LAKESHORE REGIONAL ENTITY

QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PLAN (QAPIP)

The FY26 QAPIP defines LRE's system for ongoing evaluation and improvement of service quality and performance in accordance with MDHHS and LRE standards.

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FY2026

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I. Overview & Scope

Lakeshore Regional Entity ("LRE") is a regional entity under Section 1204(b) of the Michigan Mental Health Code responsible for the financial and administrative management of Behavioral Health, Mental Health and Substance Use Disorder Services for adults and children who reside within the Region 3 Prepaid Inpatient Health Plan (PIHP) service area. Beneficiaries are served through five Community Mental Health Service Programs in the region: OnPoint (Allegan County), Network180 (Kent County), HealthWest (Muskegon County); Community Mental Health of Ottawa County, and Health West (Lake, Mason, and Oceana counties).

LRE has the distinction of being the only regional entity in Michigan where all Member CMHSPs are Certified Community Behavioral Health Clinic (CCBHC) Demonstration Sites. Although oversight of CCBHCs is no longer delegated to PIHPs, the presence of these clinics across the region is expected to strengthen overall service quality. The CCBHC model provides additional resources and flexibility that support improved access, integration, and coordination of care.

This document outlines requirements for the annual QAPIP ("Quality Assessment and Performance Improvement Program") as set forth in the MDHHS/PIHP STANDARD CONTRACT and MDHHS Policy *Quality Assessment and Performance Improvement Plans for Specialty Prepaid Inpatient Health Plans*. It also describes how these functions are accomplished and the organizational structure and responsibilities relative to these functions.

In addition to meeting contractual requirements, the QAPIP outlines functional requirements and provides guidance for operationalizing these requirements, including but not limited to:

1. Evaluating and enhancing, if appropriate, LRE's Quality Improvement ("QI") Processes and Outcomes.
2. Monitoring and evaluating the systems and processes related to the quality of clinical care and non-clinical services that can be expected to affect the health status, quality of life, and satisfaction of persons served by each Member CMHSP.
3. Identifying and prioritizing opportunities for performance improvement.
4. Creating a culture that encourages stakeholder input and participation in problem solving.

II. Quality Management System

A. Continuous Improvement Process

LRE's Quality Management System combines the traditional aspects of quality assurance and adds the elements of continuous quality improvement by utilizing the "Plan-Do-Study-Act process". This problem-solving approach is commonly used in quality control efforts. There are four steps to the process, and the process can be repeated indefinitely until the desired outcome is achieved:

Plan: design (or revise) a process to improve results

Do: implement the plan and measure its performance

Study: measure and evaluate the results and determine if the results meet the desired goals

Act: decide if changes are needed to improve the process. If so, then start the process over.

The Quality Management System helps LRE achieve its mission, realize its vision, and live its values. It protects against adverse events, and it provides mechanisms to bring about positive change. Continuous quality improvement efforts ensure a proactive and systematic approach that promotes innovation, adaptability across the region, and a passion for achieving best practices.

The *Quality Management System* includes:

1. Predefined quality standards,
2. Formal assessment activities,
3. Measurement of outcomes and performance, and
4. Strategies to improve performance that is below standard.

The various aspects of the Quality Management System are not mutually exclusive to just one category. The table below identifies the more common standards, assessment activities, measurements, and improvement strategies used by LRE's Quality Management System.

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

B. Authority And Organizational Structure

The LRE Board of Directors, which serves as LRE's Governing Board, reviews and approves the QAPIP on an annual basis thereby giving authority for the implementation of this QAPIP and all the components necessary for continuous quality improvement.

Governing Body

Membership: LRE's 15-member Governing Board includes three representatives appointed by each of the five (5) Member CMHSP Boards of Directors.

Responsibilities: The LRE Governing Board is responsible for monitoring, evaluating, and making improvements to care including, but are not limited to:

- ***Oversight of the QAPIP:*** This includes documented evidence that the Governing Board has approved the overall QAPIP and QI Plan.
- ***QAPIP Progress Reports:*** The LRE Governing Board routinely receives written reports from the Chief Operations Officer ("COO") describing performance

improvement initiatives, the actions taken, and the results of those actions.

- ***Annual QAPIP Review:*** The LRE Governing Board formally reviews a written report on the operation of the QAPIP, at least annually.
- ***Adopting and Communicating Process and Outcome Improvement:*** After presentation, the LRE Governing Board adopts the QAPIP via Board Motions and communicates the process and outcome improvement to stakeholders via Board of Directors meeting minutes, which are published on the LRE website for public accessibility. LRE also publishes the QAPIP and QAPIP Annual Effectiveness Review on its website and provides electronic copies to the LRE Governing Board and all Member CMHSPs for distribution via CMHSP Newsletters to the provider network. LRE also distributes the QAPIP, or relevant portions, to LRE Regional Operations Advisory Teams, as applicable.
- ***Reporting Accountability:*** Following review and approval by the LRE Governing Body, the LRE COO submits the QAPIP, QAPIP Annual Effectiveness Review, and MDHHS Governing Body Form to MDHHS on or before February 28th each year.

Organizational Structure

Oversight of the Quality Improvement (QI) process is provided by the Chief Operating Officer (COO). As of February 2025, all quality-related responsibilities have been consolidated under the COO, eliminating the prior division of functions between the Chief Quality Officer and the COO. This structural realignment enhances coordination across departments, reduces duplication, and strengthens the integration of quality, operations, and performance improvement activities throughout the organization.

LRE maintains a Home and Community-Based Services (HCBS) Manager position to support regional compliance with the HCBS Final Rule, which went into full effect on March 17, 2023.

The Quality team includes eight full-time employees dedicated to ensuring adequate auditing capacity to meet federal requirements under the HCBS Final Rule, as well as contractual obligations for annual physical assessments and tri-annual comprehensive assessments.

LRE also maintains 7.5 full-time equivalent (FTE) positions within the Information Technology (IT) team to ensure the timely development of data analytics tools, including Power BI dashboards.

LRE's organizational structure supports the clear and effective administration and evaluation of the QAPIP (Attachment C).

Designated Senior Official:

The LRE Chief Executive Officer ("CEO") has delegated the responsibility for submitting a regional QAPIP to the LRE Board of Directors for final approval to the COO. LRE CEO also provides regular QAPIP updates to the Operations Advisory

Council, which includes all Member CMHSP CEOs, where applicable. In addition, if issues or barriers to operational effectiveness are identified, the COO escalates the issues or barriers to the LRE CEO, who may review the identified issues or barriers with the LRE Operations Advisory Council and/or the LRE Board of Directors for input, resolution, and/or awareness.

The LRE COO has day-to-day administrative management and oversight of the QAPIP, including all its components, and is responsible for keeping the LRE CEO informed of region-wide quality improvement activities and performance improvement projects. The LRE COO also provides periodic updates to the Operations Advisory Council and LRE Board of Directors, when necessary.

Regional Operations Advisory Teams and Quality Improvement Council

LRE's overall structure supports the management and oversight of the QAPIP and all components necessary for its implementation. (Attachment D).

To facilitate the implementation and management of the QAPIP, LRE created the Quality Improvement Regional Operations Advisory Team ("QI ROAT"), which consists of representation from LRE and Member CMHSPs. The QI ROAT is responsible for regularly reviewing all activities within the QAPIP. The QI ROAT members also collaborate with one another and with other ROATs when any systemic or performance issues are identified to enhance coordination and resolve identified issues as efficiently and effectively as possible.

For Fiscal Year 2025, LRE continues to convene the Quality Improvement Council which consists of the LRE Executive team and managers, with purpose being:

1. Ensure effective oversight and monitoring of the LRE's managed care functions, for both internal and for delegated through the application of data reports.
2. Ensure all departments are collaborative and consistently utilizing data and key performance indicators.
3. Ensure LRE departments are collaborating to foster open communication and cross-pollination of information toward effective project completion.
4. Ensure Risk Assessment is completed for the Agency per the FY25 PIHP/ MDHHS Contract /OIG.

C. Active Participation of Consumers & Providers

LRE recognizes the importance of stakeholder input and its role in improving quality, customer experiences, and outcomes. Consumers and families are valued contributors in the QI process. To support this:

- LRE supports an active **Community Advisory Panel** composed of consumers representing each Member CMHSP within the region. The Panel meets quarterly and is managed by the Chief Operating Officer (COO) and the Customer Services Department. Each CMHSP recommends individuals for membership, with final

selection determined by a vote of the Panel and approval by the LRE Board of Directors. The Panel includes 15 total members, ensuring balanced representation across the region. Following each meeting, minutes are provided to the Board of Directors and included in the official board packet. LRE team members are regularly invited to attend meetings to share information and deliver presentations.

- There is a bi-directional feedback and input loop between LRE ROATs and the Community Advisory Panel to ensure consumer engagement on quality initiatives.
- There are multiple opportunities for consumers, or guardians, to respond to satisfaction surveys.
- Customer Services staff respond to any complaint, request for feedback, or request for assistance regardless of how they are received within 4 business days.
- LRE's website includes a link to allow interested parties to provide feedback on any areas of concern at any time (Contact - Lakeshore Regional Entity (feedback@lsre.org)).

As part of its Member CMHSP Site Reviews, the LRE monitors CMHSP engagement in both consumer and provider participation.

III. Performance Measurement

A. Performance Indicators

LRE measures its performance through the ongoing collection and analysis of valid, reliable data. In FY 2026, LRE will continue to monitor the performance measures required by MDHHS, including the Michigan Mission Based Performance Indicator System (MMBPIS) and the CMS Behavioral Health Core Set (BHCS) to monitor performance measures established by MDHHS. LRE supports Member CMHSPs in meeting compliance thresholds established by MDHHS for measures in the areas of access, efficiency and outcomes.

MMBPIS Monitoring (FY 2026)

While MDHHS transitions to BHCS measures, LRE will continue monitoring the MMBPIS measures identified for continuation in FY 2026, including *Measure 2a*. Each quarter, LRE:

- Reviews each Member CMHSP's data submission.
- Selects samples for quality checks and requires proofs of compliance with the MMBPIS Code Book.
- Validates data and directs CMHSPs to finalize submissions.
- Aggregates data and reports results to MDHHS.

Transition to CMS Behavioral Health Core Set

MDHHS is phasing in BHCS measures between FY 2025–2027 across five programs and seven domains (seven added in FY 2025, four in FY 2026, and 18 in FY 2027). During FY 2026, LRE will continue preparations by:

- Understanding new measures and reporting requirements
- Leveraging technology to support accurate and reliable reporting
- Identifying performance gaps and creating action plans to address them

Year 1 Measures (already underway):

Measure Abbreviation	Measure Description	Program	Domain
ADD	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	BHCS	MH
FUH	Follow-up After Hospitalization for Mental Illness	BHCS	Access
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	BHCS	MH
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	BHCS	MH
FUA	Follow-up After Emergency Department Visit for Substance Use	BHCS	Access
FUM	Follow-up After Emergency Department Visit for Mental Illness	BHCS	Access
IET	Initiation and Engagement into Substance Use Disorder Treatment	BHCS	SUD

Year 2 Measures (FY 2026):

Measure Abbreviation	Measure Description	Program	Domain
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	BHCS	Comorbid Conditions
HPCMI	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	BHCS	Comorbid Conditions
OUD	Use of Pharmacotherapy for Opioid Use Disorder	BHCS	SUD
SAA	Adherence to Antipsychotic Medications for individuals with schizophrenia	BHCS	MH

Year 3 Measures (FY 2027, anticipated):

Domain	Program	Measure Abbreviation	Measure Description
Patient Experience	Quality Rating System (QRS)	Consumer Assessment of Healthcare Providers and Systems (CAHPS)	How People Rated Their Health Plan
			Getting Care Quickly
			Getting Needed Care
			How Well Doctors Communicate
			Health Plan Customer Service
Patient Experience and Home & Community Based Services	Home & Community Based Services (HCBS)	HCBS CAHPS	Choosing the Services that Matter to You
			Community Inclusion and Empowerment
			Transportation to Medical Appointments
			Physical Safety
			Personal Safety and Respect
			Staff are Reliable and Helpful
			Staff Listen and Communicate Well
			Unmet Needs Composite Measure
	MLTSS	MLTSS-1	Medicaid Managed Long-Term Services and Supports Comprehensive Assessment and Update
	MLTSS	MLTSS-2	Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update
Social Needs	Certified Community Beh. Health Centers (CCBHC)	TBD	Social Needs Screening- Tool TBD
SUD	BHCS	MSC	Medical Assistance with Smoking and Tobacco Use Cessation
MH	BHCS	CDF	Screening for Depression and Follow-Up Plan

If MDHHS revises its 3-year implementation strategy, LRE will adjust accordingly.

