LAKESHORE REGIONAL ENTITY

Meeting Agenda
BOARD OF DIRECTORS
Lakeshore Regional Entity
July 26, 2023 – 1:00 PM
GVSU Muskegon Innovation Hub
200 Viridian Dr, Muskegon, MI 49440

1. Welcome and Introductions – Mr. Bacon
   Ms. Linda Garzelloni resignation.

2. Roll Call/Conflict of Interest Question – Mr. Bacon
3. Public Comment (Limited to agenda items only)
4. Consent Items:
   Suggested Motion: To approve by consent the following items.
   - July 26, 2023, Board of Directors meeting agenda *(Attachment 1)*
   - June 28, 2023, Board of Directors meeting minutes *(Attachment 2)*

5. Executive Committee Appointment
   Recommendation: James Storey, OnPoint
   Suggested Motion: To approve appointment of Mr. James Storey to the LRE Executive Committee.

6. LRE Board Chairperson and Vice Chairperson Discussion

7. Reports –
   a. LRE Leadership *(Attachment 3, 4, 5)*

8. Chairperson's Report – Mr. Bacon
   a. July 19, 2023, Executive Committee *(Attachment 6)*
   b. December Board Meeting Date Discussion

9. Closed Session
   Suggested Motion: To approve moving into closed session to discuss the LRE CEO Evaluation Goals

10. Action Items –
    i. CEO Evaluation Goals
       Suggested Motion: To approve LRE CEO annual evaluation goals for 2023.

    ii. CEO Evaluation Process *(Attachments 7, 8, 9)*

Suggested Motion: To approve the updated CEO Evaluation Tool and Process pending the addition of the CMH Directors and LRE Leadership questions being included in the final evaluation tool.

iii. LRE Motion 23-23 Amendment

Suggested Motion: To approve Resolution 23-23 is amended to permit the CMHs to hold the 20% of funds in a restricted account in the name of the CMH rather than via a third-party escrow agent. Resolution 23-23, including the circumstances under which the 20% of funds will be returned to the LRE or released to an unrestricted account, remain unaltered.

iv. LRE Utilization Management (UM) Plan *(Attachment 10)*

Suggested Motion: To approve LRE FY24 Utilization Management Plan as presented.

v. LRE Board Governance Policies Approval/Rescind *(Attachment 11, 12, 13, 14)*

Suggested Motion: To approve LRE Board Governance Policies

- 10.4 Board Governance
- 10.22 New Board Member Orientation
- 10.22a New Board Member Orientation Procedure
- 10.23 LRE Board Member Conduct and Board Meetings

Suggested Motion: To rescind LRE Board Governance Policies *(Attachment 15, 16, 17, 18, 19)*

- 10.2 Committees
- 10.5 Code of Conduct
- 10.12 Budget
- 10.13 Communication and Counsel
- 10.17 Management Delegation

11. Financial Report and Funding Distribution – Ms. Chick *(Attachment 20)*
    a. FY2023, June Funds Distribution *(Attachment 21)*

    Suggested Motion: To approve the FY2023, June Funds Distribution as presented.

    b. Statement of Activities as of 5/31/2023 with Variance Reports *(Attachment 22)*
    c. Monthly FSR (*Attachment 23)* –

12. CEO Report – Ms. Marlatt-Dumas
13. Board Member Comments
14. Public Comment
15. Upcoming LRE Meetings
    - August 16, 2023 – Executive Committee, 1:00PM
    - August 23, 2023 – LRE Executive Board Meeting, 1:00 PM
16. Adjourn

LAKESHORE REGIONAL ENTITY

Meeting Minutes
BOARD OF DIRECTORS
Lakeshore Regional Entity
June 28, 2023 – 1:00 PM
GVSU Muskegon Innovation Hub, 200 Viridian Dr, Muskegon, MI 49440

WELCOME AND INTRODUCTIONS – Ms. Garzelloni
Ms. Garzelloni called the June 28, 2023, LRE Board meeting to order at 1:02 PM.

Ms. Garzelloni announces that Mr. Mark DeYoung (Allegan County, OnPoint) has resigned from the LRE Board.

Ms. Garzelloni introduces Mr. Andrew Sebolt appointed by West Michigan CMH.

ROLL CALL/CONFLICT OF INTEREST QUESTION – Ms. Garzelloni
In Attendance: Ron Bacon, Jon Campbell, Linda Garzelloni, Jack Greenfield, Janice Hilleary, Sara Hogan, Alice Kelsey, Susan Meston, Ron Sanders, Andrew Sebolt, Stan Stek, Jim Storey, Ron Sanders

Absent: Richard Kanten, Janet Thomas

PUBLIC COMMENT
None.

CONSENT ITEMS:
LRE 23-24 Motion: To approve by consent the following items.

- June 28, 2023, Board of Directors meeting agenda
- May 24, 2023, Board of Directors meeting minutes

Moved: Ron Sanders Support: Ron Bacon
MOTION CARRIED

LRE 23-25 Motion: To approve to amend the agenda to move item 12 (LRE Board Member Conflict of Interest Discussion) up to item 6 and move the rest of the agenda items down 1 to accommodate.

Moved: Stan Stek Support: Susan Meston
MOTION CARRIED

CLOSED SESSION

LRE 23-26 Motion: To approve moving into closed session for the purpose of consulting with LRE attorney regarding MDHHS litigation.

Moved: Susan Meston Support: Ron Bacon
Roll Call
MOTION CARRIED

LRE 23-27 Motion: To approve moving out of closed session.

Moved: Stan Stek Support: Ron Bacon
Roll Call
MOTION CARRIED

The LRE Executive Committee will continue to review the information and come back to the Board with a recommendation.

LRE BOARD MEMBER CONFLICT OF INTEREST DISCUSSION

Mr. Motakis explains the allegations, which is followed by a discussion regarding a member of the LRE Board with a potential undisclosed conflict of interest and/or financial interest disclosure.

A motion was brought forth by Mr. Stek and seconded by Mr. Sanders. The motion reads as follows: To approve that the LRE is to provide all board members a list of all entities that LRE believes is encompassed by the financial interest rule and give all Board members 30 days in which to amend their financial disclosures as to whether or not they have any potential remediation from those entities and no further sanction against the party on the basis of the financial disclosure issue.

Mr. Storey comments that there are 2 distinct issues and suggests dividing the motion. The first item is to provide a list of entities that LRE does business with to allow Board members to verify any financial disclosures that should be made and the second about enforcement.

LRE 23-28 Motion: To approve a motion to divide the question brought forth by Mr. Stek and seconded by Mr. Sanders to consider separately: 1) To approve that the LRE is to provide all board members a list of all entities that LRE believes is encompassed by the financial interest rule and give all Board members 30 days in which to amend their financial disclosures as to whether or not they have any potential remediation from those entities and 2) no further sanction against the party on the basis of the financial disclosure issue

Moved: James Storey Support: Alice Kelsey
Roll Call
Ms. Garzelloni recuses herself from the vote.
Yes – 7 No – 3
MOTION CARRIED

LRE 23-29 Motion: To approve that the LRE is to provide all LRE Board members a list of all entities that LRE believes is encompassed by the financial interest rule and give all Board members 30 days in which to amend their financial disclosures as to whether or not they have any potential remediation from those entities.

Moved: Stan Stek Support: Ron Sanders
Ms. Garzelloni recuses herself from the vote.
MOTION CARRIED

LRE 23-30 Motion: To approve no further sanction against the party on the basis of the financial disclosure issue.

Moved: Stan Stek Support: Sarah Hogan
Ms. Garzelloni recuses herself from the vote.
MOTION CARRIED

LRE 23-31 Motion: – To approve to table consideration on the decision related to the situation on the conflict of interest until there is a statement from counsel.

Moved: Stan Stek Support: Jim Storey
Ms. Garzelloni recuses herself from the vote.
MOTION CARRIED

LRE BOARD CHAIRPERSON DISCUSSION/NOMINATIONS

Ms. Garzelloni was nominated for LRE Board Chairperson, but a vote could not be taken due to a lack of quorum. There was a lack of quorum because Ms. Garzelloni recused herself from the vote and Mr. Storey abstained from voting.

COMMUNITY ADVISORY PANEL

June 8, 2023, Meeting minutes are included in the packet for information.

LEADERSHIP BOARD REPORTS

LRE Leadership reports are included in the packet for information.

CHAIRPERSON'S REPORT

June 21, 2023, Executive Committee (EC) Meeting Minutes are included in packet for information.

- Discussed the role of the EC as there is no written charge. The EC will continue to work on a description.

- Discussed the tools for the CEO evaluation process and the summary of Ms. Marlatt-Dumas' evaluation.
- Ms. Marlatt-Dumas recommended that the CMH Directors not attend the EC meetings moving forward. The EC made the decision to allow the Directors to continue to attend.

ACTION ITEMS

LRE 23-32 Motion: To approve the LRE 2023 Strategic Plan as presented.

Moved: Jon Campbell Support: Ron Bacon

MOTION CARRIED

LRE 23-33 Motion: To approve the LRE 2023 SUD Strategic Plan as presented as recommended by the LRE Oversight Policy Board

Moved: Jim Storey Support: Jon Campbell
MOTION CARRIED

LRE 23-34 Motion: To approve a contract with Our Hope in the amount of $495,000.

Moved: Alice Kelsey Support: Ron Bacon

MOTION CARRIED

LRE 23-35 Motion: To approve membership of new Community Advisory Panel members representing Allegan County as recommended by the Community Advisory Panel

- Robert Curry
- Jennifer Evink
- Sharon Powell

Moved: Jack Greenfield Support: Janice Hilleary
Roll Call
MOTION CARRIED

LRE 23-36 Motion: To approve the LRE Board resolution opposing currently proposed models for implementation of Conflict Free Access and Planning in Michigan as presented.

Moved: Ron Bacon Support: Janice Hilleary
MOTION CARRIED

FINANCIAL REPORT AND FUNDING DISTRIBUTION

FY2023 May Funds Distribution

LRE 23-37 Motion: To approve the FY2023, May Funds Distribution as presented.

Moved: Jack Greenfield Support: Ron Bacon
MOTION CARRIED

Statement of Activities as of 4/30/2023 with Variance Report-

Included in the Board packet for information. Ms. Chick notes:

- HRA is paid on a quarterly basis.
- The legal expense line is expected to be higher.

Monthly FSR (December and January)-

Included in the Board packet for information.

CEO REPORT

Included in the Board packet for information. Ms. Marlatt-Dumas reports:

- Mr. Mark DeYoung has resigned, and we wish him well.
- Legal is working with N180 on the addendum for Motion 23-23. There was also new information regarding the escrow accounts that the CMHs will have to look into.
- Ms. Marlatt-Dumas has asked the State for an additional 269 HAB Waiver slots. At this time, we do not know how many slots we will receive.
- LRE will work with the state on the BHH/OHH (Behavioral and Opioid Health Homes)
- The state must approve the revised FSRs before LRE can submit our audits.
- Meetings continue with Wakely on rates and ISF analyses.
- The State is working on the passive enrolled individuals while CMS has granted them an extension.
- CMHAM has Board Works videos that can assist in understanding the role of Board members. https://cmham.org/education-events/boardworks/

BOARD MEMBER COMMENTS

None.

PUBLIC COMMENT

None.

UPCOMING LRE MEETINGS

- July 19, 2023 – Executive Committee, 1:00PM
- July 26, 2023 – LRE Executive Board Meeting, 1:00 PM
  GVSU, Muskegon Innovation Hub, 200 Viridian Dr, Muskegon, MI 49440

ADJOURN

Ms. Garzelloni adjourned the June 28, 2023, LRE Board of Directors meeting at 3:27 PM.

Ron Bacon, Board Secretary

Minutes respectfully submitted by:
Marion Dyga, Executive Assistant

LAKESHORE REGIONAL ENTITY

Chief Operating Officer (Stephanie VanDerKooi)
Report to the Board of Directors
July 26, 2023

Oversight Policy Board (OPB): The next meeting of the OPB is scheduled for September 6th at 4pm in the Board Room at Community Mental Health of Ottawa County in Holland.

Substance Use Disorder Strategic Plan: The plan was submitted to MDHHS on Friday July 7th. We are looking forward to the Department's approval of the plan. Once the plan has been approved, it will be shared across the region. KWB Strategies will be enlisted to help demonstrate outcomes.

LRE Strategic Plan: The plan has been shared with LRE staff and is now available on the LRE website under the About Us tab (LRE Strategic Plan). Every quarter I will provide the Board with an update and provide an in-depth yearly review at the end of each Calendar Year.

Legislative Update: An updated version (*Attachment 1*) of proposed legislation at both the State and Federal Level, as it relates to Behavioral Health, is included with today's meeting materials *(Attachment 1)*. You will note that a section was added based on feedback from our CAP (Community Advisory Panel) to identify how to find and or contact your State and or Federal legislators (page 9). This grid is updated monthly, and new legislation is highlighted in yellow for ease of identification. The Board may want to pay attention to the following Legislation:

- **(Federal)- The Cooper Davis Act (S.1080)** is a bill that honors Cooper Davis, a 16-year-old teen who tragically lost his life to prescription drugs laced with fentanyl. It was later discovered that a drug dealer solicited him via social media. Recently, the Senate passed this legislation, and it is now with the Senate. The legislation would require Big Tech to take a more proactive role against drug dealing on social media platforms.

- **(State)- HB (4833)** would amend the public health code to eliminate the requirement for acute care and behavioral health hospitals to carry a SUD Service Program license. Note: This issue was identified through a LARA workgroup revealing duplicate licensure in some circumstances. The endeavor is to clean up the duplication and reduce the burden on LARA as well as our members. Additional context:
    - There is no requirement for a health professional to be licensed if they perform their work under their own shingle and within their scope of practice. This would seemingly lift the requirement for an entity to be licensed so long as the individual they employ is licensed. It also has the unfortunate implication that nothing more than the license is required. No "scope of practice" requirement nor any foundation for training or supervised experience.
    - A potential positive of this bill is that it could expand access to care. The downside is that it could expand access to individuals unqualified to treat specific conditions.

- **State (HB4576 and HB4577)**- Proposed by Rep. Curt Vander Wall, are similar to the bills Sen. Shirkey introduced last year.

If the Board would like to take action on any of the proposed bills, please advise and the LRE team can formulate a plan.

CCBHC (Certified Community Behavioral Health Center): The most recent update to the CCBHC handbook (version 6) has been released by the state. We continue to hold regional meetings with HealthWest and West Michigan CMH. We have also been offering technical assistance with the other three CMH's to help them with their state certification for FY24. We will be adding the other 3 CMH's to our regional meeting in August.

CCBHC June enrollments
HW- MCD: 40 Non: 3
WM- MCD: 27 Non: 4

Veteran Navigator: 3rd quarter report is included in this report as *Attachment 2*.

Report Submission Tracking – June 2023
The LRE submitted a total of 23 reports to MDHHS in July 2023. All reports were completed and submitted on or before the deadline.

June 2023

Total Number of Reports	**23**
Number of Late Reports	0
% Late reports	0%
Average Number of Days Late	0

AUTISM SERVICES/ Behavioral Health Treatment (BHT) – Justin Persoon
Throughout July, the Autism team reviewed action plans from the Network 180 Site Review last month. Additionally, we have continued to work in conjunction with IT on the production and implementation of the new data file submission format, in lieu of the WSA, for ABA services. We have continued to encounter barriers to seamless integration of this file into our reports, however, believe this will be functioning within the following weeks. We have been providing technical assistance to CMHSPs as needed. The number of current ABA beneficiaries noted below is still based on April's enrollment numbers. We hope to present updated numbers next month.

CLINICAL/UM – Liz Totten
During June the MDHHS PCP workgroup released a draft PCP Core Activities document for testing by CMHSPs and PIHPs throughout the state. LRE Clinical staff participated in the PCP Core Activities "testing process" along with clinicians from both OnPoint and West Michigan CMHSPs. Each group reviewed and documented feedback which was provided to MDHHS Workgroup Leads. PCP Core Activities has been developed by the workgroup for potential use as a training aid for clinicians. The Regional CFA&P continues to process documents related to MDHHS CFA&P draft options as well discuss current conflict free policies and processes already in place at each CMHSP.

UM/Clinical Departments have completed FY23 Q1 and Q2 Audits. Q1 and Q2 audit Summaries have been presented to the UM/Clinical ROATs. Q1 internal meetings with each CMHSPs have been completed to discuss detailed findings with the purpose of supporting UM programs with improving documentation within preadmission screens and continued stay reviews. Q2 internal meetings are in the

process of being scheduled currently. Random selection of audits for Q3 have now been received. UM/Clinical ROAT have also completed annual review of Clinical/UM policies, procedures and UM Plan.

INTEGRATED HEALTHCARE – Tom Rocheleau

In June 2023, monthly joint care coordination meetings continue to take place with each of the 6 Medicaid Health Plans that serve the LRE region. During the June meetings, 61 (increase from 52 in May) consumers were discussed with their respective MHPs related to their potential or continued benefit from having an interactive care plan within the State's claims database, CC360, and subsequently improving the care they receive and their quality of life, removing barriers, and decreasing unnecessary utilization of crisis services. There were 21 consumers discussed with their MHPs, wherein an interactive care plan was not created, but joint collaboration took place resulting in a Single Episode of Care (SEC). Given this was an increase from May, the data continues to indicate the CMHSPs and MHPs are working hard to identify new members for integrated care plan discussions. In addition, 4 new interactive care plans were opened in June which was also an increase from May.

CUSTOMER SERVICES– Michelle Anguiano & Mari Hesselink

Please see the attached report regarding the Customer Satisfaction Survey that was launched in May. This report gives a nice overview of the results and potential areas for improvement. The report is included as *Attachment 3*.

CREDENTIALING – Pam Bronson, Credentialing Specialist

The Credentialing Committee reviewed and approved 8 organizational providers for credentialing/re-credentialing in June. There weren't any updates regarding the Universal Credentialing system last month. IT and Credentialing have begun to prepare for the HSAG review in August, knowing that the provider directory will be a topic of discussion.

PROVIDER NETWORK MANAGEMENT (PNM) – Don Avery, Jim McCormick

PNMs are finishing up drafting a new LRE/CMHSP Contract. Feedback is being provided to MDHHS on proposed FY24 MDHHS/PIHP Master Contract language proposals. PNMs are currently working with Contract Managers at each CMH to revise the Provider Common Contract, including creating efficiencies in the provide enrollment process to reduce administrative burden for LRE, CMH, and Provider staff.

SUD TREATMENT – Amanda Tarantowski, SUD Treatment Manager

LRE SUD Treatment Manager has been involved in the following activities during the past month:

- Attended an Our Hope Site (at construction site) with MDHHS and Our Hope Administration
- Prepared several proofs for the SOR 3 Audit scheduled for July 21.
- Aided in finalizing the SUD Strategic plan for submission to MDHHS.
- Participated in the review of prevention procurement submissions.

SUD/GAMBLING PREVENTION – Amy Embury, SUD Prevention Manager

SUD Prevention Procurement: LRE issued the SUD Prevention Procurement materials on May 19, 2023. Answers to questions were posted on LRE's website on June 5. Review of submissions is in process and providers will be notified of FY24 contract awards on Friday, July 21.

Synar (Tobacco Checks): Each county completed their Synar checks in the LRE Region (occurred during the month of June). Results will be provided to the Board in August after the state has reviewed the completed compliance checks. Unofficially, the LRE region met the required rate, a great accomplishment

for each county's Designated Youth Tobacco Use Representative and their work. *Attachment 4* provides DYTUR representative information from each county.

WAIVERS – Kim Keglovitz / Melanie Misiuk/Stewart Mills, Waiver Coordinators

The following is a chart of overdue recertifications and guardian consents. Recertifications are due annually and guardian consents are due every three years. Please note those numbers below do not include any currently pending with MDHHS due to staffing changes.

CMHSP	Overdue Certifications	Overdue Guardian Consents	Inactive Consumers
Onpoint	0	0	1
HealthWest	0	2	
Network180	4	0	3
Ottawa	0	0	
West Michigan	0	0	

In June we had 4 slots available. One went to a Children's Waiver age off from Network 180. Of the remaining 3, 1 went to Network 180 and 2 went to HealthWest. There are 6 slots available for the month of July. We have 17 complete packets and 9 packets that are pending due to goals, objectives, or needing updates to other required documents. Below is a chart of slot utilization in region 3.

	October	November	December	January	February	March	April
Used	629	628	628	628	628	628	629
Available	0	1	1	1	1	1	0
% Used	100	99.8	99.8	99.8	99.8	99.8	100
	May	**June**	**July**				
Used	629	626	623				
Available	0	3	6				
% Used	100	99.5	99				

The enrollment deadline is always the 15th of the month. If the LRE is not notified of a disenrollment immediately, there is potential of missing the deadline for the month and the associated payment while there are individuals waiting to be enrolled. For example, if we have a death in December and we don't find out about it until June we have missed out on 5 months of payments.

With the PHE unwinding, there will be a greater focus from MDHHS on making sure that recertification documents and pendbacks are submitted in a timely manner. All recertifications are due within 365 days and any pendbacks of recertifications or initial enrollment packets are due within 15 business days.

MDHHS will conduct a 90-day review for the waiver audit corrective action plan June 21-30. Many of the corrective action plans were remediated or they were able to show that remediation had begun. They did request some additional proof due to MDHHS on July 20, 2023.

Children's Waiver Program (CWP)

84 children are open and enrolled in the Children's Waiver Program for July. We have 8 children that are currently invited to enroll on the Children's waiver, three with a July start date and five with an August start date. We had six prescreens that were submitted in June, three of which were already invited to join the CWP. We currently have eighteen scored prescreens that are on the weighing list that have not yet to be invited to join the CWP. Of the eighteen prescreens that are currently on the weighing list,

three have been submitted by OnPoint, ten by Network 180, one by HealthWest, three by Ottawa, and one by West Michigan.

CMHSP	# Enrolled
HealthWest	6 (2 invited)
Network 180	63 (4 invited)
On Point	4
Ottawa	10 (2 invited)
West Michigan	1

1915(i)SPA:

MDHHS Updates:

- MDHHS's deadline for iSPA compliance to 10/1/2023. It is expected that all iSPA cases are enrolled in the WSA by that date.
  MDHHS had a goal of 75% enrollment by July 1. Three of our CMHSPs surpassed that goal: OnPoint, HealthWest, and Network180.
- MDHHS continues to push the PIHPs and CMHSPs to reach these benchmarks. MDHHS is also working on updates continuously in the WSA so that cases can be recertified when needed.
- The Regional iSPA Workgroup continues to meet monthly, with representation from each CMHSP, as well as attending the statewide meetings. The CMHSP Leads and staff assisting them for this program are doing a tremendous amount of work, and the LRE is appreciative of the time and effort put towards this program.
- Currently as a region the LRE is at a 69% enrollment rate. As of 7/11/23 the LRE had the highest enrollment rate statewide. The CMHSP Leads and staff assisting them for this program are doing a tremendous amount of work, and the LRE is appreciative of the time and effort put towards this program.
- Please see *Attachment 5* for the most up-to-date data.

SEDW:

- We currently have 92 open cases.
  - Allegan – 5
  - HealthWest – 17
  - Network180 – 48
  - Ottawa – 19
  - West MI – 3
- The LRE is working to reinstate the Regional SEDW Workgroup on a quarterly basis. Currently we are working to schedule a meeting for September 2023 with the CMHSP SEDW Leads and Arbor Circle.
- Post-Covid PHE Changes for the SEDW include the push to move all Wraparound services back to in-person.
- The 2023 Wraparound Conference is being held in Grand Rapids, July 26-28.

ATTACHMENT 1

STATE LEGISLATION

BILLS & REGULATIONS PERTAINING TO MENTAL HEALTH				
Priority	**BILL #**	**SUMMARY**	**SPONSOR**	**ACTION DATE**
	SB 27	Legislation that would require insurers to provide coverage for mental health and substance abuse disorder services on the same level as that of coverage for physical illness. Federal law requires mental health coverage to be equal to physical illness. The bill would require insurance coverage for mental health conditions, including substance use disorders, to be no more restrictive than insurance coverage for other medical conditions.	Sarah Anthony	1/18/23 – Introduced to the Senate; Referred to Committee on Health Policy
	HB 4576 & 4577	Reintroduced versions of Sen. Shirkey's legislation (SB 597 & 598) from 2022. Legislation to create an integrated plan to merge the administration and provision of Medicaid physical health care services and behavioral health specialty services.	Curtis VanderWall	5/16/23 – Introduced, read, and referred to Committee on Health Policy
	HB 4320 & 4387	Provides for penalties for coercing a vulnerable adult into providing sexually explicit visual material; and provides sentencing guidelines for crime of coercing vulnerable adult into providing sexually explicit visual material	Sharon MacDonell	3/22/23 – Introduced; referred to Committee on Families, Children and Seniors 6/27/23 – Referred to a second reading
	HB 4081	Establishes a minimum number of school counselors to be employed by a school district, intermediate school district or public school academy	Felicia Brabec	2/14/23 – Introduced; referred to Committee on Health Policy
	HB 4495 & 4496	Provides general changes to the medical assistance program	Will Snyder Graham Filler	5/2/23 – Introduced; referred to Committee on Health Policy 6/13/23 – Passed House 6/27/23 – Passed Senate 7/10/23 – Presented to Governor
	HB 4523	Modifies eligibility for mental health court for those with violent offenses	Kara Hope	5/4/23 – Introduced; referred to Committee on Judiciary
	HB 4579 & 4580	Requires reimbursement rate for telehealth visits to be the same as office visits	Natalie Price, Felicia Brabec	5/16/23 – Introduced; referred to Committee on Health Policy
	HB 4649	Require height-adjustable, adult-sized changing tables in public restrooms	Lori Stone	5/23/23 – Introduced; referred to Committee on Regulatory Reform

BILLS & REGULATIONS PERTAINING TO MENTAL HEALTH				
Priority	**BILL #**	**SUMMARY**	**SPONSOR**	**ACTION DATE**
	HB 4745-4749	Bills related to access to assisted outpatient treatment, outpatient treatment for misdemeanor offenders, hospital evaluations, mediation, and competency exams	Brian BeGole, Donni Steele, Tom Kuhn, Mark Tisdel	6/14/23 – Introduced; referred to Committee on Health Policy

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
	HB 6474	*A bill to prohibit municipalities from adopting ordinances that would require caregivers or qualified medical marijuana patients to report use or growth, pay a tax to municipality, grow marijuana according to the MRTMA, forced inspections of property by municipality, among other requirements that would create an undue burden on caregiver or qualified medical marijuana patient*	*Steve Carra*	*11/9/22-Introduced and referred to Committee on Regulatory Reform*
	S 1170/1171	*Bills to make prescribers and agencies who are trained to distribute naloxone immune from prosecution for distribution, administration, or failure to administer naloxone.*	*Dale Zorn*	*9/20/22-Introduced and referred to Committee on Health Policy and Human Services*
	SB 1222-1223	*A two-bill package designed to extend the capture of liquor tax revenue that counties use for substance abuse programs. Beginning in 2023, the baseline allocation in liquor tax dollars for counties will increase by approximately 48 percent ($25 million). It is an amendment to the State Convention Facilities Authority Act. Current law states 50 percent of the liquor tax revenue received by counties must be allocated to substance abuse programs. SBs 1222-23 will change that requirement to 40 percent (though no less than the amount allocated in FY22). This will be a significant increase in funds toward substance abuse programs, and an increase in the amount counties can allocate to their general funds. 2021-SFA-1222-F.pdf (mi.gov)*	*Wayne Schmidt*	*12/29/22 – signed by the Governor*
	TBD	Keep MI Kids Tobacco Free Alliance is working on a legislative package that will address the areas of Tobacco Retail Licensure, Taxation on Vaping Products & Parity, Ending the Sale of Flavored Tobacco, and Preemption Removal (Restoration of local authority to regulate tobacco control at the municipal level)	Keep MI Kids Tobacco Free Alliance Sam Singh	Preemption one pager (d31hzlhk6di2h5.cloudfront.net) *Note* - Introduction of the bill package may be pushed back until the fall, due to the limited

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
				amount of days left in the legislature before the summer break.
	HB 4049	A bill to require CRA to consider all applications by spouses of government officials for licensed marijuana establishments, and to not deny them based on their spouse's government affiliation.	Pat Outman	1/31/23 - Introduced and referred to Committee on Regulatory Reform
	HB 4061	Kratom Consumer Protection Act: A bill to regulate the distribution, sale, and manufacture of kratom products	Lori Stone	2/1/23 - Introduced and referred to Committee on Regulatory Reform
	SB 133	A bill to provide for the review and prevention of deaths from drug overdose; allow for creation of overdose fatality review teams and power and duties of those teams; and for other purposes	Sean McCann	3/2/23-Introduced and referred to Committee on Health Policy
	HB 4430	A bill to require all marijuana sales to provide safety information at the point of sale. Safety info includes: Safe storage, proper disposal, poison control information and the following statements: (A) To avoid dangerous drug interactions, it is recommended that you consult with your prescriber or pharmacist before consuming this product. (B) Exercise care if you consume this product with alcohol. (C) Consuming this product with a controlled substance could increase the risk of side effects or overdose. (D) Do not operate heavy machinery or perform other dangerous tasks under the influence of this product unless you know how this product affects you.	Veronica Paiz	4/19/23-introduced and referred to Committee on Regulatory Reform
	SB 180/179	Allow the Cannabis Regulatory Agency (CRA) to enter into an agreement with an Indian tribe pertaining to marijuana related business if the agreement and the Indian tribe met certain conditions. It prohibits the CRA from employing any individual with pecuniary interests in tribal marijuana; and specifies that sales of marijuana by a tribal marijuana business on Indian lands would be exempt from the State's 10% excise tax on marijuana. Require the Department of Treasury to deposit money into the Marihuana Regulation Fund that was collected under an Indian Tribe Agreement.	Roger Hauck	6/14/23-Passed Senate and received in House Committee on Regulatory Reform
	SB 141/HB 4201	The bill would amend the Michigan Liquor Control Code to eliminate a January 1, 2026, sunset on provisions that allow a qualified licensee to fill and sell qualified containers with alcoholic liquor for the purpose of off-the-premises consumption	Mallory McMorrow & Kristian Grant	6/13/23 - Passed Senate, referred for second reading in House Committee on Regulatory Reform.

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
		and to deliver alcoholic liquor to a consumer in the State if the qualified licensee meets certain conditions.		5/3/23 - Passed House, referred to Senate Committee on Regulatory Affairs
	HB 4833	The bill would amend the public health code to eliminate the requirement for acute care and behavioral health hospitals to carry a SUD Service Program license. The issue was identified through a LARA workgroup revealing duplicate licensure in some circumstances. The endeavor is to clean up the duplication and reduce burden on LARA as well as our members.	Ranjeev Puri	6/22/23 - referred to Committee on Health Policy

FEDERAL LEGISLATION

BILLS & REGULATIONS PERTAINING TO MENTAL HEALTH				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
	HR 8454	***Medical Marijuana and Cannabidiol Research Expansion Act:*** *Establishes a new, separate registration process to facilitate research on marijuana; directs DEA to follow specified procedures to register practitioners to conduct marijuana research, and manufacturers to supply marijuana for research; Bill also includes various other provisions including: require the DEA to assess whether there is an adequate and uninterrupted supply of marijuana for research purposes; prohibit the Department of Health and Human Services (HHS) from reinstating the interdisciplinary review process for marijuana research; allow physicians to discuss the potential harms and benefits of*	*Earl Blumenauer*	*11/16/22-Passed Senate* *12/2/22 – Became Law* *H.R.8454 - 117th Congress (2021-2022): Medical Marijuana and Cannabidiol Research Expansion Act | Congress.gov | Library of Congress*

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
		marijuana and its derivatives (including CBD) with patients; and require HHS, in coordination with the National Institutes of Health and relevant federal agencies, to report on the therapeutic potential of marijuana for various conditions such as epilepsy, as well as the impact on adolescent brains and on the ability to operate a motor vehicle.		
	H.Res. 39	A res. Requesting that all illicit fentanyl and illicit fentanyl-related substances should be permanently placed in Schedule I; and for other purposes.	Neal Dunn	1/17/23-Introduced and referred to Committee on Energy and Commerce & Committee on the Judiciary 1/27/23 - Referred to the House Subcommittee on Health.
	N/A – Proposed Rule	There is a proposed rule by the Substance Abuse and Mental Health Services Administration (SAMHSA) that would permanently allow providers to prescribe buprenorphine specifically for opioid use disorder treatment without an in-person visit in an opioid treatment program, but this is still in the proposal phase with comments due on Feb. 14, 2023.	SAMHSA	12/16/22 – Proposed 2/14/23 – Public Comment Due Federal Register :: Medications for the Treatment of Opioid Use Disorder
	HR 901	To require the Food and Drug Administration to prioritize enforcement of disposable electronic nicotine delivery system products.	Sheila Cherfilus-McCormick	2/09/2023 - Referred to the House Committee on Energy and Commerce. 2/17/23 - Referred to the House Subcommittee on Health.
	S. 464	A bill to amend the Internal Revenue Code of 1986 to deny the deduction for advertising and promotional expenses for tobacco products and electronic nicotine delivery systems.	Jeanne Shaheen	2/16/2023 - Read twice and referred to the Committee on Finance.
	HR 610	Marijuana 1-3 Act of 2023: A bill to provide for the rescheduling of marijuana into schedule III of the Controlled Substances Act.	Gregory Steube	1/27/23 - Referred to the Committee on Energy and Commerce, and in addition to the Committee on the Judiciary
	HR 467	HALT Fentanyl Act (S.1141): This bill places fentanyl-related substances as a class into schedule I of the Controlled Substances Act; the bill establishes a new, alternative registration process for schedule I research that is funded by the Department of Health and Human Services or the Department of Veterans Affairs or that is conducted under an investigative new drug exemption from the Food and Drug Administration.	H. Morgan Griffith/Bill Cassidy 5	03/24/2023 Ordered to be Reported (Amended) by the Yeas and Nays: 27 – 19 (S)-3/30/23-Read twice and referred to the Committee on the Judiciary. 5/17/2023 - Placed on Union Calendar #47

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
				5/25/2023 – House adopted the amendment 5/30/2023 – Received in Senate and referred to the committee on the Judiciary.
	HR 1291	Stopping Overdoses of Fentanyl Analogues Act: To amend the Controlled Substances Act to list fentanyl-related substances as schedule I controlled substances.	Scott Fitzgerald	03/01/2023 Referred to the Committee on Energy and Commerce, and in addition to the Committee on the Judiciary 3/10/23 - Referred to the Subcommittee on Health.
	HR 1839	Combating Illicit Xylazine Act (S.993): To prohibit certain uses of xylazine.	Jimmy Panetta/ Catherine Cortez Masto 7	03/28/2023 Referred to the Committee on Energy and Commerce, and in addition to the Committee on the Judiciary (S)-3/28/23-Read twice and referred to the Committee on the Judiciary 4/7/23 – Referred to the Subcommittee on Health
	S.983	Overcoming Prevalent Inadequacies in Overdose Information Data Sets Act or "OPIOIDS" Act: The Attorney General may award grants to States, territories, and localities to support improved data and surveillance on opioid-related overdoses, including for activities to improve postmortem toxicology testing, data linkage across data systems throughout the United States, electronic death reporting, or the comprehensiveness	Rick Scott	03/27/2023 Read twice and referred to the committee on the Judiciary
	HR 1734	TRANQ Research Act: To require coordinated National Institute of Standards and Technology science and research activities regarding illicit drugs containing xylazine, novel synthetic opioids, and other substances of concern, and for other purposes.	Mike Collins	03/29/2023 Ordered to be Reported (Amended) by the Yeas and Nays: 36 – 0 5/15/23 - Passed in House, Received in Senate 6/26/23 – Passed in Senate
	S 606	To require the Food and Drug Administration to revoke the approval of one opioid pain medication for each new opioid pain medication approved.	Joe Manchin	03/01/2023 - Read twice and referred to the Committee on Health, Education, Labor, and Pensions

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
	HR 2867 & S 1235	Bruce's Law: Re-introduced as new bills (formerly HR 9221 in 2022). To establish an awareness campaign related to the lethality of fentanyl and fentanyl-contaminated drugs, to establish a Federal Interagency Work Group on Fentanyl Contamination of Drugs, and to provide community-based coalition enhancement grants to mitigate the effects of drug use.	David Trone & Lisa Murkowski	04/20/2023 - Read twice and referred to the Committee on Health, Education, Labor, and Pensions. 04/25/2023 - Referred to the House Committee on Energy and Commerce 04/28/2023 – Referred to the Subcommittee on Health
	HR 2891 & S 1323	SAFE Banking Act: To create protections for financial institutions that provide financial services to State-sanctioned marijuana businesses and service providers for such businesses, and for other purposes.	David Joyce & Jeff Merkley	5/3/23 - Referred to Subcommittee on Economic Opportunity 5/11/23 - Referred to Committee on Banking, Housing, and Urban Affairs
	HR 3375	To establish programs to address addiction and overdoses caused by illicit fentanyl and other opioids, and for other purposes.	Ann Kuster	05/16/2023-Referred to the Committee on Energy and Commerce, and in addition to the Committee on the Judiciary 5/19/2023 – Referred to the Subcommittee on Health
	HR 4106	To amend the 21st Century Cures Act to expressly authorize the use of certain grants to implement substance use disorder and overdose prevention activities with respect to fentanyl and xylazine test strips.	Jasmine Crockett	06/14/2023 Referred to the House Committee on Energy and Commerce
	S. 1785	To establish programs to address addiction and overdoses caused by illicit fentanyl and other opioids; i.e, enhanced surveillance, collection of overdose data, increase fentanyl detection and screening abilities, and other purposes.	Ed. Markey	05/31/2023 Read twice and referred to the Committee on Health, Education, Labor, and Pensions
	HR 3563	To amend the Controlled Substances Act to exempt from punishment the possession, sale, or purchase of fentanyl drug testing equipment.	Jasmine Crockett	05/22/2023 Referred to the Committee on the Judiciary, and in addition to the Committee on Energy and Commerce
	S. 1080	Cooper Davis Act – this legislation would require Big Tech to take a more proactive role against drug dealing on their social media platforms.	Marshall Roger	3/30/2023 - Read twice and referred to the Committee on the Judiciary.

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
				7/13/2023 - Committee on the Judiciary. Ordered to be reported with an amendment in the nature of a substitute favorably.

