXX (consumer specific information)). - Medication Reviews (9921X) 2 times bi-annually for 30 minutes each visit to assist with medication management. - Behavior Technician (97151) 240 hours bi-annually for 2 hours each day to assist with XXXX (consumer specific information). If a consumer is seen 10 hours/week, 40 hours/month, 6 times a month at 40 hours a month, that equates to 240 hours bi-annually. - Community Living Supports (H2016) 1080 hours bi-annually for 5 hours each day to assist with XXXX (consumer specific information). If you are meeting with someone 3 days a week for 5 hours, that's 15 hours a week over the course of the year. • The providers would like BABH staff to train them and then the providers will train any new staff. Examples and cheat sheets of different services would be helpful. We are not utilizing services that are over authorizing or underutilizing. It looks better if we add authorizations than if we have to justify in the end. The intent of the bi-annual verbiage was to get to the point of the periodic review to allow flexibility during that time period. You would get to the 6-month period and can address any over/under utilization. You will have to complete the periodic review, go to the addendum, add the auths, and sign the review. There still needs to be two documents. Specialized Residential AFC Homes needs to be looked at for language. We need to make sure the units are approved so we don't have to keep adding units if it was moved to monthly vs. bi-annually. We need to look at this further. Staff will have to start this as of June 1st moving	

	Topic	Key Discussion Points	Action Steps/ Responsibility
		forward. You will need to address the periodic review for over/under-utilization and make adjustments. EMDR and therapy are the same code. You would write in the narrative what is being done so you know how many units will be needed. How do I know whether services are being provided as they are authorized in the IPOS? - At the time of the periodic review, staff will need to review the authorizations claimed and determine if there is any over-utilization or under-utilization for each service authorized and, if so, whether an addendum is necessary to adjust the authorizations. The over-utilization and under-utilization needs to be addressed in the periodic review. • If someone needs to be seen by a psychiatrist for meds, you would write in there two times every six months, but no showed, it doesn't mean they don't need the units. You can note it's being under-utilized but explain in the review the person needs the service, is no showing, and there is a lot of engagement. • Come up with a consistent plan, but then explain what happened and why the units were not used as stated. When do I need to complete an Adverse Benefit Determination (ABD)? - Any time there is a service that is reduced, terminated, or suspended as an action by BABH. If an addendum is completed to add authorizations for a service already listed in the IPOS, a signature is not required. If the addendum will be reducing the service, an ABD will need to be completed and the addendum will need to be signed. • If you are cutting back on services, stating they do not need to be seen this often, then an ABD would need to be completed. - An ABD does not need to be completed if a consumer is no-showing for appointments. - If a consumer cannot find a CLS worker through self-determination, an ABD does not need to be completed.	

Topic	Key Discussion Points	Action Steps/ Responsibility
	- If a provider cannot find a CLS worker, an ABD does not need to be completed. There is a delay in the time frame when a service occurred to when it is billed. When staff are reviewing the utilization of services based on what the authorizations show has been claimed, it may not be 100% accurate. Please make sure to use this information to the best of your ability to determine if utilization is occurring as written in the plan of service. The full implementation for creating plans of service without ranges is 06/01/25. Any IPOS completed on 06/01/25 or after should only include authorizations and narratives in specific amount, scope, duration, and frequency. If the periodic review occurs before a new IPOS is due, an addendum should be completed at the time of the periodic review to remove any ranges. Amount – This refers to the quantity or number of units of service a beneficiary is authorized to receive. For example, it might specify the number of therapy sessions, days of home health, or units of respite care. Scope – This outlines the specific details of the service, including who provides it, where it's delivered, and how it's delivered. For example, it might specify that therapy is provided by a licensed therapist in a clinic setting, or that home health is provided by a registered nurse at the beneficiary's home. Duration – This specifies the length of time the service will be provided. It might be a specific number of months, weeks, or days, or it may be ongoing. Frequency – This specifies how often the service will occur (e.g., daily, weekly, monthly) These terms are crucial for understanding how services are authorized and delivered within Medicaid programs managed by MDHHS. For example, a	

BAY-ARENAC BEHAVIORAL HEALTH

PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING

Thursday, April 10, 2025

1:30 p.m. - 3:30 p.m.

Teams Conference Call

	Topic	Key Discussion Points	Action Steps/ Responsibility
		service like "drop-in services" must specify the amount, scope, and duration of care to be medically necessary. Similarly, case management monitoring must reflect the frequency and scope of the beneficiary's needs outlined in their plan of care. q. **8/10 Elements for HCBS** – Melanie has one of the dates for the Case Management trainings but not the second meeting date so this will be addressed at the next meeting. Defer r. **Transition of Care and Coordination TR** – Defer s. **Assessments** – Defer t. **Authorizations** – Defer u. **Outpatient Only Services** – Defer v. **Opportunity Center** – Defer w. **PNOQMC Notes: Review with Department Staff** – Defer	q. 8/10 Elements for HCBS – Deferred r. Transition of Care and Coordination TR – Deferred s. Assessments – Deferred t. Authorizations – Deferred u. Outpatient Only Services – Deferred v. Opportunity Center – Deferred
5.	**Adjournment/Next Meeting**	The meeting adjourned at 3:30 pm. The next meeting is scheduled for May 8, 2025, 1:30-3:30, at the Lincoln Center in the East Conference Room.	