Substance Use Disorder Performance Measures

In addition to required regional performance measures, LRE has identified targeted substance use disorder (SUD) measures to enhance oversight of access, continuity, and integration of care across the service array that align with regional priorities and state expectations.

LRE will continue to monitor the following key SUD measures, including:

- **Timely access for individuals with intravenous drug use (IVDU):**
  Aim: Decrease the average number of days between request for service and first service for individuals with IVDU. Admissions for this population are prioritized due to elevated risk for overdose, infectious disease, and other serious health

complications. In FY2024, the regional average time to service was 8.4 days.

- **Successful Transition Following Short-Term Residential Treatment:**
  Aim: Increase the percentage of clients discharged from short-term residential services who successfully transition to the next level of care within seven days. Timely transitions are critical for sustaining treatment momentum and reducing relapse, overdose, or dropout risk during early recovery.
- **Integrated Treatment for Individuals with Co-Occurring Disorders:**
  Aim: Increase the percentage of clients discharged with a co-occurring diagnosis who received integrated care. Coordinated treatment addressing both mental health and substance use disorders improves outcomes, engagement, and continuity of care.

Data will be reviewed quarterly with Member CMHSPs at the SUD ROAT to identify trends, discuss barriers, and support local improvement efforts.

B. Performance Improvement Projects

LRE conducts Performance Improvement Plans (PIP) to achieve measurable and sustained improvements in clinical and non-clinical services that directly impact health outcomes and consumer satisfaction. All PIPs are carried out using the Plan-Do-Study-Act cycle, as detailed earlier, to ensure statistically significant and sustainable change.

Each fiscal year, LRE must conduct at least two PIPs:

- **One mandated by MDHHS,** which is reviewed and evaluated by Health Services Advisory Group (HSAG) for compliance.
- **One selected by LRE,** which must be submitted to MDHHS along with the QAPIP.

To monitor progress, LRE reviews its HEDIS® Key Performance Indicator (KPI) Dashboard quarterly using Power BI, with data sourced from Zenith Technology Services' Integrated Care Delivery Platform (ICDP). Results are distributed and discussed through the QI ROAT. Since February 2021, LRE has analyzed the KPI Dashboard by Member CMHSP and race/ethnicity to support MDHHS's 2022 Race/Ethnicity Disparity PIP requirements.

LRE encourages stakeholders to propose improvement recommendations through local QI processes. Ideas for PIPs are generated and discussed within QI ROAT and may also come from LRE staff, ROATs, Workgroups, providers, and consumers. State-mandated PIPs are reviewed by the Operations Advisory Council and submitted by the COO. All PIPs are reported to the QI ROAT, Operations Advisory Council, and Community Advisory Panel.

Current PIPs (FY 2026): LRE continues to conduct two PIPs focused on improving the HEDIS® *Follow-up After Hospitalization (FUH)* measure. Research shows that increasing FUH rates improves outcomes, decreases suicide risk, reduces recidivism, and enhances consumer satisfaction.

PIP 1: Decrease in Racial Disparity between Blacks & Whites (clinical care)

Goal: By the end of the CY 2026 measurement period, the LRE 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 from the 2021 baseline level.

In accordance with MDHHS mandate, LRE chose a PIP centered on decreasing the race/ethnicity disparity in Region 3. LRE's MDHHS mandated PIP is *whether targeted interventions result in significant improvement (over time) in the number of members who identify as African American/Black that receive follow-up within 30 days after an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm when compared to those similarly situated members who identify as White*, meaning an elimination in the racial disparity between the two measurement groups, during the measurement period, without a decline in performance for the White members.

One risk is that LRE's interventions may raise the FUH metric for all races and may not improve the race disparity between African Americans/Blacks and White, but this is a risk that LRE is willing to accept given the positive impact that follow-up care after psychiatric hospitalization appears to provide to its members.

In remeasurement year 1 (CY 2023), LRE did not achieve statistically significant improvement in reducing the disparity between Black and white clients, resulting in HSAG not validating LRE's PIP performance.

In remeasurement year 2 (CY2024), LRE achieved meaningful gains in follow-up after hospitalization compliance, particularly for Black clients, who showed a statistically significant improvement between 2021 and 2024. Although these positive trends represent important steps toward more equitable care, the formal statistical tests of overall disparity showed that although the size of disparity was decreased, the disparity was not eliminated.

In FY26, LRE will collaborate with its Member CMHSPs and Medicaid Health Plans (MHPs) to implement targeted interventions across Region 3 to improve LRE's PIP performance. Strategies will focus on rebuilding trust in the behavioral health system among Black clients and addressing social determinants of health (SDOH) which have been shown to disproportionately affect Black individuals and adversely affect follow-up care. As detailed in the submitted PIP, this will include supporting providers with training and resources for individualized discharge planning, strengthening cultural and structural competence, and using county-level FUH30 data to identify local disparities and inform targeted local interventions.

PIP 2: Follow-Up after Hospitalization for Mental Illness (clinical care)

Goal: By the end of the 2026 measurement period, the LRE will achieve a statistically significant increase in the percentage of individuals age 6 and older who receive follow-up mental health care within 30 days of psychiatric inpatient discharge, compared to the 2021 baseline.

In Fiscal Year 2023, LRE standardized the process for collecting FUH data from its Member CMHSPs, distributing FUH data to the MHPs and submitting FUH data to MDHHS. LRE's PIPs intend to improve quality of care and outcomes for all consumers within the FUH population through ongoing collaboration with MHPs and operationalizing the standardized processes for the collection, distribution, submission, and tracking of FUH data.

In Fiscal Year 2024, LRE expanded its use of Power BI Dashboards to identify the driving force behind its lagging FUH performance.

In Fiscal Year 2026, LRE will improve the FUH performance across Region 3 with targeted interventions related to the lagging FUH performance of some CMHSPs and MHPs.

During the remeasurement period for the Follow-Up After Hospitalization (FUH30) Performance Improvement Project, LRE analyzed trends in follow-up rates for both adult and child populations. For adults, the regional FUH30 rate decreased from 60.5% at baseline to 56.7% in Year 2, representing a statistically significant decline. Therefore, LRE did not achieve the PIP goal of demonstrating a statistically significant increase in timely follow-up for adults after inpatient psychiatric hospitalization.

For children and adolescents, the FUH30 rate decreased from 79.4% to 77.7% across the same period; this change was not statistically significant. However, the rate did not increase, and therefore, the region also did not meet the PIP goal of achieving statistically significant improvement for the child population.

Overall, these results indicate that while some improvement activities were implemented across the region, the current interventions did not produce measurable improvement in timely post-hospital follow-up. The analysis highlights the need to refine strategies, with particular attention to discharge coordination workflows, outpatient appointment scheduling practices, and strengthened collaboration between inpatient and community providers. These areas will be the focus of continued improvement efforts in the upcoming year.

IV. Event Reporting and Notifications

LRE requires each Member CMHSP with direct services as well as contracted, external providers to record, assess, and report critical incidents, risk events, sentinel events (SE), unexpected deaths, and immediately reportable events (a/k/a immediate event notification)

according to contractual obligations and MDHHS reporting requirements. LRE reports critical incidents, risk events, sentinel events, unexpected deaths, and immediately reportable events in accordance with MDHHS contractual requirements.

LRE's critical incident analysis includes the required incident types as defined by MDHHS, including non-suicide deaths, arrests, emergency medical treatment or hospitalization related to injury or medication error (with a distinct subcategory for injuries associated with physical management). These incidents are reviewed to assess contributing factors, appropriateness of response, and opportunities for system improvement.

MDHHS requires all critical incidents, sentinel events, and unexpected deaths be reported via the Customer Relationship Management ("CRM") platform. LRE utilizes the required field in the CRM platform to identify the provider and exact place where a critical incident occurs. LRE also incorporates programming to identify if a provider involved in a reportable event is a specialized residential provider. LRE analyzes this data with an eye towards protecting one of its most vulnerable populations, which is specialized residential consumers who partake in Long Term Supports and Services ("LTSS").

LRE's CI/RE analyses include review of critical incidents that represent heightened risk, including: (1) actions taken by individuals receiving services that result in harm to themselves, (2) actions taken that result in harm to others, and (3) instances in which an individual has two or more unscheduled medical hospital admissions within a 12-month period (excluding planned procedures or admissions related to the natural course of a chronic or terminal condition). These events are analyzed to identify contributing factors, trends, and opportunities to reduce risk and strengthen supports.

LRE collects, aggregates, and analyzes all critical incidents (CIs) and risk events (REs) on a quarterly basis. The CIRE Workgroup reviews, and investigates when necessary, all sentinel events, unexpected deaths, and immediately reportable events on a monthly basis. Through these analyses, LRE determines whether action is needed to remediate identified concerns, prevent recurrence, and ensure compliance with MDHHS reporting requirements.

LRE reports these findings, outliers, and trends to QI ROAT, and, when necessary, to the Operations Advisory Council, on a quarterly basis via the LRE's Critical Incidents Monitoring Report, Risk Event Monitoring Report, Sentinel Event/Unexpected Death Timeliness Report, and Mortality Report. LRE also reports Event Reporting and Notifications to its Governing Board annually. A CIRE Power BI data dashboard is maintained to support data review.

Beginning Fiscal Year 2025, MDHHS revised the event reporting and notifications reporting requirements, which were expected to begin October 1, 2024. MDHHS submitted a request for, and was granted, a waiver from CMS that the compliance date for the revised reporting requirements be adjourned from October 1, 2024, to December 29, 2024.

LRE has implemented MDHHS' new reporting requirements for event reporting and notifications, which include critical incidents, risk events, sentinel events, and unexpected deaths. In addition, LRE convenes a workgroup with members from each Member CMHSP, resulting in a revised SE/Unexpected death reporting form and reporting process that aligns with MDHHS requirements. This workgroup will continue to meet quarterly to discuss issues

related to sentinel events. If MDHHS revises its event reporting and notification requirements, LRE will adjust accordingly.

A. Critical Events:

LRE captures data on critical incidents for mental health and SUD consumers.

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.

LRE requires each Member CMHSP to submit its Critical Incidents by the 15th of each month. LRE reports the following Critical Incidents to MDHHS within sixty (60) days after the end of the month (except for suicides, which are reportable within thirty (30) days), in which the incident occurred for individuals who, at the time of the incident, were actively receiving services. Each CMHSP must ensure that contracted residential treatment providers identify, document, and submit Critical Incident reports to the CMHSP in accordance with MDHHS and LRE reporting requirements, including:

CRITICAL EVENTS REPORTING									
Service	**Suicide (01)**	**Death (02)**	**EMT (03)**	**Hospital (04)**	**Arrest (05)**	**Death of Unknown Cause (06)**	**PM without Injury**	**Emergency Response**	**Use of Restraint**
CLS	●	●				●			
Support Coordination	●	●				●			
Case Management	●	●				●			
ACT	●	●				●			
Homebased	●	●				●			
Wraparound	●	●				●			
Hab Waiver	●	●	●	●	●	●			
SED Waiver	●	●	●	●	●	●			
Child Waiver	●	●	●	●	●	●			
1915 iSPA	●	●	●	●		●			
Any Other Service	●	●				●			
Living Situation									
Specialized Residential	●	●	●	●	●	●			
Child Caring Institution	●	●				●			
Crisis Stabilization Unit	●	●				●	●	●	●

Upon notification by MDHHS, LRE requires each Member CMHSP to remediate critical

incidents within 30 days of the reported date to CRM, or the date requested by MDHHS that are:

1. Not reported in a timely manner,
2. For emergency medical treatment or hospitalizations due to medication errors,
3. For emergency medical treatment or hospitalizations due to a fall,
4. For emergency medical treatment or hospitalizations as a result of the use of physical management, or
5. Requested by MDDHS upon review of the critical incident.

B. Risk Events

LRE also captures data on events that put individuals at risk of harm. Risk Events required to be reviewed include the following: Harm to self, harm to others, physical management, police calls, and two or more unscheduled admissions to a medical hospital (not due to planned surgery or natural course of a chronic illness) within a 12-month period.