LEGISLATIVE CONCERNS

LOCAL THREATS AND CHALLENGES			
ISSUE	**SUMMARY**	**COUNTY**	**ADDITIONAL INFORMATION/LINKS**
End of PHE Medicaid Beneficiary Renewals	MDHHS has started mailing renewal letters for Medicaid redeterminations following the end of the Public Health Emergency . Emergency Medicaid coverage protection extended during the COVID-19 pandemic expired on April 1st. This could result in up to 400,000 Michigan residents losing Medicaid coverage.		www.Michigan.gov/2023BenefitChanges Medicaid review could drop 400,000 Michigan residents from coverage | Bridge Michigan

MISCELLANEOUS UPDATES

ISSUE	SUMMARY	COUNTY	ADDITIONAL INFORMATION/LINKS
FY24 State Budget Recommendations	Governor Whitmer's FY2024 State Budget Recommendation includes the following areas related to behavioral health and SUD: • $300 million for student mental health to ensure students' needs can be identified and provided with the right support. • $210.1 million for Direct Care Worker Wages ($74.5 million general fund) to increase wage support to direct care professionals providing Medicaid behavioral health services, care at skilled nursing facilities, community-based supports through MI Choice, MI Health Link, and Home Help programs and in-home services funded through area agencies on agencies. These funds support an increase that would average about $1.50 / hour (10%) • $5 million for behavioral health recruitment supports (general fund) that would fund scholarships and other recruiting tools to attract and support people interested in training to become behavioral health providers.		Access budget material at: https://www.michigan.gov/budget

ISSUE	SUMMARY	COUNTY	ADDITIONAL INFORMATION/LINKS
MIHealthyLife	In fall 2023, MDHHS will ask Medicaid health plans for new contract proposals to provide health services to people enrolled in Medicaid, including Behavioral Health. MDHHS is providing a survey for stakeholders to submit ideas to make the program better and collecting input about potential changes to the new contracts.		MIHealthyLife (michigan.gov)
CMS Plan for States to Use Medicaid for Incarcerated Substance Use Treatment	Recently, the Director of the Office of National Drug Control Policy (ONDCP), Dr. Rahul Gupta, announced that all federal prisons will offer medication-assisted treatment (MAT) for substance use disorder by this summer. Additionally, Dr. Gupta noted that the Centers for Medicare and Medicaid Services (CMS) will release guidance to support states in using Medicaid 1115 waivers to cover substance use treatment for people who are incarcerated		A disappointing report card for primary care - POLITICO (relevant information is about halfway down the page)
Post-Pandemic Telehealth Policy	The recently released Michigan Medicaid bulletin reflects all of the recommendations of the CMHA Behavioral Telehealth Advisory Group		Final Bulletin MMP 23-10-Telemedicine.pdf (govdelivery.com)

Elected Officials

FEDERAL			
	NAME	**NATIONAL OFFICE CONTACT INFORMATION**	**LOCAL OFFICE CONTACT INFORMATION**
US Senate	Debbie Stabenow	731 Hart Senate Office Building Washington, D.C. 20510-2204 Phone: (202) 224-4822	1025 Spaulding Avenue Southeast Suite C Grand Rapids, MI 49546 Phone: (616) 975-0052

FEDERAL			
	NAME	**NATIONAL OFFICE CONTACT INFORMATION**	**LOCAL OFFICE CONTACT INFORMATION**
US Senate	Gary Peters	Hart Senate Office Building Suite 724 Washington, D.C. 20510 Phone: (202) 224-6221	110 Michigan Street NW Suite 720 Grand Rapids, MI 49503 Phone: (616) 233-9150
US Representative	Bill Huizenga	2232 Rayburn HOB Washington, D.C. 20515 Phone: (202) 225-4401	170 College Ave. Suite 160 Holland, MI 49423 Phone: (616) 251-6741
US Representative	Hillary Scholten	1317 Longworth House Office Building Washington, DC 20515 Phone: (202) 225-3831	110 Michigan Street NW Grand Rapids, MI 49503 Phone: (616) 451-8383
US Representative	John Moolenaar	246 Cannon House Office Building Washington, DC 20515 Phone: (202) 225-3561	8980 North Rodgers Court Suite H Caledonia, MI 49316 Phone: (616) 528-7100

STATE	
Find Your State Senator	Home Page Find Your Senator - Michigan Senate (https://senate.michigan.gov/FindYourSenator/)
Find Your State Representative	Michigan House - Home Page (https://www.house.mi.gov/)

ATTACHMENT 2

Submitted by: Eric Miller
231-260-0721
ericm@lsre.org
Year: FY23
Quarter: 3

The Veteran Navigator (VN) role was created to assist veterans and military families of all branches, eras, and discharge types. The VN works to connect veterans and their families to federal, state, and local resources to offer support for issues regarding mental health, substance use disorders, housing, and other unique circumstances that may impact veterans. The FY 22 Summary of Activities can be found here.

Outreach:

Identify and engage veterans and their families.

Throughout Q3, the Veteran Navigator has participated in outreach events hosted by partner organizations like the 92 for 22 Event at the Hudsonville fairgrounds or the Zero Day Event. The VN also created new outreach opportunities by connecting with the Pakagon Band of Potawatomi Tribe to join them in a golf outing where they learned the benefits of the VN program.

# of Community Members Reached:

265

Support:

Work with individual veterans to assess their needs, connect to services, and address challenges that negatively affect their health and well-being.

This quarter, the Veteran Navigator provided support throughout the region in several ways, including:

- Referred several veterans to 92 for 22 and Forged by Freedom to receive financial aid. In a few cases, VN remained involved after the referral to ensure that the needs were met. In one case, the VN coordinated financial support of $600 in supplies and 3 individuals to construct an accessible deck for a veteran with physical disabilities.
- Provided support for a veteran who needed food access for himself and his younger siblings who were removed from their parent's home due to abuse.

New veterans Served:

27

Total Service Contacts:

127

Referrals:

Establish a robust referral network to assist veterans in accessing services and supports to meet their needs.

This quarter, the Veteran Navigator strengthened partnerships and referral sources in the following ways:

- 23 Veterans were referred to the VA for services this quarter, and 20 individuals were referred to the VSO.
- VN created and strengthened relationship with small businesses that are owned and operated by veterans such as Clems Custom Rods. These small businesses provide free or discounted services to veterans.
- VN continues to strengthen relationships with partner CMHs. This quarter, 5 veterans were referred to partner CMHs for mental health services.

Stakeholder Collaborations this Quarter:

13

Expertise:

Training and assistance for local organizations and groups to effectively engage and support veterans.

This quarter, the Veteran Navigator was asked to provide their expertise in the following ways:

- Presented at Gentex alongside Pine Rest to reach Veterans within their workforce.
- Met with Pokagon Band of Potawatomi Tribe to provide information on resources for veterans within the tribe.
- Met with the VA to increase care opportunities within the VA.

# of trainings/ consults provided this quarter:

6

ATTACHMENT 4

KNOW THE FACTS

The Toll of Tobacco in Michigan

Data and source information can be found at tobacco-freekids.org

NO CIGS FOR OUR KIDS

YOUTH TRENDS

3,200

The number of youth (under 18) who become new daily smokers each year.

AMONG MICHIGAN HIGH SCHOOL STUDENTS...

4.5

The percent who smoke, compared to 4.6 percent nationally.

20.8

The percent who use e-cigarettes, compared to 11.3 percent nationally.

HEALTH IMPACT

32.3

The percent of cancer deaths in Michigan attributed to smoking.

16,200

The number of Michigan adults who die each year from smoking.

Smoking kills more people than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined — and thousands more die from other tobacco-related causes — such as fires caused by smoking (more than 1,000 deaths/year nationwide) and smoke- less tobacco use.

FINANCIAL BURDEN

$4,620

The amount per household of state and federal taxes Michigan residents pay for smoking-caused government expenditures.

$11.5 billion

The amount of smoking-caused productivity losses.

$5.33 billion

The amount of annual health care costs directly caused by smoking.

DESIGNATED YOUTH TOBACCO USE REPRESENTATIVES

Allegan County
Heidi Denton
(269) 673-6617 x2714
hdenton@accmhs.org

Kent County
Ally Kaza
(616) 367-0575
ally.kaza@kentcountymi.gov

Lake County
Qur'an Griffin
(231) 368-1051
qgriffin@dhd10.org

Mason County
Grace Richardson
(231) 316-8583
grichardson@dhd10.org

Muskegon County
Danielle Hall
(231) 724-1211
Hallda@co.muskegon.mi.us

Oceana County
Gracie Kierczynski
(231) 465-1782
gkierczynski@dhd10.org

Ottawa County
Tim Findlay
(616) 393-5776
tfindlay@miottawa.org

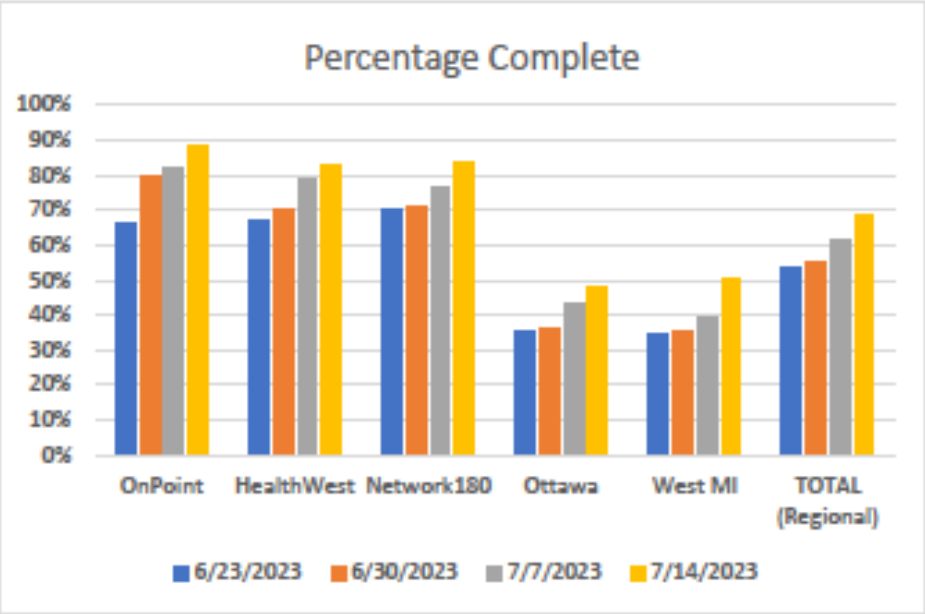
The mission of No Cigs for Kids is to educate tobacco retailers about compliance with the youth tobacco act andreduce the number of vendors selling tobacco to minors.

LAKESHORE REGIONAL ENTITY

This publication was supported by a grant from the Michigan Department of Community Health/Office of Drug Control Policy, through Lakeshore Regional Entity. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of MDCH/ODCP or LRE.

ATTACHMENT 5

1915(I)SPA ENROLLMENT PROGRESS (CMH REPORTED DATA)



GOAL:

50% Enrollment by April 1, 2023

75% by July 1, 2023

100% by October 1, 2023

CMHSP	6/23/2023	6/30/2023	7/7/2023	7/14/2023
OnPoint	66%	80%	82%	89%
HealthWest	67%	70%	79%	83%
Network180	71%	71%	76%	84%
Ottawa	36%	36%	43%	48%
West MI	35%	35%	40%	50%
TOTAL (Regional)	**54%**	**56%**	**62%**	**69%**

CMHSP	Total Expected Cases Reported by CMH	Currently Enrolled - 7/7/2023	Currently Enrolled - 7/14/23	Withdrawn - 7/7/2023	Withdrawn - 7/14/23	Total Pending in WSA Queue - 7/14/2023
OnPoint	170	139	150	276	277	0
HealthWest	500	394	414	420	422	0
Network180	831	633	696	317	327	0
Ottawa	590	254	282	34	34	0
West MI	567	224	285	237	237	2
TOTAL (Regional)	**2468**	**1644**	**1827**	**1284**	**1297**	**2**

LAKESHORE REGIONAL ENTITY

Information Officer Report – July 2023

7/19/2023

Summary:

1. **MCIS Software**:
   Recently completed:
   - Added programming to provide drill-down data within the MCPAR Appeal and Grievance Reports.

   Implementations still underway (to be completed by 10/1/2023):
   - MDHHS required changes to EQI reporting for new/revised FY23 EQI Period 2.
   - MDHHS required changes/additions to BHTEDS for FY24.
   - MDHHS required changes to encounters for FY24 enhancements to Coordination of Benefits reporting (detailed implementation specifications are not out yet but are anticipated soon – will involve TPL reporting in association with direct run services).

2. **Data Analytics and Reporting:**
   New implementations:
   - Critical Incidents Dashboard - in development.
   - LRE Customer Satisfaction Surveys FY23 – in development.
   - BHTEDS Performance Improvement (add focus on Veteran and Miliary fields) – in development.

   Recently updated/enhanced:
   - UM High Level Of Care Stats – Add Average to multiple visualizations (Admits/Units - Per 1000).
   - Services for deceased consumers – added separate page for fiscal intermediary services.

3. **Encounter reporting to MDHHS**:
   FY23 Encounter reporting is showing good volume through May 2023, as would be expected at this point in time. Please see also the encounter graphs attached. The reporting delay noted last month in institutional encounters from 2 CMHSPs (Network180 and Ottawa) was investigated and fully resolved.
   BH-TEDS reporting to MDHHS: FY23 BH-TEDS: Completeness measurement recently received from MDHHS (7/18/2023) shows that LRE BH-TEDS continue to be reported above the 95% compliance threshold regionally on all measures (Mental Health, Mental Health Crisis Only, and SUD). See additional detail on pages 2 - 3 below.

4. **HSAG conducted its Performance Measure Validation (PMV) Audit with LRE on July 13, 2023.** Our virtual review with HSAG was held on July 13th. The audit included a thorough review of all IT systems (and associated business processes) which gather and submit data used in calculating the quality indicators used in the **M**ichigan **M**ission **B**ased **P**erformance **I**ndicator **S**ystem (**MMBPIS**). Three of our 5 CMHSPs were also selected by HSAG to participate in the virtual review (Network180, OnPoint, and CMH of Ottawa County). In addition to a general Q&A regarding business processes and IT functionality, additional MMBPIS proofs were requested and displayed on-demand. The review went generally very well. A draft report from HSAG should arrive in early September.

Additional Details: BHTEDS Completeness Measures, FY23 per MDHHS as of 7/18/2023:

FY23 MH Encounters w/BH-TEDS records				
Encounters: 10/01/2022 - 05/31/2023*				**BH-TEDS: 07/01/2021 - 07/18/2023**
		Distinct Count of Individuals With		
Region Name	**Submitter ID**	**Non-H0002 & Non-Crisis, Non-OBRA Assessment & Non-Transportation Encounters**	**Non-H0002, Non-Crisis, Non-Health Home, Non-OBRA Assess-ment & Non-Transportation Encounters But NO BH-TEDS Record Since 07/01/2020**	**Current Completion Rate**
CMH Partnership of SE MI	00XT	10,844	358	96.70%
Detroit/Wayne	00XH	54,607	3,537	93.52%
Lakeshore Regional Entity	00ZI	18,728	681	96.36%
Macomb	00GX	12,630	443	96.49%
Mid-State Health Network	0107	38,200	1,444	96.22%
NorthCare Network	0101	5,846	43	99.26%
Northern MI Regional Entity	0108	11,809	318	97.31%
Oakland	0058	22,916	418	98.18%
Region 10	0109	19,183	242	98.74%
Southwest MI Behavioral Health	0102	21,095	228	98.92%
Statewide		215,858	7,712	96.43%
Key				
95.00+ = Compliant		*Encounters = All MH encounters **excluding**: A0080, A0090, A0100, A0110, A0120, A0130, A0140, A0170, A0425, A0427, H0002, H2011, H2034, Q3014, S0209, S0215, S0280, S0281, S9484, T1023, T1040, T2001-T2005 ,90839, 90840, 99304-99310		
90.00-94.99				
85.00-89.99				
<85.00				

FY23 Crisis Encounters w/BH-TEDS records				
Encounters: 10/01/2022 - 05/31/2023**			**BH-TEDS: 07/01/2021 - 07/18/2023**	
		Distinct Count of Individuals With		
Region Name	**Submitter ID**	**Crisis Encounters**	**Crisis Encounters But NO BH-TEDS Record Since 07/01/2021**	**Completion Rate**
CMH Partnership of SE MI	00XT	2,137	38	98.22%
Detroit/Wayne	00XH	7,452	54	99.28%
Lakeshore Regional Entity	00ZI	4,860	117	97.59%
Macomb	00GX	1,551	58	96.26%
Mid-State Health Network	0107	8,485	249	97.07%
NorthCare Network	0101	1,442	6	99.58%
Northern MI Regional Entity	0108	3,232	101	96.88%
Oakland	0058	1,866	12	99.36%
Region 10	0109	2,592	84	96.76%
Southwest MI Behavioral Health	0102	2,823	4	99.86%
Statewide		36,440	723	98.02%
Key				
95.00+ = Compliant		**Encounters include H2011, S9484, T1023, 90839, 90840		
90.00-94.99				
85.00-89.99				
<85.00				

FY23 SUD Encounters w/BH-TEDS records				
SUD Encounters from 10/01/2022-05/31/2023***			Does Not Have Open Admission at Time of Encounter as of 07/18/2023	
		Distinct Count of Individuals With		
Region Name	Submitter ID	Non-Health Home Encounters	Non-Health Home Encounters But NO BH-TEDS Record	Completion Rate
CMH Partnership of SE MI	00XT	2,406	21	99.13%
Detroit/Wayne	00XH	6,444	2	99.97%
Lakeshore Regional Entity	00ZI	4,711	104	97.79%
Macomb	00GX	3,147	10	99.68%
Mid-State Health Network	0107	8,120	7	99.91%
NorthCare Network	0101	1,462	2	99.86%
Northern MI Regional Entity	0108	3,212	42	98.69%
Oakland	0058	2,563	17	99.34%
Region 10	0109	4,278	18	99.58%
Salvation Army	002Y	151	29	80.79%
Southwest MI Behavioral Health	0102	4,662	116	97.51%
Statewide		41,156	368	99.11%

Key
95.00+ = Compliant
90.00-94.99
85.00-89.99
<85.00

***Encounters = All SUD encounters **excluding** H2034, S0280 & T1040

Data Source: LRE_DW_CorporateInfo.LRE_Encounters

Purpose: Show Distinct client counts along with counts of Encounter Lines and Claim Units for both Mental Health and Substance Use Disorder by FY and Service Month.

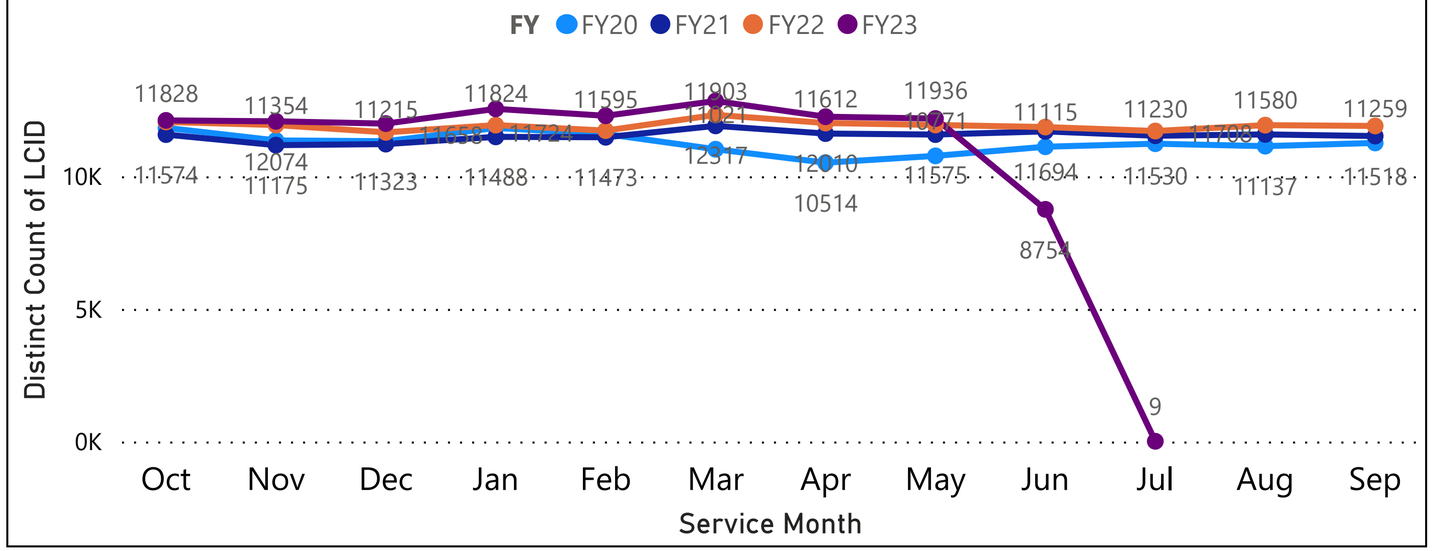
Reports in Dashboard:

1. **LRE - MH Lines** - Shows distinct client count and mental health encounter line totals for both Professional and Institutional type transactions for the LRE as a whole.
2. **LRE - MH Units** - Shows distinct client count and mental health encounter claim unit totals for both Professional and Institutional type transactions for the LRE as a whole.
3. **LRE - SUD** - Shows distinct client count and both SUD encounter line totals and SUD encounter claim unit totals for the LRE as a whole.
4. **CMHSP - MH Lines** - Shows distinct client count and mental health encounter line totals for both Professional and Institutional type transactions for the individual CMHSP.
5. **CMHSP - MH Units** - Shows distinct client count and mental health encounter claim unit totals for both Professional and Institutional type transactions for the individual CMHSP.
6. **CMHSP - SUD** - Shows distinct client count and both SUD encounter line totals and SUD encounter claim unit totals for the individual CMHSP.

Notes: Items 4-6 above are repeated for each individual CMHSP.

LRE
Behavioral Health

LRE Distinct Clients



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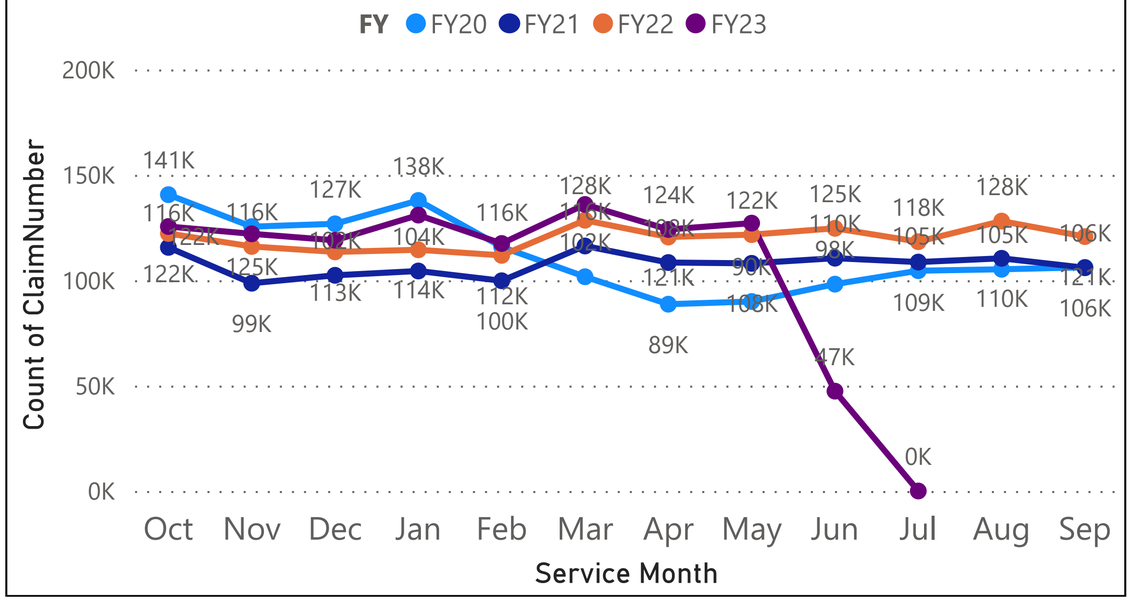
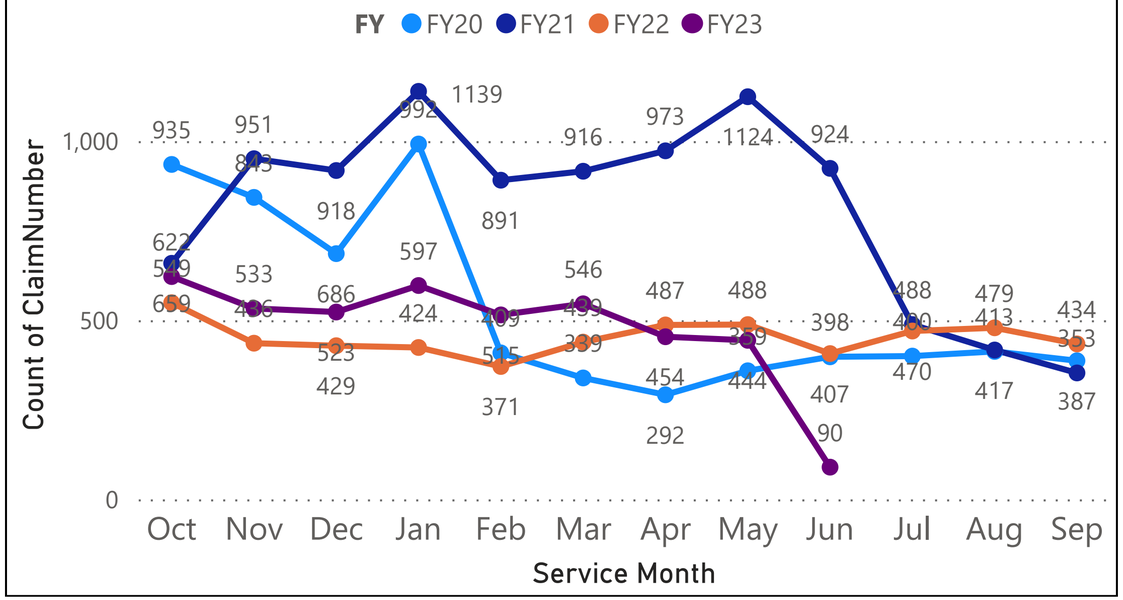
- Select all
- FY20
- FY21
- FY22
- FY23

LRE Professional Encounter Lines



LRE Institutional Encounter Lines



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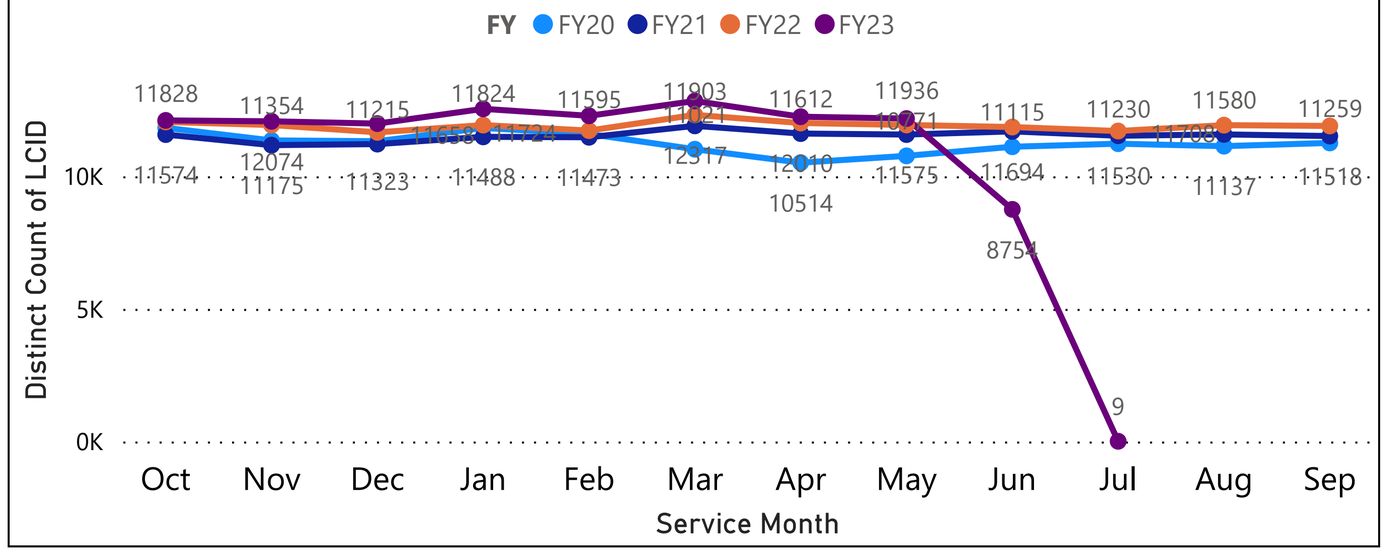
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

LRE
Behavioral Health

LRE Distinct Clients



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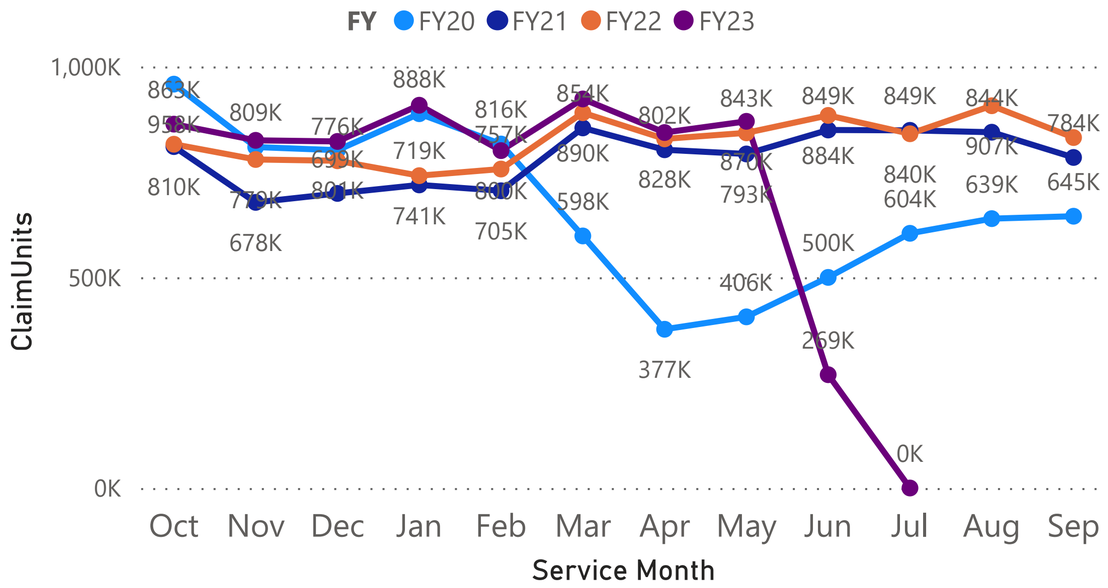
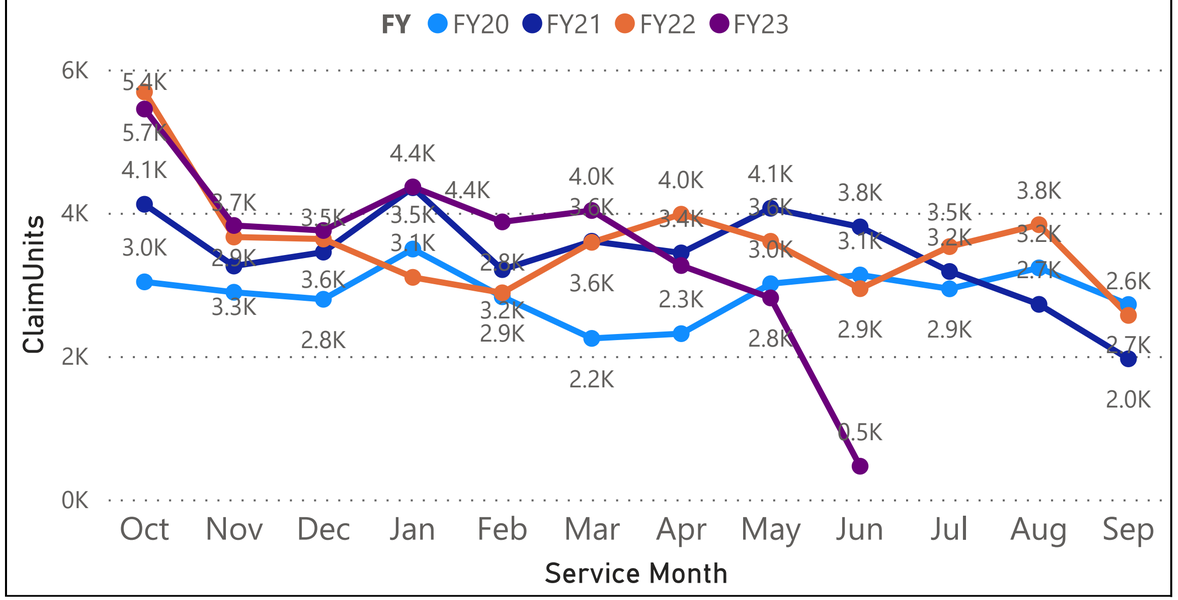
LRE Professional Units



LRE Institutional Units



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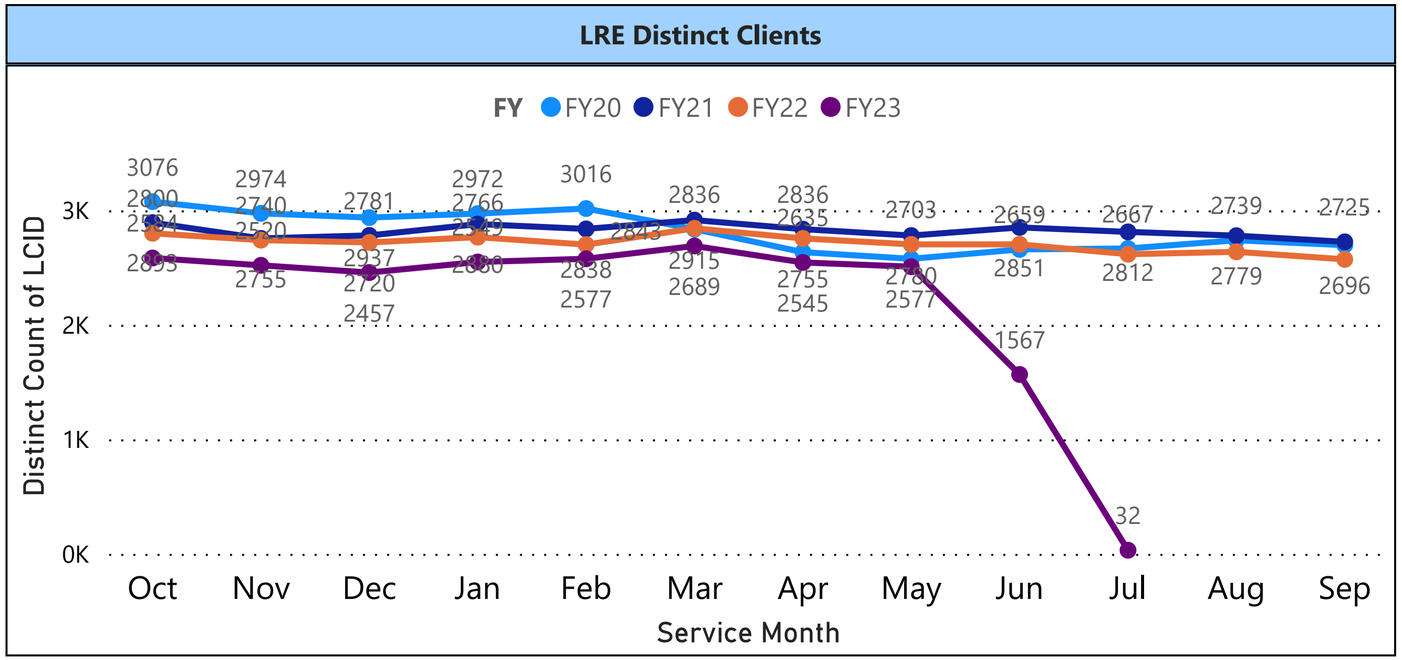
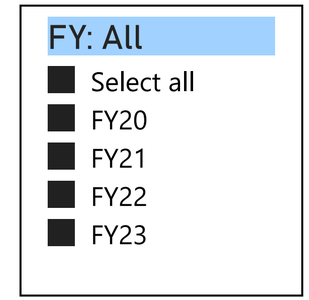
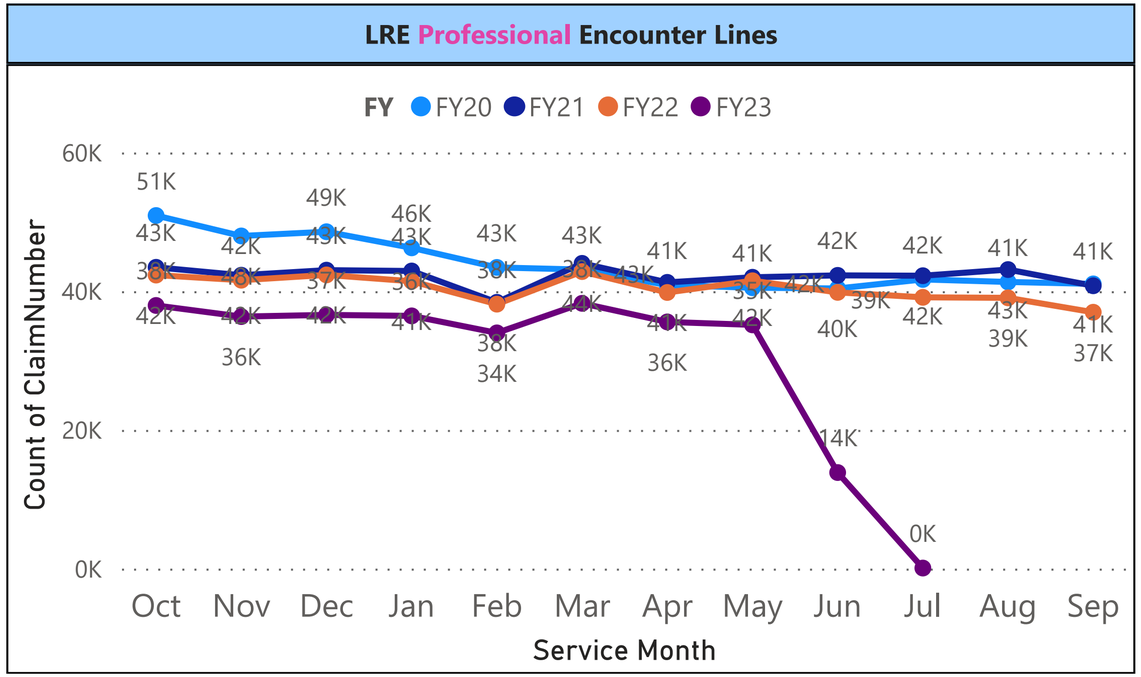
Latest ProcessDate