LRE requires each Member CMHSP to submit its Risk Event by the 15th of each month and to report the following Risk Events to LRE 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:

RISK EVENT REPORTING					
Service	**Harm to Self (106)**	**Harm to Others (107)**	**Police Calls (108)**	**Physical Management (109)**	**Hospitalization 2+ within 12 months (110)**
Supports Coordination	●	●	●	●	●
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	●	●	●	●	●

C. Sentinel Events And Unexpected Deaths

LRE reports sentinel events and unexpected deaths consistent with MDHHS contract requirements. Sentinel Events include but are not limited to incidents that result in the following: Unexpected deaths, permanent harm, severe temporary harm and intervention required to sustain life. (The Joint Commission 2022).

Member CMHSPs, per contract, must notify LRE within 24 hours of learning of an Unexpected Death or possible Sentinel Event. Member CMHSPs have three (3) business days after the occurrence of a Critical Incident to determine if it is a Sentinel Event. If the Critical Incident is classified as a Sentinel Event, the Member CMHSP then has two (2) subsequent business days to commence a Root Cause Analysis ("RCA") of the event. LRE established that RCAs must be completed within 90 days.

The LRE CIRE Workgroup, which may include LRE's Medical Director, reviews all unexpected deaths of persons receiving specialty supports and services at the time of their death including medical examiner's reports, death certificates, and RCAs inclusive of findings and remediation recommendations, if applicable. LRE validates remediation efforts during annual site visit reviews. The LRE CIRE Workgroup also aggregates all mortality data into the LRE Mortality Report to identify possible trends related to all deaths and address any issues related to quality of care.

D. SUD Sentinel Events

In addition to reporting critical incidents and risk events that occur in SUD 24-hour Specialized Residential settings, LRE also reports and reviews all SUD Sentinel Events as follows:

SUD SENTINEL EVENTS REPORTING								
Service	**Death of Unknown Cause (06)**	**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	●	●	●	●	●	●	●	●

E. Immediately Reportable Events

LRE reports all Immediately Reportable Events to Customer Relations Management (CRM) according to contract, as follows:

- Any death that occurs because of suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation, must be reported to MDHHS within 48 hours of either the death,

the PIHPs receipt of notification of the death, or the PIHPs receipt of notification that a recipient rights, licensing, and/or police investigation has commenced.

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

V. Clinical Quality Standards

A. Utilization Management

LRE ensures access to publicly funded behavioral health services in alignment with MDHHS contracts, the Medicaid Provider Manual, and Michigan Mental Health Code requirements. LRE, directly or through delegated functions to CMHSP Members, oversees the region's Utilization Management (UM) system. Each CMHSP is accountable for delegated UM activities for the individuals they serve, whether through directly operated or contracted services, in keeping with LRE guidance.

Delegated 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. CMHSPs are also responsible for communication with individuals about UM decisions, including adverse benefit determination notices, rights to a second opinion, and grievance and appeals processes.

UM is guided by LRE policy and an annual UM Plan. Through policy and monitoring, LRE ensures that:

- Review decisions are supervised by qualified health professionals;
- Any denial or reduction of services is made by a licensed clinician with expertise in the beneficiary's condition;

- Reasons for treatment decisions are documented and accessible to the person served;
- Consumers are informed of appeals processes and assistance through Customer Services;
- Notification requirements are met in accordance with the Medicaid Managed Specialty Supports and Services contract with MDHHS.

LRE uses mechanisms to identify and correct both under- and over-utilization, including prospective, concurrent, and retrospective reviews. Power BI dashboards support the review and analysis of utilization patterns. LRE also conducts utilization reviews of individual consumer records, provider practices, and system-level trends. When negative statistical outliers are identified, LRE analyzes contributing factors to determine potential causes, including clinical, operational, access, and documentation considerations. Findings and recommended actions are aggregated and reviewed through the UM ROAT and reported to the Quality Improvement Council (QIC), Clinical ROAT, IT ROAT, and other ROATs as appropriate to support system-level decision making and improvement interventions.

LRE maintains a robust Inter-rater Reliability (IRR) process to ensure consistent decisions about medical necessity across the region. This includes using the most current static version of Milliman Care Guidelines (MCG) for all higher level of care decisions. Quarterly audit cycles of pre-admission screenings and continued stay reviews confirm that reviewers apply MCG criteria uniformly, sustaining high regional performance in inter-rater reliability. Service Authorization Denial (SAD) reports are monitored to identify timeline compliance gaps, while analysis of higher levels of care and readmission rates provides a comprehensive picture of utilization trends. Together, these efforts strengthen the integrity and consistency of UM decision-making across CMHSPs.

The Integrated Health/Care Coordination program, required by MDHHS, brings together CMHSPs and Medicaid Health Plans (MHPs) in Region 3 to support individuals with both mental and physical health needs. LRE currently partners with Blue Care Connect, McLaren, Meridian, Molina, Priority Health, and United Health Care. CMHSPs and MHPs identify individuals who frequently use emergency services and collaborate to create care plans that improve quality of life and reduce barriers. Monthly meetings are held to review progress and update plans in Care Connect 360 (CC360). In FY26, LRE is finalizing its Core Service Menu Project, an innovative, state-leading initiative designed to enhance service utilization auditing and oversight. The project, targeted for launch in January 2026, will integrate LOCUS-based analytics and real-time dashboards to identify and review potential overutilization. Built around a collaborative, improvement-focused audit model, the system emphasizes supporting CMHSPs in strengthening care

quality. Additionally, LRE will continue quarterly audits of Pre-Admission Screenings and Continued Stay Reviews.

B. Practice Guidelines

LRE supports the use of Clinical Practice Guidelines (CPGs) to assist practitioners and members in making informed decisions about appropriate care for specific clinical circumstances. LRE endorses the CPGs adopted by the American Psychiatric Association, which were formally adopted in collaboration with Member CMHSPs through the Clinical ROAT and Utilization Management ROAT. The guidelines are disseminated through LRE's website and newsletter.

In addition to the established regional process for maintaining and disseminating Clinical Practice Guidelines (CPGs) across all service areas, LRE has strengthened its approach by using diagnostic data to identify and emphasize the most frequently occurring conditions in the region (e.g., Autism, SUD, PTSD, Depression). For these, LRE highlights relevant national guidelines—such as those from the American Psychiatric Association—within Clinical, UM, Autism, and SUD ROATs to ensure practical application and discussion. These efforts supplement the broader CPG process, which continues to encompass all service areas. Updated CPGs and links to national sources are posted on LRE's website and distributed through the newsletter to ensure systemwide accessibility.

Together with Member CMHSPs, LRE developed and approved an Inter-rater Reliability Process to ensure consistent application of the guidelines in utilization management, member education, service coverage, and related areas. Audit Summary results are reviewed by the LRE QIC, Clinical ROAT, and Utilization Management ROAT.

LRE also monitors guideline adherence during Member CMHSP Site Reviews and, when non-compliance is identified, issues a Corrective Action Plan.

C. Long Term Services and Supports

Long-Term Services and Supports (LTSS) are services provided to beneficiaries of all ages with functional limitations or chronic illnesses. Their primary purpose is to help individuals live or work in the setting of their choice, such as their own home, a workplace, a provider-owned or controlled residence, a nursing facility, or another institutional setting (42 CFR 438.2). LTSS are provided to persons with disabilities who need additional support due to: (42 CFR §438.208(c)(1)(2)):

- Advancing age; or
- Physical, cognitive, developmental, or chronic health conditions; or
- Other functional limitations that restrict their abilities to care for themselves; and
- Receive care in home and community-based settings or facilities such as nursing homes.

LRE is committed to ensuring the quality and appropriateness of care for all beneficiaries. Because individuals receiving LTSS are among the region's most vulnerable populations, additional analyses of their care are conducted using both quantitative and qualitative methods, including:

- Satisfaction Surveys: The quality, appropriateness, availability, and accessibility of LTSS are assessed through adult and youth satisfaction surveys (MHSIP and YSS). In addition, the Customer Services ROAT conducts a separate analysis of LTSS populations to further support satisfaction data review.
- Site Visits: LRE evaluates the quality and appropriateness of care for individuals receiving LTSS through multiple methods integrated into CMHSP Site Reviews:
  - Sampling Methodology: Consumers are selected for clinical chart audits using a representative sampling approach across service types and populations. Nearly 70% of distinct consumers received LTSS under the 1115 Pathway to Integration Waiver; accordingly, most sampled charts reflect LTSS participants.
  - Clinical Chart Audit Tool: Used during CMHSP Site Reviews to assess LTSS quality and appropriateness. The tool includes:
    - Person-Centered Planning (PCP): Evaluates care coordination and planning across settings.
    - Service Delivery: Compares delivered services to each individual's treatment or service plan.

    The tool aligns fully with MDHHS PCP Guidelines and the Medicaid Provider Manual, ensuring consistency in assessing care quality for LTSS beneficiaries.
  - Screening Compliance: LRE ensures that all individuals, including those receiving LTSS, are screened with the appropriate MDHHS-prescribed tool at admission, annually, and whenever there is a significant change in presentation. In addition, LRE has developed Power BI dashboards to enhance visibility and oversight of LOCUS utilization.
- Facility Reviews: LRE conducts annual Facility Reviews and HCBS Physical Assessments for all Specialized Residential (licensed and non-licensed), Autism, and other providers when appropriate or requested. These reviews include a comprehensive assessment of HCBS compliance within each setting. If a modification or restriction is identified, LRE conducts a full audit of all Region 3 consumers' Individual Plan of Service (IPOS) to ensure compliance with the HCBS Final Rule, MDHHS HCBS Monitoring Requirements Technical Advisory, and Person-Centered Planning (PCP) Policy.[1]

[1] HCBS_Monitoring_Compliance_Technical_Advisory.pdf, Updated March 31, 2024; Person-Centered_Planning_Practice_Guideline.pdf, Updated March 31, 2024.

- Adverse Events Monitoring: LRE monitors adverse events for individuals receiving LTSS through Power BI dashboards, which can be filtered by specialized residential setting to allow focused review of this population. This functionality enables analysis of risk events, critical incidents, and sentinel events to identify trends, issues, or concerns that may warrant further exploration. Findings are reviewed by the QI ROAT annually as part of the Annual Effectiveness Review (AER).

VI. Behavior Treatment Review

To ensure compliance with MDHHS Technical Requirements and the PIHP contract, LRE has established a standardized process for the collection, review, and analysis of Behavior Treatment data. This process ensures that data from all Member CMHSPs is accurate, complete, and used to identify trends, address concerns, and guide quality improvement efforts. In addition, a Power BI dashboard is maintained for Physical Management related data to support data review and analysis.

The following outlines the required steps for Member CMHSPs, the Behavior Treatment Plan Review Committee (BTPRC), and LRE staff.

Process:

Quarterly Data Collection and Submission	• Each Member CMHSP collects, reviews, and analyzes Behavior Treatment data on a quarterly basis. • An attestation is submitted to LRE each quarter demonstrating compliance with the MDHHS Technical Requirement for Behavior Treatment Plans.
Regional Review Committee	• The Behavior Treatment Plan Review Committee (BTPRC), with representation from each Member CMHSP and LRE, convenes quarterly. • The BTPRC reviews and analyzes regional data, including: • 911 calls to law enforcement in an emergency • Use of physical management interventions • The committee verifies the accuracy and completeness of submitted data and identifies trends or areas of concern.
Analysis of Intrusive or Restrictive Techniques	• When intrusive or restrictive techniques have been approved, or when physical management or 911 calls have occurred, the BTPRC conducts additional quarterly analysis. • The purpose of this review is to identify trends and determine actions necessary to reduce the potential for future events.
Physical Management Episode Tracking	• LRE prepares the Physical Management Episode Tracking Report on a quarterly basis. • The report is reviewed by both the BTPRC and the QI ROAT.

Report	• Data reviewed includes:
	  ○ Number of interventions per individual
	  ○ Duration of interventions

LRE reviews Behavior Treatment data quarterly to assess trends in the use of physical management interventions, emergency law enforcement contacts, and instances where intrusive or restrictive techniques are approved. Through this ongoing review, the BTPRC and QI ROAT evaluate whether interventions are becoming more or less frequent, whether use varies across CMHSPs or settings, and whether previous corrective or preventive actions have led to improvements in practice. Progress toward reducing the frequency, duration, and intensity of physical management interventions and preventing crisis escalation is monitored over time. When increases, patterns, or outliers are identified, LRE works with Member CMHSPs to implement targeted improvement strategies and then monitors subsequent data to determine impact. This process supports the analysis of progress toward performance goals, improvements in care quality, and desired changes in service delivery practices across the region.

LRE maintains compliance with the MDHHS *Technical Requirement for Behavior Treatment Plans* and the MDHHS–PIHP Contract by ensuring that all Member CMHSPs follow required reporting standards, Behavior Treatment Committee processes, and review procedures for intrusive or restrictive techniques, physical management, and related events.

VII. Member Experience:

A. Customer Satisfaction Assessment

LRE requires its Member CMHSPs to deploy, at least annually, the Regional Customer Satisfaction Survey ("Survey") in a way that is representative of the individuals served, including individuals receiving long-term supports and services ("LTSS"), such as consumers receiving case management, supports coordination, and other ongoing services.

Survey results are reviewed through multiple regional structures, including the QIC, Customer Satisfaction ROAT, QI ROAT, Community Advisory Panel, Customer Satisfaction Workgroup, and the LRE Governing Board. LRE monitors CMHSP Survey deployment during CMHSP Site Reviews and issues corrective action plans when non-compliance is identified. LRE also prepares an annual Regional Customer Satisfaction Report that is posted publicly, shared with the Governing Board, and reviewed by the Community Advisory Panel.

Since Fiscal Year 2024, LRE has used a survey instrument that 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. To enable valid year-over-year trend analysis, LRE will maintain use of the MHSIP and YSS-F instruments in FY26. LRE will also document each CMHSP's deployment method and conduct (1) a brief pre-launch technology check (e.g., links, QR codes, access permissions) and (2) a mid-cycle completeness check to prompt follow-up for late or missing submissions. Per policy, LRE will continue follow-up outreach to any respondent who indicates dissatisfaction within four (4) business days and will require a CMHSP corrective action plan within 30 days for any survey domain scoring below 3.0. All CMHSPs maintain self-service access to Power BI dashboards to review and analyze their results.

Analysis of Improvement Over Time

LRE analyzes survey results year-over-year to identify trends in member experience and assess whether quality improvement activities are associated with positive change. Survey domain scores and qualitative themes are compared across fiscal years to determine areas of improvement, stability, or decline. When improvements are observed, LRE documents and shares effective practices across the region; when declines or concerns are identified, LRE works with Member CMHSPs to identify contributing factors and develop targeted improvement strategies. These analyses are reviewed by the Customer Satisfaction ROAT, QI ROAT, and Community Advisory Panel to ensure that member voice directly informs regional quality improvement priorities.

LRE supplements Survey data with qualitative feedback. The Community Advisory Panel, which consists of consumer representatives from each Member CMHSP, reviews Survey findings and provides qualitative interpretation and recommendations to inform service improvements and system-level priorities.

LRE also identifies and responds to sources of dissatisfaction through its Customer Services function. Customer Services staff review and respond to all complaints, concerns, and requests for assistance within four (4) business days, regardless of how concerns are received. LRE maintains an online feedback submission option on its public website, allowing individuals, families, and community members to report concerns at any time. Trends in complaints and service concerns are reviewed through the Customer Services ROAT and QI ROAT to determine whether systemic issues require follow-up or broader quality improvement action.

B. Notices, Grievances, and Appeals Compliance

LRE remains committed to ensuring that all Notices of Adverse Benefit Determination (NABDs), provider grievances, and appeals comply with MDHHS standards and policy. Building on HSAG's FY24 review and recommendations, LRE continues implementation of the FY25 PIP into FY26, focusing on NABD quality and compliance.

LRE will continue NABD audits (sampled from the state report) and conduct annual grievance/appeals audits (sustained high performance), issuing Corrective Action Plans (CAPs) for any deficiency and validating remediation.

To improve the clarity and accessibility of NABDs, LRE coordinates quarterly region-wide training while each CMHSP provides individualized training as needed. The NABD Workgroup maintains supportive resources (guidance for NABD development, crosswalk tools, legal citation references, and terminology guidance for grade-level readability). LRE is collaborating with PCE Systems to incorporate an on-screen reading grade-level aid within NABD templates. In FY26, LRE will also add one new audit metric item (as identified by the workgroup) to tighten plain-language content and required elements; the standard CAP trigger of "any miss" remains in place.

The LRE conducts NABD audits at the CMHSP level, using samples from the state report. Corrective Action Plans (CAPs) are issued for any noncompliance, with a target of 100% compliance on the following standards:

- 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

LRE also monitors provider 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.

VIII. Oversight Of Provider Network

A. Provider Qualifications:

Credentialing and Recredentialing

LRE ensures that services are delivered by qualified providers who are properly credentialed in accordance with LRE Policy #4.4: *Credentialing and Recredentialing* to ensure compliance with 42 CFR 438.214 and the LRE/MDHHS Master Agreement.

Organizations must complete a credentialing application and provide required documentation including state licenses, insurance certificates, accreditation certificates, and disclosure of ownership and controlling interest statements, as applicable. LRE also performs OIG, SAM, and MDHHS checks to ensure organizations are not excluded from doing business with LRE or its Member CMHSPs. Since January 2025, organizational credentialing has been completed within the online MDHHS

Universal Credentialing system.

For individual practitioners, LRE manages and monitors credentialing and recredentialing. Credentialing for CMHSP-employed or contracted staff is delegated to Member CMHSPs, with oversight provided in two ways:

1) **Reporting:** Each CMHSP submits quarterly credentialing/recredentialing data, which LRE aggregates, validates, and submits to MDHHS. LRE staff present data analysis quarterly to the QIC.
2) **Auditing:** During Site Reviews, LRE audits a sample of credentialed staff to confirm compliance. If gaps are identified, LRE assigns a corrective action plan and reports findings to the Executive Team, CMHSP leadership, QI ROAT, and other ROATs as appropriate. The annual Site Reviews also provide an opportunity to have discussions with and interact with the CMHSP staff who do the actual credentialing. These discussions also open the door for instruction and correction for any items that have been identified in regulatory audits as well.

Since FY2024, LRE has incorporated quality measures into recredentialing through regular sharing of information at LRE Credentialing Committee Meetings regarding grievances and appeals, survey results, performance indicator compliance, site review findings, and trends in critical or sentinel events. This ensures that the committee is aware of any provider-related issues identified through these processes and can consider them as part of organizational recredentialing reviews. In FY2025, LRE revised the Credentialing Committee Charter to ensure compliance with regulations regarding conflict of interest.

LRE and its Member CMHSPs have fully implemented MDHHS's Universal Credentialing Module in the CRM as of March 2025, with training provided in December 2024.

To reduce administrative burden and improve data consistency across CMHSPs, LRE is exploring opportunities to streamline provider data and credentialing processes. Variations in how provider information, insurance documentation, and credentialing data are managed create challenges for regional reporting and oversight. During FY2026, LRE will assess options for greater standardization and shared data processes to improve accuracy and efficiency while maintaining local flexibility.

FY2026 Credentialing and Recredentialing Improvement Plan

In FY2025, HSAG's Compliance Review identified opportunities for improvement under 42 CFR 438.214 ("Provider Selection") related to documentation of primary source verification and the consistency of credentialing processes among Member CMHSPs. Accordingly, for FY2026, LRE has implemented a Credentialing Improvement Plan focused on providing targeted technical-assistance sessions and refresher training for CMHSP credentialing staff based on FY2025 audit findings.

These actions are intended to resolve the HSAG corrective action findings, improve consistency in credentialing documentation, and strengthen LRE's oversight of delegated functions through data-driven monitoring and standardized validation processes.

Staff Training and Development

LRE and its Member CMHSPs ensure that consumers are served by staff with the training, competencies, and qualifications required by contract, policy, and regulation. While materials and processes are developed regionally to ensure compliance, Member CMHSPs establish local procedures to implement them.

Each CMHSP is responsible for monitoring staff training needs and providing in-service training, continuing education, and professional development. LRE maintains a regional Training Workgroup which assists in developing standards to support reciprocity and efficiency across the region.

In FY2025, the LRE Provider Network ROAT completed a comprehensive review and revision of the Regional Provider Common Contract Boilerplate, resulting in substantial updates to Exhibit A – Training Requirements. The updated Exhibit aligns regional staff training standards with current state and federal requirements, integrates cross-references to MDHHS contract provisions and Administrative Rules, and provides greater clarity on timelines, applicability, and methods of compliance for all provider types.

CMHSP and Substance Use Disorder (SUD) Site Reviews confirm compliance with (where applicable):

1) Educational background
2) Relevant work experience
3) Required certifications, registrations, and licenses
4) Criminal background, conviction, and SOR checks
5) Sanctions checks
6) Population-specific qualifications
7) Completion of general and specialized trainings
8) Orientation and training of new personnel on responsibilities, program policies, and staff development activities

B. Provider Monitoring and Follow-Up

LRE maintains oversight of its provider network through annual CMHSP Site Reviews and ongoing monitoring activities to ensure compliance with federal, state, and regional requirements. Reviews use a systematic and comprehensive process to monitor, benchmark, and improve the quality of mental health and substance use disorder services.

Reviews assess CMHSPs' and external providers' compliance with:

- Federal regulations, state requirements, and regional policies

- Contractual obligations
- Delegated managed care functions
- Clinical documentation standards

Through this process, LRE is able to:

- Establish clinical and non-clinical priorities for improvement
- Analyze service delivery and quality of care using audit tools
- Develop performance goals and compare results to past performance
- Provide feedback through exit conferences and written reports
- Conduct targeted monitoring of vulnerable populations as defined by MDHHS
- Require corrective action plans (CAPs) for deficiencies
- Monitor remediation of CAPs
- Identify systemic or regional issues and implement improvement plans

MDHHS Waiver Site Reviews: LRE also participates in site reviews conducted by MDHHS. When findings are issued, LRE distributes the CAP report to all relevant stakeholders. Each Member CMHSP is responsible for drafting CAPs to address citations. LRE ensures corrective actions are implemented and may consult Workgroups or ROATs to address systemic concerns identified by MDHHS reviewers.

External Quality Reviews (EQRs): Under the Balanced Budget Act of 1997, LRE participates in External Quality Reviews conducted by the Health Services Advisory Group (HSAG). EQRs evaluate the quality, timeliness, and access to care and provide MDHHS and LRE with information to:

- Assess service quality, timeliness, and access
- Identify and monitor system-level quality improvement interventions
- Evaluate one of LRE's two performance improvement projects
- Plan activities to sustain and enhance performance

Facility Reviews: LRE conducts annual Facility Reviews of all contracted external providers in its catchment area. These reviews ensure compliance with:

- General health and safety standards
- Emergency procedures
- Medication management
- Resident funds management
- Policies and procedures
- HCBS Final Rule requirements
- Review for ADA accommodations

Miscellaneous Site Reviews: LRE also conducts annual Site Reviews for:

- Crisis residential providers
- Inpatient providers
- SUD treatment providers

LRE site review with Member CMHSPs also includes oversight of Fiscal Intermediaries and agencies serving the Self-Determined population to ensure compliance with all relevant requirements.

For all reviews, LRE collaborates with providers to develop CAPs for non-compliant findings and assists with remediation. Aggregate review data is used to identify provider training needs and tools to improve service quality and delivery.

Oversight and Compliance Monitoring

The LRE Compliance Officer and Provider Network Manager share responsibility for ensuring contract compliance and issuing formal notices of noncompliance when deficiencies are identified. In addition to the annual Site Review process, LRE monitors ongoing provider compliance throughout the year. When a compliance issue is identified outside of the annual Site Review, the Provider Network Manager, working in coordination with the Compliance Officer and other subject matter experts, issues a formal notice of contract noncompliance and requests a root cause analysis and corrective action plan.

LRE then monitors the implementation and completion of corrective actions to ensure sustained compliance. This process is governed by LRE Policy and Procedure #4.9: Corrective Action Plan and #4.9a: Corrective Action Plan Procedure, which establishes standards for identifying, documenting, and resolving provider noncompliance, including defined timelines, documentation requirements, and escalation procedures.

C. Provider Network Adequacy

LRE evaluates the adequacy and accessibility of its provider network in accordance with 42 CFR 438.68, 438.207, and the MDHHS Network Adequacy Standards for Medicaid Specialty Behavioral Health Services. These standards define requirements for provider-to-enrollee ratios, time and distance benchmarks, service capacity, and timeliness of care across both behavioral health and substance use disorder (SUD) services.