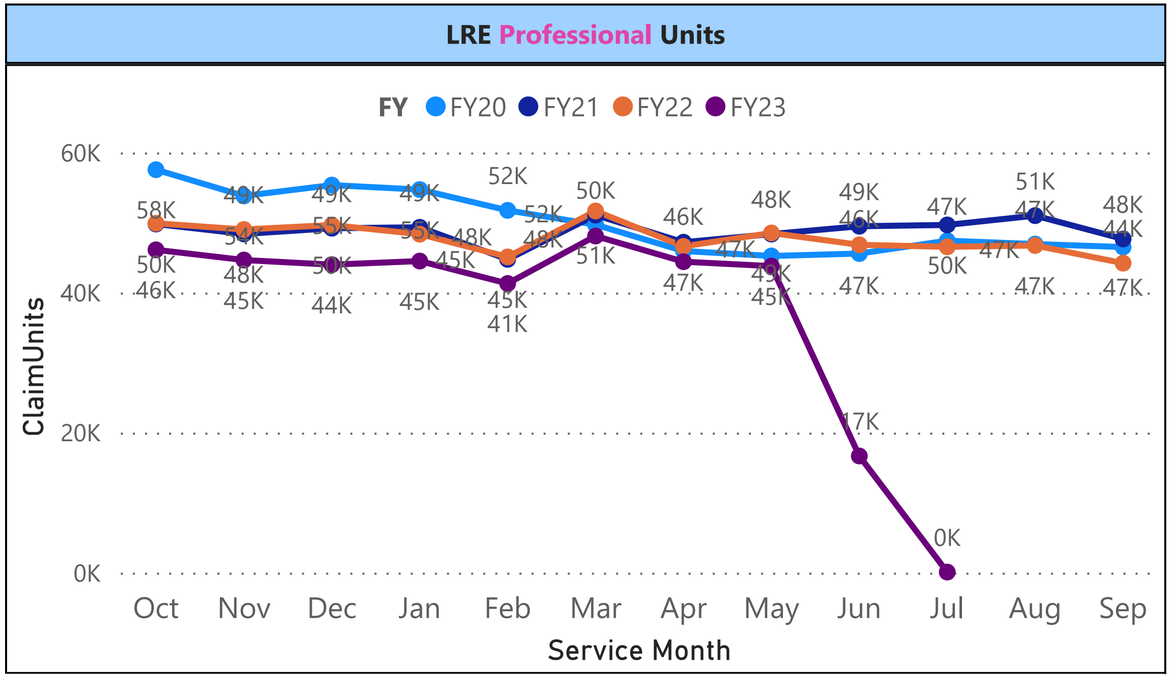
LRE

Substance Use Disorder









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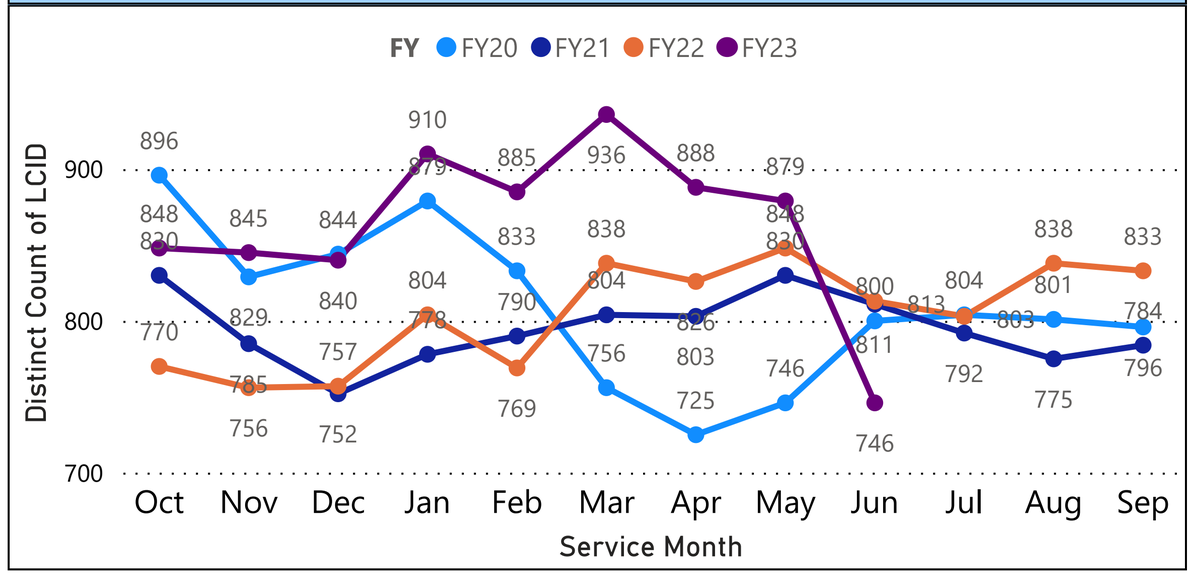
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

Allegan Behavioral Health

Allegan Distinct Clients



FY: All
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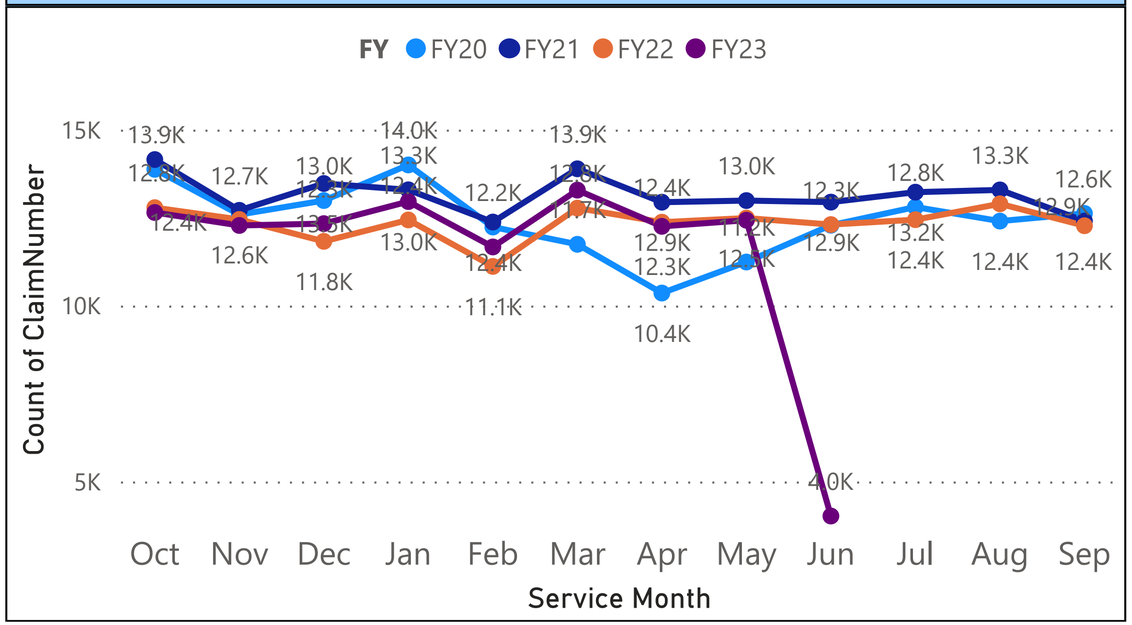
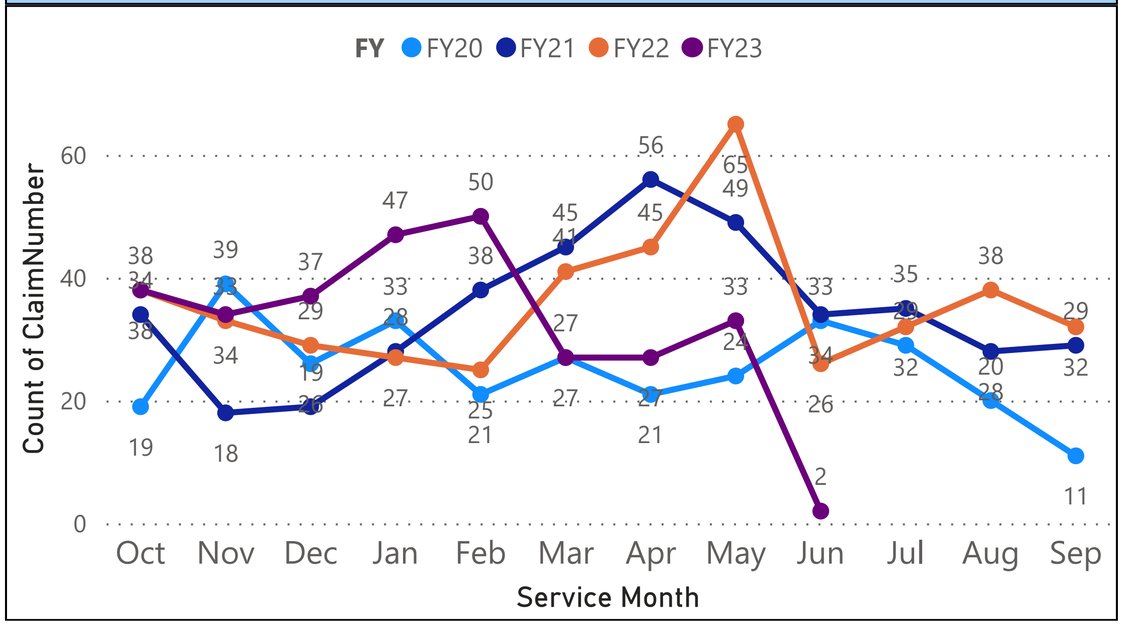
Allegan Professional Encounter Lines



Allegan Institutional Encounter Lines



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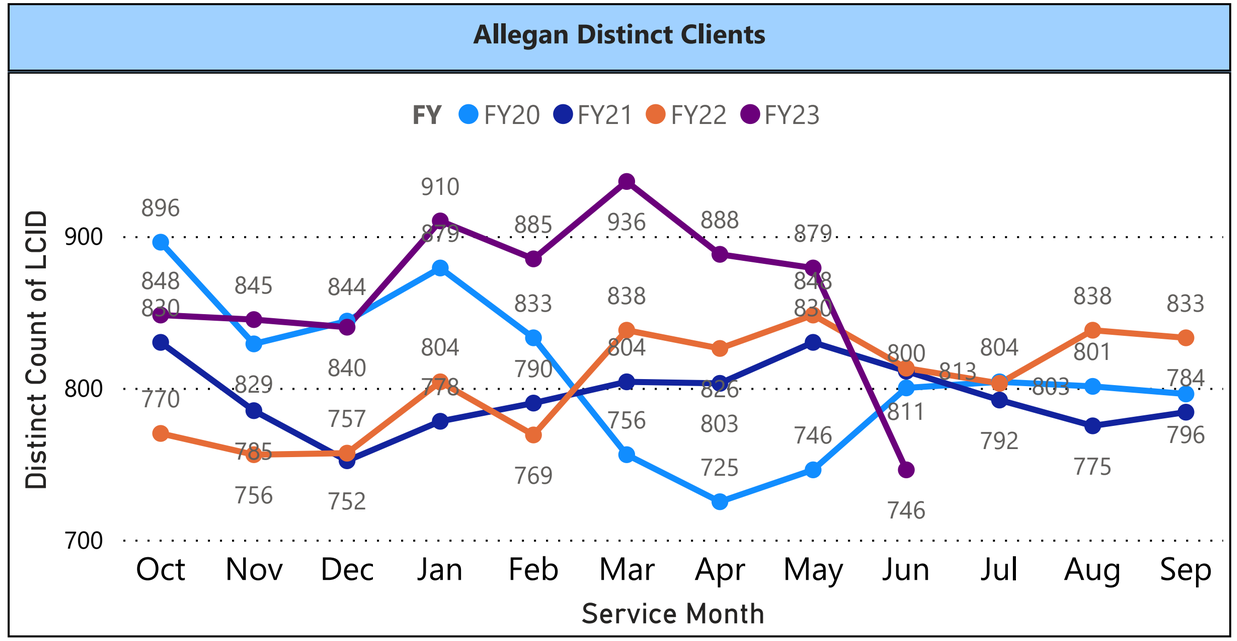
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

Allegan Behavioral Health

Allegan Distinct Clients



FY: All
- Select all
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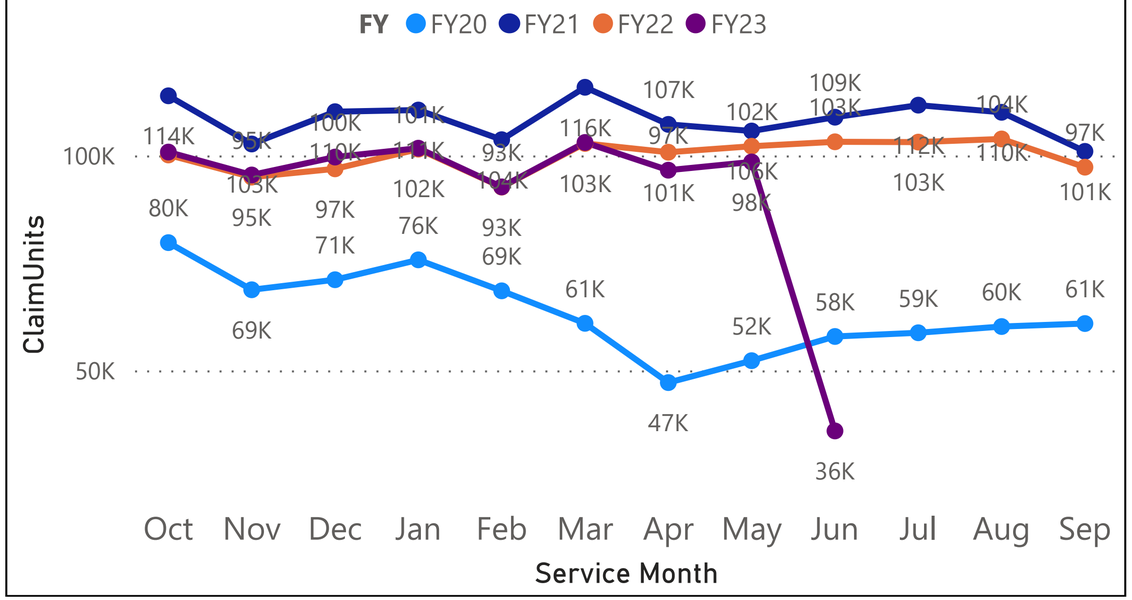
Allegan Professional Units



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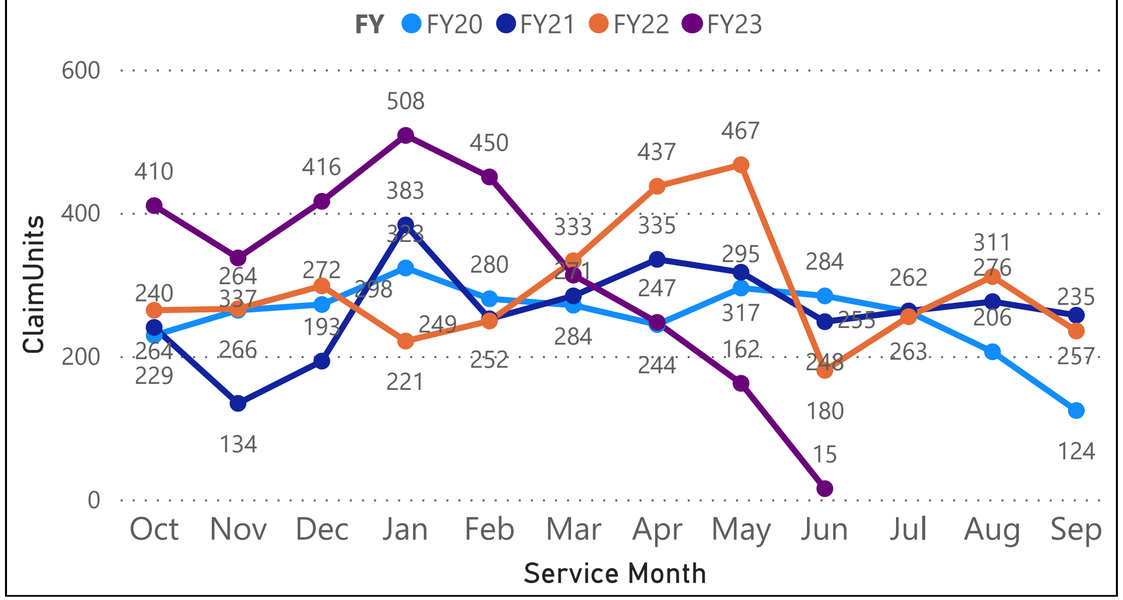

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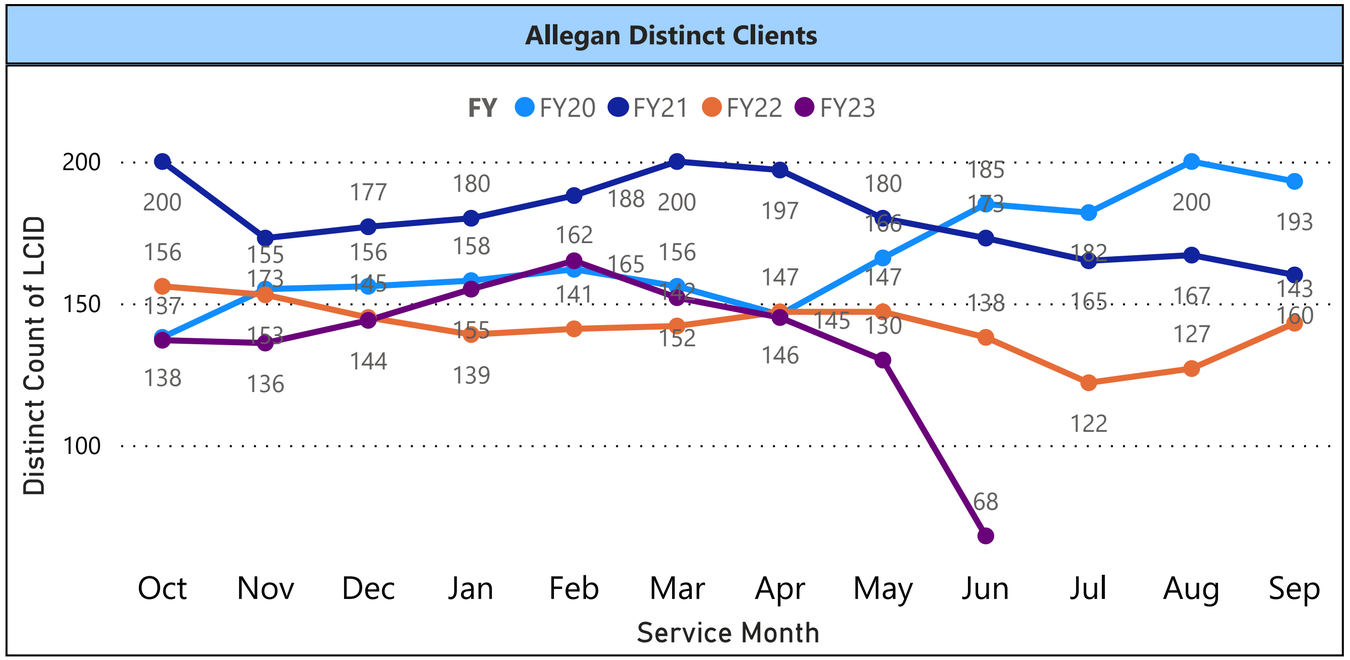
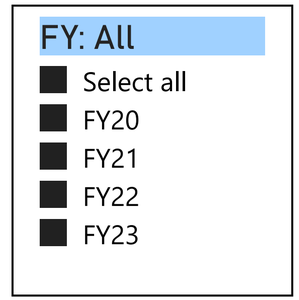
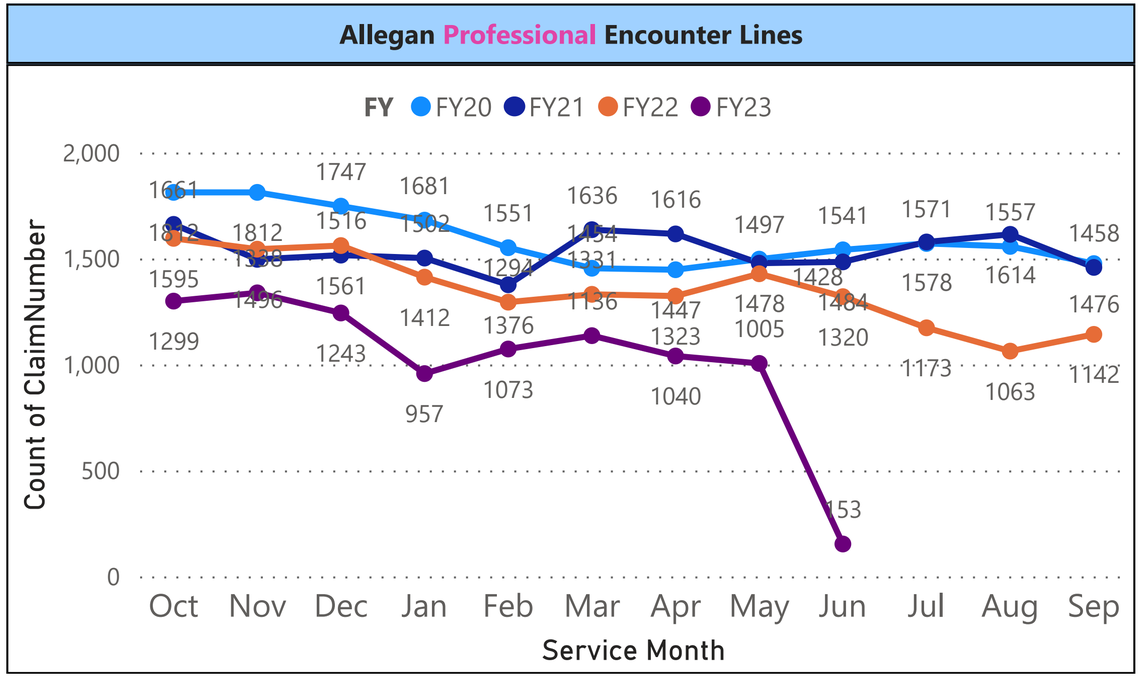
Latest ProcessDate

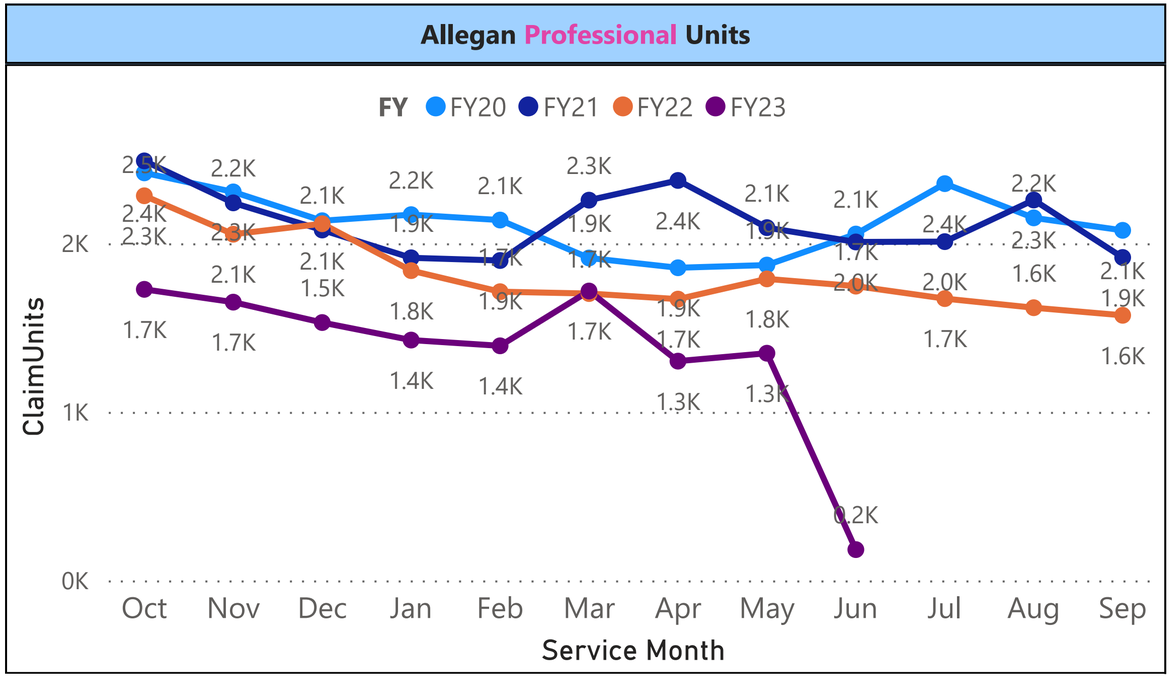
LAKESHORE REGIONAL ENTITY

Allegan
Substance Use Disorder









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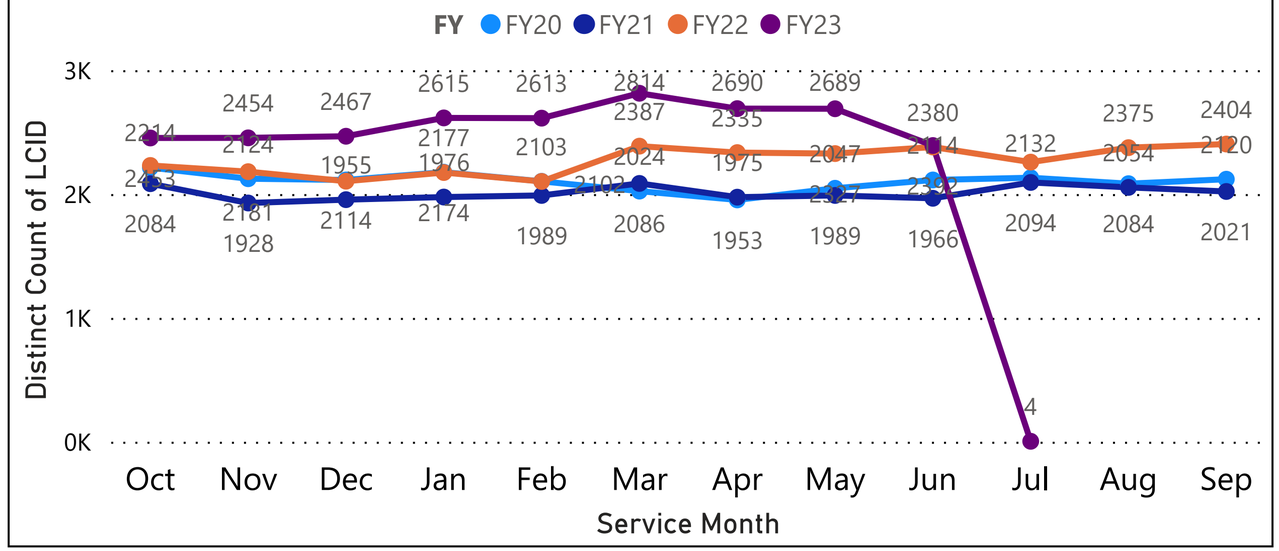
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

HealthWest Behavioral Health

HealthWest Distinct Clients



FY: All
- Select all
- FY20
- FY21
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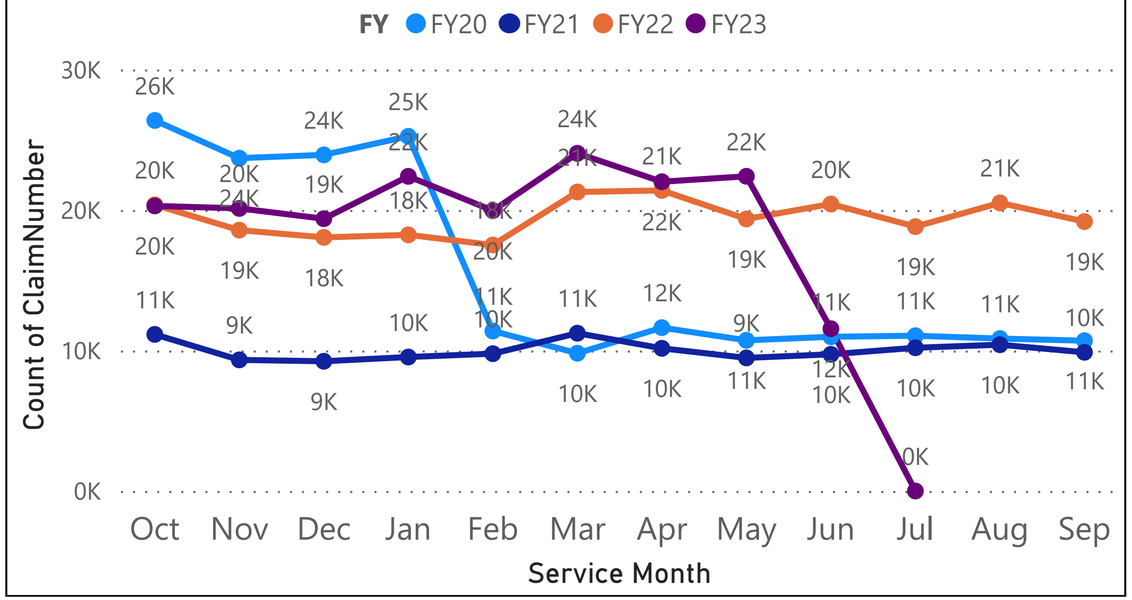
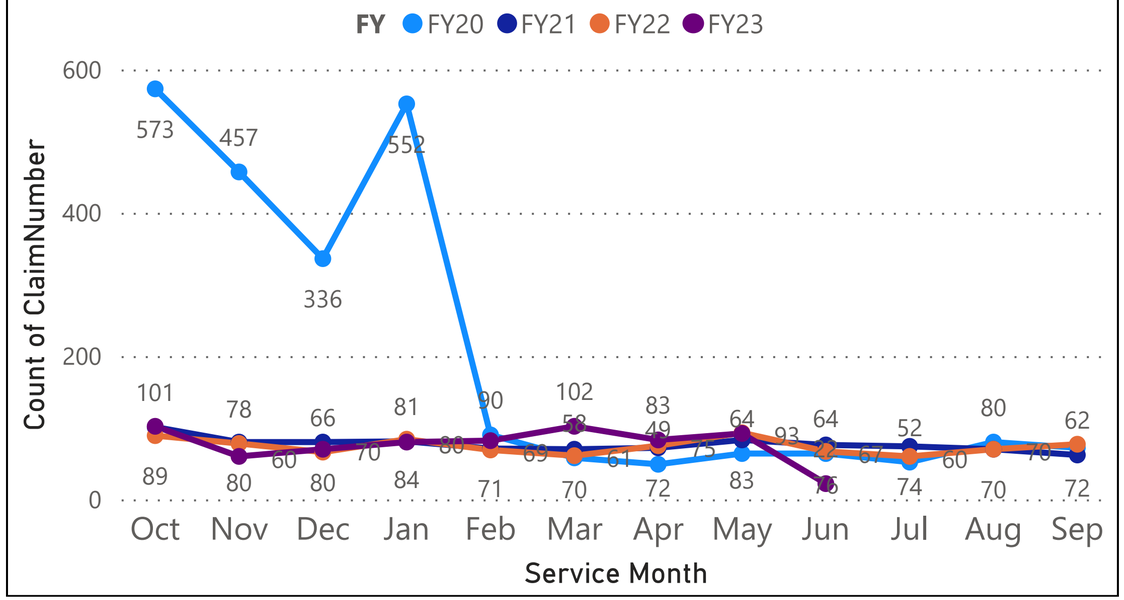
- FY23

HealthWest Professional Encounter Lines



HealthWest Institutional Encounter Lines



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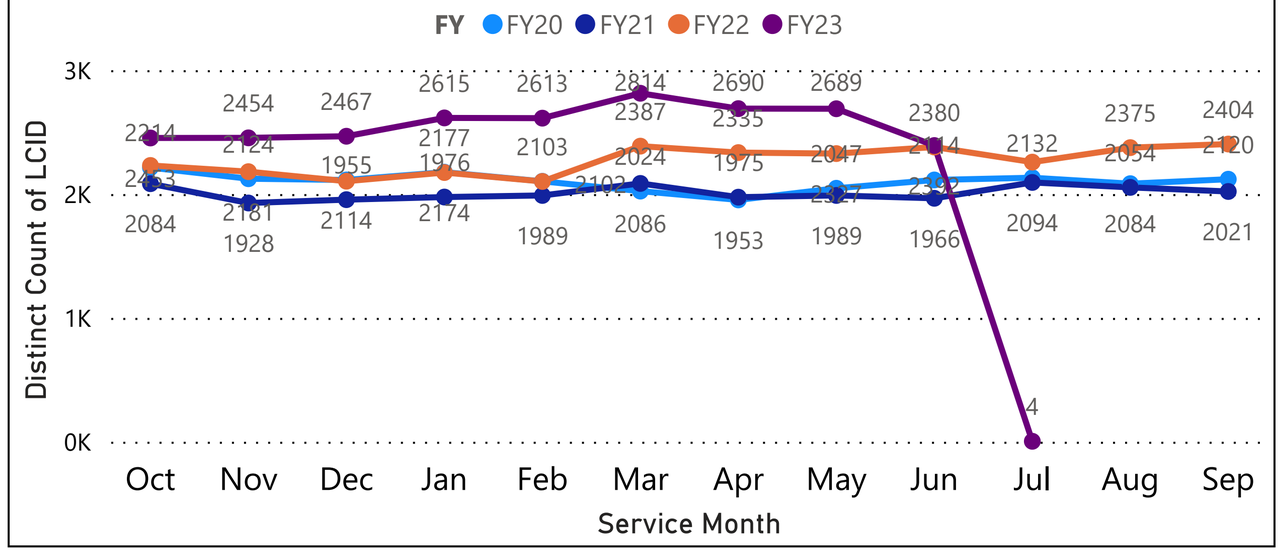
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

HealthWest Behavioral Health

HealthWest Distinct Clients



FY: All
- Select all
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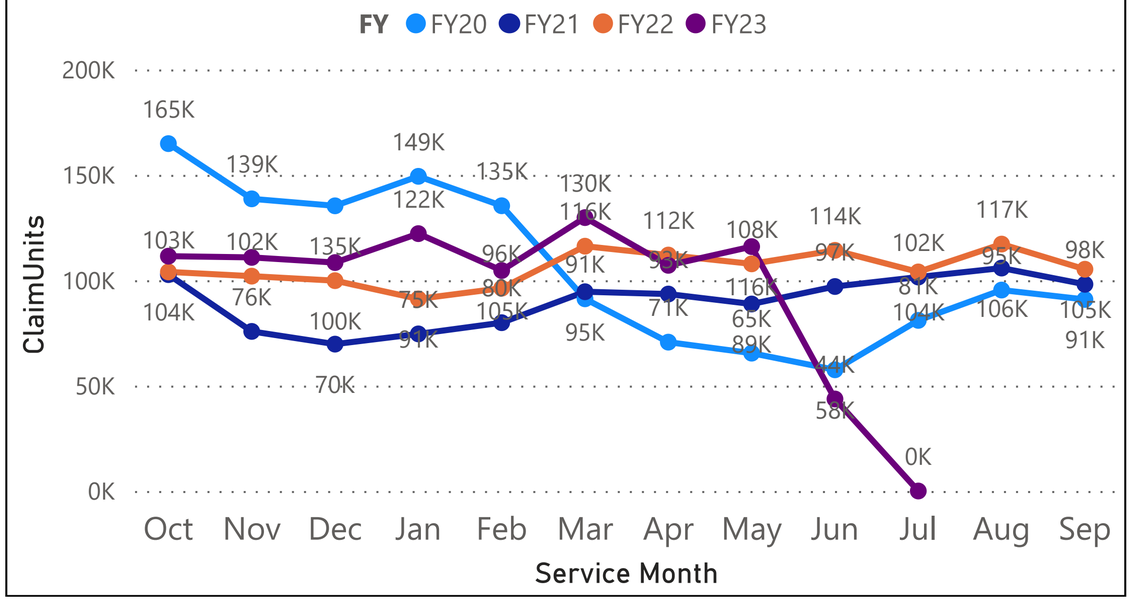
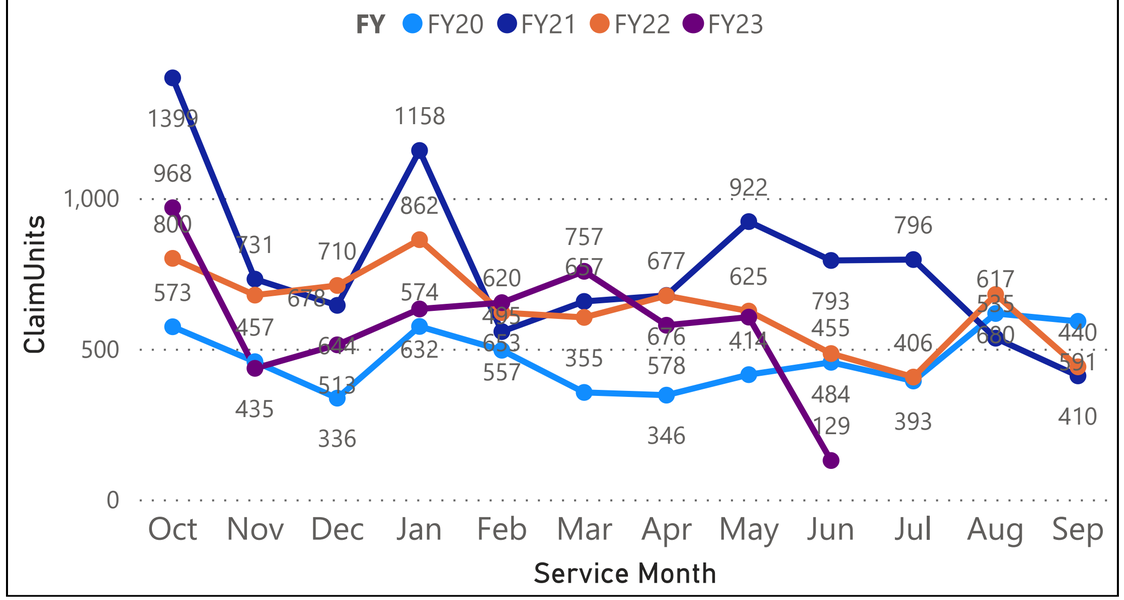
- FY23

HealthWest Professional Units



HealthWest Institutional Units



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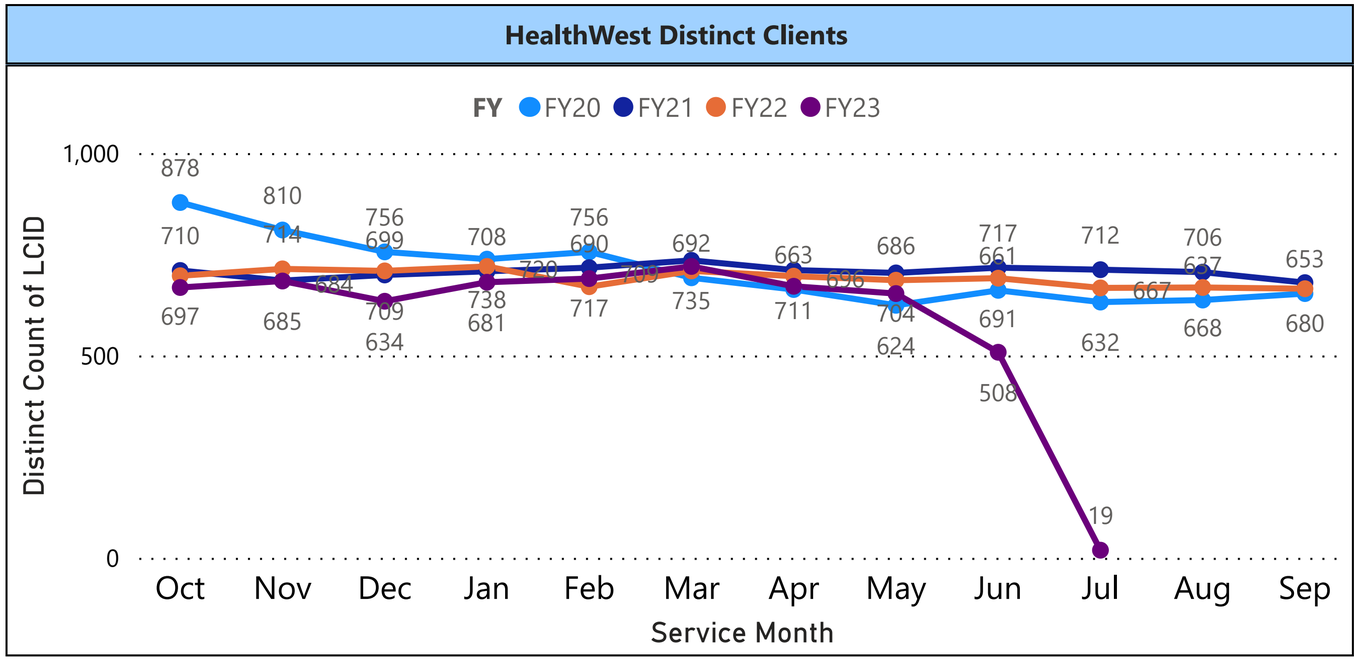
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

HealthWest
Substance Use Disorder



FY: All
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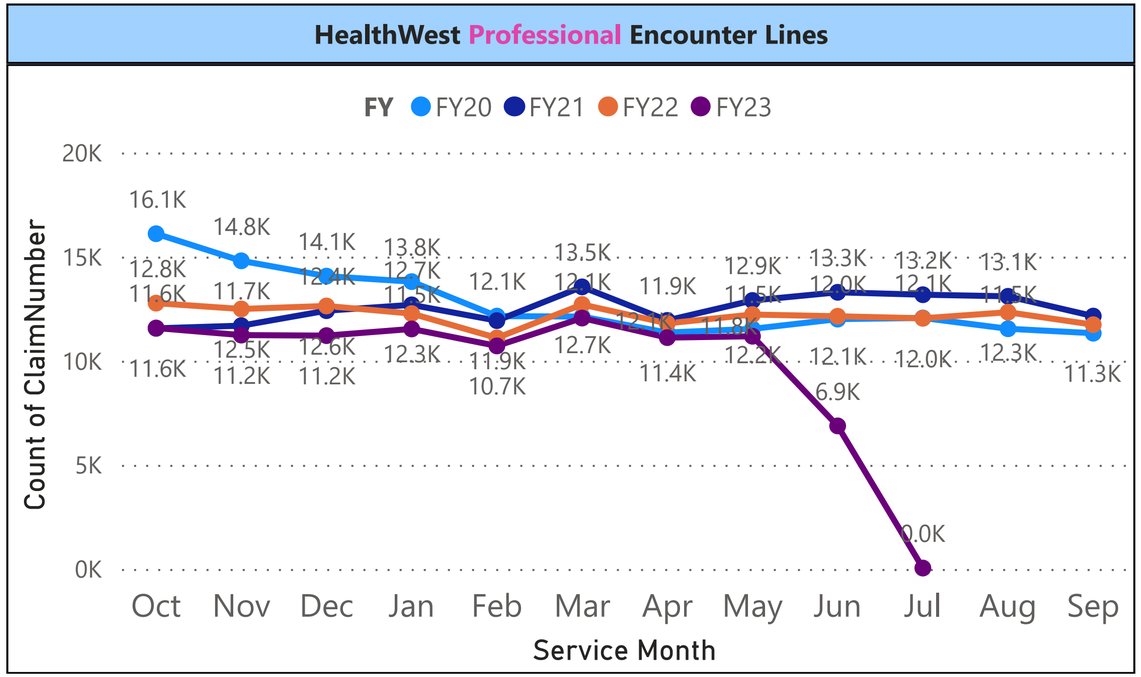

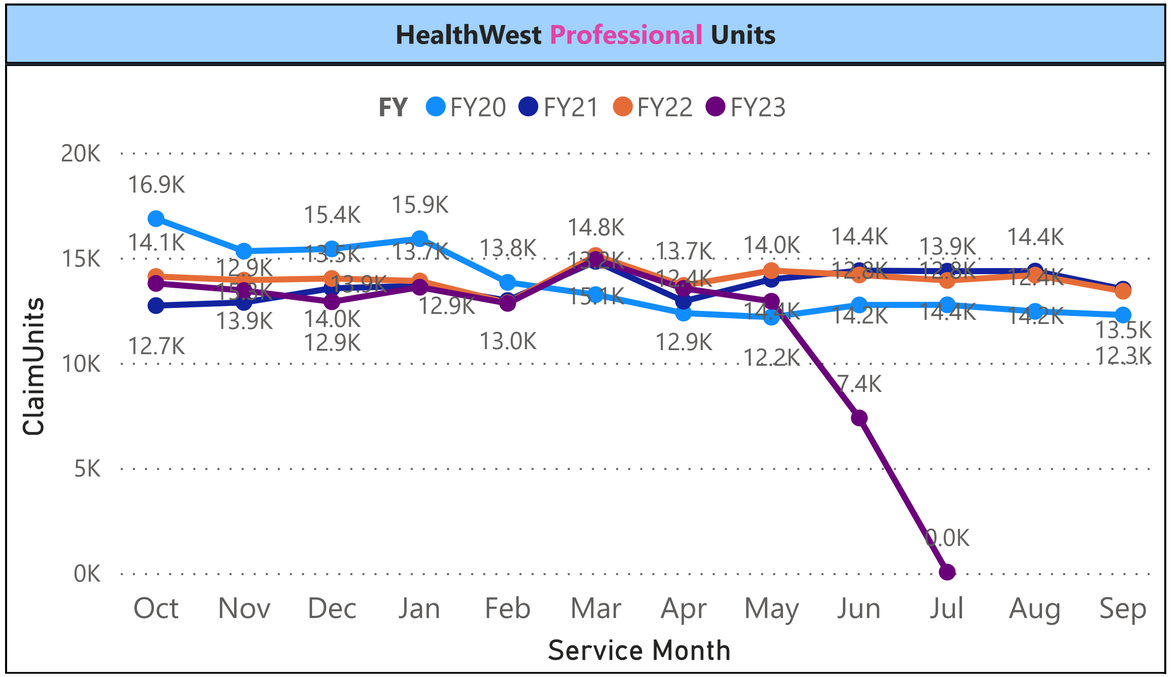

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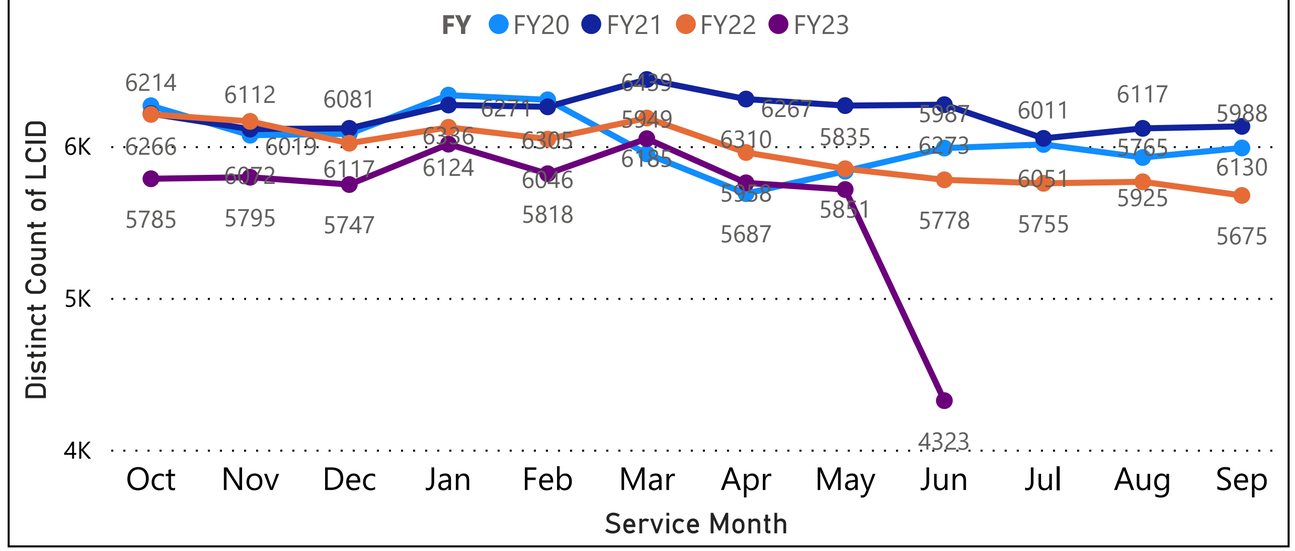
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

Network180 Behavioral Health

Network180 Distinct Clients



FY: All
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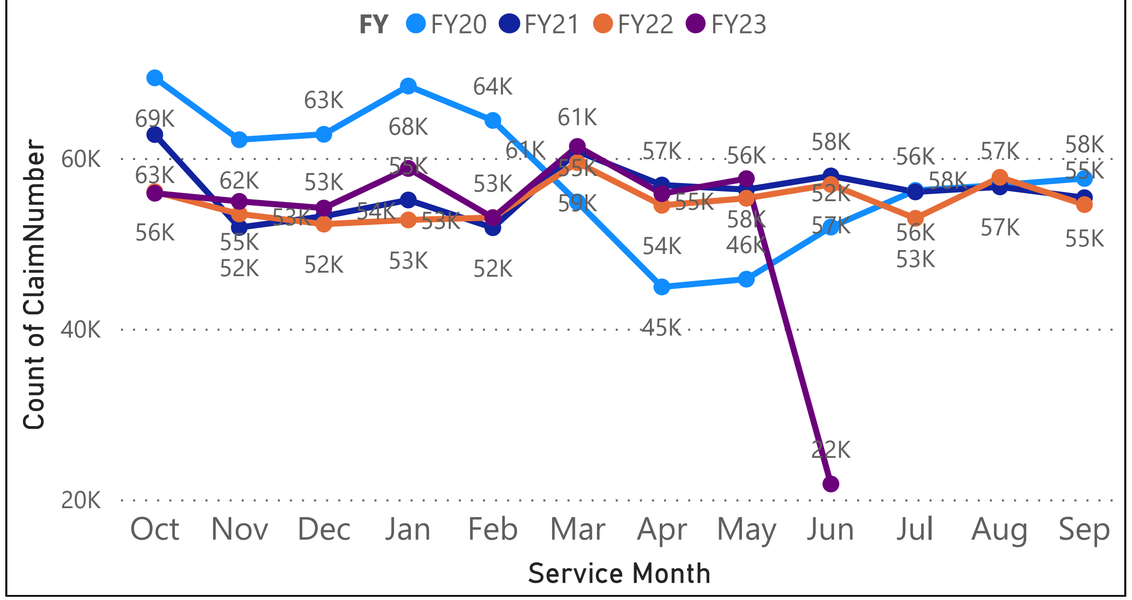
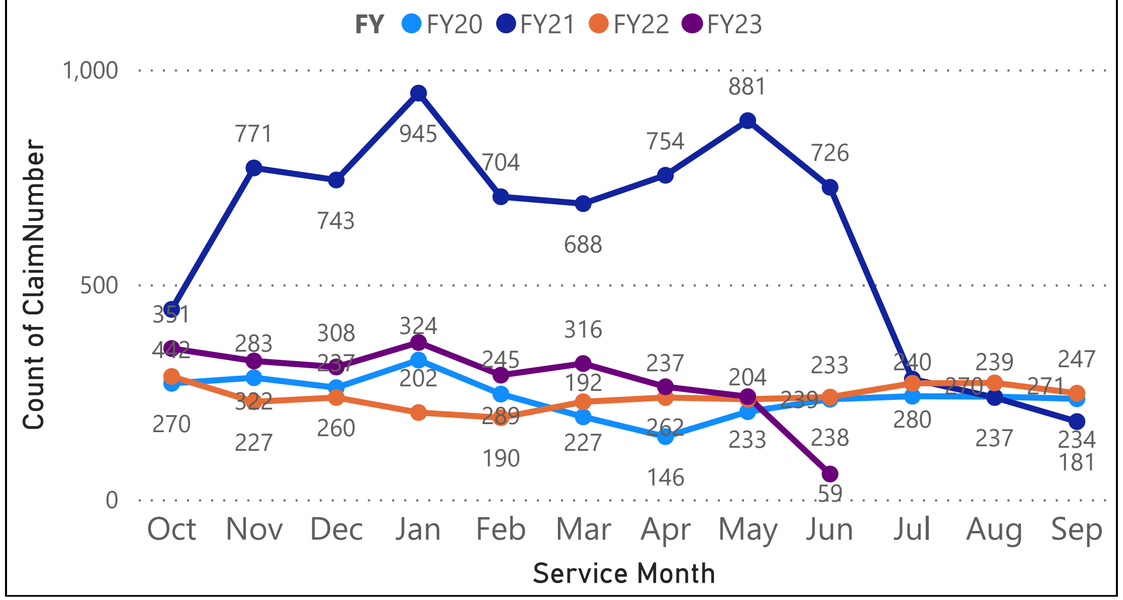
- FY23

Network180 Professional Encounter Lines



Network180 Institutional Encounter Lines



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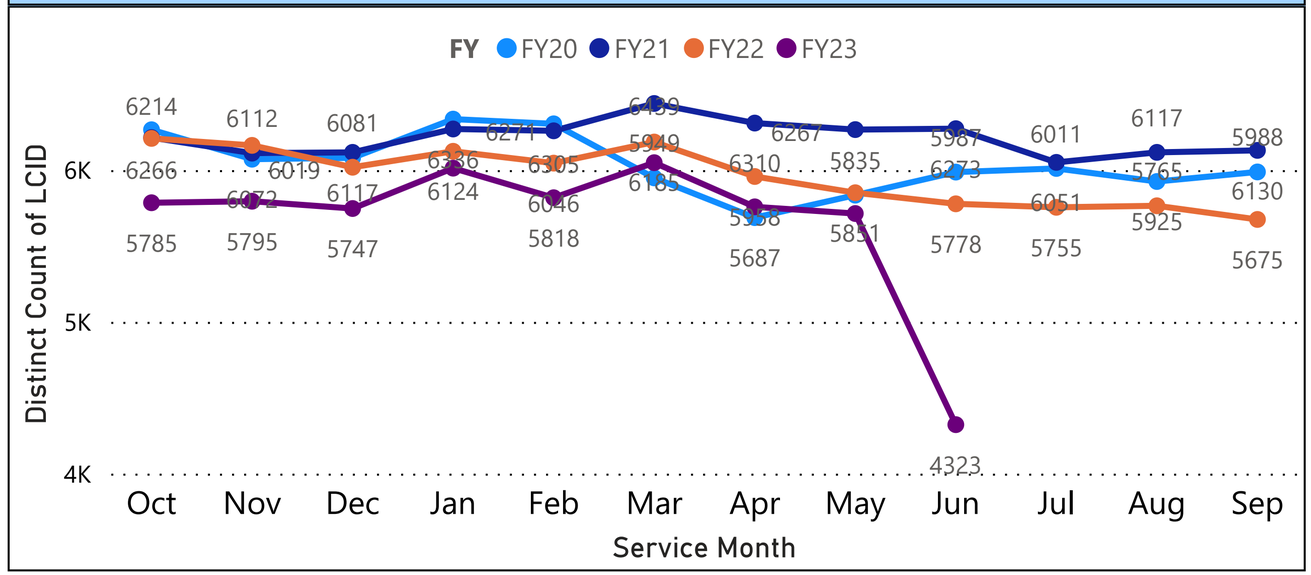
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

Network180 Behavioral Health

Network180 Distinct Clients



FY: All
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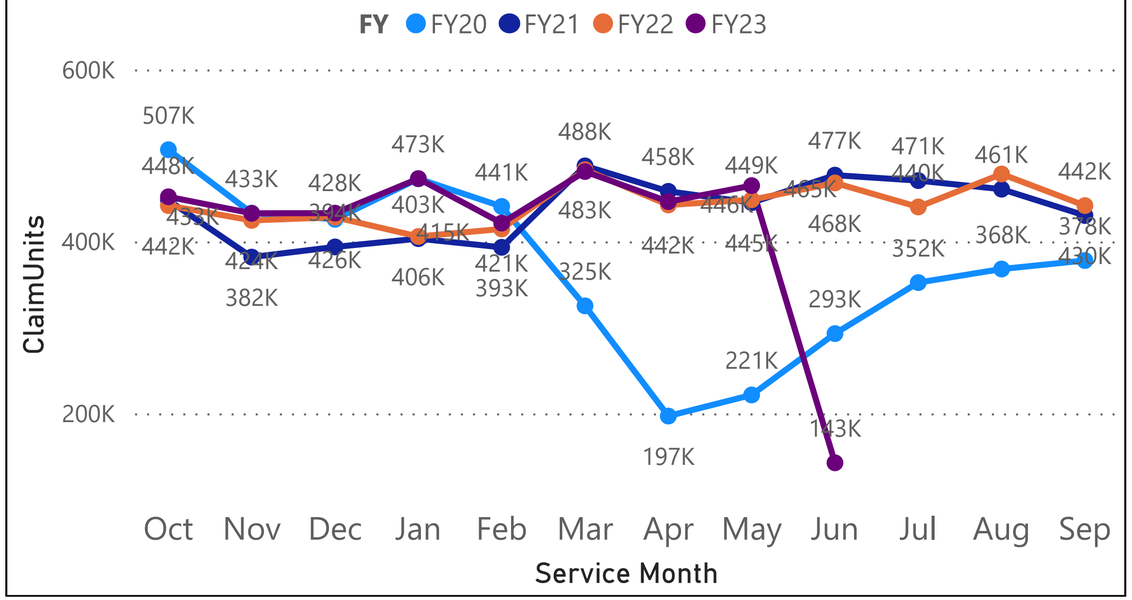
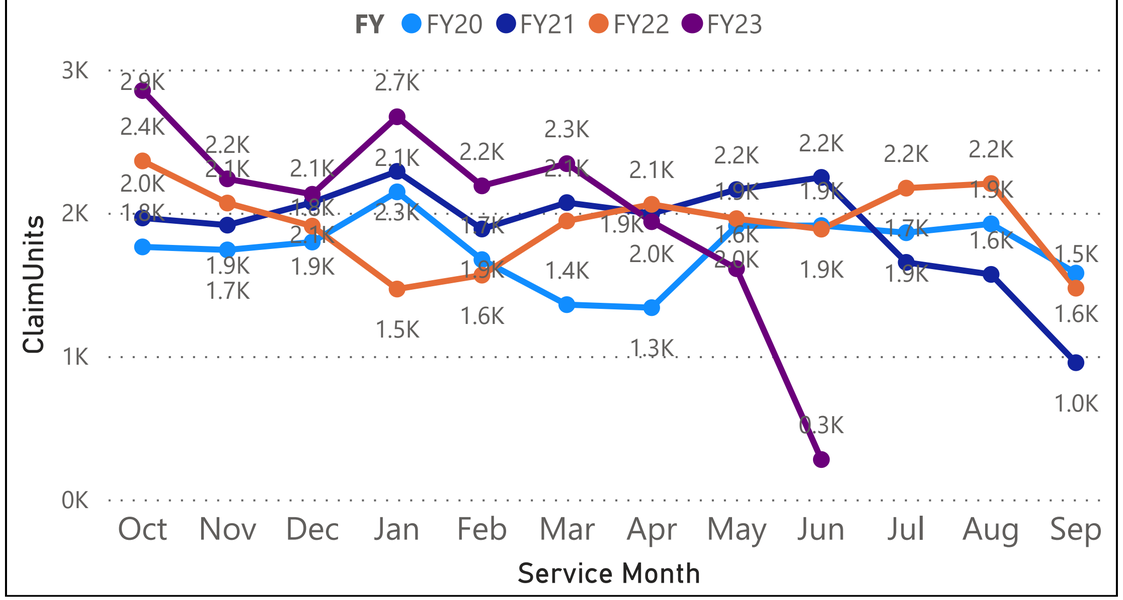
Network180 Professional Units



Network180 Institutional Units



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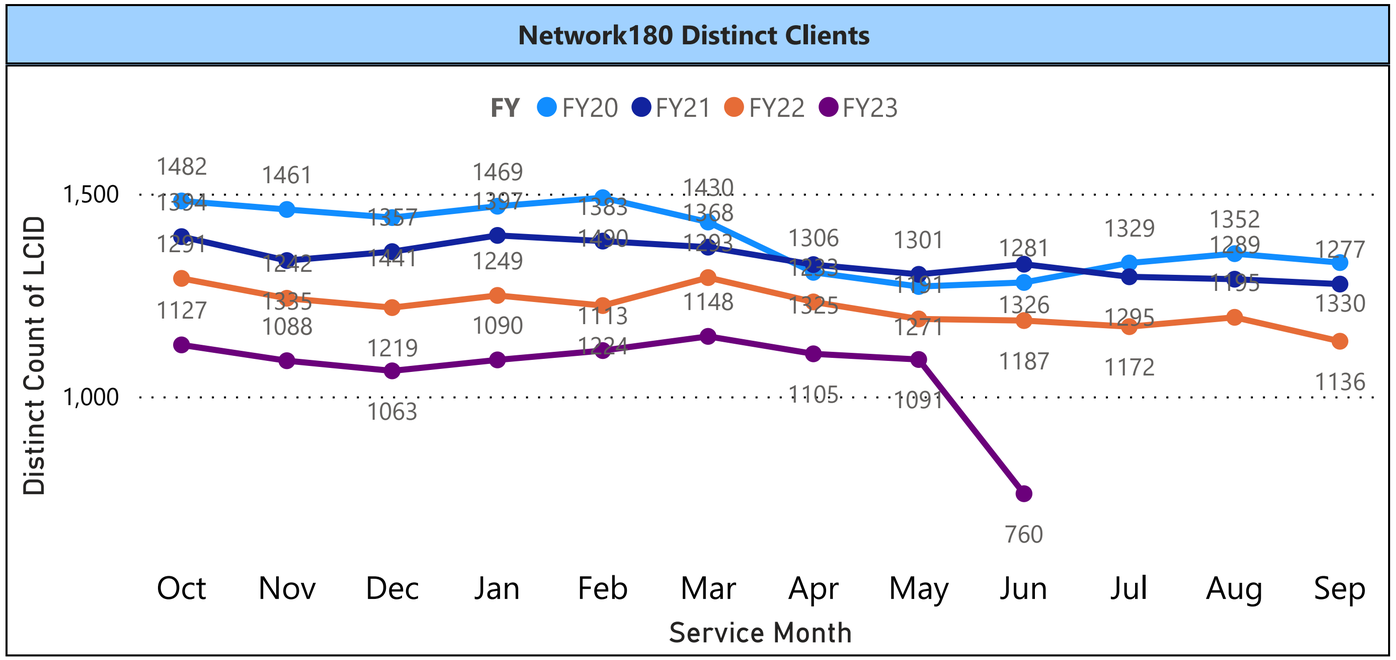
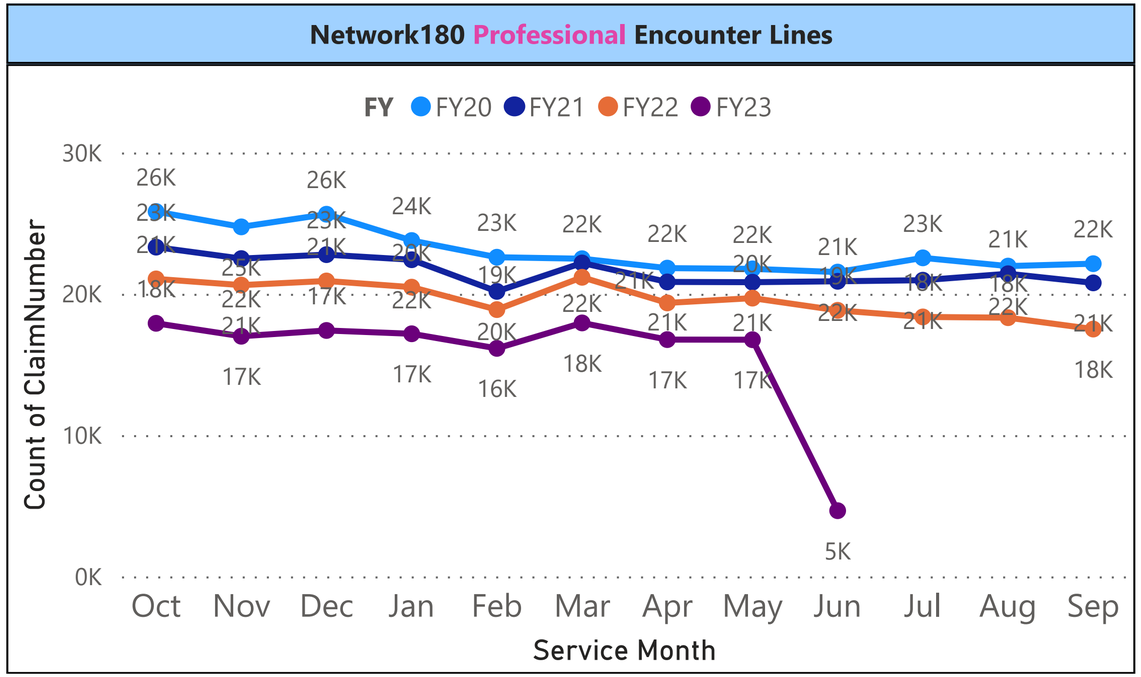
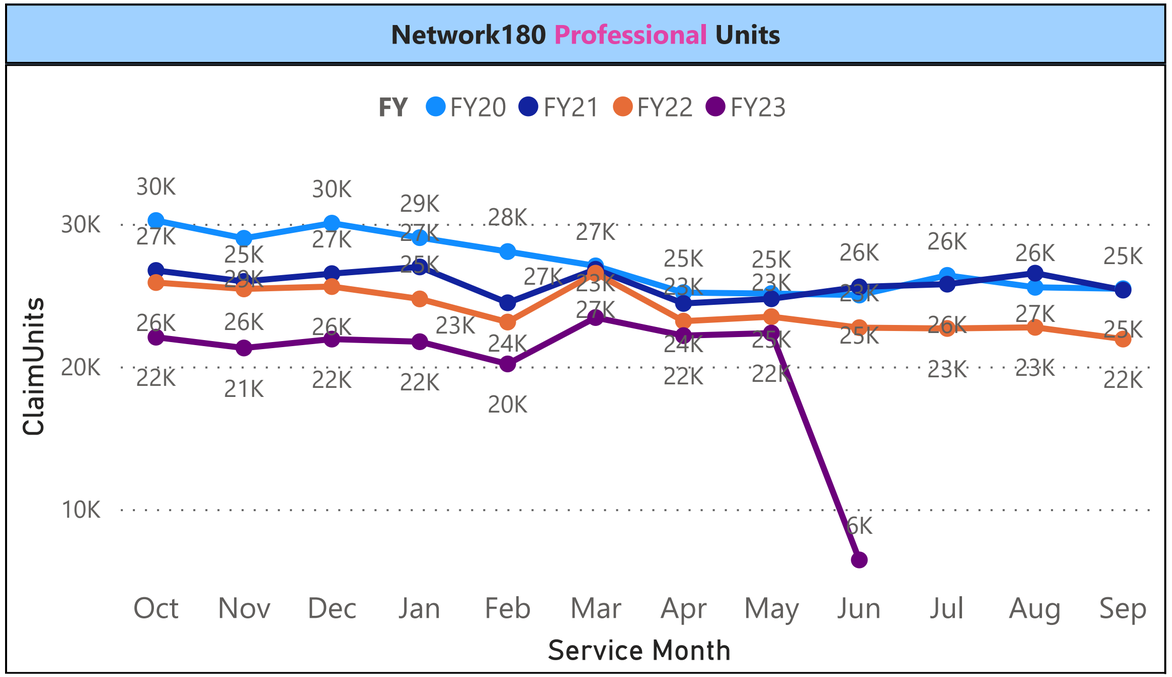
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

Network180
Substance Use Disorder







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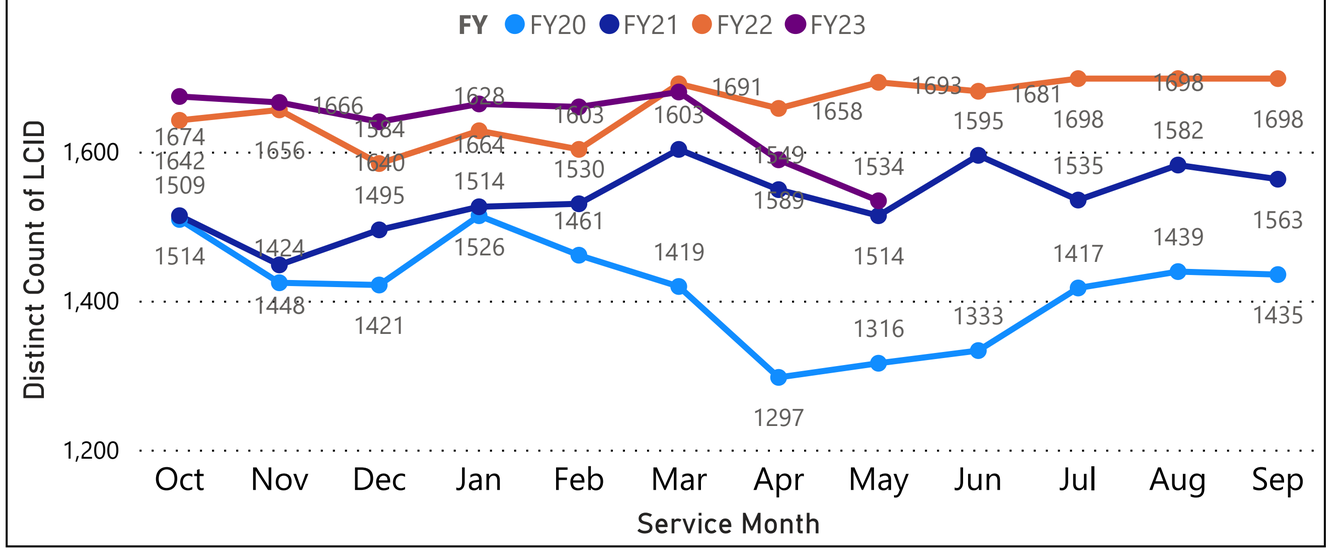
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

Ottawa Behavioral Health

Ottawa Distinct Clients



FY: All
- Select all
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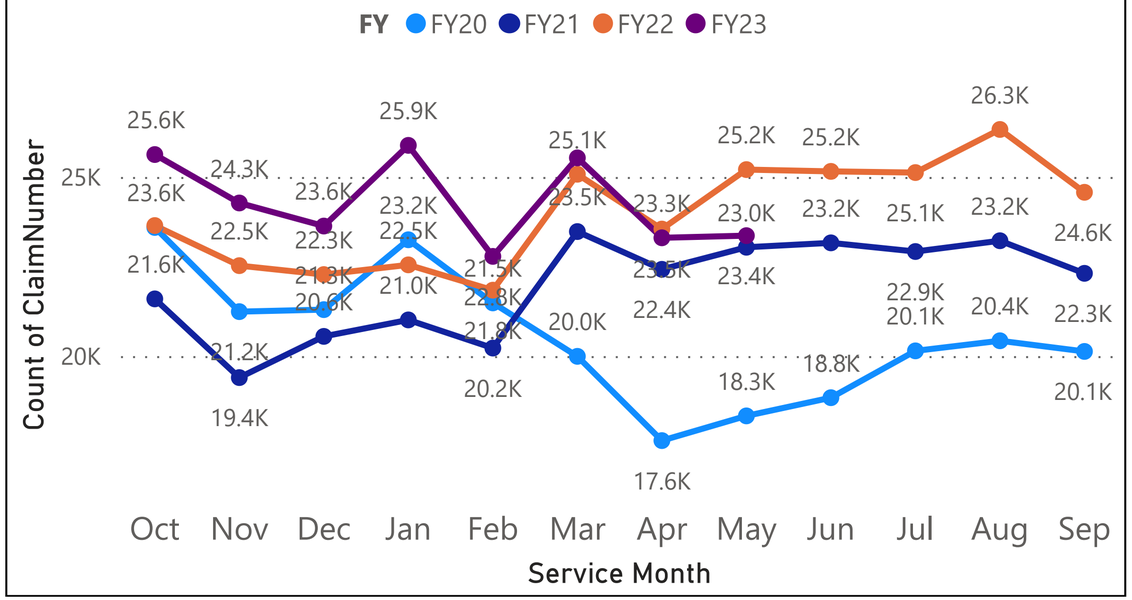
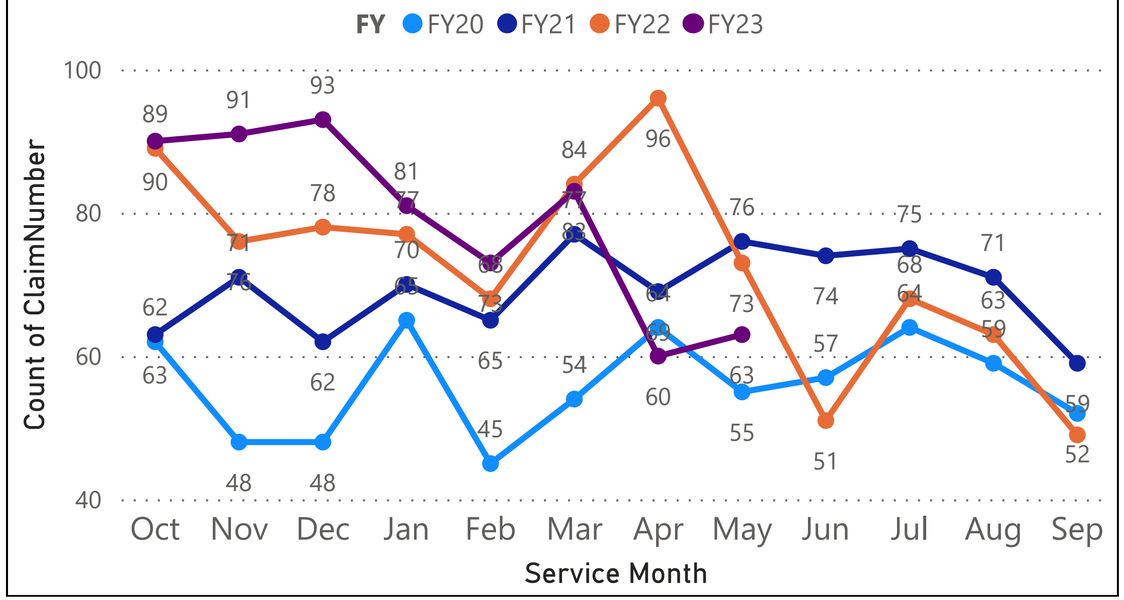
Ottawa Professional Encounter Lines