Annual Provider Network Adequacy Reporting (PNAR)

LRE submits the MDHHS Provider Network Adequacy Report (PNAR) template annually, as required under the PIHP–MDHHS Master Contract (Schedule E). Historically, PIHPs entered their own network data and calculated adequacy outcomes directly within the PNAR template.

Beginning in FY 2025, MDHHS implemented a major procedural change: PIHPs now submit network data, and MDHHS performs the adequacy calculations and returns the

results to each region. While this change aims to improve statewide consistency, it has introduced new challenges for validation and accountability.

The state-calculated PNAR outcomes have, in several instances, reflected methodological and data alignment issues that produce results inconsistent with LRE's internal data calculations. These discrepancies include:

- Population denominator errors, where children are included in adult-only service calculations such as Opioid Treatment Programs (OTPs), artificially inflating ratios and understating adequacy.
- Service aggregation errors, where adult and pediatric populations are combined for Crisis Residential Services, obscuring true regional capacity.
- Statistical reliability concerns related to timeliness metrics, where small denominator counts yield distorted percentages.

Because MDHHS controls the calculation process under this new model, LRE must rely on state-produced results that it has, in several cases, formally contested due to these methodological flaws.

Network Adequacy Plan

In addition to the PNAR, MDHHS requires PIHPs to maintain a Network Adequacy Plan that outlines strategies, timelines, and corrective actions for addressing network gaps or deficiencies. This plan is submitted to MDHHS only upon request, rather than on an annual basis.

Completion of the Network Adequacy Plan has proven challenging in recent fiscal years as LRE resources have been directed toward meeting the expanded PNAR data and reporting requirements and validating MDHHS-calculated results. The frequent methodological revisions made by MDHHS in FY2024 and FY2025, including updates to population definitions, service mapping, and template structures, have required LRE to rebuild its analytic tools annually, diverting staff effort from long-term planning toward compliance with shifting state specifications.

Current Network Status and Improvement Efforts

Despite these challenges, LRE continues to demonstrate strong network capacity in key service areas. FY2024 results indicated high adequacy in inpatient psychiatric (99 %) and Assertive Community Treatment (ACT) programs, while identifying ongoing statewide and regional shortages in pediatric crisis residential capacity. The region anticipates improvement in FY2026 adequacy measures for inpatient psychiatric treatment with the addition of Southridge Behavioral Hospital (96 adult/geriatric beds) and the 12-bed pediatric medical-psychiatric unit at Corewell Health Helen DeVos Children's Hospital.

To strengthen reliability and compliance, LRE is implementing several corrective and improvement strategies:

- Methodology Advocacy: Continued communication with MDHHS to resolve denominator and service alignment issues and to ensure that future calculations reflect accurate service populations.
- Network Adequacy Plan Development: Establishing a living Network Adequacy Plan framework that can be updated as validated data become available, ensuring readiness for MDHHS submission upon request.
- Integrated Monitoring Tools: Development of a regional network adequacy dashboard linking provider directory, credentialing, and encounter data to enable continuous oversight between reporting cycles.

LRE will continue to collaborate with MDHHS and regional partners to refine the PNAR process, advocate for methodological accuracy, and ensure that reported adequacy results accurately reflect the true capacity and accessibility of behavioral health services throughout the region.

D. Medicaid Services Verification

As required by MDHHS for all PIHPs, LRE submits an annual report, due December 31, covering the claims/encounters verification process for the prior fiscal year. The report describes the PIHP's Medicaid Services Verification methodology and summarizes the audit results, which contain the following required elements:

1. Population of providers,
2. Number of providers tested,
3. Number of providers put on corrective action plans,
4. Number of providers on corrective action for repeat/continuing issues,
5. Number of providers taken off corrective action plans,
6. Population of claims/encounters tested (units & dollar value),
7. Claims/Encounters tested (units & value), and
8. Invalid claims/encounters identified (units & dollar value).

LRE follows its written policy and procedure for monitoring and evaluating the claims/encounters submitted by its Member CMHSPs ensuring compliance with federal and state regulations as well as the MDHHS Medicaid Verification Process technical requirements.[2]

LRE's policy and procedure consider conflicts of interest, validation of

[2] Behavioral Health and Developmental Disabilities Administration, Medicaid Services Verification, Updated July 29, 2020.

claims/encounters data, sampling methodology, audit criteria, review and reporting standards, recoupment procedures, corrective action plan procedures, and documentation standards, as required by the MDHHS Medicaid Verification Process technical requirements.

LRE conducts its Medicaid Services Verification audits quarterly across all service types.

LRE's dedicated staff conducts all Medicaid Services Verification audits to verify that adjudicated claims for services rendered are sufficiently supported by clinical documentation.

LRE's workplan for Oversight of Provider Network can be found here.

IX. Acronyms

BBA – Balanced Budget Act
BHCS - Behavioral Health Core Set
BTC – Behavior Treatment Committee
BTP – Behavior Treatment Plan
CAP – Corrective Action Plan
CEO – Chief Executive Officer
CIRE – Critical Incidents & Risk Events
CMHSP – Community Mental Health Service Program
CMS – Centers for Medicare and Medicaid Services
COO – Chief Operations Officer
CPG – Clinical Practice Guideline
CRM – Customer Relationship Management
CS – Customer Satisfaction
EQR – External Quality Review / External Quality Review Organization
FUH - Follow up to Hospitalization
HSAG – Health Services Advisory Group
HCBS – Home and Community-Based Services
HIPAA – Health Insurance Portability and Accountability Act
HMP – Healthy Michigan Plan
ICO – Integrated Care Organization
I/DD – Intellectual/Developmental Disability
IPOS – Individual Plan of Service
KPI – Key Performance Indicator
LOCUS – Level of Care Utilization System
LTSS – Long-Term Services and Supports
LRE – Lakeshore Regional Entity
MDHHS – Michigan Department of Health and Human Services
MHP – Medicaid Health Plan
MI – Mental Illness
MHSIP – Mental Health Statistics Improvement Program Adult Consumer Experience of Care Survey
MMBPIS – Michigan Mission Based Performance Indicator System
PCP – Person-Centered Planning
PIHP – Prepaid Inpatient Health Plan
PIP – Performance Improvement Project
QAPIP – Quality Assessment and Performance Improvement Plan
QIC – Quality Improvement Council
QI – Quality Improvement
ROAT – Regional Operations Advisory Team Survey
CSS– Customer Satisfaction Survey
UM – Utilization Management
YSS-F – Youth/Family Services Survey for Families Experience of Care Survey

Attachment A: LRE QAPIP Workplan FY26

Performance Measurement					
Goal	Activities		Measurement of Successes	Start/Frequency/Due Dates	Responsible
Organizational Structure and Leadership					
Comply with MDHHS and Board requirements for Quality Improvement related activities.	Complete and submit a Board approved QAPIP Plan, Evaluation and Workplan	– Collaborate with Member CMHSPs, ROAT teams, and committees to complete an annual effectiveness review with recommendations to be incorporated into the QAPIP Evaluation. – Collaborate with workgroups/ROATs to develop regional QAPIP workplan. – Review/revise QAPIP Plan to include new regulations. – Submit to MDHHS via FTP site.	Board of Director Meeting Minutes Confirmation of submission to FTP	2/28/2025	Lead Staff: COO Lead ROAT: QI
	Provide and/or make available to consumers & stakeholders, including providers & general public, the QAPIP Report, QAPIP Plan and other quality reports.	Distribute the completed Board approved QAPIP Effectiveness Review (Report) and QAPIP Plan to Member CMHSPs, provider network, workgroups and ROAT teams, and general public through email, website posts, distribution at LRE meetings, and upon request.	Proof	Ongoing	Lead Staff: COO Lead ROAT: QI
Goal	Activities		Measurement of Successes	Start/Frequency/Due Dates	Responsible
Performance Indicators (MMBPIS and CMS BHCS)					
Achieve MMPBIS 62% Standards for Indicator 2a	LRE will meet and maintain the performance standards as set by the MDHHS/PIHP Contract for Indications **2a** (a-d) (biopsychosocial assessment w/in 14 days request for non-emergent)	Implement and monitor Plans of Correction (POCs) for any CMHSP not meeting the 62% MDHHS standard for Indicators 2a for all subpopulations (a-d). QI ROAT will review MMBPIS Indicator 2a data quarterly to track compliance, identify trends, and coordinate communication with Clinical and Utilization Management ROATs as needed. The MMBPIS Workgroup will review data quarterly prior to submission, assess barriers to performance, support	Decrease % of 2a out of compliance/exceptions for following codes: Client No Show, System Issue, and Documentation Issue Proof of Plans of	Ongoing; Quarterly	Lead ROAT: QI Lead Staff: Deb Fiedler Data reviewed and monitored by: – MMBPIS Workgroup – Clinical

		local improvement efforts, and develop or refine regional strategies. Effectiveness of interventions will be monitored and reported through QI ROAT.	Correction for each instance of CMHSPs not meeting compliance standards.		
Baselines established and documented for CMS BHCS Year 1 and Year 2 measures.	Implement and monitor CMS BHCS Year 1 and Year 2 measures in alignment with MDHHS guidance.	QI ROAT will review data for all Year 1 and Year 2 measures, establish baseline performance levels, identify priorities for improvement, and collaborate with Clinical, Utilization Management, and IT ROATs to address barriers and monitor the effectiveness of interventions.	Quarterly reports reflect ongoing review, identified barriers, and improvement actions	March 2026 Quarterly	Lead ROAT: QI Lead Staff: Deb Fiedler Review & Monitor: Clinical ROAT (ADD, APM, APP, SAA) UM ROAT (FUH, FUM) SUD ROAT (IET, FUH SUD, OUD)
	Enhance data visualization and reporting capabilities to support ongoing BHCS monitoring.	IT ROAT to develop and maintain Power BI dashboards for Year 1 and Year 2 BHCS measures, including: – Workgroup to clarify technical specifications for HEDIS measures and dashboard design - Add **HPCMI** data measure to CC360 KPI dashboards (all other Year 1 & 2 measures already included). - Enhance **ZTS HEDIS** dashboard for more up-to-date reporting of CMS Core measures. - Work with CMHSPs to automate data feeds and reduce manual processes for FUH30 data to improve data accuracy and refresh timeliness	New dashboards operational and accessible to CMHSPs; documented use in QI ROAT and QIC meetings.	Quarterly	Lead ROAT: IT Lead Staff: Jordan
Goal	Activities		Measurement of Successes	Start/Frequency/Due Dates	Responsible
Performance Improvement Projects					
PIP 1: By the end of CY 2026, LRE will eliminate the statistically significant disparity in FUH 30 follow-up rates between AA/Black &	Coordinate regional improvement planning	– QI ROAT will coordinate with Clinical and UM ROAT groups to explore root causes to inform improvement and monitoring. If new PIP is required, QI will develop PIP and coordinate with other ROAT groups as necessary to inform root cause analysis, local improvement efforts, develop regional improvement strategies, and monitor effectiveness of interventions. – Explore convening and expansion of the PIP workgroup for additional coordinated discussion with CMHSP representatives as necessary.	Completed PIP Report submitted in July 2026. Proof of monitoring though QI ROAT minutes.	July 2026 Quarterly Annually in July for previous calendar year.	Lead ROAT: QI Lead Staff: Kori Bissot, KWB Strategies Monitored by: – Clinical ROAT – UM ROAT – PIP Workgroup