Ottawa Institutional Encounter Lines



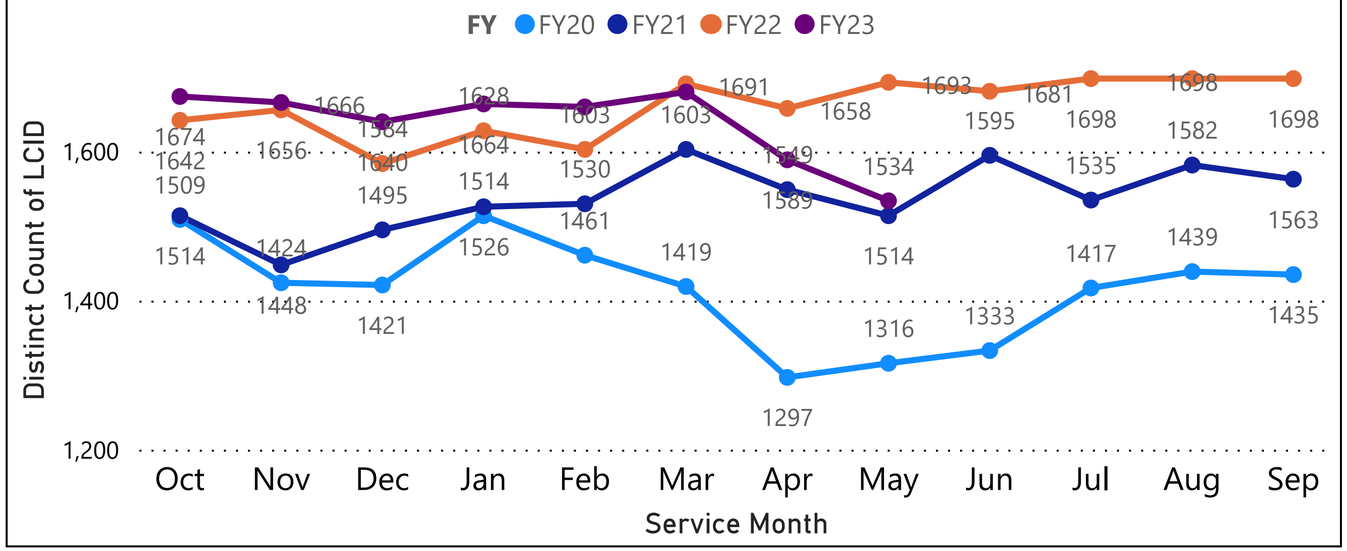
6/28/2023 4:11:33 PM

Latest ProcessDate

LAKESHORE REGIONAL ENTITY

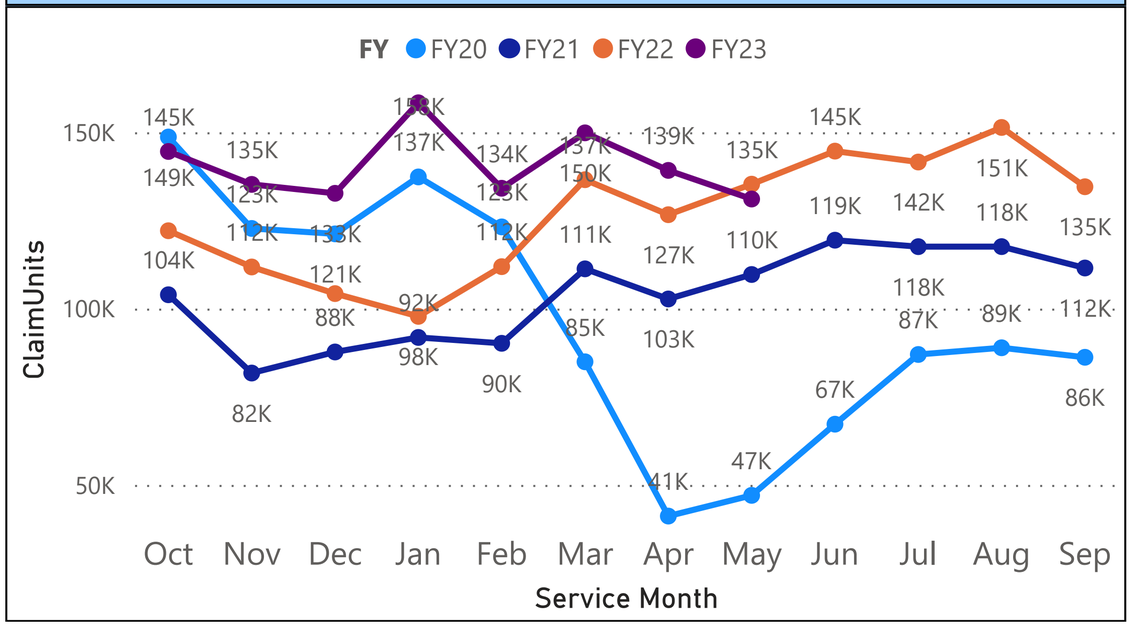
Ottawa
Behavioral Health

Ottawa Distinct Clients

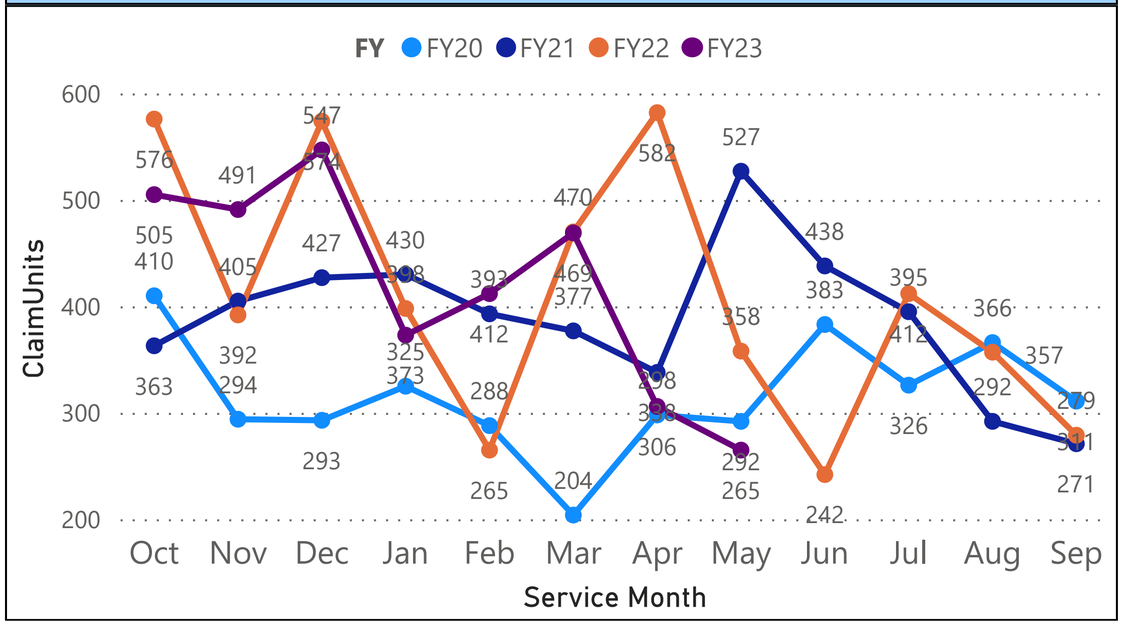


FY: All
- Select all
- FY20
- FY21
- FY22
- FY23

Ottawa Professional Units



Ottawa Institutional Units



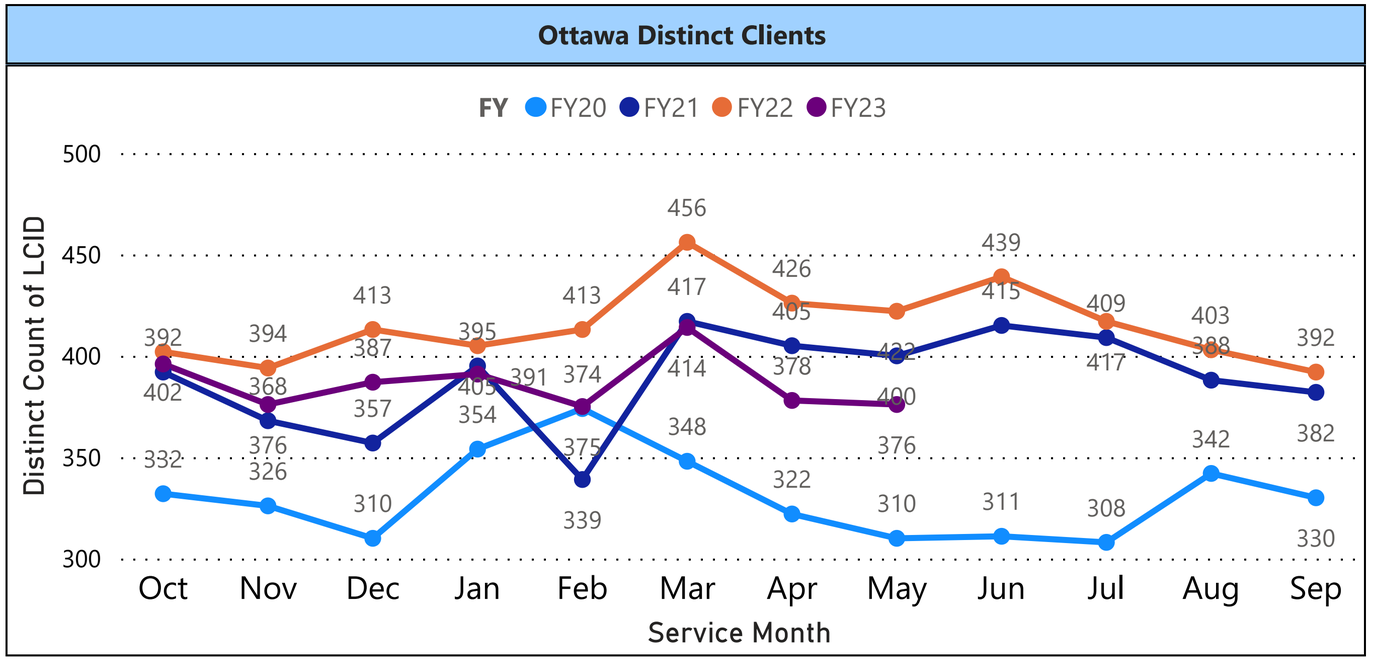
6/28/2023 4:11:33 PM

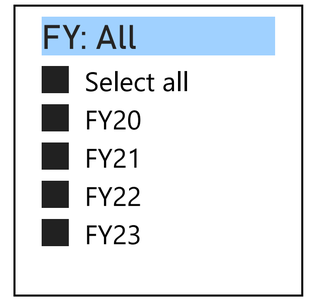
Latest ProcessDate

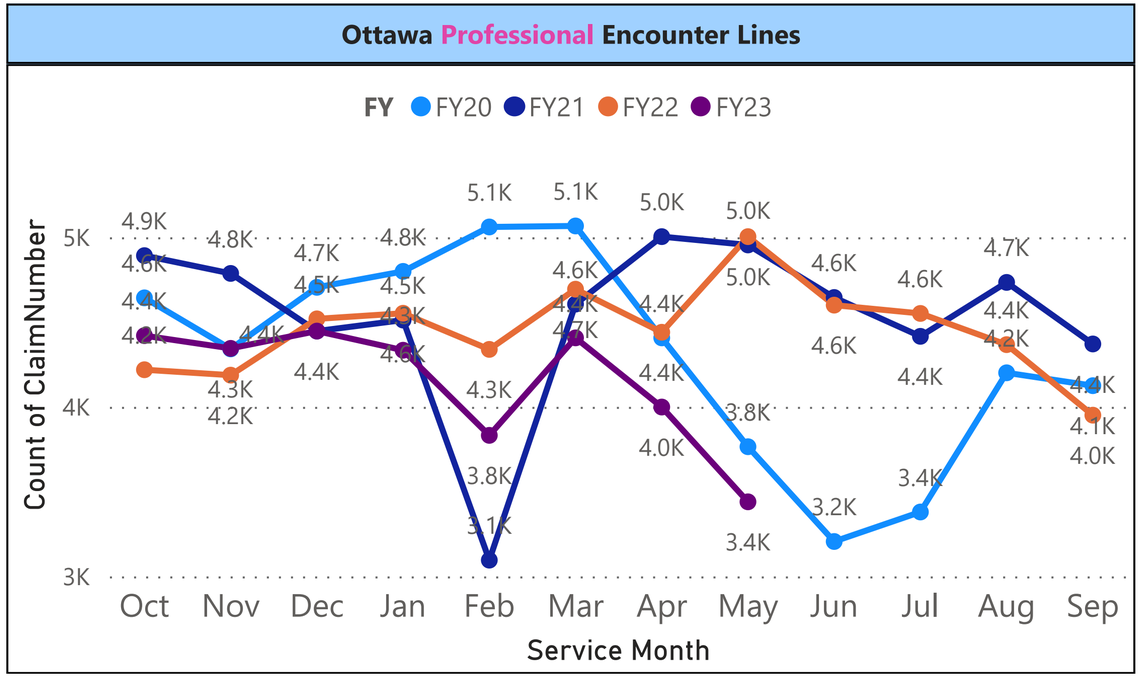
LAKESHORE REGIONAL ENTITY

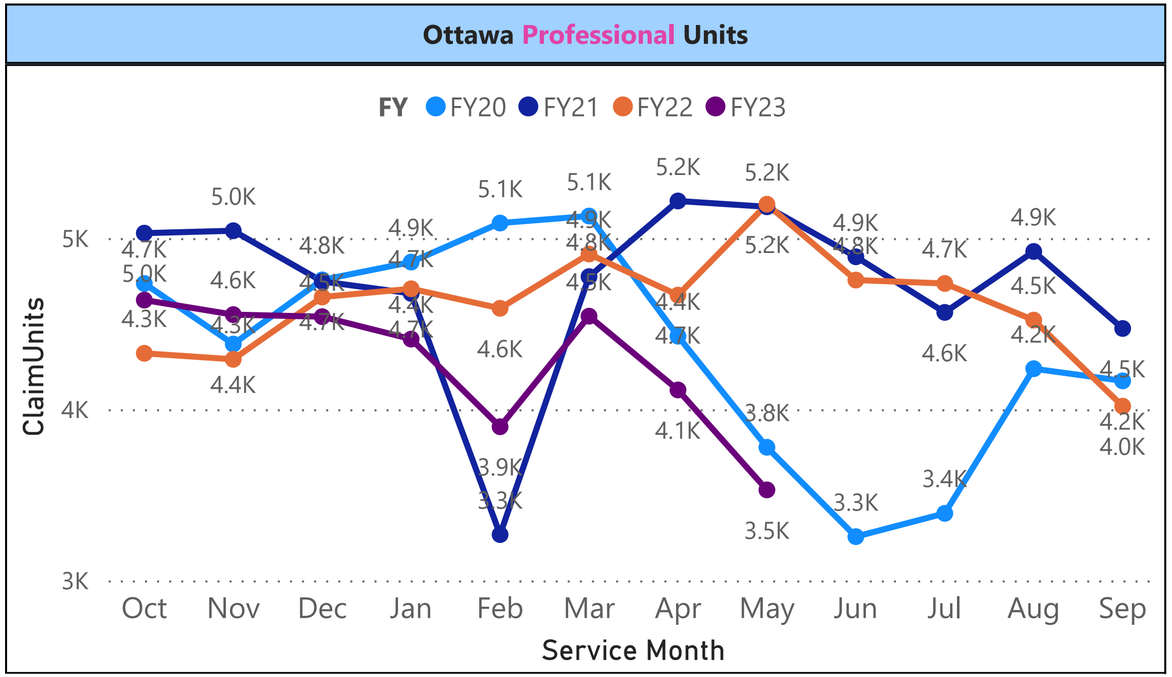
Ottawa

Substance Use Disorder









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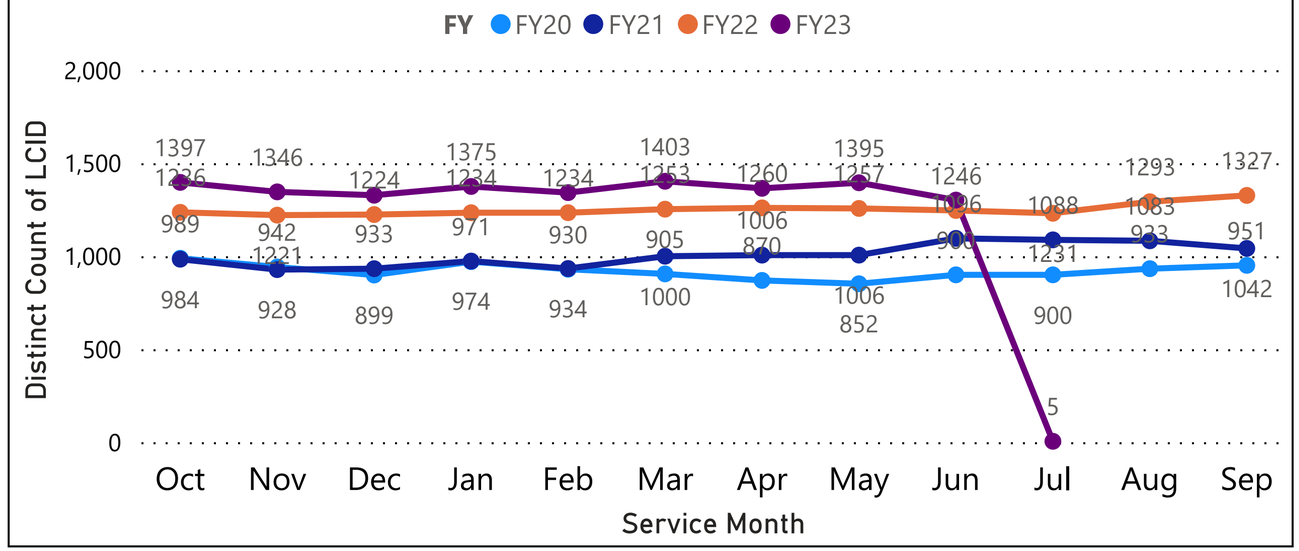
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

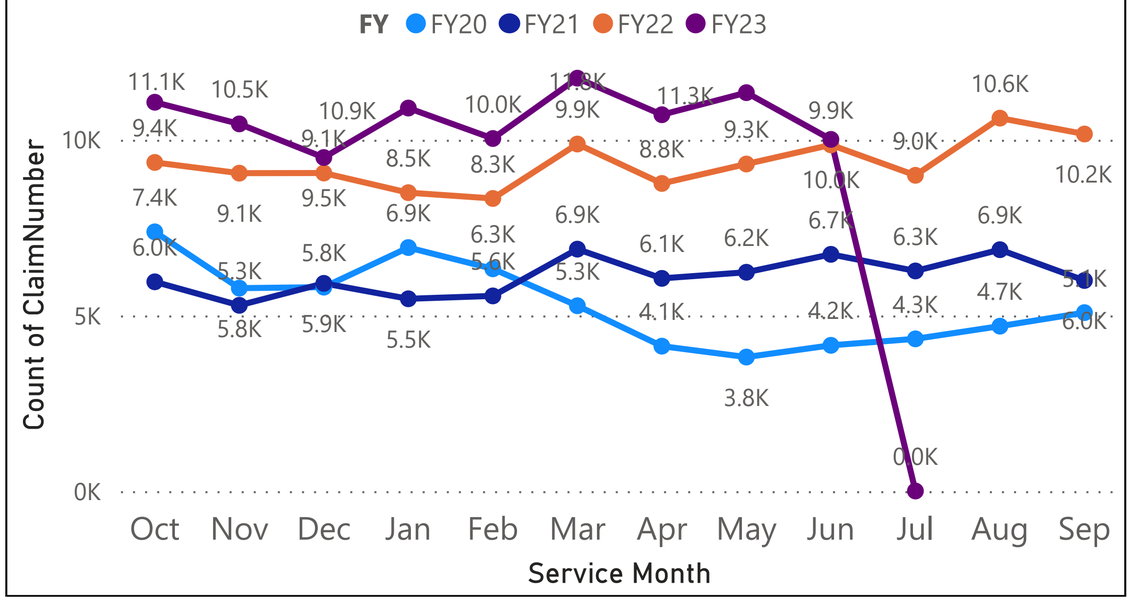
West Michigan Behavioral Health

West Michigan Distinct Clients

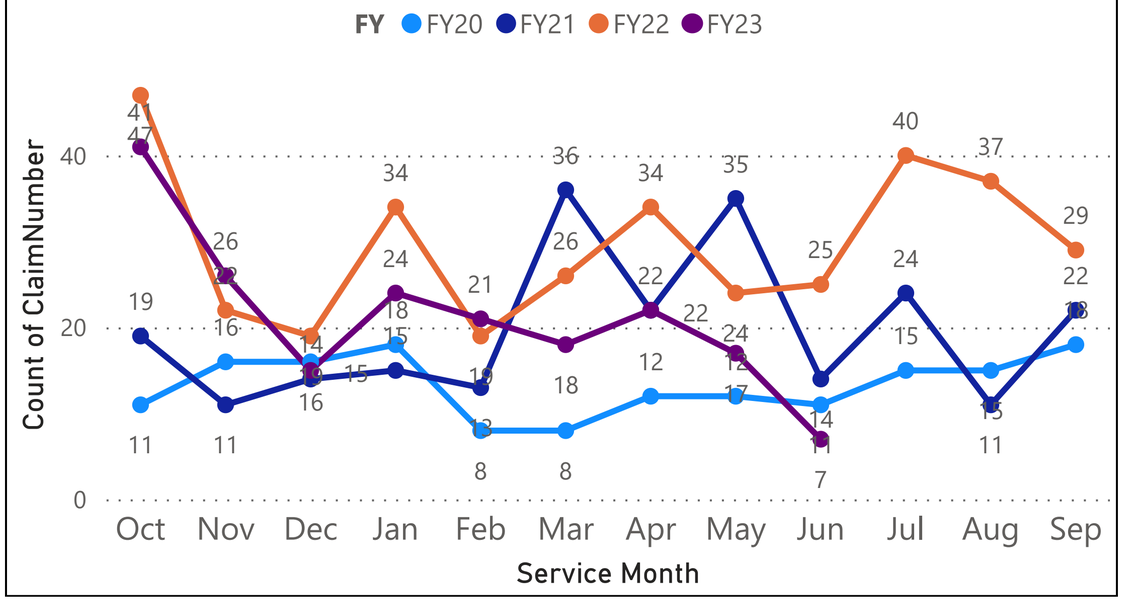


FY: All
- Select all
- FY20
- FY21
- FY22
- FY23

West Michigan Professional Encounter Lines



West Michigan Institutional Encounter Lines



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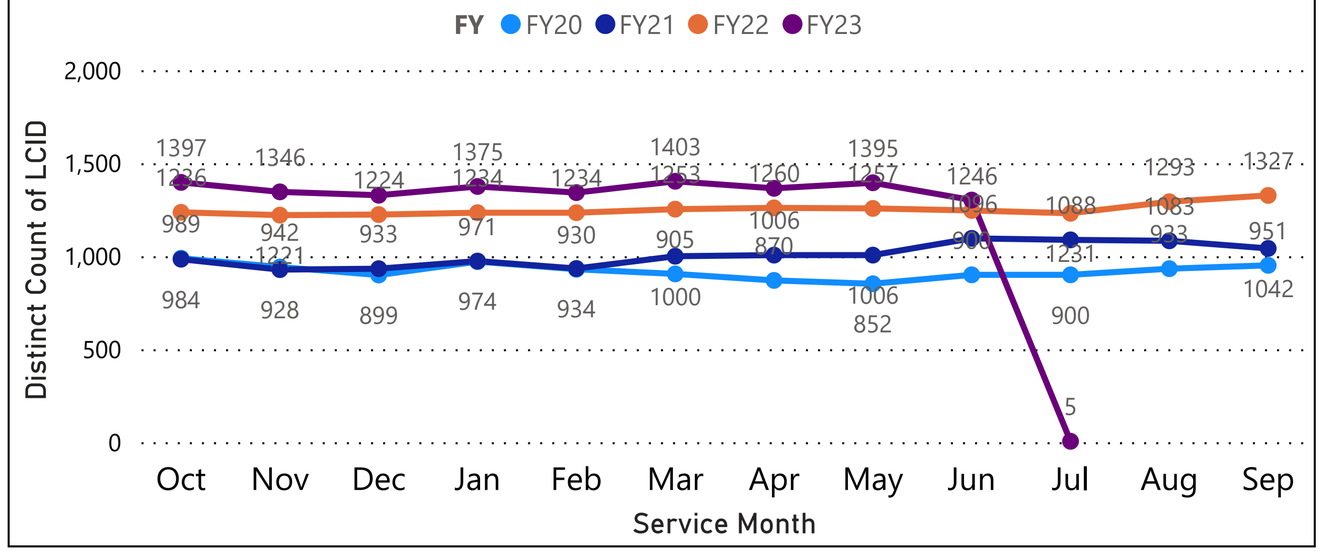
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

West Michigan Behavioral Health

West Michigan Distinct Clients



FY: All
- Select all
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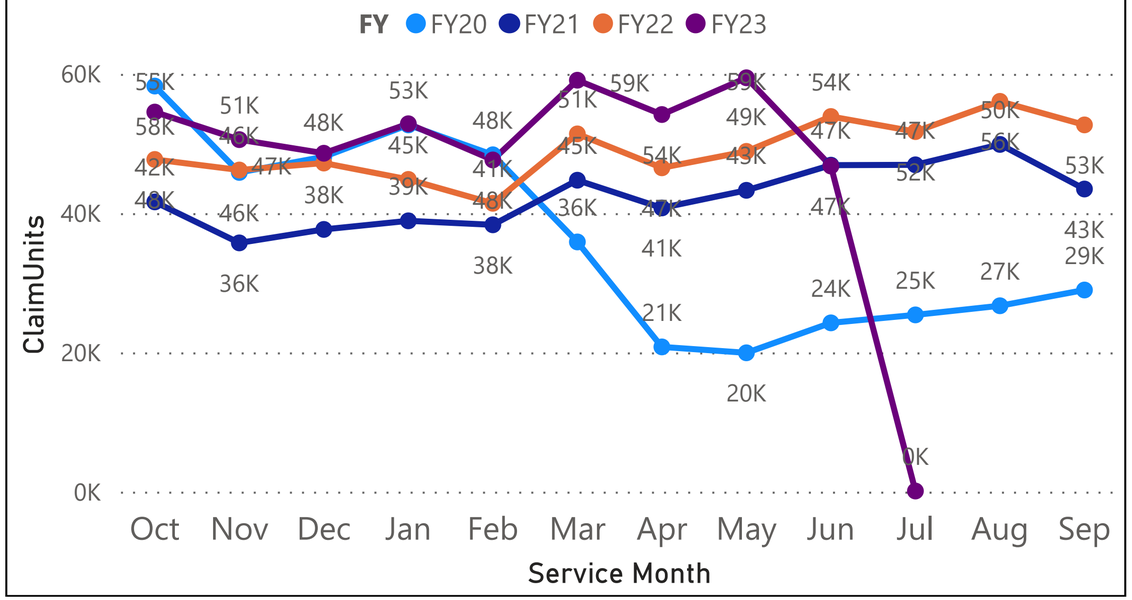
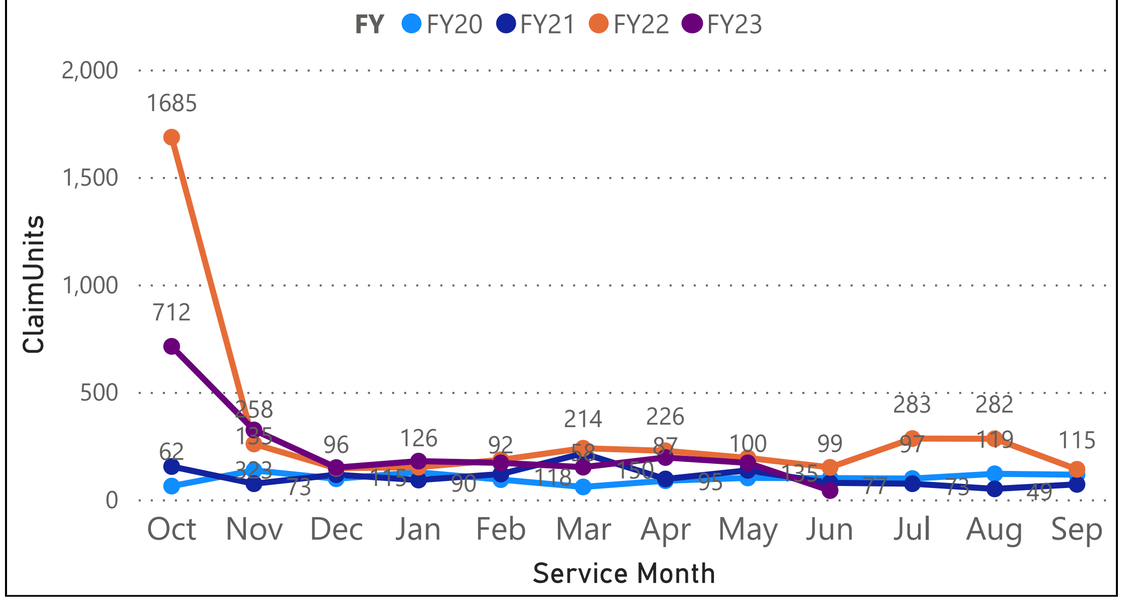
West Michigan Professional Units



West Michigan Institutional Units



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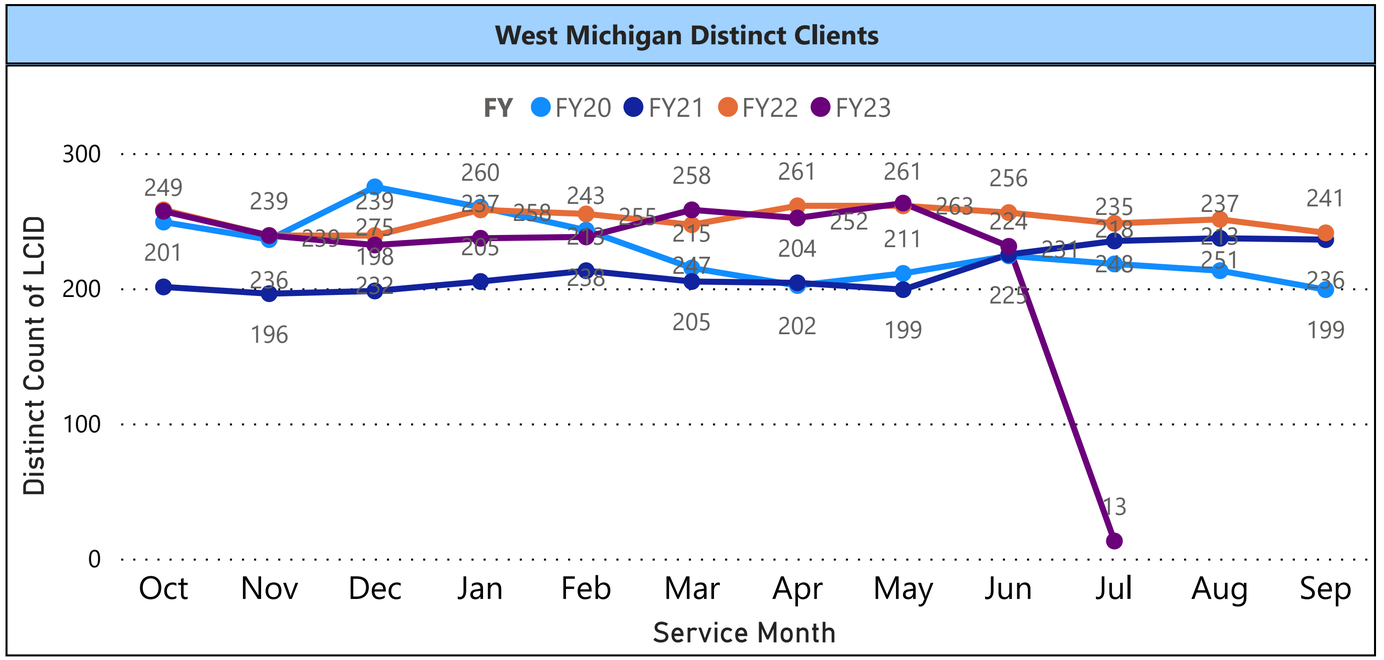
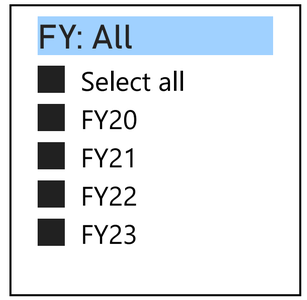
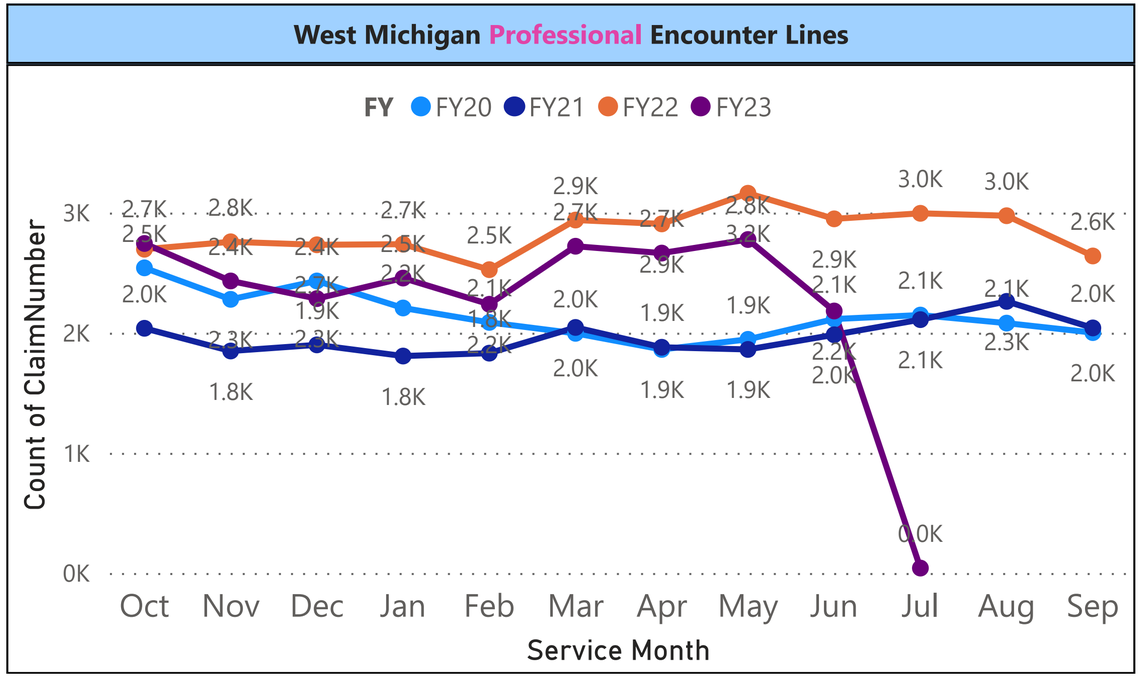
Latest ProcessDate

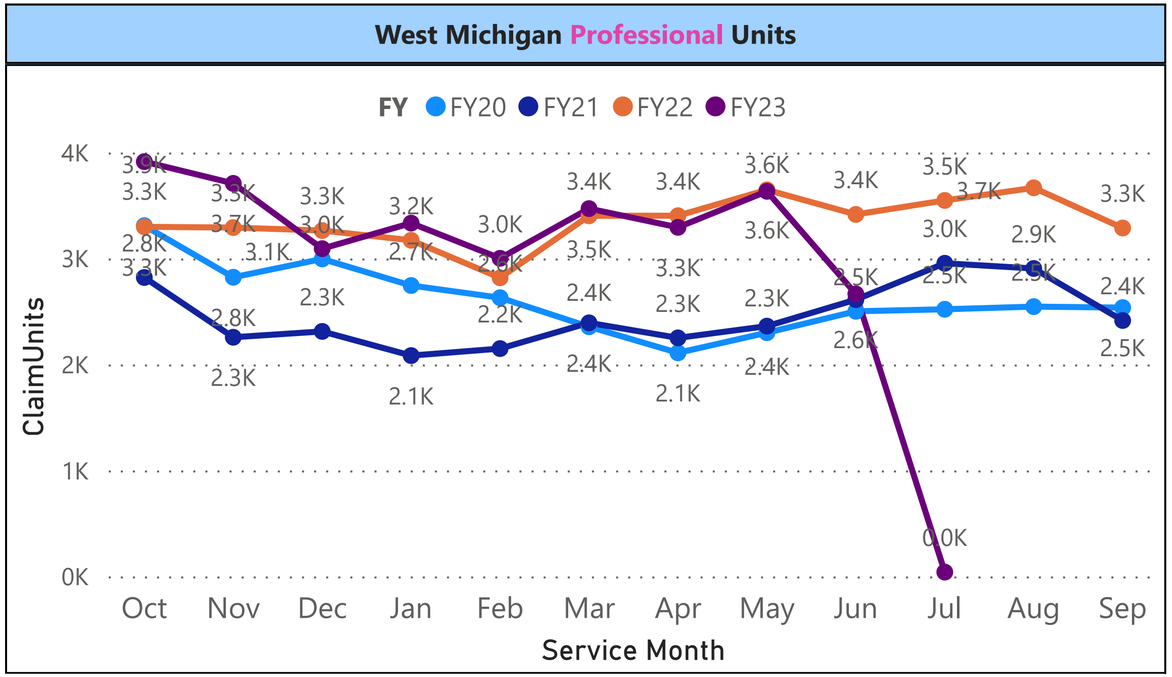
LAKESHORE REGIONAL ENTITY

West Michigan Substance Use Disorder









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Latest ProcessDate

Data Sources and Definitions

Data Source LRE_DW_CorporateInfo.LRE_Encounters

Definitions

Distinct Clients: Distinct Count of LCID (Unique Regional Consumer ID)

Service Month: MMM (ex. Oct) pulled from ServiceFromFullDate

Encounter Lines: Count of ClaimNumber

Units: Sum of ClaimUnits

CMHSP: LRE visuals are using ALL MemberCodeCombined
Individual CMHSP visuals using Individual MemberCodeCombed (ALGN, MKG, N180, OTT, WMCH)

Division: Behavioral Health (MH) using Mental Health Division
Substance Use Disorder using Substance Abuse Division

Professional Lines and Units: TransactionType = Professional

Institutional Lines and Units: TransactionType = Institutional

Fiscal Year: FY

LAKESHORE REGIONAL ENTITY

Chief Quality Officer - Report to the Board of Directors

July 26, 2023

HSAG:

1. Performance Measurement Validation (PMV): HSAG conducted its virtual PMV audit of LRE on July 13, 2023. HSAG has requested more information from HealthWest, OnPoint, and West Michigan, which is due to HSAG on July 28, 2023. LRE has disseminated HSAG's request for more information to the appropriate CMHSPs for follow-up.
2. Compliance Review (CR): LRE received the HSAG CR Tool and attended HSAG training in early June. LRE Subject Matter Experts (SME) have submitted proofs to Quality, which is performing a gap analysis to determine what additional proofs, if any, are needed prior to the HSAG submission date of July 25, 2023. For FY23 HSAG CR, HSAG will be validating the remediation for FY21 and FY22 Corrective Action Plans (CAPs). HSAG will conduct its virtual CR audit of LRE on August 16, 2023.
3. Performance Improvement Program (PIP): LRE timely submitted its update for the FY22 HSAG PIP, which required LRE to complete Step 8 in the PIP Tool. (Attachment 1). LRE provided comprehensive information and proofs. HSAG will provide feedback for LRE's consideration in its final FY23 submission in mid-August.

FY24 Proposed MDHHS Policy and CMS Rule Changes (FY24 Proposed Changes): LRE has reviewed and analyzed the MDHHS FY24 Proposed Changes and the CMS Proposed Ruled Changes (NRM 2442-P and 2439-P).

Michigan Mission Based Performance Incentive System (MMBPIS): LRE reviewed the proposed thresholds and provided Public Comment on July 3, 2023, with specific questions regarding the impact of CCBHC on MMBPIS performance. According to MDHHS, starting in FY24, LRE must adopt following Indicator thresholds:

1. Indicator 2: 62%
2. Indicator 2e: 72.9%
3. Indicator 3: 75.3%

LRE will begin tracking performance on Indicators 2, 2e, and 3 according to these newly established thresholds immediately.

LRE timely submitted its FY23 Q2 MMBPIS data to MDHHS on June 30, 2023. (Attachment 2). LRE met the compliance thresholds for MMBPIS Indicators 1, 4a, and 10. LRE failed to meet the compliance thresholds for Indicator 4b, with 3 CMHSPs returning a compliance rate between 89%-91.3%, well below the 95% compliance threshold. Concerning Indicators 2 and 3, which MDHHS has established new compliance thresholds for FY24, LRE failed to reach the new compliance threshold for both Indicators. LRE has issued corrective action plans for all Indicators to those CMHSPs that fell below the compliance thresholds, which are due back to LRE on July 31, 2023.

CMHSP SITE REVIEWS:

1. Status of CMHSP Site Reviews:
   a. Ottawa: Site Review complete, CAP complete, and final report distributed. (Attachment 3).

b. West Michigan: Site Review complete, CAP complete, and final report distributed. (Attachment 3).
c. N180: Site Review complete and final report distributed. (Attachment 3). N180 submitted its CAP; LRE is reviewing CAP.
d. OnPoint: OnPoint is in the proofs preparation phase with the Site Review starting August 25, 2023.
e. HealthWest: HealthWest will receive its notification letter on August 1, 2023, which will commence its proofs preparation phase.

2. CMHSP Site Review Results as of July 19, 2023: For FY23 thus far, CMSHPs have performed equal to or better than FY22 at an overall level and for the vast majority of the audit types.

	FY23				FY22				
CMHSP	Desk Audit	Program Specific Audit	Clinical Audit	Credentialing Audit	Desk Audit	Program Specific Audit	Clinical Audit	Credentialing Audit	Year over Year Change
CMH of Ottawa County	97.7%	87.5%	93.7%	96.6%	97.6%	96.7%	91.2%	92.4%	0.09%
network180	99.3%	100.0%	95.7%	96.7%	98.3%	98.6%	96.1%	94.4%	1.04%
West Michigan CMH	100.0%	100.0%	96.1%	90.1%	99.0%	94.9%	93.2%	93.9%	1.03%
Region 3 Overall	99.0%	95.8%	95.2%	95.3%	98.3%	96.9%	94.2%	93.8%	0.69%

LRE is aggregating and reviewing FY22 Site Review data on a Regional-level in an attempt to identify any systemic issues, if they exist. Throughout this Site Review season, LRE is developing procedures and job aids to ensure proper documentation of the CMHSP Site Review process. Quality continues to interface with LRE IT to develop standardized reports for improved data analysis and report communications with CMHSPs. LRE deployed an Audit PowerBI Dashboard that drastically reduced report writing and CAP development times.

NON-CMHSP REVIEWS:

1. **SUD Treatment Providers:**
   a. Status of SUD Site Reviews:
      - LRE continues to conduct SUD Treatment Site Reviews.
      - LRE has distributed Corrective Action Plans following the results of the Desk, Clinical, and Credentialing Audits.
      - For FY23, SUD Providers have scored as follows:

SUD Audit Type	Compliance Rate
Clinical	91.9%
Credentialing	86.1%
Desk	81.6%
Program Specific	96.4%
Residential	96.9%
Recipient Rights	100%

2. **Specialized Residential, Non-AFC, & Autism Providers:**
   a. Status of Specialized Residential, Non-AFC, and Autism Facilities Reviews:
      - LRE continues to conduct Facilities Reviews at a rate of 20 per month, which has slowed due to the HCBS training required to have providers demonstrate compliance with the HCBS Final Rule.
      - LRE has distributed Corrective Action Plans following the results of the Facilities Review.

- As of July 19, 2023, Specialized Residential, Non-AFC, and Autism Providers performed very well with a ***98.7% compliance rate***, which should be applauded. The greatest opportunities for improvement relate to the understanding of how to operationalize the HCBS Final Rule. LRE continues to coach these providers on the HCBS Final Rule Regulations and how best to demonstrate compliance, which is now required by MDHHS and CMS as of March 17, 2023.

3. **Inpatient Providers:**
   a. Status of Inpatient Site Reviews:
      - LRE has completed all Inpatient Provider Site Reviews.
      - LRE has distributed Corrective Action Plans following the results of the Inpatient Site Reviews.
      - As of July 19, 2023, Inpatient Providers performed very well with a ***98.3% compliance rate***, which is up from 97.4% in FY22.

LRE continues to develop the policy, procedure, and workflows for all Non-CMHSP Reviews. LRE has finalized its Facilities Review Tool, which incorporates pinpoint citations and expectations related to proofs to demonstrate compliance, for implementation starting October 1, 2023. QI ROAT will review the revised Tool in July 2023 and anticipates recommending its adoption to Operations Council in August 2023.

HOME AND COMMUNITY-BASED SERVICES ("HCBS"): MDHHS and all PIHPs continue to wait for CMS to provide guidance regarding the more than 440 provider files MDHHS sent to CMS for consideration of removal from the Heightened Scrutiny status. Recall that if CMS does not agree with MDHHS' recommendations, MDHHS will inform LRE and the setting that it must immediately begin discharging consumers. MDHHS has stated it is finalizing HCBS job aids/FAQs and preparing an HCBS training for stakeholders.

LRE continues to work with providers that are non-compliant with the HCBS Final Rule as it relates to properly documenting restrictions in Individual Plans of Service and, if applicable, Behavior Treatment Plans.

LRE has conducted HCBS training for all but one Member CMHSP and in some cases, CMHSPs have asked LRE to conduct multiple trainings to various groups depending on their charter (Case Managers, Behavior Treatment Committees, Office of Recipient Rights, etc.). LRE will conduct the HCBS Final Rule training to the Customer Services (CS) ROAT and Clinical ROAT this month. LRE is revising its HCBS Policies and developing HCBS Procedures.

LRE is completing its next round of quarterly survey for those groups identified by MDHHS.

MDHHS has hired TBD Solutions to develop an ongoing compliance monitoring procedure. LRE has provided extensive feedback on the procedure development.

CRITICAL INCIDENT REBOOT: LRE continues to electronically uploading the Critical Incident (CI) data into MDHHS' CRM Platform. MDHHS notifies LRE when an incident is out of compliance requires remediation, and LRE works with the CMHSPs to remediate each issue and communicates resolution with MDHHS. MDHHS' CRM Platform for Critical Incidents has increased remediation demands on LRE and CMHSPs. LRE IT is developing a Critical Incident PowerBI Dashboard.

MASTER PROVIDER DIRECTORY ROAD MAP: LRE's Master Provider Directory Workgroup has finalized all

workflows, identified all unmet needs, and prioritized all unmet needs. LRE is preparing to meet with its EHR vendor to negotiate next steps towards developing IT technical specifications and their eventual implementation over the next 24 months.

MEDICAID VERIFICATION ("MEV"): LRE is on schedule with its MEV audits.

Audit Timeframe	Audit Month – Member CMHSP	Status
FY23 Q1 Oct 2022 – Dec 2022	January 2023: OnPoint, West Michigan, HealthWest February 2023: N180 March 2023: Ottawa, SUD	Report Complete
FY23 Q2 Jan 2023 – March 2023	April 2023: OnPoint, West Michigan, HealthWest May 2023: N180 June 2023: Ottawa, SUD	Complete
FY23 Q3 April 2023 – June 2023	July 2023: OnPoint, West Michigan, HealthWest August 2023: N180 September 2023: Ottawa, SUD	In Progress
FY23 Q4 July 2023 – Sept 2023	October 2023: OnPoint, West Michigan, HealthWest November 2023: N180 December 2023: Ottawa, SUD	On-Deck

For FY23 Q1, LRE audited 2,725 claim lines totaling $628,151 Medicaid dollars for 410 unique consumers for SUD and non-SUD services across 47 providers. LRE required recoupment from one CMHSP for a total of $5,094.23 due to insufficient documentation to support the service. (Attachment 4).

LRE found the following FY23 Q1 performance by CMHSP:

CMHSP	MEV Compliance Rate	Recoupment
HealthWest	99.95%	$5,094.23
OnPoint	100%	none
Ottawa	100%	none
N180	100%	none
West Michigan	100%	none

State of Michigan 2021-22 PIP Submission Form
FUH Metric: Decrease in Racial Disparity between African Americans/Blacks and Whites for Lakeshore Regional Entity

Demographic Information	
PIHP Name: Lakeshore Regional Entity	
Project Leader Name: Wendi M. Price	Title: Chief Quality Officer
Telephone Number: 231-286-2042	Email Address: wendip@lsre.org
PIP Title: **FUH Metric: Decrease in Racial Disparity between Whites and African Americans/Blacks**	
Submission Date: July 15, 2022	
Resubmission Date (if applicable): September 2, 2022	
Update Date: July 14, 2023	

State of Michigan 2021-22 PIP Submission Form
FUH Metric: Decrease in Racial Disparity between African Americans/Blacks and Whites for Lakeshore Regional Entity

Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

PIP Topic: **FUH Metric: Decrease in Racial Disparity between African Americans/Blacks and Whites.**

Plan-Specific Data: For FUH, Region 3 is experiencing a race/ethnicity disparity of 11.74% between African Americans/Blacks and Whites.

LRE's PIP Topic Selection Decision Path:

LRE's decision path was a winding one, but in the end, LRE's PIP selection is anticipated to improve member health, functional status, and satisfaction across Region 3 over the measurement periods.

On October 22, 2021, MDHHS communicates that all PIHPs must choose a Performance Improvement Project ("PIP") to "Reduce racial and ethnic disparities in healthcare and health outcomes" for the 2021-2022 PIP.

From November 2021 through January 2022, LRE reviews Region 3's ("R3") data by racial stratification in an effort to determine what metric, if any, demonstrates racial/ethnicity disparity across the R3.

Several factors contributed to LRE's PIP Topic selection. Each will be taken one at a time.

1) **Presence of Race/Ethnicity Disparity:** During its analysis utilizing the Shared Metrics Specifications, LRE identified FUH and FUA as topics that demonstrated the presence of race/ethnicity disparity within R3. (Attachment A). Specifically, LRE determined that 11.74% less African Americans/Blacks engaged in follow-up after hospitalization for mental illness within 30 days with a mental health provider than Whites. (Attachment A). Additionally, LRE determined that 14.29% less African American/Black Adults engaged in follow-up after Emergency Department visit for alcohol and other drug dependance within 30 days with a mental health provider than White Adults. (Attachment A). LRE then pivots to availability of data.
2) **Availability of Data:** LRE investigated the availability of FUH and FUA data by reviewing the MDHHS FY2022 Specifications for FUH for and FUA, reviewing the HEDIS® Measurement Reference Guide NCQA 2022 Technical Specifications, meeting with MDHHS on February 8, 2022, and meeting with HSAG and MDHHS on February 9, 2022. Following these meetings, LRE selects the FUH, not FUA Metric as its PIP Topic strictly due to the accessibility of FUH data over FUA data. (Attachment B).
3) **Chi-Square Test for Independence:** LRE then completed a Chi-Square Test of Independence demonstrating that there is a significant association between race and whether a person receives follow-up treatment after hospitalization for mental illness. (Attachment C).

Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

4) **Sufficient Sample Size to Support Statistically Significant Improvement Over Time:** Further, LRE determined that the sample size for FUH were sufficient to support a statistically significant improvement. (Attachment D). Specifically, LRE must achieve a minimum increase of 32 additional African Americans/Blacks who meet the FUH metric to achieve a statistically significant improvement over the baseline period with the caveat that this calculation presumes that the FUH metric for Whites remains relatively constant over the measurement periods, which is a risk and is address in Step 7. LRE then leans into reach to better understand the impact of an improvement in FUH in the lives of its members.
5) **Impact on Member Health, Functional Status, and/or Satisfaction:** Historically, for FUH-AD and FUH-CH, LRE has performed above the State Shared Metric Targets. (Attachment E, pp. 3-4). LRE's research indicates that interventions exist that will improve R3's FUH performance.[1] (Attachment F). Most importantly, the NCQA states that "providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, decrease the likelihood of re-hospitalization and the overall cost of outpatient care."[2] (Attachment G).

LRE's research strongly suggests that an increase in the FUH metric can improve outcomes, decrease suicide, decrease recidivism, and increase satisfaction. One risk, which is addressed in Step 7, 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.

[1] Batscha C, McDevitt J, Weiden P, Dancy B., The Effect of an Inpatient Transition Intervention on Attendance at the First Appointment Postdischarge From a Psychiatric Hospitalization. Journal of the American Psychiatric Nurses Association. 2011;17(5):330-338. doi:10.1177/1078390311417307.

[2] NCQA, Follow-Up After Hospitalization for Mental Illness (FUH), https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/ (last visited 7/10/2022) Citing Barekatain M, Maracy MR, Rajabi F, Baratian H. (2014). Aftercare services for patients with severe mental disorder: A randomized controlled trial. J Res Med Sci. 19(3):240-5; Luxton DD, June JD, Comtois KA. (2013). Can post-discharge follow-up contacts prevent suicide and suicidal behavior? A review of the evidence. Crisis. 34(1):32-41. doi: 10.1027/0227-5910/A000158.

Step 2: Define the PIP Aim Statement(s). Defining the aim statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

The statement(s) should:

- Be structured in the recommended X/Y format: "Does doing X result in Y?"
- The statement(s) must be documented in clear, concise, and measurable terms.
- Be answerable based on the data collection methodology and indicator(s) of performance.

Statement(s):

Do Region 3 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 a decrease in the racial disparity between the two measurement groups, during the measurement period, without a decline in performance for the White members?

Step 3: Define the PIP Population. The PIP population should be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

In accordance with Attachments H (pp. 2-3) and J (pp. 29-30), LRE provides the following to define the population for its PIP:

Population definition for Race/Ethnicity: MDHHS had a data quality issue with the race/ethnicity determinations in the 834 eligibility data. As a short-term, stop-gap measure, the state is sending a monthly race/ethnicity "Fix File" to the PIHPs that has the correct race and ethnicity data for our Medicaid eligible population. LRE uses the uses the race/ethnicity information in the "Fix File" as the primary source of data. For individuals who do not have records in the fix file, we use the race/ethnicity determinations based on the monthly record in the 834 eligibility data. If that data is also missing, then we pull the race/ethnicity from the most recently provided race/ethnicity from the 834 eligibility data. LRE then combines the race and ethnicity understanding that the ethnicity flag always takes precedence over the race flag. Individuals who identified themselves as Hispanic ethnicity will be reported as Hispanic regardless of the race that is reported for the individual. If ethnicity is not Hispanic, then the race field is used. In short, the White population is identified with the following code combination: Ethnicity = Non-Hispanic AND race = White. The African American/Black population is identified with the following code combination: Ethnicity = Non-Hispanic AND race = Black.

Population definition for FUH: Region 3 members with mental illness diagnoses who experience an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set).

Enrollment requirements (if applicable): All Medicaid-Only members enrolled in Region 3 anytime between the date of discharge through 30 days after discharge.

Step 3: Define the PIP Population. The PIP population should be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Member age criteria (if applicable): Members over the age six (6) and older as of date of discharge.

Inclusion, exclusion, and diagnosis criteria:

Inclusionary Event/Diagnosis: An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year.

Exclusions:

1) Exclude discharges followed by readmission or direct transfer to a non-acute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission.
2) Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within 30-day follow-up period if the principal diagnosis was for non-mental health.

Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable): Relevant codes can be found in the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP Technical Specifications and Resource Manual for Federal Fiscal Year 2021 Reporting (Value Set OID: 2.16.840.1.113883.3.464.1004.1179) (Attachment H, p 3), Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for Federal Fiscal Year 2021 Reporting (Value Set OID: 2.16.840.1.113883.3.464.1004.1179) (Attachment H, p 3), and HEDIS® FUH Procedure, Diagnosis, and Place of Service codes (Attachment I, pp 29-30).

State of Michigan 2021-22 PIP Submission Form
FUH Metric: Decrease in Racial Disparity between African Americans/Blacks and Whites for Lakeshore Regional Entity

State of Michigan 2021-22 PIP Submission Form
FUH Metric: Decrease in Racial Disparity between African Americans/Blacks and Whites for Lakeshore Regional Entity

Step 4: Use Sound Sampling Methods. If sampling is used to select members of the population (denominator), proper sampling methods are necessary to ensure valid and reliable results. Sampling methods should be in accordance with generally accepted principles of research design and statistical analysis. If sampling was not used, please leave table blank and document that sampling was not used in the space provided below the table.

The description of the sampling methods should:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each indicator.
- Include a detailed narrative description of the methods used to select the sample and ensure sampling methods support generalizable results.

Measurement Period	Performance Indicator Title	Sampling Frame Size	Sample Size	Margin of Error and Confidence Level
MM/DD/YYYY-MM/DD/YYYY	Not Applicable			

Describe in detail the methods used to select the sample: LRE is not using a sampling method for this PIP.

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) should:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

Indicator 1	**FUH Metric for Adults and Children Combined Who Identify as African American/Black**
	Rationale: Please see Steps 1 – 3; **Data Sources:** HEDIS® 2019 Technical Specifications for FUH; CMS Core Set Core Set of Children's Health Care Quality Measures for Medicaid and CHIP Technical Specifications and Resource Manual for Federal Fiscal Year 2021 Reporting (Value Set OID: 2.16.840.1.113883.3.464.1004.1179) (Attachment H, p 3), Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for Federal Fiscal Year 2021 Reporting (Value Set OID: 2.16.840.1.113883.3.464.1004.1179) (Attachment H, p 3).
Numerator Description:	A follow-up visit with a mental health provider within 30 days after discharge from an inpatient hospitalizations for specified mental illness for African Americans/Blacks in Region 3.
Denominator Description:	The eligible population who identify as African American/Black as defined in Step 3.
Baseline Measurement Period	01/01/2021 to 12/31/2021
Remeasurement 1 Period	01/01/2023 to 12/31/2023
Remeasurement 2 Period	01/01/2024 to 01/01/2024

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) should:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

Mandated Goal/Target, if applicable	Not applicable
Indicator 2	**FUH Metric for Adults and Children Combined Who Identify as White**
	Rationale: Please see Steps 1 – 3; **Data Sources:** HEDIS® 2019 Technical Specifications for FUH; CMS Core Set Core Set of Children's Health Care Quality Measures for Medicaid and CHIP Technical Specifications and Resource Manual for Federal Fiscal Year 2021 Reporting (Value Set OID: 2.16.840.1.113883.3.464.1004.1179) (Attachment H, p 3), Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for Federal Fiscal Year 2021 Reporting (Value Set OID: 2.16.840.1.113883.3.464.1004.1179) (Attachment H, p 3).
Numerator Description:	A follow-up visit with a mental health provider within 30 days after discharge from an inpatient hospitalizations for specified mental illness for Whites in Region 3.
Denominator Description:	The eligible population who identify as White as defined in Step 3.
Baseline Measurement Period	01/01/2021 to 12/31/2021
Remeasurement 1 Period	01/01/2023 to 12/31/2023

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) should:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

Remeasurement 2 Period	01/01/2024 to 01/01/2024
Mandated Goal/Target, if applicable	Not applicable
Use this area to provide additional information. Not applicable	

State of Michigan 2021-22 PIP Submission Form
FUH Metric: Decrease in Racial Disparity between African Americans/Blacks and Whites for Lakeshore Regional Entity

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable.

The data collection methodology should include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the indicator percentage.
- A copy of the manual data collection tool, if applicable.
- An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.

Data Sources (Select all that apply): LRE will utilize data from MDHHS's CC360 Data Warehouse, Claims/Encounters data from 834, and HEDIS® Data via ZTS, and Quality Improvement/Demographic/BH-TEDS file for each member served.

[ ]Manual Data Data Source [ ] Paper medical record abstraction [ ] Electronic health record abstraction Record Type [ ] Outpatient [ ] Inpatient [ ] Other, please explain in narrative section. [ ] Data collection tool attached (required for manual record review)	[X] Administrative Data Data Source [X] Programmed pull from claims/encounters [ ] Supplemental data [ ] Electronic health record query [ ] Complaint/appeal [ ] Pharmacy data [ ] Telephone service data/call center data [ ] Appointment/access data [ ] Delegated entity/vendor data _____ [X] Other: State of Michigan Approved Data Extract via MDHHS CC360 Data Warehouse (Attachment H); HEDIS® FUH Data via ZTS (Attachments I), 834 Eligibility, MDHHS Fix File. Other Requirements [X] Codes used to identify data elements (e.g., ICD-10, CPT codes)- See Attachment H, p 2-3; Attachment I, p 29-30. [ ] Data completeness assessment attached [ ] Coding verification process attached	[ ] Survey Data Fielding Method [ ] Personal interview [ ] Mail [ ] Phone with CATI script [ ] Phone with IVR [ ] Internet [ ] Other _____ Other Survey Requirements: Number of waves: _____ Response rate: _____ Incentives used: _____

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable.

The data collection methodology should include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the indicator percentage.
- A copy of the manual data collection tool, if applicable.
- An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.

	Estimated percentage of reported administrative data completeness at the time the data are generated: ___99___ % complete. Description of the process used to calculate the reported administrative data completeness percentage. Include a narrative of how claims lag may have impacted the data reported: Please see below.	

In the space below, describe the step-by-step data collection process used in the production of the indicator results:

Data Collection Process for Race/Ethnicity: MDHHS had a data quality issue with the race/ethnicity determinations in the 834 eligibility data. As a short-term, stop-gap measure, the state is sending a monthly race/ethnicity "Fix File" to the PIHPs that has the correct race and ethnicity data for our Medicaid eligible population. As its Source Data Files, LRE uses the uses the race/ethnicity information in the "Fix File" as the primary source of data. For individuals who do not have records in the fix file, we use the race/ethnicity determinations based on the monthly record in the 834 eligibility data. If that data is also missing, then we pull the race/ethnicity from the most recently provided race/ethnicity from the 834 eligibility data. LRE then combines the race and ethnicity understanding that the ethnicity flag always takes precedence over the race flag. Individuals who identified themselves as Hispanic ethnicity will be reported as Hispanic regardless of the race that is reported for the individual. If ethnicity is not Hispanic, then the race field is used. In short, the White population is identified with the following code combination: Ethnicity = Non-Hispanic AND race = White. The African American/Black population is identified with the following code combination: Ethnicity = Non-Hispanic AND race = Black.

Data Collection Process for FUH: The data for this Performance Improvement Project will be obtained monthly from Zenith Technology Solutions (ZTS) using data analytics through the Integrated Care Delivery Platform (ICDP). ZTS obtains the data from the MDHHS Data Extract every two weeks. (Attachment J).

~~**Data Collection Process Summary:**~~ **(LRE is only removing this header)**

Lakeshore Regional Entity (LRE) is one of Michigan's ten Prepaid Inpatient Health Plans (PIHPs), is responsible for Medicaid benefits management across seven counties which include Allegan, Kent, Lake, Mason, Muskegon, Oceana, and Ottawa. LRE's Affiliate members include five CMHSPs: Allegan HealthWest, OnPoint, Ottawa, Network 180, and West Michigan. Services are provided at the CMHSP level. CMHSPs are required to submit Encounter data to the PIHP within 7 days prior to the end of the calendar month following adjudication. Validation rules are applied as encounter data is imported into the LRE Data Warehouse. Records with missing, invalid, or incomplete data are flagged as errors and submission to the State is withheld. Reports of errors in the data are immediately available to the CMHSP so that they can correct and resubmit data. PCE Systems provides logs and reports which show each file that was uploaded by each CMH, and the result of that upload process (file rejected, file accepted with flagged errors list, etc.) and submission status of each outbound file (submitted/accepted at MDHHS). Inbound/Outbound reports show whether any outstanding CMH uploaded/validated transactions have not yet been submitted to MDHHS. The LRE processes the data and transmits the QI and Encounter data for the month to MDHHS before 5pm on the last day of the calendar month (per MDHHS contract). The standard for the PIHP is to process 100% of the clean records received from CMHs through to MDHHS by the end of the month.

Lakeshore Regional Entity submits 100% of claims/encounter data electronically to MDHHS for each Medicaid service provided. MDHHS processes these encounters/claims and stores them in the MDHHS Data Warehouse. Per contract, MDHHS requires that a quality improvement/demographic/BH-TEDS file be reported for everyone whom encounter data was reported. Lakeshore Regional Entity also retains a copy of all encounters/claim files, BH-TEDs, and QI Demographic files submitted to MDHHS in the LRE Data Warehouse. The MDHHS Care Connect 360 software application selects and aggregates on a consumer level basis all reported Behavioral Health claims/encounters in the MDHHS Data Warehouse with all Medicaid health care data reported from all other Health Care Providers including physical health, pharmacy, labs, and hospitalizations. The MDHHS Care Connect 360 is used for and available for looking up healthcare data for any Medicaid Eligible individual on an individual basis.

The State-provided Data Extract from the MDHHS Data Warehouse is an extract of Medicaid Services Administration. This data includes all Medicaid Claim Encounters including Physical Health, Pharmacy, Labs, Hospitalizations, and Behavioral Health. This data does not include SUD encounters. To enable the use of this data in an aggregate form, Lakeshore Regional Entity (LRE) contracts with Zenith Technology Solutions (ZTS) to receive a MDHHS Data Extract from the State. The Data Extract from MDHHS is updated every other week. To receive this MDHHS Data Extract, ZTS, on behalf of the LRE, submits a file of all Medicaid ID numbers that have been enrolled in the region and MDHHS then produces a file of all Medicaid Claim Encounters for those individuals

and the completed file is sent to ZTS. This file is submitted to ZTS for cleansing and organizing and is then made accessible to LRE for Data Analytics. The State-provided Data Extract from the MDHHS Data Warehouse includes claim/encounter line-level detail for all services provided by Medicaid even if Medicaid only paid the co-pay for the claim. The State-provided Data Extract includes individual client-level healthcare data; including, prescriptions, laboratory, professional, behavior health and primary care claims and encounters for at least a 24-month time-period. This Data Extract is the primary data source for this PIP. It takes about 90 days for the claims/encounter data to be complete in the MDHHS Data Warehouse due to lags in claim submissions. As LRE QI Staff want the data used for this PI Project to be complete, the data will be reviewed and included in the study 90 days after the selected month for review.

ZTS has obtained the technical specifications for the HEDIS® Measures, FUH30-Adult and FUH30-Child. Using the HEDIS® technical specifications for this measure, ZTS programmed a report in their data analytics system. The report is available to the LRE through the Integrated Care Delivery Platform (ICDP). LRE requested ZTS obtain the 2021 technical specifications for this HEDIS® measure and to program a report in the ICDP system for this HEDIS® measure. ZTS currently runs the HEDIS® 2019 Technical Update, but ZTS is finalizing the implementation of the HEDIS® 2021 Technical Update. LRE understanding that it will be required validate ZTS's implementation of the HEDIS® 2021 Technical Update for the FUH Metric and that LRE will be required to update is baseline data accordingly.

Step 7: Indicator Results. Enter the results of the indicator(s) in the table below. For HEDIS-based/CMS Core Set PIPs, the data reported in the PIP Submission Form should match the validated performance measure rate(s).

Enter results for each indicator by completing the table below. *P* values should be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.

Indicator 1 Title: FUH Metric for Adults and Children Combined Who Identify as African American/Black

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
01/01/2021-12/31/2021	Baseline	287 ~~190~~	477 ~~287~~	60.17%	N/A for baseline	N/A for baseline
01/01/2023-12/31/2023	Remeasurement 1					
01/01/2024-12/31/2024	Remeasurement 2					

Indicator 2 Title: FUH Metric for Adults and Children Combined Who Identify as White

Time Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target , if applicable	Statistical Test, Statistical Significance, and *p* Value
01/01/2021-12/31/2021	Baseline	1,080	1,502	70.90%	N/A for baseline	N/A for baseline
01/01/2023-12/31/2023	Remeasurement 1					
01/01/2024-12/31/2024	Remeasurement 2					

In its original submission of July 15, 2022, LRE provided the incorrect numerator and denominator for the January 1, 2021, through December 31, 2021. In its September 2, 2022, resubmission, LRE now provides the corrected numerator and denominator.

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

Baseline Narrative: LRE's primary data source for this PIP is the MDHHS Data Warehouse for FUH and race data. Given the 90-day lag between when receipt and rendering of the claims/encounters data within the MDHHS Data Warehouse, MDHHS finalized Quarter 4 of Calendar Year 2021 on July 15, 2022, the day LRE is scheduled to submit its PIP Validation Tool to HSAG. LRE downloaded the data from the MDHHS Data Warehouse on the morning on July 15, 2022. LRE then used MDHHS's manual workaround of integrating the race/ethnicity data into the FUH Metrics and produced the data contained herein. MDHHS states it automate the race/ethnicity data into the 834 files in September 2022 and be ready to dispatch with the manual workaround for Fiscal Year 2023.

LRE then performed a chi-square test with Yates correction and determined that the physical difference between African Americans/Blacks and Whites receiving complaint FUH services was statistically significant. Specifically, for African Americas/Blacks during the timeline of January 1, 2021, through December 31, 2021, only 60.17% of African Americans/Blacks received compliant FUH services, with the numerator equal to 287 and the denominator equal to 477. During the same timeline, 71.90% of Whites received compliant FUH services, with the numerator equal to 1,080 and the denominator equal to 1,502. Upon utilizing the website provided by HSAG, the chi-square test with Yates correction "equals 22.7980 with 1 degrees of freedom. The two-tailed P value is less than 0.0001. The association between rows African Americans/Blacks and Whites who received compliant FUH services is considered to be "extremely statistically significant."[3]

Risks Associated with this PIP are as follows:

1. Lack of timely access to FUH data contained in the MDHHSA Data Warehouse. As discussed above, LRE requires timely access to the FUH data to successfully meet HSAG's expectations regarding data integrity and timely submissions. LRE will continue to communicate and data access issues to HSAG, especially if the lack of timely access will negatively impact LRE's ability to perform as expected.
2. ZTS must finalize its implementation of the HEDIS® 2021 Technical Specifications for FUH. LRE must subsequently validate ZTS's HEDIS® FUH data/programming. Both of these risks put the PIP data integrity in jeopardy.
3. MDHHS's Race/Ethnicity Data Integrity Issue (Attachments K and L), its manual workaround, and timing of the upgraded 834 file set for September 2022. While LRE has reviewed reports provided by its outside data analytics vendors, LRE is not entirely confident that the race/ethnicity data issue has been thoroughly resolved nor that the automated 834 file scheduled for deploy in September 2022 will be timely. Each of these risks put the PIP data integrity in jeopardy. As previously stated, if LRE determines throughout the data collection year that the race/ethnicity data integrity issue, it will promptly notify MDHHS/HSAG of its findings so that MDHHS may resolve any issue before it undermines the integrity LRE's PIP Topic.
4. If LRE's targeted interventions improve the FUH Metric across all races/ethnicities, it is possible that LRE will fail to establish a significant reduction in the race/ethnicity disparity between the African American/Black and the White categories. LRE is willing to accept this risk given the potential positive impact that follow-up care after psychiatric hospitalization appears to provide to its members.

[3] Analyze a 2x2 contingency table. (graphpad.com)

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

Baseline to Remeasurement 1 Narrative:

Baseline to Remeasurement 2 Narrative:

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should be updated for each measurement period by adding to existing documentation. Include the following:

- Quality Improvement Team and Activities Narrative Description
- Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- Intervention Evaluation Table: Evaluation of each intervention
- Clinical and Programmatic Improvement Table: Discussion of any clinical or programmatic improvement achieved at any remeasurement during the PIP

Quality Improvement Team and Activities Narrative Description: Under the measurement period placeholder below corresponding to the most recent completed measurement period, add a description of the quality improvement team members, the causal/barrier analysis process, and quality improvement tools used to identify and prioritize barriers for each measurement period below.

Baseline Narrative: Submitted July 14, 2023

LRE considered how best to operationalize its FY22 PIP. LRE agreed that a two-pronged approach was the best course of action. On the front end, LRE focused on ensuring that the FUH data it submits to MDHHS on a weekly basis is accurate, complete, and timely. This proactive approach ensures that quality FUH data is available to both the LRE and the Medical Health Plans (MHPs) ensuring quality of care for consumers post-discharge. LRE's approach then pivots to the back-end of the FUH process ensuring that FUH is completed timely, meaning within 30-days post-discharge, with the appropriate professional and identify when follow-up did not occur and determine the root cause for non-compliance.

To deploy its two-pronged approach, LRE engaged two workgroups: 1) FUH Workgroup and 2) PIP Workgroup.

FUH Workgroup:

The FUH Workgroup's purpose was to understand how data is being submitted; monitor data accuracy, completeness, and timeliness; identify opportunities for efficiency gains; and monitor CMHSP progress towards submitting 100% accurate, complete, and timely data.

In July 2022, LRE resumed the FUH Data Reporting process from the previous managing organization. On average, LRE was spending fifteen hours per week reviewing and editing Member CMHSP file submissions prior to LRE's upload into CC360 due to inaccurate, incomplete, and untimely data. LRE identified many data errors and rejections and realized the process of collecting and uploading the data needed improvement. Upon further research, LRE learned that there was a lack of standardized procedures by the CMHSPs that was also impacting timely and accurate reporting.

From July 2022 to November 2022, LRE engaged in numerous iterations of data mining to quantify the source of the errors and determine how best to identify, remove, and track the errors. Through its efforts, LRE realized that CMH stakeholder involvement was critical to developing a common understanding of Regional FUH improvement goals; identifying current data collection procedures; and developing the data processing methods needed to improve the FUH data accuracy and completeness.

In November 2022, LRE held a meeting with its CMHSPs to discuss its findings related to the FUH data and the group collectively agreed to create the FUH Workgroup.

In December 2022, LRE. in collaboration with its CMHSPs. launched a FUH Workgroup led by one of LRE's Provider Network Manager with membership consisting of LRE Leadership, IT, and Clinical staff and CMHSP IT and Clinical staff.

From December 2022 through February 2023, the FUH Workgroup met at least six times (11/29/22, 12/5/22, 12/13/22, 1/2/23, 1/10/23, 2/21/23, 2/28/23) and utilized brainstorming and voting to develop the Key Driver Diagram with the PIP Workgroup, Process Map, Road-Map, and Project Plan to outline the current process and identify the barriers preventing CMHSPs from submitting accurate, complete, and timely FUH data. (Attachments A-D). The FUH Workgroup identified process improvements and prioritized them based on the logical sequence of event, length of time for each improvement to be made and resource availability, especially IT staff workloads, needed to complete the improvement.

During this time, the FUH Workgroup developed and revised the standardized FUH Technical Specification (Attachment E), FUH Procedure (Attachment F), FUH Error Report (Attachment G), HLOC Authorization Data Integrity Reports PowerBI Dashboard (Attachment H), and FUH Compliance Report (Attachment I) until each were complete and ready for deployment. (Attachments E-I). The FUH Workgroup established a key improvement to the FUH process requiring CMHSPs to upload FUH data two times per week instead of once per week.

LRE deployed the new FUH Technical Specification on April 3, 2023. On or around July 3, 2023, the FUH Workgroup make slight changes to the FUH Technical Specification and Error Report due to the start of Medicaid redeterminations by MDHHS, which impacted what consumers should be reported in the FUH Data. On July 30, 2023, the FUH Workgroup finalized the FUH Procedure. In addition to these improvement, LRE deployed the Value Based Incentive Program with Inpatient Providers to encourage these providers to begin discharge planning upon admission and ensure a follow-up appointment is scheduled within 7 days of discharge. (Attachments J-K).

Overall, the FUH Workgroup efforts have resulted in the following improvement:

1. LRE staff spends 60 minutes a week instead of 900 minutes (15 hours) – a 93% efficiency gain in IT resource availability,
2. A significant reduction in CMHSP data errors. (Exhibit L).
3. Increased availability of FUH data to MHPs – some MHPs have reported data is received more timely and more actionable for them as a result.
4. Improved relationships with CMHSPs.

LRE conducts ongoing monitoring by using the FUH Error Reports (Attachment G) and FUH Compliance Reports (Attachment L) and meets with CMHSPs that may be trending in a negative direction.

PIP Workgroup:

Secondly, LRE deployed the PIP Workgroup led by LRE's Chief Quality Officer (CQO) with membership consisting of the LRE Quality and IT staff and ad hoc membership of LRE Clinical Staff, CMHSP Quality, Access, and Clinical staff.

As with the FUH Workgroup, the PIP Workgroup utilized brainstorming and voting to develop the Key Driver Diagram with the FUH Workgroup. The PIP Workgroup meets weekly to discuss barriers, progress, and next steps with a focus on ensuring data sources are accurate, identifying a no-show/cancelation without rescheduling policy and procedure, developing training and outreach tools, and developing predictive models to overcome the CC360 data lag and allow for more real-time data mining. (Attachments B).

ZTS DATA INTEGRITY, POWERBI DASHBOARDS, AND PREDICTIVE MODELS:

In early January 2023, the PIP Workgroup identified several programming modifications that needed to be made to the ZTS data source, which included:

1. Race Corrections: Due to the MDHHS' race coding issue that LRE identified in August 2020 and MDHHS corrected in September 2023.
2. Facility Name: Remap all NPIs to correctly named facilities so that reports return the IP facility name and not N/A.
3. Incorporate the HEDIS® Aggregate FUH 2021 Averages, which are now available.
4. Update the HEDIS® FUH data identifying what, if anything, changed that may impact the Baseline measurement from 2021.

Once ZTS implements these programming modifications, LRE complete its PowerBI Dashboard development, resume its development of predictive models, and engage in datamining facilitating follow-up on non-compliant cases at the granular level while developing interventions for those areas identified as systemic issues either by Region, CMHPS, or IP Provider. In May, 2023, LRE began developing its MMBPIS|FUH PowerBI Dashboard, which will be completed after ZTS makes the necessary programming modifications. (Attachment M).

CMHSP COLLABORATION REGARDING FUH AND PIP:

In March 2023, PIP Workgroup presented its data mining findings with respect to MMBPIS 4a and the FUH PIP to the QI ROAT, which is comprised of all CMHSP Quality Leads, LRE's COO, LRE's Provider Network Manager, LRE's Clinical Manager, and one CMHSP CEO. (Attachment N). Based on the data mining of all MMBPIS FY22 data, LRE deduced that "No-Shows" and "Staff Shortages" were the key drivers to non-compliance for MMBPIS Indicators 2a, 3, and 4a:

	Indicator 2a	Indicator 3	Indicator 4a
FY22 Total MMBPIS Cases	5,035	4.038	1,909
FY22 Total MMBPIS Non-Compliance Cases	1,777	1.447	740
#1 Exception Code & Rate	No-Show – 24%	Staff Shortages – 26%	No-Show – 47%
#2 Exception Code & Rate	Staff Shortages – 26%	No-Show – 19%	N/A

.

The PIP Workgroup made two recommendations to the LRE QI ROAT for adoption:

1. Issue Corrective Action Plans at the CMHSP level for any Indicator with a Downward Trend for Two (2) Quarters in a Row **OR**
2. Deploy a Region Wide Initiative Surrounding Client "No Show" or "Cancelation without Rescheduling" coupled with FUH Appointment Outreach after Client "No-Show or "Cancelation without Rescheduling."

The QI ROAT voted for Recommendation #2 - Deploy a Region Wide Initiative Surrounding Client "No Show" or "Cancelation without Rescheduling" coupled with FUH Appointment Outreach after Client "No-Show or "Cancelation without Rescheduling."

The PIP Workgroup has met with ad hoc members twice since April 2023 and brainstormed, which produced the following prioritized interventions:

1. Best practice for Outreach after Client "No-Show or "Cancelation without Rescheduling,"
2. Impact of CCBHC on MMBPIS Indicators and HEDIS® FUH metrics,
3. Development of CMHSP Training Materials,
4. Development of Joint Training Materials with MHPs,
5. Outreach modalities outside of "warm" exchanges such as text messaging and emails along with how to obtain consent prior to discharge, and
6. Development of Consumer Materials to Assist Adults and Children's Guardian with how to best navigate the behavioral health system post-discharge with hopes of distributing prior to discharge.

The PIP Workgroup will meet with ad hoc members in August to review Outreach Workflows and Materials, which are in the process of being developed.

MHP COLLABORATION REGARDING FUH AND PIP:

Finally, starting in May 2023, LRE began meeting with MHPs to introduce LRE's PIP and develop opportunities for 1) cycle-time improvements concerning getting FUH data into the MHP's hands as soon as possible post discharge and 2) development of joint training materials. LRE also

recommended the standardization of all FUH data uploads days and times as well as all MHP data download days and times to the PIHP-MHP Workgroup, which was heard but not adopted, in an effort to reduce the cycle time of FUH data distribution to MHPs. (Attachment O). LRE will recommend its position again if the data mining determines that LRE's move to uploading twice per week to CC360, versus once per week as done prior to April 3, 2023, improves FUH compliance rates among MHPs serving Region 3 consumers.

LRE and Meridian have made the most progress in conducting FUH Training and developing Joint Training Materials for CMHSP and MHP staff. (Attachment P).

LRE will continue its engagement with MHPs to effectuate improvement in the HEDIS® FUH 30-day metric.

Other interventions can be found in LRE's Key Driver Diagram + that outlines prioritized barriers, interventions, progress to date, and next steps.

Remeasurement 1 Narrative:

Remeasurement 2 Narrative:

Barriers/Interventions Table: In the table below, report prioritized barriers, corresponding interventions, and intervention details (initiation date, current status, and type.

Barrier Priority Ranking	Barrier Description	Intervention Initiation Date (MM/YY)	Intervention Description	Select Current Intervention Status	Select if Member, Provider, or System Intervention
1	Lack of Data Integrity from CMHSPs/Lack of	August 1, 2022	**Modify Systems to Standardize Processes and Ensure FUH Data Integrity**	Completed	System Intervention

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	Standardization of Data Expectation		1) Develop FUH Technical Specifications. 2) Develop FUH Reporting Templates and train CMHSP on the templates. 3) Develop error reports to identify CMHSP data errors for follow-up and retraining with CMHSPs. 4) Develop way to quantify "improvement" in CMHSP data integrity. 5) Due to the 6-month CC360 data lag, how do we know that what we are doing is making a positive impact? Can we use ZTS FUH Dashboard as a predictor of what the CC360 data will report?			

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			6) Ensure each CMHSP has trained back-ups to cover primary staff responsible for reporting FUH Data to LRE in case of leave, PTO, etc.		
1	Lack of Data Integrity from ZTS	January 10, 2023	**Modify ZTS Programming Logic to Ensure FUH Data Integrity** 1) Race corrections - This was due to the old and new race coding the state was sending for the same record. They are working to make the necessary changes to the data. Remnants of the MDHHS R/E issues from August 2020. 2) N/A under "Facility" in report due to NPI not being	Continued	System Intervention

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			mapped correctly – ZTS is working on it. 3) PBIP FUH Metric - State has incorporated the HEDIS Aggregate 2021 FUH Averages into the PBIP for FY24; ZTS needs to do the same. 4) ZTS Dashboard has not been updated due to data lag and data integrity issues. 5) Ensure ZTS updates the HEDIS version and if so, what was different and will it impact the FUH baseline. (Completed)		
1	Lack of CC360 Data Availability/CC360 Data Lag	January 27, 2023	**Develop Predictive Models, if applicable, that Reduces the Risk of the CC360 Data Lag**	Continued	System Intervention

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	• CC360's 6-month lag time makes it difficult to determine if interventions are effective or not and if not, it does not give any time to adjust and determine if the adjustments have made a positive impact on the metric. LRE won't have the data for the first measurement period until early July 2024, and MDHHS/HSAG expects a report in Mid-July 2024. • LRE (and any other PIHP working with the FUH measure) is		1) Due to the 6-month CC360 data lag, how do we know that what we are doing is making a positive impact? Can we use ZTS FUH Dashboard as a predictor of what the CC360 data will report? a. See Driver "Lack of ZTS Data Integrity" for more details. 2) Due to the 6-month CC360 data lag, how do we know that what we are doing is making a positive impact? Can we use MMBPIS 4a as a predictor of what the CC360 data will report --- this would have to presume that any standardization in outreach processes would			

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		"flying blind" until such time as it is too late to do anything to make corrections or adjustments to effectuate improvement in race/disparity.		impact all FUH metrics the same, regardless of whether its HEDIS or MMBPIS a. Build a FUH Monitoring PowerBI Dashboard page with MMBPIS 4a, HEDIS FUH-7 day, and HEDIS FUH-30 day indicators/metrics for comparison. (Completed) 3) Determine if the consumers in the HEDIS FUH 7-day are the same as the consumer in the MMBPIS 4a Indicator? If so, this may bolster the hypothesis that MMBPIS 4a is a good predictor of HEDIS FUH-7day and FUH-30 day because if a consumer hits		

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				the HEDIS FUH 7-day, the HEDIS FUH 30-day will be in-compliance. 4) Due to the 6-month CC360 data lag, how do we know that what we are doing is making a positive impact? Can we use ZTS FUH Dashboard as a predictor of what the CC360 data will report? 5) Create a PowerBI Dashboard for compliance rate of MMBIS 4a, HEDIS FUH 7-day, and HEDIS FUH 30-day by CMHSP, MHP, race/ethnicity for download at the consumer level.			