white individuals (age 6+), while maintaining the white populations 2021 baseline		– LRE will work with the five CMHSP's and MHP's within Region 3 to implement agreed upon interventions.			
PIP 2: By the end of CY 2026, the LRE will achieve a statistically significant increase in FUH 30 follow up rates for individuals (age 6+), compared to the 2021 baseline.	Coordinate regional improvement planning	– QI ROAT will coordinate with Clinical and UM ROAT groups to explore root causes to inform improvement and monitoring. If new PIP is required, QI will develop PIP and coordinate with other ROAT groups as necessary to inform root cause analysis, local improvement efforts, develop regional improvement strategies, and monitor effectiveness of interventions. – Explore convening and expansion of PIP workgroup for additional coordinated discussion with CMHSP representatives as necessary. – LRE will work with the five CMHSP's and MHP's within Region 3 to implement agreed upon interventions.	Completed PIP Report submitted Proof of monitoring though QI ROAT minutes.	Feb 2027 Quarterly Annually in July for previous calendar year.	Lead ROAT: QI Lead LRE Staff: Kori Bissot, KWB Strategies Monitored By: – Clinical ROAT – UM ROAT – PIP Workgroup
Event Reporting & Notifications					
Goal	Activities		Measurement of Successes	Start/Frequency/ Due Dates	Responsible
Event Reporting					
100% of critical incidents, risk events, sentinel events, unexpected deaths, SUD sentinel events, and immediately reportable events will be reported, reviewed, and	Event Data Collection, Analysis, and Reporting	Collect, aggregate, and analyze all event data (critical incidents, risk events, sentinel events, unexpected deaths, IREs)	Timely submission and accurate reporting in CRM; Quarterly analysis completed	Monthly / Quarterly	Lead ROAT: QI Led Staff: Deb Fiedler and Sandy Stanko Aggregate data reviewed and monitored by: – Operations Advisory Council – Sentinel Events Workgroup – UM ROAT – Clinical ROAT
		Submit required event reports (Critical Incidents, Risk Events, Mortality, etc.) to MDHHS per contractual timelines	Reports submitted within required timeframes	Monthly / Quarterly	
		Provide findings and trend reports to QI ROAT and Operations Advisory Council to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.	Reports and meeting minutes documenting review	Quarterly / Annually	
	Continuous Improvement and	Implement event-reporting enhancements: publish a Sentinel/Critical/IRE dashboard; revise reporting forms;	Power BI dashboard update finished	Ongoing	

remediated in compliance with MDHHS and contractual requirements.	System Enhancement	issue clear completion instructions; and run a submitter workgroup to validate usability and address issues.			
		Review sentinel events, unexpected deaths, and SUD sentinel events through the CIRE Workgroup; validate remediation	RCA completion and verified corrective actions	Monthly	
		Implement MDHHS revised event reporting requirements and provide training and technical support to CMHSPs	Successful adoption and compliance with new reporting process	As needed / FY2025–FY2026 transition period	
Clinical Quality Standards					
Goal	Activities		Measurement of Successes	Start/Frequency/Due Dates	Responsible
Utilization Management					
Decrease the number of corrective action plans from prior fiscal year for Member CMHSPs during site reviews related to UM compliance.	Ensure appropriate utilization of higher levels of care (HLOC), inpatient, and crisis residential services through consistent UM auditing and analysis.	Conduct quarterly UM audits to monitor over- and under-utilization.	Conduct quarterly UM audits to monitor over- and under-utilization.	Quarterly	Lead ROAT: UM Lead Staff: Tom Rocheleau Monitored by: - UM ROAT - QI ROAT - Clinical ROAT
		Use UM audit data and Power BI dashboards to identify trends and opportunities for improved authorization and utilization practices.	Use UM audit data and Power BI dashboards to identify trends and opportunities for improved authorization and utilization practices.	Quarterly	
		Share findings and recommendations with UM ROAT, QIC, and Clinical ROAT for action planning.	Share findings and recommendations with UM ROAT, QIC, and Clinical ROAT for action planning.	Quarterly	
	Strengthen utilization management through enhanced data analytics and real-time monitoring.	Finalize and launch the LOCUS-based Core Service Menu system with integrated dashboards and validated LIDS audit tool to enable real-time identification and review of potential overutilization across CMHSPs that provides enhanced insight.	LOCUS-based Core Service Menu system operational by January 2026.	January 2026	

Goal	Activities		Measurement of Successes	Start/Frequency/Due Dates	Responsible
Practice Guidelines					
Comply with 100% of CPG requirements as evidenced by HSAG compliance review.	Regional Review and Endorsement of Clinical Practice Guidelines	Review and discuss Clinical Practice Guidelines (CPGs) in collaboration with Member CMHSPs through the Clinical ROAT and UM ROAT, biannually at a minimum as required by HSAG. Endorse and adopt new clinical practice guidelines when appropriate.	Documentation of adoption in ROAT meeting minutes; updated list of endorsed guidelines	Biannually (when new or updated guidelines are released)	Lead Staff: Dr. Scott Monteith Review by: – UM ROAT – Clinical ROAT – Provider Network ROAT
		Disseminate CPGs via LRE's website and newsletter at least annually	Evidence of postings on website; newsletter distribution logs	Ongoing / Annually (minimum)	
	Implementation, Reliability, and Monitoring of CPG Application	Implement and maintain the Inter-Rater Reliability Process to ensure consistent application of CPGs	Completed Inter-Rater Reliability reviews; update process as needed	Ongoing; reviewed annually	
		Review Audit Summary results with QIC, Clinical ROAT, and UM ROAT	Meeting minutes documenting review; tracking follow-up actions	Quarterly	
		Monitor adherence to CPGs during CMHSP Site Reviews	Site Review reports noting adherence or non-compliance findings	Annually	
		Issue and track Corrective Action Plans (CAPs) when non-compliance with CPGs is identified	CAPs issued and tracked thru remediation; validation of compliance closure	As needed (upon identification of non-compliance)	
Goal	Activities		Measurement of Success	Start/Frequency/Due Dates	Responsible
Long Term Services and Supports					
Increase % of clients receiving LTSS services surveyed who report satisfaction, compared to	Conduct targeted analysis of Long-Term Supports and Services (LTSS) quality and compliance through multiple mechanisms,	Conduct separate Customer Services ROAT analysis and review of satisfaction surveys results for the LTSS population using MHSIP and YSS measures	Meeting minutes and analysis reports reflecting LTSS-specific review	Annually	Lead Staff: Stephanie VDK Lead ROAT: UM Monitored By: 1. UM ROAT 2. Clinical ROAT
		Apply sampling methodology during CMHSP Site Reviews and use the Clinical Chart Audit Tool to evaluate Person-Centered Planning (PCP) and Service Delivery for LTSS consumers	Documented sampling process; audit reports showing representative coverage	Annually (per Site Review cycle)	

prior fiscal year.	including:	Ensure appropriate assessments are completed at admission, annually, and upon significant change	Power BI dashboards showing assessment completion rates; CMHSP compliance monitoring	Ongoing	3. QI ROAT
	Monitor provider compliance with HCBS Final Rule and health/safety requirements by:	Conduct Facility Reviews and HCBS Physical Assessments across residential, autism, supported employment, and skill building providers	Completed review tools; reports of HCBS compliance	Annually	
		Audit IPOSs when modifications or restrictions are identified to confirm HCBS Final Rule and MDHHS compliance	Documentation of IPOS audits; corrective actions tracked and resolved	As needed	
		Enhance the Power BI dashboard to include longitudinal tracking of audit performance for residential facility site reviews	Dashboard enhancement complete	As needed	Lead ROAT: IT Lead Staff: Jordan
	Monitor risk, critical, and sentinel events specific to individuals receiving LTSS to identify potential system-level concerns.	Annual QI ROAT review of risk events, critical events and sentinel event data specific to LTSS by QI ROAT to identify any areas of concern; if identified increase to quarterly review until resolved.	Meeting minutes and analysis reports reflecting LTSS-specific review	Annually	Lead Staff: Stephanie VDK Lead ROAT: QI
Goal	Activities		Measurement of Successes	Start/Frequency/Due Dates	Responsible
Behavior Treatment Plan Review					
95%+ compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period.	Monitor to ensure only techniques permitted by the Technical Requirement for Behavior Treatment Plans and have been approved during person-centered planning by the member or their guardian will be	LRE QI staff will ensure CMHSP's submit physical management data for every instance of physical management used in an emergency behavioral health crisis to the LRE, that includes the number of interventions used and length of time for each intervention per individual. Monitored during site visits.	All CMHSPs submit complete data sets; data verified during Site Reviews.	Quarterly / During Site Reviews	Lead ROAT: QI ROAT Lead Staff: Lynne Doyle Monitored by: – Behavior Treatment Committee (BTC) – Clinical ROAT
		LRE QI staff will compile and analyze aggregate physical management data quarterly to identify trends, issues, and opportunities for improvement where: – intrusive or restrictive techniques have been approved for use with members and	Quarterly analysis completed; trends and improvement actions documented.	Quarterly	

	used with members.	– where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis. – Maintain Power BI CIRE dashboard			
		Behavior Treatment Committee will: – Review findings of quarterly data analysis – Analyze individual cases to understand contributing factors and – Coordinate with LRE Clinical Staff to elevate issues to the Clinical ROAT when appropriate.	Committee minutes reflect case review and identified action steps.	As needed	
		The QI ROAT will review findings of the quarterly data analysis to identify regional trends and system-level quality improvement opportunities.	Issues elevated to Clinical ROAT and tracked to resolution.	Quarterly	
Member Experience					
Goal	Activities		Measurement of Successes	Start/Frequency/Due	Responsible
Member Experience with Services					
80%+ of consumers indicate satisfaction with services: – SUD – children and/or families w/ mental health services. – Adults w/ mental health services. – long term supports and services	Ensure annual, representative assessment of consumer satisfaction across all populations, including LTSS consumers.	Require Member CMHSPs to deploy the Regional Customer Satisfaction Survey annually using the MHSIP and YSS-F tools. Monitor deployment for representativeness and compliance during CMHSP Site Reviews.	100% of CMHSPs deploy surveys as required; corrective action plans issued and remediated as needed	Annually	Lead Staff: Michelle Anguiano Lead ROAT: Customer Services Data reviewed by: – Customer Satisfaction Workgroup – Clinical ROAT – UM ROAT – Board of Directors
	Analyze and review survey results to identify trends & improvement opportunities,	Prepare and publish an annual regional satisfaction report; post to website, share with Governing Board, and review with Community Advisory Panel.	Annual report published and disseminated	Annually	
		Review regional results and solicit feedback through QIC, QI ROAT, Customer Satisfaction ROAT, Community Advisory Panel, and the Governing Board.	Meetings held with documented review	Annually	
		Maintain Power BI dashboards to support regional and CMHSP-level analysis of satisfaction data and monitor year-over-year trends.	Trend analysis completed and incorporated into the annual report.	Annually	
	Prepare for integration of new CMS Behavioral	Evaluate MDHHS guidance and determine approach for incorporating new patient experience and HCBS measures into regional survey process.	Implementation plan developed and documented prior to	FY26–FY27	

	Health Core Set patient experience and HCBS measures.		MDHHS rollout of Year 3 measures.		
Notices, Grievance and Appeals Compliance					
-95%+ of Medicaid appeals resolved in compliance with state and federal timeliness standards, incl. written disposition letter (30 calendar days) of a standard request for appeal. -95%+ of Medicaid grievances resolved with a written disposition sent to the consumer w/in 90 calendar days of request	Ensure NABDs meet MDHHS standards for accuracy, clarity, and accessibility.	Conduct region-wide NABD trainings quarterly; support CMHSPs in providing individualized training to staff.	Trainings completed; improved compliance in NABD audits.	Quarterly	Lead Staff: Michelle Anguiano Lead ROAT: Customer Services When action is required, members will work with their CMHSP to address issues.
		Develop and maintain NABD tools and resources (guidance sheets, crosswalks, legal citation reference, readability exclusions list).	Tools available regionwide; CMHSPs demonstrate use and understanding.	Ongoing/ Annual Review	
		Conduct quarterly NABD audits using state report samples; issue CAPs for compliance below 100% (e.g., professional tone, grammar, person-centered language, acronym clarity, reading level ≤6.9, guardianship documentation).	Quarterly audit results reflect 100% compliance or validated CAP closure.	Quarterly	
	Ensure grievances and appeals are managed in compliance with federal and state regulations.	Conduct annual grievance and appeal audits at each CMHSP. Issue and monitor CAPs for any findings of noncompliance.	CAPs implemented and validated within required timeframes.	Annually	Lead Staff: Michelle Anguiano Lead ROAT: CS Data reviewed by: – Community Advisory. Panel – QI ROAT