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				a. Confirm the CC360 FUH data source from MDHHS – email Sha. b. Compare the FUH data from CC360 and the FUH Submission file to determine if the CMHSPs/IP Providers are accurately identifying all consumers upon admission and discharge. c. Compare MMBPIS 4a data to the FUH Submission File and the CC360 FUH file to see if all consumers are being captured in the MMBPIS 4a data and visa versa.		

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				6) Investigate whether LRE can identify 4-5 "exception" codes (like with MMBPIS 4a) to pinpoint "WHY" a consumer does not keep a follow-up appointment, such as: no-show/cancel, staff shortage, system issue/lack of staff training, client choice of date, etc. Use the aggregate exception codes to facilitate improved outreach or education tools to improve FUH compliance. If a CMHSP issue is the reason for the exception (staff shortage, system issue/lack of staff training, etc.) then retraining of staff and CAP put into place.		

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	1	Lack of FUH Collaboration at MHP Level	April 24, 2023	**Improve MHP Collaboration Regarding FUH** 1) Develop FUH Technical Specifications. 2) Develop FUH Reporting Templates and train CMHSP on the templates. 3) Determine best timing and frequency of uploading FUH data into CC360. 4) Hold at least quarterly meetings with MHPs to discuss FUH and how to best tackle improving metric across the board. a. Joint training materials. b. Sync LRE upload and MHP download timeframes to maximize the amount of time MHPs have to ensure	Completed	System Intervention Member (MHP) Intervention	

				compliance. i. Develop Reporting Protocols (such as Meridian table) and compare to other PIHPs and MHPs compare among one another. ii. Ask PIHP/MHP Workgroup if a standardized upload day/time for PIHPs and download day/time for MHPs would improve overall compliance rates. iii. Determine outreach protocols for no-shows or cancelations without reschedules. 5) Leverage PBIP to engage MHPs		
1	Lack of FUH Collaboration at CMHSP Level	November 29, 2022	**<u>Improve CMH Collaboration Regarding FUH</u>** 1) Present FUH Data errors to CMHSP. (Completed) 2) Recommend FUH Workgroup to collaborate in	Continued	System Intervention Member Intervention	

				operationalizing the solution to eliminating the FUH Data errors. (Completed) 3) Review error reports with each CMHSP on a regular basis. (Completed) 4) Hold quarterly meetings with CMHSP personnel (quality, access, and clinical) to discuss FUH and how to best tackle improving metric across the board. a. Develop training materials. b. Determine outreach protocols for no-shows or cancelations without reschedules. 5) Work with CMHSPs/IP facilities to get "consent to text" regarding making f/u appts, reminders for f/u appts, and rescheduling options if need to cancel/reschedule, etc. [Clinicians want a warm hand-off and follow-up; but is this practical given the technology age we live in – everyone enjoys a text			

				reminder … would it decrease no-show and cancelation with no rescheduling rates?] 6) Report FUH efforts/results on a regular basis to QI ROAT and Clinical ROAT – what about the IT ROAT (Completed)		
2	Lack of FUH Collaboration at Provider Level 1) Lack of Coordination with IP facilities and Standardized protocols regarding Timeliness on Discharge Follow-up – within 24 hours of Discharge, Facility is supposed to notify CMHSP or MHP within 24 hours of discharge date/time … Provider Network Management – Part of Performance Incentive (ask D/J about the specifics) 2) Lack of access to consumers while admitted	For #1 – October 1, 2022 For #2-#4 – June 16, 2023	**Improve Provider Collaboration Regarding FUH** 1) Draft Value Based Incentive Program for providers to establish goals to begin discharge planning upon admission and ensure timely notification of discharge to the PIHP. (Completed) 2) Collaborate with Providers to identify opportunities for CMHSP/MHP to meet with consumer/guardian prior to discharge. 3) Develop education materials for Adults and Children/Guardian to provide to consumers/guardians prior to discharge.	#1 – Completed #2-4 – Continued	Provider Intervention

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	to Inpatient settings (R3 wants "warm hand-off" and contact prior to discharge) 3) Lack of permission to include education materials to consumers in the IP Discharge paperwork		4) Work with CMHSPs/IP facilities to get "consent to text" regarding making f/u appts, reminders for f/u appts, and rescheduling options if need to cancel/reschedule, etc.		
3	Lack of Trust of the Behavioral Health System among African Americans/Blacks.	TBD	**Build Trust in the BH System amongst the Target Population** 1) Use the FUH PowerBI Dashboard to data mine for zip codes, race, etc. to develop specific outreach programming to positively influence African Americans/Blacks to trust the system. 2) Develop outreach efforts	New	System Intervention Member Intervention

			specifically geared towards African Americans/Blacks to trust the system. 3) Meet with local Black community leaders to determine if they are a possible pathway to improving trust of the system.		

Intervention Evaluation Table: In the table below, list each intervention that was included in the Barriers/Interventions Table, above. For each intervention, document the processes and measures used to evaluate effectiveness, the evaluation results, and next steps taken in response to the evaluation results. Additional documentation of evaluation processes and results may be attached as separate documents. Attachments should be clearly labeled and referenced in the table below.

Measurement Period	Intervention Description	Evaluation Process	Evaluation Results	Next Steps
July 15, 2022-July 14, 2023	**Modify Systems to Standardize Processes and Ensure FUH Data Integrity** 1) Develop FUH Technical Specifications. 2) Develop FUH Reporting Templates and train CMHSP on the templates.	1) Conducted CMH training on FUH Technical Specification, and Reporting Templates 2) Ran Error and Compliance Reports for each CMHSP and aggregate and reviewed with each	1) LRE staff spends 60 minutes a week instead of 900 minutes (15 hours) – a 93% efficiency gain in IT resource availability, 2) A significant reduction in CMHSP data errors. (Exhibit L).	1) Run Error (IT) and Compliance Reports (OPS) on a regular basis. 2) Provider Network Managers send Error and Compliance Reports on a regular basis requiring timely correction. 3) Provider Network Managers meet with CMHSPs who appear to be trending in a negative direction related to

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	3) Develop error reports to identify CMHSP data errors for follow-up and retraining with CMHSPs. 4) Develop way to quantify "improvement" in CMHSP data integrity. 5) Due to the 6-month CC360 data lag, how do we know that what we are doing is making a positive impact? Can we use ZTS FUH Dashboard as a predictor of what the CC360 data will report?	CMHSP to sharpen the training.	3) Increased availability of FUH data to MHPs – some MHPs have reported data is received more timely and more actionable for them as a result. 4) Improved relationships with CMHSPs concerning FUH. 5) Improved relationships with IP Providers concerning FUH.	inaccurate, incomplete, or untimely data submissions.

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	6) Ensure each CMHSP has trained back-ups to cover primary staff responsible for reporting FUH Data to LRE in case of leave, PTO, etc.			
July 15, 2022-July 14, 2023	**Modify ZTS Programming Logic to Ensure FUH Data Integrity** 1) Race corrections - This was due to the old and new race coding the state was sending for the same record. They are working to make the necessary changes to the data. Remnants of	Too early to Evaluate	Too early to Evaluate	1) Continue to have ZTS modify its programming logic to resolve race issues, N/A facility entry, add HEDIS 2021 Aggregate Averages for baselines. 2) Once ZTS completes the modifications and tests its system, LRE will modify the KPI and FUH Power BI Dashboards.

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	the MDHHS R/E issues from August 2020. 2) N/A under "Facility" in report due to NPI not being mapped correctly – ZTS is working on it. 3) PBIP FUH Metric - State has incorporated the HEDIS Aggregate 2021 FUH Averages into the PBIP for FY24; ZTS needs to do the same. 4) ZTS Dashboard has not been updated due to data lag and data integrity issues. 1) Ensure ZTS updates the HEDIS version			

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	and if so, what was different and will it impact the FUH baseline. (Completed)			
July 15, 2022-July 14, 2023	**Develop Predictive Models, if possible, that Reduces the Risk of the CC360 Data Lag** 1) Due to the 6-month CC360 data lag, how do we know that what we are doing is making a positive impact? Can we use ZTS FUH Dashboard as a predictor of what the CC360 data will report? a. See Driver "Lack of ZTS Data	Too early to Evaluate	Too early to Evaluate	1) Continue to have ZTS modify its programming logic to resolve race issues, N/A facility entry, add HEDIS 2021 Aggregate Averages for baselines 2) Once ZTS completes the modifications and tests its system, LRE will modify the KPI and FUH Power BI Dashboards. 3) Develop predictive models to determine if one is acceptable to overcome the CC360 Data Lag

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	Integrity" for more details. 2) Due to the 6-month CC360 data lag, how do we know that what we are doing is making a positive impact? Can we use MMBPIS 4a as a predictor of what the CC360 data will report --- this would have to presume that any standardization in outreach processes would impact all FUH metrics the same, regardless of whether its HEDIS or MMBPIS			a. Determine whether LRE can use authorization dates as placeholders until encounter data is available – similar to the HLOC Report 4) Develop PowerBI Dashboad pages once a predictive model is selected. 5) Develop a "Exceptions" code list (similar to MMBPIS) that can be used to understand the basis for why FUH is not happening so that more targeted interventions can be developed and deployed. a. LRE is going to need to get CMHSP and MHP buy-in to make this Next Step work.

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	a. Build a FUH Monitoring PowerBI Dashboard page with MMBPIS 4a, HEDIS FUH-7 day, and HEDIS FUH-30 day indicators/metrics for comparison. (Completed) 3) Determine if the consumers in the HEDIS FUH 7-day are the same as the consumer in the MMBPIS 4a Indicator? If so, this may bolster the hypothesis that MMBPIS 4a is a good			

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	predictor of HEDIS FUH-7day and FUH-30 day because if a consumer hits the HEDIS FUH 7-day, the HEDIS FUH 30-day will be in-compliance. 4) Due to the 6-month CC360 data lag, how do we know that what we are doing is making a positive impact? Can we use ZTS FUH Dashboard as a predictor of what the CC360 data will report? 5) Create a PowerBI Dashboard for compliance rate of			

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	MMBIS 4a, HEDIS FUH 7-day, and HEDIS FUH 30-day by CMHSP, MHP, race/ethnicity for download at the consumer level. a. Confirm the CC360 FUH data source from MDHHS – email Sha. b. Compare the FUH data from CC360 and the FUH Submission file to determine if the CMHSPs/IP Providers are accurately identifying all			

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	consumers upon admission and discharge. c. Compare MMBPIS 4a data to the FUH Submission File and the CC360 FUH file to see if all consumers are being captured in the MMBPIS 4a data and visa versa. 6) Investigate whether LRE can identify 4-5 "exception" codes (like with MMBPIS 4a) to pinpoint "WHY" a consumer			

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	does not keep a follow-up appointment, such as: no-show/cancel, staff shortage, system issue/lack of staff training, client choice of date, etc. Use the aggregate exception codes to facilitate improved outreach or education tools to improve FUH compliance. If a CMHSP issue is the reason for the exception (staff shortage, system issue/lack of staff			

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	training, etc.) then retraining of staff and CAP put into place.			
July 15, 2022-July 14, 2023	**Improve MHP Collaboration Regarding FUH** 1) Develop FUH Technical Specifications. 2) Develop FUH Reporting Templates and train MHP on the templates. 3) Determine best timing and frequency of uploading FUH data into CC360. 4) Hold at least quarterly meetings with MHPs to discuss FUH and	1) Shared FUH Technical Specification, Procedure, Error Reports, Compliance Reports, PowerBI Dashboard and reviewed with MHP staff. 2) Conducted MHP training on FUH Technical Specification, and Reporting Templates	1) Increased availability of FUH data to MHPs – some MHPs have reported data is received more timely and more actionable for them as a result. 2) Improved relationships with MHPs.	1) Run Error (IT) and Compliance Reports (OPS) on a regular basis. 2) Provider Network Managers send Error and Compliance Reports on a regular basis requiring timely correction. 3) Provider Network Managers meet with MHPs who appear to be trending in a negative direction related to inaccurate, incomplete, or untimely data submissions. 4) Hold quarterly meetings with MHP personnel (quality, access, and clinical) to discuss FUH and how to best

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	how to best tackle improving metric across the board. a. Joint training materials. b. Sync LRE upload and MHP download timeframes to maximize the amount of time MHPs have to ensure compliance. i. Develop Reporting Protocols (such as Meridian table) and compare to	3) Began developing joint training materials with Meridian. 4) Scheduled LRE-MHP meetings with MHPs.		tackle improving metric across the board. a. Develop training materials. b. Determine outreach protocols for no-shows or cancelations without reschedules. 5) Work with CMHSPs/IP facilities to get "consent to text" regarding making f/u appts, reminders for f/u appts, and rescheduling options if need to cancel/reschedule, etc. [Clinicians want a warm hand-off and follow-up; but is this practical given the technology age we live in – everyone enjoys a text reminder … would it

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	other PIHPs and MHPs compare among one another. ii. Ask PIHP/MHP Workgroup if a standardized upload day/time for PIHPs and download day/time for MHPs would improve overall compliance rates.			decrease no-show and cancelation with no rescheduling rates?].

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	c. Determine outreach protocols for no-shows or cancelations without reschedules. 5) Leverage PBIP to engage MHPs.			
July 15, 2022-July 14, 2023	**Improve CMH Collaboration Regarding FUH** 1) Present FUH Data errors to CMHSP. (Completed) 2) Recommend FUH Workgroup to collaborate in operationalizing the solution to eliminating	1) Developed FUH Technical Specification, Procedure, Error Reports, Compliance Reports, PowerBI Dashboard. 2) Conducted CMH training on FUH Technical	1) LRE staff spends 60 minutes a week instead of 900 minutes (15 hours) – a 93% efficiency gain in IT resource availability, 2) A significant reduction in CMHSP data errors. (Exhibit L).	1) Run Error (IT) and Compliance Reports (OPS) on a regular basis. 2) Provider Network Managers send Error and Compliance Reports on a regular basis requiring timely correction. 3) Provider Network Managers meet with CMHSPs who appear to be trending in a negative direction related to

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

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- Quality Improvement Team and Activities Narrative Description
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	the FUH Data errors. (Completed) 3) Review error reports with each CMHSP on a regular basis. (Completed) 4) Hold quarterly meetings with CMHSP personnel (quality, access, and clinical) to discuss FUH and how to best tackle improving metric across the board. a. Develop training materials. b. Determine outreach protocols for no-shows or cancelations	Specification, and Reporting Templates 3) Ran Error and Compliance Reports for each CMHSP and aggregate and reviewed with each CMHSP to sharpen the training.	3) Increased availability of FUH data to MHPs – some MHPs have reported data is received more timely and more actionable for them as a result. 4) Improved relationships with CMHSPs.	inaccurate, incomplete, or untimely data submissions. 4) Hold quarterly meetings with CMHSP personnel (quality, access, and clinical) to discuss FUH and how to best tackle improving metric across the board. a. Develop training materials. b. Determine outreach protocols for no-shows or cancelations without reschedules. 5) Work with CMHSPs/IP facilities to get "consent to text" regarding making f/u appts, reminders for f/u appts, and rescheduling options if need to cancel/reschedule, etc.

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

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	without reschedules. 5) Work with CMHSPs/IP facilities to get "consent to text" regarding making f/u appts, reminders for f/u appts, and rescheduling options if need to cancel/reschedule, etc. [Clinicians want a warm hand-off and follow-up; but is this practical given the technology age we live in – everyone enjoys a text reminder … would it decrease no-show and			[Clinicians want a warm hand-off and follow-up; but is this practical given the technology age we live in – everyone enjoys a text reminder … would it decrease no-show and cancelation with no rescheduling rates?] 6) Work with CMHSPs to establish a No-Show or Cancelation without Reschedule Policy & Procedure with the goal to standardize Region wide, if feasible.

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

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	cancelation with no rescheduling rates?] 6) Report FUH efforts/results on a regular basis to QI ROAT and Clinical ROAT – what about the IT ROAT? (Completed)			
July 15, 2022 – July 14, 2023	**Improve Provider Collaboration Regarding FUH** 1) Draft Value Based Incentive Program for providers to establish goals to begin discharge planning upon admission and ensure timely	1) Developed FUH Technical Specification, Procedure, Error Reports, Compliance Reports, PowerBI Dashboard and reviewed with Provider staff. 2) Conducted Provider training on FUH	1) LRE staff spends 60 minutes a week instead of 900 minutes (15 hours) – a 93% efficiency gain in IT resource availability, 2) A significant reduction in CMHSP data errors. (Exhibit L).	1) Run Error (IT) and Compliance Reports (OPS) on a regular basis. 2) Provider Network Managers send Error and Compliance Reports on a regular basis requiring timely correction. 3) Provider Network Managers meet with Providers who appear to be trending in a negative direction related to

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	notification of discharge to the PIHP. 2) Collaborate with Providers to identify opportunities for CMHSP/MHP to meet with consumer/guardian prior to discharge. 3) Develop education materials for Adults and Children/Guardian to provide to consumers/guardians prior to discharge. 4) Work with CMHSPs/IP facilities to get "consent to text" regarding making f/u appts, reminders for f/u appts, and	Technical Specification, and Reporting Templates 3) Ran Error and Compliance Reports for each Providers and aggregate and reviewed with each Providers to sharpen the training.	3) Increased availability of FUH data to MHPs – some MHPs have reported data is received more timely and more actionable for them as a result. 4) Improved relationships with Providers.	inaccurate, incomplete, or untimely data submissions. 4) Hold quarterly meetings with Providers personnel (quality, access, and clinical) to discuss FUH and how to best tackle improving metric across the board. a. Develop training materials. b. Determine outreach protocols for no-shows or cancelations without reschedules. 5) Work with CMHSPs/IP facilities to get "consent to text" regarding making f/u appts, reminders for f/u appts, and rescheduling options if need to cancel/reschedule, etc.

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	rescheduling options if need to cancel/reschedule, etc.			[Clinicians want a warm hand-off and follow-up; but is this practical given the technology age we live in – everyone enjoys a text reminder … would it decrease no-show and cancelation with no rescheduling rates?]
July 15, 2022 – July 14, 2023	**Build Trust in the BH System amongst the Target Population** 1) Use the FUH PowerBI Dashboard to data mine for zip codes, race, etc. to develop specific outreach programming to positively influence African	Too early to evaluate	Too early to evaluate	1) Modify ZTS programming logic. 2) Develop predictive tool to overcome the CC360 data lag. 3) Develop PowerBI Dashboard to enable data mining. 4) Develop outreach workflow for Black community leaders.

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

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	Americans/Blacks to trust the system. 2) Develop outreach efforts specifically geared towards African Americans/Blacks to trust the system. 3) Meet with local Black community leaders to determine if they are a possible pathway to improving trust of the system.			

Clinical and Programmatic Improvement Table: In the table below, describe any clinical and/or programmatic improvement that was achieved at any remeasurement period during the PIP. Specify each remeasurement period when improvement was obtained and the intervention(s) that led to the improvement. Provide intervention evaluation results in the *Supporting Quantitative or Qualitative Data* column.

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

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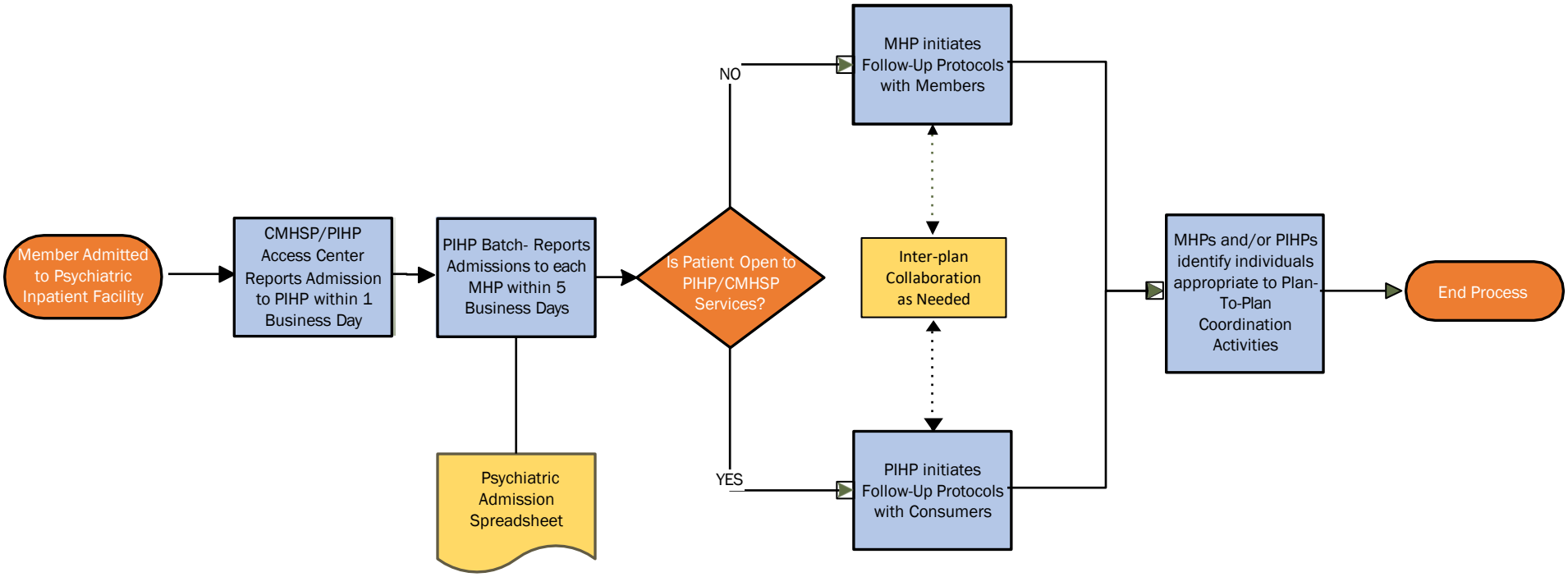
Clinical Improvement		
Remeasurement Period	**Narrative Summary of Clinical Improvement**	**Supporting Quantitative or Qualitative Data**
Programmatic Improvement		
Remeasurement Period	**Narrative Summary of Programmatic Improvement**	**Supporting Quantitative or Qualitative Data**

FUH – Process Map

12/5/2022



Date: June 11, 2023

Version: 4

Global Aims:

1) FUH Aim: Decrease the overall recidivism rate among consumers, regardless of race or ethnicity.
2) Race Disparity Aim: Decease the race disparity between African Americans/Blacks and Whites.

PIP Aim:

Do Region 3 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 a decrease in the racial disparity between the two measurement groups, during the measurement period, without a decline in performance for the White members?

Rank	Key Drivers	Initiation Date	Responsible Staff	Interventions by Priority	Status (New, Continued, Completed, Discontinued, Revised)	Intervention Type (System, Member, Provider)	Evaluation Process	Evaluation Results	Next Steps
1	Lack of Data Integrity from CMHSPs/Lack of Standardization of Data Expectation	August 1, 2022	FUH Workgroup	**Modify Systems to Standardize Processes and Ensure FUH Data Integrity** 1) Develop FUH Technical Specifications. 2) Develop FUH Reporting Templates and train CMHSP on the templates. 3) Develop error reports to identify CMHSP data errors for	Completed	System Member	1) Conducted CMH training on FUH Technical Specification, and Reporting Templates 2) Ran Error and Compliance Reports for each CMHSP and aggregate and reviewed with each CMHSP to sharpen the training.	1) LRE staff spends 60 minutes a week instead of 900 minutes (15 hours) – a 93% efficiency gain in IT resource availability, 2) A significant reduction in CMHSP data errors. (Exhibit L). 3) Increased availability of FUH data to MHPs –	1) Run Error (IT) and Compliance Reports (OPS) on a regular basis. 2) Provider Network Managers send Error and Compliance Reports on a regular basis requiring timely correction. 4) Provider Network Managers meet with CMHSPs who appear to be trending in a

				follow-up and retraining with CMHSPs. 4) Develop way to quantify "improvement" in CMHSP data integrity. 5) Due to the 6-month CC360 data lag, how do we know that what we are doing is making a positive impact? Can we use ZTS FUH Dashboard as a predictor of what the CC360 data will report? 6) Ensure each CMHSP has trained back-ups to cover primary staff responsible for reporting FUH Data to LRE in case of leave, PTO, etc.				some MHPs have reported data is received more timely and more actionable for them as a result. 4) Improved relationships with CMHSPs concerning FUH. 3) Improved relationships with IP Providers concerning FUH.	negative direction related to inaccurate, incomplete, or untimely data submissions.
1	Lack of Data Integrity from ZTS	January 10, 2023	PIP Workgroup	**<u>Modify ZTS Programming Logic to Ensure FUH Data Integrity</u>** 1) Race corrections - This was due to the old and new race coding the state was	Continued	System	Too early to Evaluate	Too early to Evaluate	1) Continue to have ZTS modify its programming logic to resolve race issues, N/A facility entry, add HEDIS 2021 Aggregate Averages for baselines.

				sending for the same record. They are working to make the necessary changes to the data. Remnants of the MDHHS R/E issues from August 2020. 2) N/A under "Facility" in report due to NPI not being mapped correctly – ZTS is working on it. 3) PBIP FUH Metric - State has incorporated the HEDIS Aggregate 2021 FUH Averages into the PBIP for FY24; ZTS needs to do the same. 4) ZTS Dashboard has not been updated due to data lag and data integrity issues. 5) Ensure ZTS updates the HEDIS version and if so, what was different ***Get from Juan/Jordan and will it impact the FUH baseline. (Completed)					1) Once ZTS completes the modifications and tests its system, LRE will modify the KPI and FUH Power BI Dashboards.

1	Lack of CC360 Data Availability 1) **RISK:** CC360 Data and Report: – CC360's 6-month lag time makes it difficult to determine if interventions are effective or not and if not, it does not give any time to adjust and determine if the adjustments have made a positive impact on the metric. LRE won't have the data for the first measurement period until early July 2024, and MDHHS/HSAG expects a report in Mid-July 2024. LRE (and any other	January 27, 2023	PIP Workgroup	**Develop Predictive Models, if applicable, that Reduces the Risk of the CC360 Data Lag** 1) Due to the 6-month CC360 data lag, how do we know that what we are doing is making a positive impact? Can we use ZTS FUH Dashboard as a predictor of what the CC360 data will report? a. See Driver "Lack of ZTS Data Integrity" for more details. 2) Due to the 6-month CC360 data lag, how do we know that what we are doing is making a positive impact? Can we use MMBPIS 4a as a predictor of what the CC360 data will report --- this would have to presume that any standardization in outreach processes would impact all FUH metrics the	Continued	System	Too early to Evaluate	Too early to Evaluate	1) Continue to have ZTS modify its programming logic to resolve race issues, N/A facility entry, add HEDIS 2021 Aggregate Averages for baselines 2) Once ZTS completes the modifications and tests its system, LRE will modify the KPI and FUH Power BI Dashboards. 3) Develop predictive models to determine if one is acceptable to overcome the CC360 Data Lag a. Determine whether LRE can use authorization dates as placeholders until encounter data is available – similar to the HLOC Report 4) Develop PowerBI Dashboad pages once a predictive model is selected.

	PIHP working with the FUH measure) is "flying blind" until such time as it is too late to do anything to make corrections or adjustments to effectuate improvement in race/disparity. 2) **Can MMBPIS 4a – FUH-7 be a predictive metric for the HEDIS FUH-30?** 3) **Use ZTS as a predictive metric for the HEDIS FUH-30 given that the lag time is only one-month?** 4) **Use Power BIs as a monitoring effort?** 5) **Reports to QI ROAT and**			same, regardless of whether its HEDIS or MMBPIS a. Build a FUH Monitoring PowerBI Dashboard page with MMBPIS 4a, HEDIS FUH-7 day, and HEDIS FUH-30 day indicators/metrics for comparison. (Completed) 3) Determine if the consumers in the HEDIS FUH 7-day are the same as the consumer in the MMBPIS 4a Indicator? If so, this may bolster the hypothesis that MMBPIS 4a is a good predictor of HEDIS FUH-7day and FUH-30 day because if a consumer hits the HEDIS FUH 7-day, the HEDIS FUH 30-day will be in-compliance.					5) Develop a "Exceptions" code list (similar to MMBPIS) that can be used to understand the basis for why FUH is not happening so that more targeted interventions can be developed and deployed. 1) LRE is going to need to get CMHSP and MHP buy-in to make this Next Step work.

	Clinical ROAT monthly.			4) Due to the 6-month CC360 data lag, how do we know that what we are doing is making a positive impact? Can we use ZTS FUH Dashboard as a predictor of what the CC360 data will report? 5) Create a PowerBI Dashboard for compliance rate of MMBIS 4a, HEDIS FUH 7-day, and HEDIS FUH 30-day by CMHSP, MHP, race/ethnicity for download at the consumer level. a. Confirm the CC360 FUH data source from MDHHS – email Sha. b. Compare the FUH data from CC360 and the FUH Submission file to determine if the CMHSPs/IP Providers are accurately					

				identifying all consumers upon admission and discharge. c. Compare MMBPIS 4a data to the FUH Submission File and the CC360 FUH file to see if all consumers are being captured in the MMBPIS 4a data and visa versa. 6) Investigate whether LRE can identify 4-5 "exception" codes (like with MMBPIS 4a) to pinpoint "WHY" a consumer does not keep a follow-up appointment, such as: no-show/cancel, staff shortage, system issue/lack of staff training, client choice of date, etc. Use the aggregate exception codes to facilitate improved outreach or education tools to					

				improve FUH compliance. If a CMHSP issue is the reason for the exception (staff shortage, system issue/lack of staff training, etc.) then retraining of staff and CAP put into place.					
1	Lack of FUH Collaboration at MHP Level	April 24, 2023	FUH Workgroup	**<u>Improve MHP Collaboration Regarding FUH</u>** 1) Develop FUH Technical Specifications. 2) Develop FUH Reporting Templates and train CMHSP on the templates. 3) Determine best timing and frequency of uploading FUH data into CC360. 4) Hold at least quarterly meetings with MHPs to discuss FUH and how to best tackle improving metric across the board. a. Joint training materials.	Completed	System Member (MHP)	1) Shared FUH Technical Specification, Procedure, Error Reports, Compliance Reports, PowerBI Dashboard and reviewed with MHP staff. 2) Conducted MHP training on FUH Technical Specification, and Reporting Templates 3) Began developing joint training materials with Meridian. Scheduled LRE-MHP meetings with MHPs.	1) Increased availability of FUH data to MHPs – some MHPs have reported data is received more timely and more actionable for them as a result. Improved relationships with MHPs.	1) Run Error (IT) and Compliance Reports (OPS) on a regular basis. 2) Provider Network Managers send Error and Compliance Reports on a regular basis requiring timely correction. 3) Provider Network Managers meet with MHPs who appear to be trending in a negative direction related to inaccurate, incomplete, or untimely data submissions. 4) Hold quarterly meetings with MHP personnel (quality, access, and clinical) to

				b. Sync LRE upload and MHP download timeframes to maximize the amount of time MHPs have to ensure compliance. i. Develop Reporting Protocols (such as Meridian table) and compare to other PIHPs and MHPs compare among one another. ii. Ask PIHP/MHP Workgroup if a standardized upload day/time for PIHPs and download day/time for MHPs would					discuss FUH and how to best tackle improving metric across the board. a. Develop training materials. b. Determine outreach protocols for no-shows or cancelations without reschedules. Work with CMHSPs/IP facilities to get "consent to text" regarding making f/u appts, reminders for f/u appts, and rescheduling options if need to cancel/reschedule, etc. [Clinicians want a warm hand-off and follow-up; but is this practical given the technology age we live in – everyone enjoys a text reminder … would it decrease no-show and cancelation with no rescheduling rates?].

				improve overall compliance rates. c. Determine outreach protocols for no-shows or cancelations without reschedules. 5) Leverage PBIP to engage MHPs.					
1	Lack of FUH Collaboration at CMHSP Level	November 29, 2022	FUH Workgroup	**<u>Improve CMH Collaboration Regarding FUH</u>** 1) Present FUH Data errors to CMHSP. (Completed) 2) Recommend FUH Workgroup to collaborate in operationalizing the solution to eliminating the FUH Data errors. (Completed) 3) Review error reports with each CMHSP on a regular basis. (Completed) 4) Hold quarterly meetings with	Continued	System Member	1) Developed FUH Technical Specification, Procedure, Error Reports, Compliance Reports, PowerBI Dashboard. 2) Conducted CMH training on FUH Technical Specification, and Reporting Templates Ran Error and Compliance Reports for each CMHSP and aggregate and reviewed with each CMHSP to sharpen the training.	1) LRE staff spends 60 minutes a week instead of 900 minutes (15 hours) – a 93% efficiency gain in IT resource availability, 2) A significant reduction in CMHSP data errors. (Exhibit L). 3) Increased availability of FUH data to MHPs – some MHPs have reported data is received more timely and more actionable for them as a result.	1) Run Error (IT) and Compliance Reports (OPS) on a regular basis. 2) Provider Network Managers send Error and Compliance Reports on a regular basis requiring timely correction. 3) Provider Network Managers meet with CMHSPs who appear to be trending in a negative direction related to inaccurate, incomplete, or untimely data submissions.

				CMHSP personnel (quality, access, and clinical) to discuss FUH and how to best tackle improving metric across the board. a. Develop training materials. b. Determine outreach protocols for no-shows or cancelations without reschedules. 5) Work with CMHSPs/IP facilities to get "consent to text" regarding making f/u appts, reminders for f/u appts, and rescheduling options if need to cancel/reschedule, etc. [Clinicians want a warm hand-off and follow-up; but is this practical given the technology age we live in – everyone enjoys a text				Improved relationships with CMHSPs.	4) Hold quarterly meetings with CMHSP personnel (quality, access, and clinical) to discuss FUH and how to best tackle improving metric across the board. a. Develop training materials. b. Determine outreach protocols for no-shows or cancelations without reschedules. 5) Work with CMHSPs/IP facilities to get "consent to text" regarding making f/u appts, reminders for f/u appts, and rescheduling options if need to cancel/reschedule, etc. [Clinicians want a warm hand-off and follow-up; but is this practical given the technology age we live in – everyone

				reminder … would it decrease no-show and cancelation with no rescheduling rates?] 6) Report FUH efforts/results on a regular basis to QI ROAT and Clinical ROAT – what about the IT ROAT? (Completed)					enjoys a text reminder … would it decrease no-show and cancelation with no rescheduling rates?] Work with CMHSPs to establish a No-Show or Cancelation without Reschedule Policy & Procedure with the goal to standardize Region wide, if feasible.
2	Lack of FUH Collaboration at Provider Level 1) Lack of Coordination with IP facilities and Standardized protocols regarding Timeliness on Discharge Follow-up – within 24 hours of Discharge, Facility is supposed to notify CMHSP or MHP within 24 hours of discharge		FUH Workgroup (for 1) PIP Workgroup (for 2-3)	**<u>Improve Provider Collaboration Regarding FUH</u>** 1) Draft Value Based Incentive Program for providers to establish goals to begin discharge planning upon admission and ensure timely notification of discharge to the PIHP. 2) Collaborate with Providers to identify opportunities for CMHSP/MHP to meet with consumer/guardian prior to discharge.	#1 – Completed #2-4 – Continued	Provider	1) Developed FUH Technical Specification, Procedure, Error Reports, Compliance Reports, PowerBI Dashboard and reviewed with Provider staff. 2) Conducted Provider training on FUH Technical Specification, and Reporting Templates Ran Error and Compliance Reports for each Providers and aggregate and reviewed with each Providers to sharpen the training.	1) LRE staff spends 60 minutes a week instead of 900 minutes (15 hours) – a 93% efficiency gain in IT resource availability, 2) A significant reduction in CMHSP data errors. (Exhibit L). 3) Increased availability of FUH data to MHPs – some MHPs have reported data is received more timely and more actionable for them as a result. Improved relationships with Providers.	1) Run Error (IT) and Compliance Reports (OPS) on a regular basis. 2) Provider Network Managers send Error and Compliance Reports on a regular basis requiring timely correction. 3) Provider Network Managers meet with Providers who appear to be trending in a negative direction related to inaccurate, incomplete, or untimely data submissions. 4) Hold quarterly meetings with

	date/time … Provider Network Management – Part of Performance Incentive (ask D/J about the specifics) 2) Lack of access to consumers while admitted to Inpatient settings (R3 wants "warm hand-off" and contact prior to discharge) 3) Lack of permission to include education materials to consumers in the IP Discharge paperwork			3) Develop education materials for Adults and Children/Guardian to provide to consumers/guardians prior to discharge. 4) Work with CMHSPs/IP facilities to get "consent to text" regarding making f/u appts, reminders for f/u appts, and rescheduling options if need to cancel/reschedule, etc.					Providers personnel (quality, access, and clinical) to discuss FUH and how to best tackle improving metric across the board. a. Develop training materials. b. Determine outreach protocols for no-shows or cancelations without reschedules. Work with CMHSPs/IP facilities to get "consent to text" regarding making f/u appts, reminders for f/u appts, and rescheduling options if need to cancel/reschedule, etc. [Clinicians want a warm hand-off and follow-up; but is this practical given the technology age we live in – everyone enjoys a text reminder … would it decrease no-show and cancelation with no rescheduling rates?]

3	Lack of Trust of the Behavioral Health System among African Americans/Blacks.	TBD	PIP Workgroup	**<u>Build Trust in the BH System amongst the Target Population</u>** 1) Use the FUH PowerBI Dashboard to datamine for zip codes, race, etc. to develop specific outreach programming to positively influence African Americans/Blacks to trust the system. 2) Develop outreach efforts specifically geared towards African Americans/Blacks to trust the system. 3) Meet with local Black community leaders to determine if they are a possible pathway to improving trust of the system.	New	System Member	Too early to evaluate	Too early to evaluate	1) Modify ZTS programming logic. 2) Develop predictive tool to overcome the CC360 data lag. 3) Develop PowerBI Dashboard to enable data mining. Develop outreach workflow for Black community leaders.