Oversight of Provider Network

Goal	Activities		Measurement of Successes	Start/Frequency/ Due Dates	Responsible
Provider Qualifications					
Maintain >95% compliance with requirement	Ensure all providers are properly credentialed,	Maintain organizational credentialing process, including application and verification of licenses, insurance, W-9/IRS letter, NPI, accreditation, bonding, and ownership disclosures. Conduct OIG,	Organizational credentialing is completed and validated for all providers.	Ongoing	Lead Staff: Pam Bronson Lead ROAT: Provider Network

for completion of credentialing and recredentialing within 90 calendar days of application submission. Maintain >95% compliance with requirement for recredentialing to occur at least every three years.	licensed, and qualified in accordance with LRE Policy #4.4 and MDHHS standards.	SAM, and MDHHS exclusion checks for all providers.			Credentialing Workgroup managing process/action. Data reviewed by: – QI ROAT receives quarterly credentialing report
		Oversee delegated credentialing at Member CMHSPs by collecting and aggregating quarterly credentialing/ recredentialing reports, validating data, and submitting to MDHHS.	Quarterly credentialing data submitted to MDHHS; validation and aggregation complete.	Quarterly	
		LRE Credentialing Staff will facilitate discussion with PN Managers for any identified trends and areas of concern. Staff will work with Providers and CMHSPs to develop improvement plans to address ongoing areas of concern when needed.	Meeting minutes reflect discussion	As needed	
		QI ROAT review credentialing data report to discuss trends and ID any areas of concern.	Meeting minutes reflect quarterly review and discussion of results.	Quarterly	
		Audit provider credentialing records during CMHSP Site Reviews; issue and monitor Corrective Action Plans (CAPs) for gaps.	Credentialing compliance verified during Site Reviews	As needed	
	Ensure all staff serving consumers meet training, competence, and qualification requirements.	Maintain regional Training Workgroup to set training standards and support reciprocity across CMHSPs.	Workgroup minutes and approved regional training standards.	Ongoing/ Annual review	Lead ROAT: Provider Network Lead Staff: Jim McCormick
		Require CMHSPs to establish local training procedures that align with regional standards.	CMHSP policies reviewed; compliance verified during Site Reviews.	Ongoing	
		Confirm during Site Reviews that staff meet qualification standards, including education, experience, licensure, background/SOR checks, population-specific training, and ongoing education.	Site Review results demonstrate staff meet qualification and training standards.	Annually	
		Audit completion of general and specialized trainings at CMHSP and SUD providers; review and validate corrective actions for training or qualification gaps.	CAPs implemented and remediated within required timeframe; staff training compliance achieved.	Annually/ As need	
		Monitor compliance with LRE Policy #4.2: Provider Network and Contract Management.	Compliance maintained with no outstanding corrective actions.	Ongoing/ Annual validation	
Provider Monitoring & Follow Up					
100% of CAPs issued during CMHSP Site Reviews will be	Comprehensive Site Review and Oversight	Conduct annual CMHSP Site Reviews covering regulatory requirements, contractual obligations, delegated managed care functions, and clinical documentation.	Annual Site Reviews completed; compliance documented; reports shared with CMHSPs.	Annually	Lead ROAT: Provider Network Lead Staff:

remediated & compliance validated at subsequent review.		Use audit tools to analyze service delivery, quality of care, and outcomes; identify systemic or regional issues for improvement.	Completed audit tools and summary reports; identified issues tracked to resolution.	Annually	Jim McCormick
		Provide feedback through exit conferences and written reports; require and approve Corrective Action Plans (CAPs) for deficiencies within 30 days.	CAPs issued and remediated; compliance validated at next Site Review.	Annually / As needed	
100% of CAPs issued during Targeted Specialized Monitoring will be remediated & compliance validated at subsequent review.	Targeted and Specialized Monitoring	Conduct targeted monitoring of vulnerable populations as defined by MDHHS.	Targeted reviews completed; findings documented.	Annually / As needed	
		Review Out-of-Region providers when consumers are currently or recently served and no reciprocal review exists.	Out-of-region Site Reviews completed as required.	As needed	
		Conduct desk audits (e.g., outpatient, home-based therapy, SUD treatment) using random sampling procedure.	Desk audits completed and documented; results incorporated into annual summary.	Annually	
Achieve an overall compliance score of >90% during the: – annual HSAG External Quality Review (EQR). – MDHHS Substance Use Disorder Site Visit	Support system-level improvement through external quality and facility reviews.	Participate in HSAG External Quality Reviews (EQRs); provide data and documentation to support evaluation of quality, timeliness, and access.	LRE participation documented; data submissions validated by HSAG.	Annually	
		Review and implement HSAG recommendations; use EQR findings to sustain and enhance performance.	EQR recommendations implemented; improvement tracked through QI ROAT.	Annually / Ongoing	
		Conduct annual Facility Reviews for all contracted external providers for compliance with health/safety, emergency procedures, medication management, resident funds, policies/procedures, and HCBS Final Rule.	Facility Reviews completed; CAPs implemented for any deficiencies.	Annually	
	Ensure specialized providers meet all compliance and quality standards.	Conduct annual Site Reviews of crisis residential, inpatient, and SUD treatment providers.	Reviews completed and reported; deficiencies addressed via CAPs.	Annually	
		Aggregate findings from all Site Reviews to identify provider training needs and develop resources to improve service quality and delivery.	Training documented in QI ROAT minutes.	Annually	
Provider Network Adequacy					
The Provider Network Adequacy report for FY26	Evaluate the adequacy and accessibility of the regional	Conduct annual provider network adequacy assessment covering enrollee-to-provider ratios, crisis residential bed availability, time and distance standards, ASAM Levels of Care, timely access,	Provider network adequacy report provided to QI ROAT and BOD annually.	Annually (Q1)	Lead ROAT: Provider Network

will show a decrease in substantial gaps in service availability.	provider network in accordance with MDHHS standards.	language and cultural competence, and physical accessibility.			Lead Staff: Jim McCormick
		Submit finalized Network Adequacy and Accessibility Report to MDHHS by the due date identified in Schedule E of the MDHHS–PIHP contract.	Report submitted to MDHHS by required deadline.	Annually	
		Review results with QIC and QI ROAT to identify and monitor improvement actions.	Meeting minutes reflect review and follow-up actions documented.	Annually / Ongoing	
	Ensure each Member CMHSP maintains an accurate and compliant provider directory.	Verify through Site Reviews that CMHSP provider directories meet MDHHS requirements and are updated to reflect current provider information.	All CMHSP directories meet compliance standards; corrective actions issued if gaps identified.	Annually / As needed	
Medicaid Service Verification					
Medicaid Event Verification review results in Medicaid Claims Accuracy of 95%+.	Verify that adjudicated claims and encounters are supported by appropriate clinical documentation and comply with MDHHS Medicaid Verification Process requirements.	Conduct quarterly Medicaid Services Verification audits across all service types to confirm claims are supported by documentation, using approved sampling methodology, audit criteria, and documentation standards. Identify invalid claims and initiate recoupment and corrective action procedures when necessary.	Quarterly audits completed; invalid claims identified and addressed; CAPs and recoupments resolved within required timelines.	Quarterly	Lead Staff: Jill Osterhout Lead ROAT: Compliance Data reviewed by: – QI ROAT
		Monitor and evaluate corrective action plans for providers with identified deficiencies, including tracking repeat or continuing issues.	Reduction in repeat CAPs; timely CAP remediation documented.	Quarterly/ Ongoing	
		Prepare and submit the annual Medicaid Services Verification Report by December 31 summarizing verification methodology, audit results, and all required elements.	Annual report submitted to MDHHS by deadline with all required elements.	Annually (by Dec. 31)	

Attachment B:

Governing Body Form

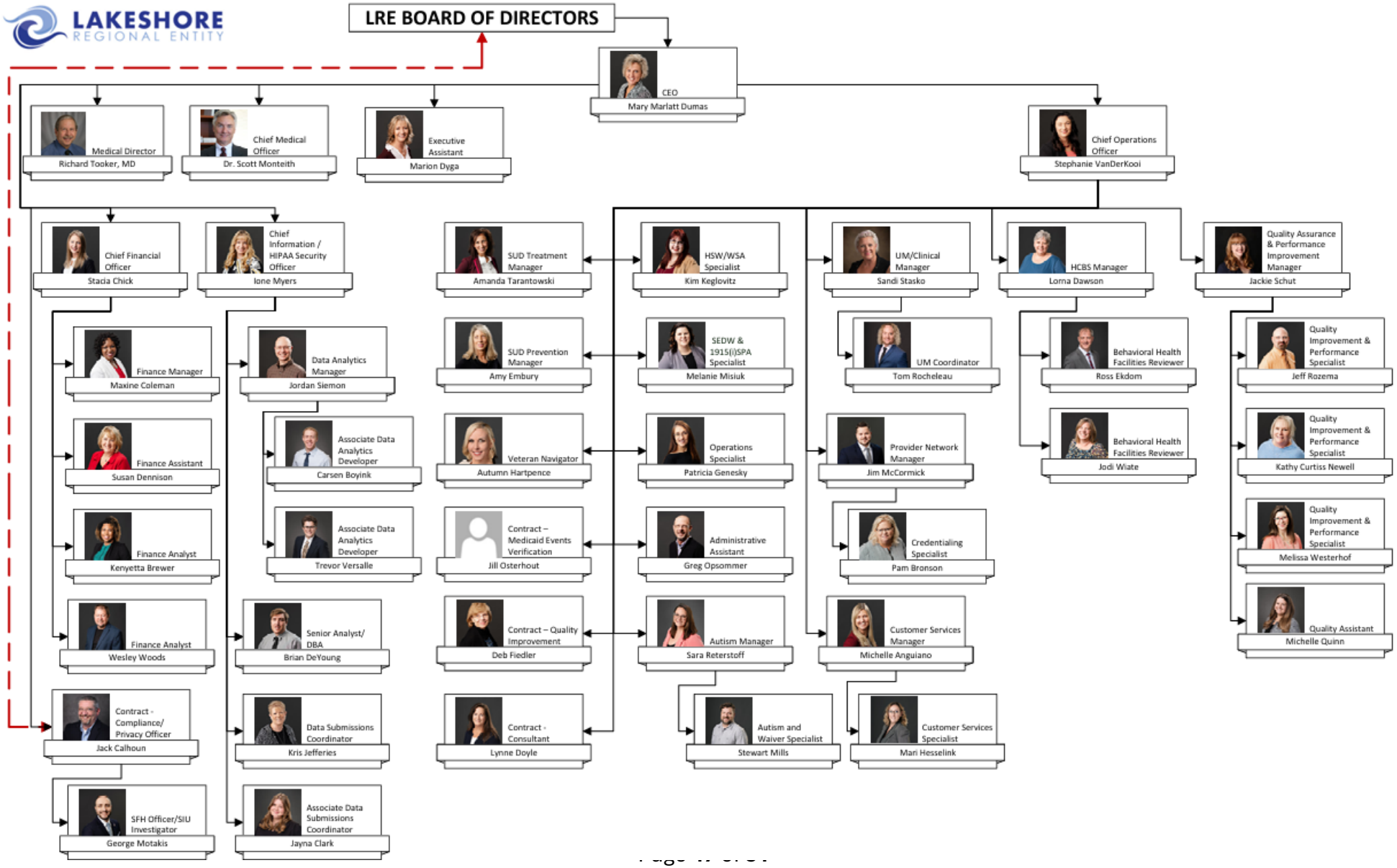
To be completed by the PIHP and submitted to MDHHS along with its annual QAPIP submission no later than February 28th of each year.

Name of PIHP		
Lakeshore Regional Entity		
Update: October 21, 2025		
Description of Change: 2025/2026 Update		
List of members of the Governing Body (add additional rows as needed)		
Name	**Credentials**	**Organization** (if applicable)
Jim Storey	LRE Board Member, Allegan County Commissioner, LRE OPB	OnPoint CMH (f/k/a Allegan CMH)
Alice Kelsey	LRE Board Member	OnPoint CMH (f/k/a Allegan CMH)
Pastor Craig Van Beek	LRE Board Member, Pastor	OnPoint CMH (f/k/a Allegan CMH)
Janet Thomas	LRE Board Vice-Chair, Lawyer, HW Board Chair	HealthWest
Janice Hileary	LRE Board Member, HealthWest Board	HealthWest
Patricia Gardner	LRE Board Chair, Kent County Judge	Network180
Stan Stek	LRE Board Member, Kent County Commissioner, N180 Board Member	Network180
Jon Campbell	LRE Board member, State Division Administrator LARA	Network180
Bob Davis	LRE Board Member, CMH Board Member	CMH of Ottawa County
Richard Kanten	LRE Board Member, LRE OPB, CMH Board Member	CMH of Ottawa County
Dave Parnin	LRE Board Member, LRE OPB	CMH of Ottawa County

Ron Bacon	LRE Board Secretary, WM CMH Board Member	West Michigan CMH
O'Nealya Gronstal	LRE Board Member	West Michigan CMH
Andrew Sebolt	LRE Board Member, MDHHS County Board, Veteran	West Michigan CMH
Changes to membership during the past year: **Board Members no longer on LRE Board:** Ron Sanders, **New Board Members in the past year:** O'Nealya Gronstal, Dave Parnin		
Date the Governing Body approved the annual QAPIP (prior SFY QAPIP evaluation, current SFY QAPIP description, and current SFY QAPIP work plan)*		
November 19, 2025		
Dates the Governing Body received routine written reports from the QAPIP (during the prior SFY; add additional rows as needed)*		
November 20, 2024		
February 26, 2025		
March 26, 2025		
August 27, 2025		
MDHHS Feedback		

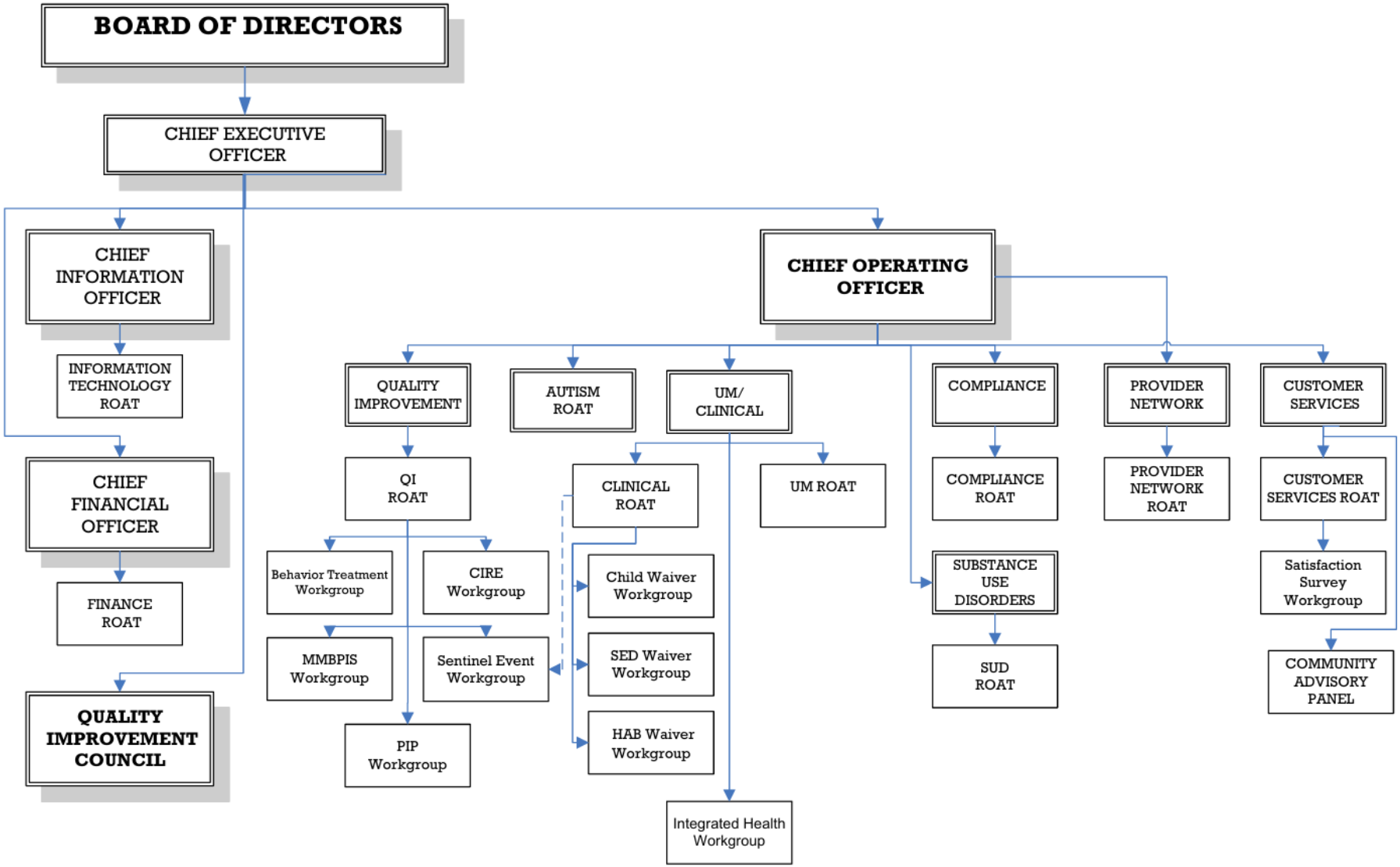
*The PIHP should be prepared to submit Governing Body meeting minutes and written reports to MDHHS upon request.

Attachment C: LRE Organizational Chart



Attachment D:

LAKESHORE REGIONAL ENTITY - QUALITY IMPROVEMENT PLAN
ROAT/WORKGROUP/COMMITTEE FLOW CHART



Attachment E: LRE Quality Improvement ROAT Charter

REGIONAL OPERATION ADVISORY TEAM CHARTER

NAME: QUALITY IMPROVEMENT ROAT
LRE DESIGNEE: CHIEF OPERATING OFFICER or DESIGNEE
ADOPTED: 2/14/2021
REVISED: 4/24/2025

This charter shall constitute the structure, operation, membership and responsibilities of Lakeshore Regional Entity (LRE) Quality Improvement Regional Operations Advisory Team (QI ROAT).

Purpose of the Quality Improvement Regional Operations Advisory Team: The Quality Improvement ROAT advises the Operations Council and the Chief Executive Officer concerning quality improvement matters..

Responsibilities and Duties: The responsibilities and duties of the QI ROAT are as follows:

- Review and provide feedback on the Quality Assessment and Performance Improvement Plan (QAPIP) and accompanying LRE policies and procedures.
- Recommend and monitor development of internal systems and controls to achieve QAPIP goals.
- Establish, review, and monitor quality metrics contained in the QAPIP and, if metrics do not meet compliance thresholds, determining next steps to promote compliance.
- Review the effectiveness of QAPIP.
- Develop valid and reliable data collection related to performance measures/indicators at the organizational/provider level.
- Identify organizational and regional opportunities for quality improvement.
- Determining the appropriate strategy/approach to promote compliance and detect potential violations and areas of risk as well as areas of focus.
- Review audit results and corrective action plans, making recommendations as appropriate.

Decision-Making Context and Scope:
General Decision-Making Process: Consensus shall be the primary mode of decision making and efforts shall be made to extend dialogue and gather information toward consensus to the extent possible.

Should consensus not be achieved, any QI ROAT Member may call for a vote of the QI ROAT Members. A vote of the QI ROAT Members is not binding on the LRE; rather it is used to further inform as to the strength of the ROAT Members' position on a subject. Any decision made subsequent to a vote of the QI ROAT Members, including any item referred to the LRE Chief Executive Officer, shall reflect both the majority and minority opinions. The CMHSP CEO/Executive Director appointed to the QI ROAT is responsible for reporting quality improvement activities and decisions to the Operations Advisory Council.

Goals:

1. The QI ROAT shall establish metrics and monitor criteria to evaluate progress on various quality improvement efforts related to Quality Reviews including but not limited to the LRE Site Reviews, LRE Facility Reviews, Health Services Advisory Group, and MDHHS Audits.
2. Implement the Quality Assessment and Performance Improvement Plan (QAPIP) and achieve QAPIP goals as required by MDHHS.

3. Assure compliance and oversight of QAPIP components and Quality Review standards and elements.
4. Additionally, the QI ROAT seeks to achieve the following secondary goals:
    a. Establish and retain collaborative relationships.
    b. Work collaboratively to determine expectations and achieve expected outcomes.
    c. Realize efficiency gains through standardization and performance improvement.
    d. Improve overall Regional quality performance.

Membership:
The LRE QI ROAT will be comprised of the LRE Chief Operating Officer and/or designee, one subject matter expert from each member CMHSP's Quality Improvement staff who is appointed by the respective CMHSP Chief Executive Officer/Executive Director, and one CMHSP Chief Executive Officer/Executive Director. All Member CMHSPs will be equally represented. The LRE QI ROAT will be chaired by the LRE Chief Operating Officer and/or designee.

a. There will be equal CMHSP representation and voting on all ROATs, workgroups and committees unless otherwise required by law.
b. Membership shall be representative of the LRE Region with each CMHSP having one vote.
c. CMHSP representatives become members of the committee through appointment by their respective CEO/Executive Director (ED) and approval by the LRE Operations Council.
d. Primary and/or secondary consumer(s) representing adults with mental illness, adults with developmental challenges, adults with a substance use disorder, parents/guardians of a child/children with mental illness, and/or parents/guardians of a child/children with developmental challenges, to be appointed through an application process.
e. Alternates may attend and speak with the power granted by their appointed CMHSP Executive Director. Alternates do not have a vote when it comes to decision making.
f. Others in attendance are by invitation only (not regularly attending), should have a clearly defined purpose for attendance, are not intended to offer commentary on other agenda topics, and shall be excused when they have completed their purpose for meeting attendance. Subject matter expert (SME) may be invited by the QI ROAT for a specific agenda topic and shall only participate during the related topic.

Membership Roles and Responsibilities:

a. LRE Chairperson/Facilitator – Prepares the agenda, facilitates the meeting and maintains order; provides guidance and direction, serves as the point of contact for the ROAT; serves as a conduit for other planning/action occurring at LRE, is accountable for representing the ROAT and making reports on behalf of the ROAT. Serves as the point of contact with the Operations Council. The chairperson/facilitator is a voting member of the ROAT.
b. LRE Recorder – Serves as the staff support to the ROAT. Captures discussions, problem solving and planning of the committee in an unbiased manner and prepares minutes following each meeting.
c. Member – A participant appointed to the committee by the LRE or CMHSP Director who is selected based on content/process expertise/interest or customer/supplier representation.
d. Subject Matter Experts (SME's) –may participate in a ROAT meeting for the purpose of providing information, consultation, etc. Participation as a Subject Matter Expert does not constitute authority to participate in decision making. Subject matter experts should typically leave once their expressed purpose is complete.
e. CMHSP CEO/Executive Director – appointed by the Operations Committee to attend the ROAT meeting and serve as a liaison between the ROAT and the Operations Committee. Responsible for providing regular reports to the Operations Committee from the ROAT and communicating directives for work product to the ROAT from the Operations Committee. CEO/Executive Director is not a voting member of the ROAT.

Conduct: Membership of the ROAT seeks a meeting culture that is professional, productive, and collaborative. To that end, the following conduct rules have been adopted:

a. Respect of Others
   - Only one person speaks at a time; no one will interrupt while someone is speaking.
   - No sidebars or end-runs.
   - All persons will avoid grandstanding (i.e., extended comments/speaking), so that everyone has a fair chance to speak.
   - No personal attacks. "Challenge ideas, not people."
   - Everybody will seek to focus on the merits of what is being said, making a good faith effort to understand the concerns of others. Questions of clarification are encouraged. Disparaging comments are prohibited.
   - Each person will seek to identify options or proposals that represent shared interests, without minimizing legitimate disagreements. Each person agrees to do their best to take account of the interests of the group as a whole.

b. Meeting Efficiency
   - Members are prepared for the agenda content and have completed related assignments on time.
   - Everybody agrees to make a strong effort to stay on track with the agenda and to move the deliberations forward.
   - Members share equally in the work of the body.

<u>Meetings</u>:

a. Regular Meetings – Will normally occur monthly.
b. Special Meetings – Special meetings shall occur as determined by the consensus of the group and as the business of the body necessitates.
c. Attendance at Meetings – Members shall regularly attend or send a Designee (rarely) who is prepared to act on behalf of the Member.
d. Agenda – The Agenda shall be prepared by the LRE Chief Operating Officer and/or designee and shall be distributed or uploaded to a designated shared folder in advance of the meeting with related attachments, preferably one week prior to the meeting. To the extent possible the agenda should clarify the context and timing of a discussion to support the need for SMEs for meeting attendance.
e. Minutes of Proceedings – The recorder shall prepare a meeting summary that reflects key decisions and required actions to occur after the meeting. The required actions shall specify what, who, and by when. LRE Chief Operating Officer and/or designee will review the meeting summary and distribute or upload to a designated shared folder within one-week following the completed meeting. The required actions shall specify what, who, and by when.

Sources: LRE QAPIP,
LRE Corporate Compliance Plan,
LRE Policies