Attachment C

FUH Workgroup Roadmap

LRE
CMHSP

Topic	Past	Present	Future
Clinical Section			
Payer Sources Reported on FUH	CMHSPs asked to submit MC, GF and 3rd Party insured who also have Medicaid. GF/3rd Party not uploaded into the report – maintained for possible future MC enrollment	No change	*Only report Medicaid primary enrolled cases
		HW – does not submit non-Medicaid N180 monitors GF cases and requires a 7-day follow-up CMHOC – report Medicaid to LRE; everyone to MDHHS	
Medicaid IDs	Only uploaded cases with current and active Medicaid	IDs often not found – LRE Investigates and makes changes as needed – checks eligibility – often "not found" due to incorrect numbers, other insurance or GF Only uploading active Medicaid	LRE will look at ways to provide information to CMHSPs weekly. Will schedule individual meetings with CMHSPs if needed. Will only ask CMHSPs to submit inpatient stays where Medicaid is the primary payor – do not submit other payors (GF, other insurance)
		HW – does not check enrollment	Payor is Medicaid (*See payor source above)
Care Coordination – process of CMH obtaining discharge information from the hospital or coordinating with the hospital to schedule follow up appointment.	BHO – Getting Daily Census from Inpatient Hospitals (PR/FV), and going into N180 EHR to review chart for missing discharge information.	N/A	N/A
		N180 – required hospitals upload discharge w/in 24 hours.	
		Report admissions until discharge	Report admissions until discharge

FUH Workgroup Roadmap

LRE
CMHSP

Topic	Past	Present	Future
Process of reporting Admissions/ Discharges		• LRE eliminates duplicates	• LRE eliminates duplicates
Report Due date		Uploaded to MDHHS by cob Friday of each week	Goal to move submission to cob Tuesday
		Noon on Tuesday of each week.	No change
Discharges within 24 hours of report submission deadline must be reported			No change
			No change
COFR	No need to report	MDHHS has requested that COFR information be reported	
			Report data if available
Aftercare information reporting (Other Services)		Missing discharge date, aftercare appointment with individual. LRE reaching out to CMHPSs trying to fill that information in. Can provide this in error reports.	
Reporting SUD Aftercare		Review line by line and remove all SUD information. Keep aftercare appointment information	
		Reported in aftercare date, appoint with and/or other column	Only provide information that does not violate 42 CFR • Date/Time • Therapy Appointment • Non SUD-related appointment (any physical healthcare or mental healthcare) • N/A if nothing available to report or if an SUD encounter

FUH Workgroup Roadmap

LRE
CMHSP

Topic	Past	Present	Future
			• Non-SUD include name of therapist and provider
Discrepancies between Admit or Discharge Date and actual days authorized			
			Provide reason for discrepancy in the comments column.
Reporting Retro Reviews			Will not report retro review data
IT Section			
PIHP or MHP Column completion			No concerns reported – required field
Data formatting requirements	excel	Pipe delimited (|) text file (.txt) format.	Pipe delimited (|) text file (.txt) format.
File Naming			
			No recommended changes
File Transmission Method			
			LRE FTP Drop Folder
Frequency of Submissions			
			Maintain weekly submissions and revisit if/when a more automated process that would allow for twice-weekly submissions is available
File Contents:			
Topic	**Past**	**Present**	**Future**
Admit_Discharge	Reported Admit/Discharge	Report A or D to state	Report A or D to state
		Reporting Admit or Discharge	HW – running extract out of PCE – request PCE to change to A or D CMHOC – either is fine N180 – either is fine

FUH Workgroup Roadmap

LRE
CMHSP

Topic	Past	Present	Future
			OnPoint – can be switched CMHSPs will report an A or D
Member_Name		When looking up, eligibility file does not always match the file (sometimes can't find a name because it does not match what is in the eligibility file) results in a not found LRE stores member name that is submitted to look up MDHHS enrollment name for comparison by LRE staff.	Will continue to validate and share issues as needed
		No validation done at HW, No validation done Ottawa for the name. No validation done at WM OP no validation	CMHSPs will validate prior to submitting to LRE to ensure Medicaid ID number matches the name. Will include any additional information in the comments field
MedicaidID		Issues with transposition of numbers.	
CMHSP		No issues identified with this field	No changes
			No changes
Inpatient_Facility_Name		LRE manually changes facility names to ensure consistency.	LRE will provide a list of inpatient facilities to use in this field. Will be outlined in the file specifications.
		Facility names submitted by CMHSPs are inconstant.	Select hospital name from list in file specification document. If hospital is an SCA and not listed in the file specification document, add the legal

FUH Workgroup Roadmap

LRE
CMHSP

Topic	Past	Present	Future
			name of the facility in the facility name filed.
Admission_Date		If end date doesn't match discharge date it is noted in the comments	No changes
			No changes
Discharge_Date		Contact w/CMHSPs is required when this data is missing.	LRE
		This has been an issue for CMHOC, OnPoint, WMCMH, and at times HW.	Ensure admission and discharge dates are included on the submission.
Authorization_End_Date			
			Provide if available, if not, leave blank
BH_Aftercare_Appointment_With		Kris highlights for Liz when information is missing	
			Include name of clinician, type of service if available, organization.
Aftercare_Appointment_Date		Kris highlights for Liz when information is missing	
		Date is often missing (need MM/DD/YYYY)	
Responsibility			Addressed above
			Addressed above
Other_Services			Addressed above
			Addressed above
Other_Services_Comments			Addressed above
			Addressed above
Candidate_For_Plan_To_Plan_Coord			Addressed above
			Addressed above
Payer			Addressed above
			Addressed above

FUH Workgroup Roadmap

LRE
CMHSP

Topic	Past	Present	Future
CMH_Case_ID			Addressed above
			Addressed above

Attachment D

FUH Report Process Project Plan

To be completed by: LRE
Deadline: 1-Oct-23

% done	Phase	Notes	Staff	Due By	Meeting Notes - 4/26/23	Meeting Notes - 11/30	Meeting Notes - 11/22	Meeting Notes - 11/8	Meeting Notes - 11/1	Meeting Notes - 10/18	Meeting Notes - 10/11	Meeting Notes - 10/4	Meeting Notes - 9/27
50%	Active Change Work	Address issues with individual CMHSPs	Jim	1-Nov-23						We are thinking this will be part of the workgroup process.	Do we meet with each CMH to bring the issues to them Individually? Would this be done in our workgroup?		
50%	Evaluation	Inpatient Value Based agreements	Jim	1-Oct-23		Will evaluate Oct 23 with PR and FV in December		Pine Rest was able to provide discharge information for 6 of the 10 encounters.	Report was run for June-August 22. A total of about 10 discharge appointments were scheduled by Pine Rest, but did not get passed on by CMHs in FUH submission process. Jim is following up with CMHs on these cases.				Current Value Based agreements with Pine Rest and Forest View include an indicator for FUH which will allow for PR and FV to review missing/out of compliance discharge appointment data used in FUH report. This will allow us to evaluate the FUH data for accuracy with our two largest utilized psychiatric hospitals.
50%	Ongoing Change Work	Audit process	All	1-Aug-23	Discussed implementing a process to audit or check FUH file submissions. Liz is going to schedule another meeting with Midstate to discuss how they are doing this.								
50%	Evaluation	Automatic rejection for data errors upon submission	Ione	1-Aug-23	Internal LRE FUH Workgroup began to discuss the process and timeline for automation of FUH Data flow process. First process will be to automate an error report which will automatically return an error report of rejected submissions to the CMHs pick up folder.	We have begun and will continue to discuss this at the regional workgroup		Will discuss at workgroup	Will discuss at workgroup	Will discuss at workgroup. At first this could just be an "FYI" and send back letting them know, in the future this would be a formal rejection.		Do we want to reject CMH FUH data at the front door?	
100%	Active Change Work	Improve LRE Data grooming process	All	1-Apr-23	Improvements and clarifications completed. Will make more changes as the FUH Dataflow process is automated.	LRE group will continue this work once the regional workgroup concludes.				Change work on report from July 1-October - Liz/Kris identify areas of need to create efficiency. Developed coding system for spreadsheet to identify errors. Books of excel spreadsheet increased over time to create efficiency. Identify- Items removed (GF or duplicates) , Changed SUD entries, COFR, Secondary Insurance, etc.) Kris/Liz meet when needed to address ongoing issues/needs.			***Add some details about the work we have already done.
100%	Ongoing Change Work	Keep eyes on automation	Ione	1-Feb-23		We have begun and will continue to discuss this at the regional workgroup				Need to submit final FUH report into LRE data base with idea of creating a dashboard to track the things that are being tracked manually.	Keep in mind, while we are working on active change, some of this work will be more manual, but as we streamline this, how can these processes be automated?		
100%	Active Change Work	Develop Workgroup	Jim	1-Dec-22				Done. First Meeting is 11/29. Six meetings over ~8 weeks.		Both Clinical ROAT and IT ROAT agreed to forming a short term workgroup. Questions to answer today: When should this start? Agenda setting/Meeting minutes, org process for workgroup? Who from LRE? Who from CMHSPs? Idea to have 4-6 meetings and then have a time of reviewing effectiveness and then come back together to evaluate. Need to begin to set an agenda for the first workgroup.	If agreed upon by Clinical and IT ROAT, workgroup meetings will need to be scheduled. We can use our internal weekly meeting for agenda planning.		
100%	Workgroup	Develop Workgroup Roadmap	Jim	14-Nov-22			This is completed and ready for utilization in workgroup.	Jim and Liz to work on this and review with the group next week.	Jim and Liz to create rough draft				
100%	Active Change Work	Where are we keeping documents for FUH/Workgroup?	All	8-Nov-22		The workgroup determined documents will be kept in meeting invites. Once final documents (such as the FUH File Specification Document) are completed they will be dispersed and housed in their respective places.		Kris and Brian have made progress on the SP/Teams project and need some time to review. Will review next week.	Do we need a SP folder or a Teams Channel for this? Where are we going to keep these document? Ione and team discussed how the "new" LRE SharePoint will blend more seamlessly with Teams Channels in the future. The group is leaning toward having a Teams Channel. We can discuss this at the first workgroup meeting.				
100%	Evaluation	Review LRE process of data grooming	Brian	1-Nov-22		LRE group will rediscuss this once the regional workgroup concludes.							Review process and plan for improvement.
100%	Evaluation	Cord with Wendi/Quality due to FUH impact on PIP	Jim	25-Oct-22	Final file specification documents, workgroup roadmap, and meeting minutes provided to Wendi, as well as update provided to QI ROAT.			Had a meeting with Wendi on 11/2. Jim and Stephanie plan to keep Wendi up to date on process and will provide meeting minutes from FUH workgroup so QI can plan accordingly.	Meeting scheduled for 11/2.	Jim will schedule an meeting with Wendi and Stephanie and report back on 10/25			
100%	Evaluation	Draft FAQ document	Jim	18-Oct-22		Will continue this once the regional workgroup is done.			This will need to be updated given recent changes.	Liz began FAQ document with additions from MDHHS on 10/11-in progress			Jim will draft a FAQ document and Jim/Liz/Kris will add to the document and review as a group on 10/18/22. Will this be a fluid
100%	Evaluation	Re-review file specification document.	Jim	18-Oct-22	File Specification Document has been updated and finalized by the regional workgroup.	We will do this in the regional workgroup once the roadmap process is completed.			Finalized review so this can be sent back out.				In LRE meetings on 10/4 and 10/11 will review the document and determine if the document needs to be re-disseminated.
100%	Communication	Bring FUH conversation to Clinical and IT ROATs to discuss and pitch the idea of forming a FUH workgroup	Jim	18-Oct-22						Both Clinical ROAT and IT ROAT agreed to forming a short term workgroup. Questions to answer today: When should this start? Agenda setting/Meeting minutes, org process for workgroup? Who from LRE? Who from CMHSPs? Idea to have 4-6 meetings.			10/7/22: Jim and Liz discussed FUH at Clinical ROAT. Agreement for a workgroup. CMHs would decide who to send, but agreed both IT/IS folks as well as UM/Clinical. CMHs requested the workgroup be short term (think 2 months, four meetings).
100%	Evaluation	Review and outline the data submission process	Brian	11-Oct-22					Follow up from Brian. Brian made an "internal" FUH file specification document. Brian will upload that into the FUH SP folder. We will walk through this next week.	Will discuss next week.	Ione has an ask for that work to be drilled down another step.	Brian will review the data submission process and list out what is being done with the report to get from what is being submitted from CMHs to what is coming from Brian. Brian sent out email on 10/7 outlining process. Ione has an ask for that work to be drilled down another step.	
100%	Evaluation	Clarify FUH expectations with MDHHS	Liz	11-Oct-22					Liz update on recent findings:	Adding clarifications to FAQ document. 1.)COFR, MDHHS states they DO want us to report individuals who are determined to be a COFR of another CMH/PIHP. 2.) Regarding reporting Admissions,	Liz confirmed Jackie Sproat is the contact for FUH at the state. Clarifications to come.	Liz will reach out to MDHHS to get clarification on questions from 10/2/22 meeting.	

% done	Phase	Notes	Staff	Due By	Meeting Notes - 4/26/23	Meeting Notes - 11/30	Meeting Notes - 11/22	Meeting Notes - 11/8	Meeting Notes - 11/1	Meeting Notes - 10/18	Meeting Notes - 10/11	Meeting Notes - 10/4	Meeting Notes - 9/27
100%	Evaluation	Review LRE IS File Specification Document for FUH	Liz/Jim	1-Aug-22									Review LRE IS File Specification Document for FUH Report and assess for any needed changes. Added "Reporting Reminders" section. This updated document was sent to CMHSPs on 8/31/22.
100%	Transition	Transition Process - From BHO to LRE	Liz	1-Jul-22						Meetings began late w/Andrea Rosema January 2022. Meetings with MHP February. Met with internal IT on re: possible internal automation. Not possible at that time with IT startup of many dashboards.. Began Train/Trainer approach in March - follow all emails sent to CMH's, content and responses/meetings with Beacon. Liz created workflow and asked for feedback from Beacon. April trialed report upload and added IT (Kris) to process. IT/UM/Beacon met re: report needs, Kris created training document for uploads. Late May early June Liz began completion/comparison process with beacon. Reminders draft document completed in preparation for CMH meetings. Liz requested additional internal assistance. Jim assigned. Jim/Andrea/Liz meet. Final workflow created by Beacon. All previous uploads added to Clinical FUH folder/shared drive. Begin internal review of process.			Several coordination and training meetings between BHO and LRE to transition this process back to LRE. BHO reports process of grooming data after CMH submission was taking 15-20 hours weekly.

Attachment E

LAKESHORE REGIONAL ENTITY

Follow-Up to Hospitalization (FUH) File Specifications

3/1/2023 – Revision 3

Purpose

The Follow-Up to inpatient Hospitalization (FUH) file will supply admission and discharge data to LRE relating to inpatient psychiatric hospitalizations.
In addition to supporting the submission of Follow-Up to Hospitalization (FUH) records to MDHHS, LRE will also use the data in this file for data analytics and reporting including inpatient utilization management monitoring/trending within the region.
Records with Service_Type = Inpt and Payer = Medicaid will be forwarded to MDHHS for use with FUH collaboration with the Medicaid Health Plans.

Document Contents

Requirements

1. Continue to report admission each week until discharge.
2. Remove entries where discharge was reported on the previous week's submission.
3. Submit admission and discharge records as soon as all required data elements are available or at 30 days if all required data elements cannot be met.
4. Report must be submitted by Tuesday 12 noon; AND Friday no later than 8:30 am (Thursday c.o.b. preferable).
    - The goal is to provide the data to the MHPs at least 24 hours prior to the scheduled post discharge follow up appointment to promote effective care coordination between systems of care.

CMHSP to LRE File Submission - File Specifications

File Content

Consumers with admissions or discharges to/from an inpatient hospitalization facility. Submit only FUH records where Medicaid is primary payor of the inpatient episode.

File Formatting Specifications

- Pipe delimited (|) text file (.txt) format.
- Reminder: To preserve the integrity of the file format, if any pipe (|) characters exist in the data to be transmitted, they must be scrubbed out prior to file creation.
- Column headers should be included as the first row (with each column named as shown in the pages below).
- No other header or trailer rows are expected.

File Naming

Please be sure the file name contains the following string so that it will be recognized and picked up by the appropriate LRE data processes:

fuhlist

File Transmission Method

Secure FTP to the LRE server into the submitting partner's "Drop" folder.

FUH Fields

Admit_Discharge

Description: Admission/Discharge indicator field.

Format	Description	Detail
Character data	Contains either "A" (Admission) or "D" (Discharge)	Length up to max (9) characters.

Guidelines:

- This is a required data element.
- For records where a discharge date is being reported, specify "D" for Discharge.
- For records where only an admission date is being reported, specify "A" for Admission.
- Submission of "Admission" or "Discharge" in this column will also be accepted.

Validation Edits:

- This value is required and must not be left blank.

Member_Name

Description: The consumer's full name.

Format	Description	Detail
Character data	Patient full name	Length up to max (100) characters.

Guidelines:

- This is a required data element.
- CMHSP must verify the consumer name submitted must match the name associated with the Medicaid ID. Discrepancies should be noted in the comment section.

Validation Edits:

- This value is required and must not be left blank.

CMH_Case_ID

Description: The case ID number from the CMH electronic health record.

Format	Description	Detail
Character data	Case ID number from CMH health record	Length up to max (20) characters

Guidelines:

- This is a required data element.

Validation Edits:

- None.

MedicaidID

Description: The consumer's Medicaid ID number.

Format	Description	Detail
9999999999	Consumer's Medicaid ID number	Length = 10 (10 digits)

Guidelines:

- This is a required data element.
- CMHSP must verify the consumer name submitted matches the name associated with the Medicaid ID. Discrepancies should be noted in the comment section.
- Please ensure that Medicaid ID numbers are checked for accuracy. Report a complete 10-digit Medicaid ID Number and ensure numbers are in the correct order.

Validation Edits:

- The MedicaidID must be a length of 10 characters. If less than 10 characters zero pad the MedicaidID on the left side to equal a length of 10.

CMHSP

Description: The code for the CMHSP submitting the data file.

Format	Description	Detail
Character data	Code for the associated CMHSP	Length up to max (4) characters

Guidelines:

- This is a required data element.
- Use the appropriate code value shown below for the submitting CMHSP:

Code – Description
ALGN – OnPoint
N180 – Network180
MKG – HealthWest
OTT – Ottawa CMH
WMCH – West Michigan CMH

Validation Edits:

- The value submitted must be a valid code from the list shown above.
- This value is required and must not be left blank.

Facility_EIN

Description: The inpatient facility EIN where the client admission occurred.

Format	Description	Detail
999999999	Inpatient Facility EIN	Length = 9 (9 digits)

Guidelines:

- This is a required data element.

Validation Edits:

- This value is required and must not be left blank.

Inpatient_Facility_Name

Description: The inpatient facility name where the client admission occurred.

Format	Description	Detail
Character data	Inpatient Facility Name	Length up to max (100) characters

Guidelines:

- This is a required data element.
- It is preferred that the Facility Name match the name associated with the facility EIN.

Validation Edits:

- This value is required and must not be left blank.

Admission_Date

Description: The consumer's admission date to psychiatric inpatient services.

Format	Description	Detail
mm/dd/yyyy	The consumer's admission date	Valid date and not future dated

Guidelines:

- This is a required data element.

Validation Edits:

- This value is required and must not be left blank.
- Value provided must be a valid date and must not be future dated.

Discharge_Date

Description: The consumer's discharge date from psychiatric inpatient services.

Format	Description	Detail
mm/dd/yyyy	The consumer's discharge date	Valid date and not future dated

Guidelines:

- This is a required data element if the record type is "D" (Discharge).
- If the discharge date is not the date after the authorization end date please provide rationale for discrepancy in the comment section.

Validation Edits:

- If the record type is "D" (Discharge) then a discharge date must be provided.
- If a value is provided it must be a valid date and must not be future dated.

Authorization_End_Date

Description: The current CMH Authorization End Date.

Format	Description	Detail
mm/dd/yyyy	The CMH authorization end date.	Must be a valid date.

Guidelines:

- This value is required if available for "D" Discharge records. For "A" Admission Records leave blank.
- For all "D" Discharge records, if the discharge date is not the date after the authorization end date, please provide rationale for discrepancy in the comment section.

Validation Edits:

- If a value is provided it must be a valid date.

BH_Aftercare_Appointment_With

Description: Narrative indicating whether a Behavioral Health aftercare appointment has been arranged, and with who. Include provider title, e.g.: case manager, therapist, psychiatrist, etc. Also include name of providing agency or organization.

Format	Description	Detail
Character data	Behavioral Health Aftercare appointment information	Length up to max (2048) characters.

Guidelines:

- This is a required data element if an aftercare appointment was made. In the event an Aftercare appointment is not made, a rationale must be provided in the comment section.
- Submitted Aftercare appointments must be a date no more that 30 days post discharge
- Aftercare information must include the following:
  - Agency Name
  - The name and title of the staff member with whom the appointment is scheduled (this could sometimes be a team name or program name).
- Acronyms specific to the behavioral health industry should be avoided (such as, "HOT" = "Homeless Outreach Team", "BHH" = "Behavioral Health Home") to ensure MHP have full understanding of the care coordination information being shared.
- CMHSPs must ensure any protected SUD specific information is removed prior to submission of FUH report.

Validation Edits:

- Any submitted values in excess of 2048 characters in length will be truncated.

Aftercare_Appointment_Date

Description: Behavioral Health Aftercare appointment date.

Format	Description	Detail
mm/dd/yyyy	Aftercare appointment date	Must be a valid date

Guidelines:

- This is a required data element for FUH "D" Discharge records if an Aftercare appointment was made. In the event an Aftercare appointment is not made, a rationale must be provided in the comment section.
- If present, must be a valid date.

Validation Edits:

- None.

Responsibility

Description: The agency responsible for follow-up coordination (PIHP or MHP).

Format	Description	Detail
Character data	Responsible agency for follow-up coordination	Length up to max (4) characters

Guidelines:

- This is a required data element.
- Use the appropriate code value shown below for the responsible agency:

  Code – Description
  PIHP – Prepaid inpatient health plan (Lakeshore Regional Entity)
  MHP – Medicaid health plan

Validation Edits:

- This field must not be left blank.

Other_Services

Description: Narrative field indicating any other additional services and needs that should be arranged as part of Aftercare.

Format	Description	Detail
Character data	Narrative indicating additional services and needs	Length up to max (2048) characters

Guidelines:

- This value is required when there are known additional follow up appointments. If not available, then leave blank.
- Examples:
  - "Primary Care Provider appointment on DD/MM/YYYY at 1:00pm with Dr. Smith at OnPoint."
  - "Neurology appointment on DD/MM/YYYY at 9:30am with Dr. Stevens at Spectrum Health."
  - "Medication Review Appointment with Psychiatrist, Dr. Johns, on DD/MM/YYYY at Pine Rest Clinic."
- CMHSPs must ensure any protected SUD specific information is removed prior to submission of FUH report.

Validation Edits:

- Any submitted values in excess of 2048 characters in length will be truncated.

Candidate_For_Plan_To_Plan_Coord

Description: Narrative field indicating if the person is receiving Plan-to-Plan care coordination.

Format	Description	Detail
Character data	Specify either Yes or No	Length up to max (3) characters

Guidelines:

- This is a required data element.
- If the patient has an active integrated care plan in Care Connect 360 (CC360), then specify Yes. Otherwise use No.

Validation Edits:

- Valid values: Yes, No, or leave blank.
- Values other than Yes / No, if submitted in this field, will be blanked out on import to the LRE system.

Comments

Description: Narrative field which can be used for additional comments as needed.

Format	Description	Detail
Character data	Narrative field which can be used for additional comments as needed.	Length up to max (2048) characters

Guidelines:

- This is a required data element when the record is a "D" discharge and either the (After care apt with) or (After care apt date) are blank.
- Do not include embedded line ends or carriage returns or pipe (|) characters within this text-based field, as it will interfere with the proper row-based processing of the record set.
- CMHSP must verify the consumer name submitted matches the name associated with the Medicaid ID. Discrepancies should be noted in the comment section.
- For all "D" Discharge records, if the discharge date is not the date after the authorization end date, please provide rationale for discrepancy in the comment section.
- CMHSPs must ensure any protected SUD specific information is removed prior to submission of FUH report.

Validation Edits:

- Any submitted values in excess of 2048 characters in length will be truncated.

Payer

Description: Specifies the anticipated primary payer/funding source.

Format	Description	Detail
Character data	Code for the associated Payer.	Length up to max (12) characters

Guidelines:

- This is a required data element.
- Always use the default code **Medicaid**

Validation Edits:

- This value is required and must not be left blank.

Revision Log

8/31/2022:

- Added “Reporting Reminders” section.

3/22/2021:

- The third (last) sentence on page 1 (under “Purpose”) was changed for better clarity to read: Records with Service_Type = Inpt and Payer = Medicaid will be forwarded to MDHHS for use with FUH collaboration with the Medicaid Health Plans.
- Several other corrections (typo fixes and other clarifications) were also added throughout the document. Please disregard the previous version in favor of this one.

3/1/2023

- Document was revised by FUH Regional Workgroup with several changes.
- BH Aftercare Appointment With-Move submission date closer due to discharge date so it is not lacking information.
- Added to Requirements Section – Submit admission and discharge records as soon as all required data elements are available or at 30 days if all required data elements cannot be met.
- Added in AfterCare Appointment With Section -Submitted AfterCare appointments must be a date no more than 30 days post discharge.
- Facility EIN (Changed) – have added section to report the facility EIN before inpatient facility name.
- Inpatient Facility Name – rather than using a list with naming convention, facility name to match the facility EIN.
- EIN or TIN changed in Facility EIN Section CMHSPs can continue reporting facility name as is as long as the EIN is provided.
- Added to” Reporting Reminders” Section Submission Times changed - Tuesday 12 noon AND Friday no later than 8:30 am (Thursday c.o.b. preferable).

ORGANIZATIONAL PROCEDURE #5.6a

ORGANIZATIONAL PROCEDURE #5.6A: FOLLOW-UP AFTER HOSPITALIZATION	EFFECTIVE DATE	REVISED DATE
ATTACHMENT TO	June 30th, 2023	
	REVIEW DATES	
POLICY #: 5.6		
POLICY TITLE: Integrative Care Coordination		

I. PURPOSE

To ensure that Lakeshore Regional Entity (LRE) as the Pre-Paid Inpatient Health Plan (PIHP) has a confidential process in place for sharing accurate and timely data regarding inpatient hospital admissions, discharges, and follow-up for shared beneficiaries with Medicaid Health Plan (MHP) partners in a manner consistent with the guidelines that were developed by the State PIHP/MHP workgroup.

The goal is to provide the data to the MHPs at least 24 hours prior to the scheduled post discharge follow up appointment to promote effective care coordination between systems of care.

II. PROCEDURE

Each of LRE's Community Mental Health Service Program (CMHSP) participants will be responsible for maintaining data pertaining to inpatient psychiatric hospital admissions and discharges for Medicaid/HMP beneficiaries. This data is provided to LRE twice per week via FUH file submission to 'Drop Folder'.

FUH file data should be submitted each Tuesday by 12:00pm and each Friday by 8:30 am.

CMHSPs will report information for all children and adult Medicaid/Healthy Michigan Plan (HMP) beneficiaries who have an assigned Medicaid Health Plan. Beneficiaries with Fee-for-service Medicaid, General Fund, or beneficiaries who have a different primary insurance with secondary Medicaid should not be reported. State hospital encounters should not be submitted as Medicaid authorizations lapse during admission.

Please refer to the LRE Follow-Up to Hospitalization file specification document for additional detailed guidance including validation rules for the required fields in the report template.

CMHSP's will adhere to the following:

1. CMHSPs will verify active eligibility for Medicaid/HMP prior to data submission.
2. Each CMHSP is responsible for submitting an FUH Record when the CMHSP is financially responsible for the beneficiary. FUH Records for beneficiaries from other PIHPs should be submitted if complete information is available at the time of discharge.
3. CMHSPs must use the reporting template provided by LRE. A new reporting template must be used for each submission.
4. CMHSPs will report 2 types of records on the report template.
    a. **Admission (A)** – entered within 24-48 hours of a beneficiary admission to psychiatric hospital unit. If discharge date/aftercare information is known, it should be entered at the same time as the admission record and then a separate Discharge (D) record is not needed.
    b. **Discharge (D)** – If discharge date/aftercare information was not known at the time of the admission record submission, a separate discharge record should be entered for the beneficiary at a later date, as soon as all required data elements are available or at 30 days after discharge if all required data elements cannot be met.

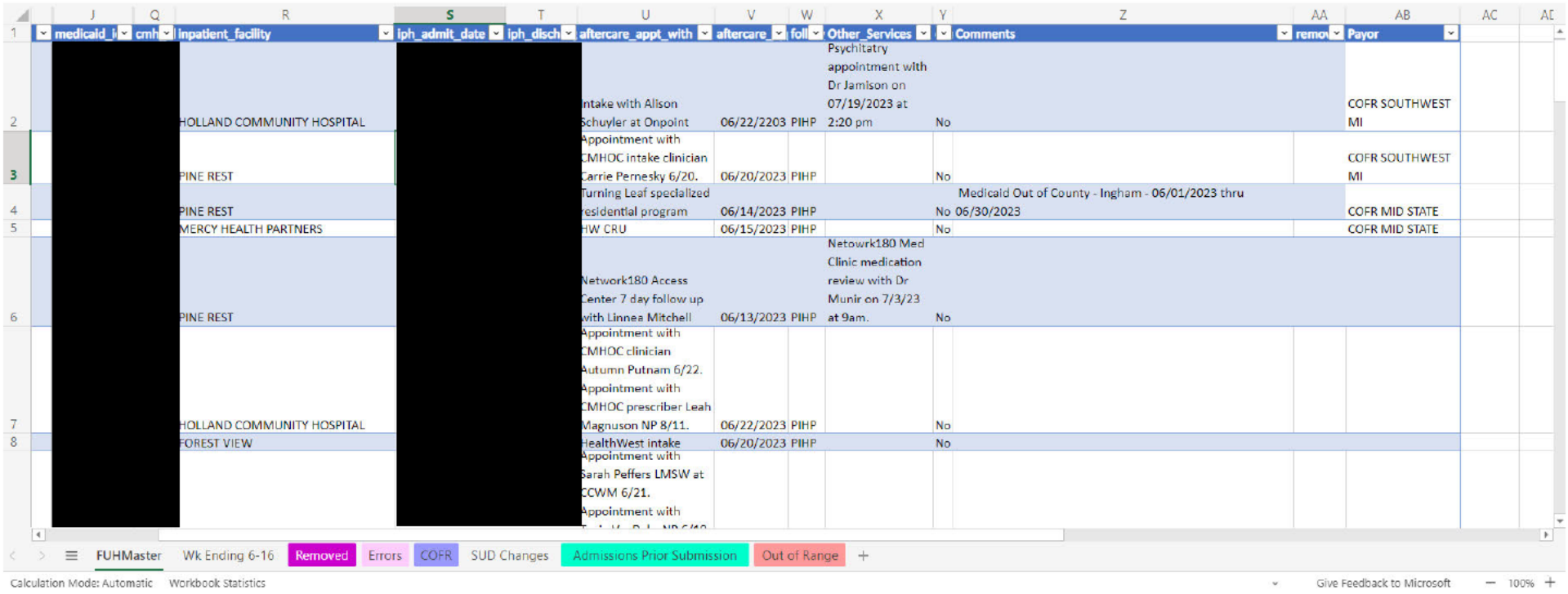
5. Information related to substance use disorder (SUD) treatment should be removed by the CMHSP prior to file submission.
6. Although FUH data submission requires provider agency name and clinician name, do not disclose information which would violate SUD 42 CFR part 2 regulations.
7. CMHSP FUH File Submissions will be reviewed upon submission to LRE. Any FUH Submissions which do not pass LRE FUH data validation process will be returned to the CMHSP in an error report. The CMHSP is responsible for correcting any data errors and resubmitting through the standard process.
8. If CMHSP submits an entry that is later found to be incorrect, please re-submit the entry with the corrected information. Please note in the comment section "Corrected Information", the date of the original submission and the information that was corrected.
9. LRE will verify and upload FUH report into CC360 according to the regionally agreed upon schedule.
10. If MHP is responsible for follow-up please include the beneficiary's most current phone number(s) in the comments section, if known.

III. DEFINITIONS

- CMHSP: Community Mental Health Service Programs
- FUH- Follow-Up After Hospitalization
- PIHP-Pre-paid Inpatient Health Plan
- MHP: Medicaid Health Plan
- SUD: Substance Use Disorder
- IT: Information Technology

IV. RELATED MATERIALS

- Follow-Up to Hospitalization file specifications 3.23 Version 4
- Policy 5.6 Integrative Care Policy
- References/Legal Authority: 1. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY22 Contract



	J	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD
1	medicaid_i	cmh	inpatient_facility	iph_admit_date	iph_disch	aftercare_appt_with	aftercare_	foll	Other_Services		Comments	remov	Payor		
2	[redacted]	[redacted]	HOLLAND COMMUNITY HOSPITAL	[redacted]	[redacted]	Intake with Alison Schuyler at Onpoint	06/22/2203	PIHP	Psychitatry appointment with Dr Jamison on 07/19/2023 at 2:20 pm	No			COFR SOUTHWEST MI		
3			PINE REST			Appointment with CMHOC intake clinician Carrie Pernesky 6/20.	06/20/2023	PIHP		No			COFR SOUTHWEST MI		
4			PINE REST			Turning Leaf specialized residential program	06/14/2023	PIHP		No	Medicaid Out of County - Ingham - 06/01/2023 thru 06/30/2023		COFR MID STATE		
5			MERCY HEALTH PARTNERS			HW CRU	06/15/2023	PIHP		No			COFR MID STATE		
6			PINE REST			Network180 Access Center 7 day follow up with Linnea Mitchell	06/13/2023	PIHP	Netowrk180 Med Clinic medication review with Dr Munir on 7/3/23 at 9am.	No					
7			HOLLAND COMMUNITY HOSPITAL			Appointment with CMHOC clinician Autumn Putnam 6/22. Appointment with CMHOC prescriber Leah Magnuson NP 8/11.	06/22/2023	PIHP		No					
8			FOREST VIEW			HealthWest intake	06/20/2023	PIHP		No					
						Appointment with Sarah Peffers LMSW at CCWM 6/21. Appointment with									

FUHMaster | Wk Ending 6-16 | Removed | Errors | COFR | SUD Changes | Admissions Prior Submission | Out of Range

Calculation Mode: Automatic | Workbook Statistics | Give Feedback to Microsoft | 100%

LRE - HLOC Authorization Data Integrity Reports

Attachment H

Data Source: LRE_DW_CorporateInfo.Fact_Authorizations - CMHSP Submitted files

Data Set: PDS_Authorizations

Purpose: HLOC Authorization Data Integrity Reports for the region or each individual CMHSP

Intended Audience: LRE/PIHP/CMHSP usage (exposes PHI for all CMHSPs)

Reports in Dashboard:

- **Invalid Med ID Length** - Shows HLOC Authorizations where the Medicaid ID (Member ID) is not a length of 10
- **Invalid Provider NPI** - Shows HLOC Authorizations where the Provider NPI is not a length of 10 or contains dashes (-)
- **Invalid Line of Business** - Shows HLOC Authorizations where the Line of Business field is blank
- **Approved Units Greater Than Requested Units** - Shows HLOC Authorizations where the Approved Units are greater than Requested Units
- **Invalid Approved Units** - Shows HLOC Authorizations where the Approved Units are Blank, Zero (0), or greater than Discharge Date/Line Exp Date - Admission Date/Line Eff Date
- **Invalid Requested Units** - Shows HLOC Authorizations where the Approved Units are Blank, Zero (0), or greater than Discharge Date/Line Exp Date - Admission Date/Line Eff Date
- **Invalid IP Approved Amount** - Shows IP Authorizations where the Approved Cost per Unit is Blank, Zero (0), < $500 or > $1,500
- **Invalid PHP Approved Amount** - Shows PHP Authorizations where the Approved Cost per Unit is Blank, Zero (0), < $325 or > $900
- **Invalid CR Approved Amount** - Shows CR MH Authorizations where the Approved Cost per Unit is Blank, Zero (0), < $95 or > $725
- **Admit Fiscal Year Mismatch** - Shows HLOC Authorizations where the FY field does not match the Fiscal Year based on the Admit/Line Eff Date
- **Data Sources and Definitions**

Dashboard page titles that are colored orange (see left) directly impact the authorizations data in the HLOC dashboard. These corrections should be prioritized over dashboard pages with titles that are white.

LAKESHORE REGIONAL ENTITY

HLOC Authorization Data Integrity
Invalid Medicaid ID Length

Authorizations Refresh Date:
7/13/2023

File_FY: 21
21

CMHSP: Heal...
HealthWest

1
Count of Records

Count of Records include duplicate records where table below shows duplicate records once

CMHSP	File FY	Medicaid ID	LINE_EFF_DATE	LINE_EXP_DATE	ADMISSION_DATE	DISCHARGE_DATE	BUNDLE_CODE	SERVICE_PROCEDURE	REVENUE_CODE	REQUEST_UNITS	APPROVED_
HealthWest	21	[redacted]	2/25/2021	2/26/2021				H0018		1.00	1.00
Total										**1.00**	**1.00**

LAKESHORE REGIONAL ENTITY

HLOC Authorization Data Integrity
Invalid Provider NPI

Authorizations Refresh Date:
7/13/2023

File_FY: Mult...
- 20
- 21
- 22
- 23

CMHSP: Multip...
- Allegan
- HealthWest
- Network 180
- Ottawa
- West Michigan

(Blank)

Count of Records

Count of Records include duplicate records where table below shows duplicate records once

CMHSP	File_FY	MEDICAID_ID	PROVIDER_NPI	LINE_EFF_DATE	LINE_EXP_DATE	ADMISSION_DATE	DISCHARGE_DATE	BUNDLE_CODE	SERVICE_PROCEDURE	REVENUE_CODE	REQUI

LAKESHORE REGIONAL ENTITY

HLOC Authorization Data Integrity
Invalid Line of Business

Authorizations Refresh Date:
7/13/2023

File_FY: Multiple selecti...
- [x] 20
- [x] 21
- [x] 22
- [x] 23

(Blank)
Count of Records

Count of Records include duplicate records where table below shows duplicate records once

CMHSP	File_FY	MEDICAID_ID	LINE_OF_BUSINESS	LINE_EFF_DATE	LINE_EXP_DATE	ADMISSION_DATE	DISCHARGE_DATE	BUNDLE_CODE	SERVICE_PROCEDURE	REVENUE_CODE	REQUESTEI

LAKESHORE REGIONAL ENTITY

HLOC Authorization Data Integrity
Approved Units Greater Than Requested Units

Authorizations Refresh Date:
7/13/2023

File_FY: Multi...
- [x] 20
- [x] 21
- [x] 22
- [x] 23

CMHSP: Multipl...
- [x] Allegan
- [x] HealthWest
- [x] Network 180
- [x] Ottawa
- [x] West Michigan

55
Count of Records

Count of Records include duplicate records where table below shows duplicate records once

CMHSP	File_FY	MEDICAID_ID	REQUEST_UNITS	APPROVED_UNITS	LINE_EFF_DATE	LINE_EXP_DATE	ADMISSION_DATE	DISCHARGE_DATE	BUNDLE_CODE	SERVICE_PROCEDURE	RE
Allegan	22	[redacted]	1.00	9.00	5/20/2022	6/1/2022				0913	
Allegan	23		1.00	9.00	5/20/2022	6/1/2022				0913	
Allegan	23		0.00	3.00			9/26/2022	9/29/2022			01(
Allegan	22		1.00	7.00	8/24/2022	8/30/2022				H0018	
Allegan	23		1.00	7.00	8/24/2022	8/30/2022				H0018	
Allegan	22		1.00	7.00	8/24/2022	8/30/2022				H0018	
Allegan	22		1.00	21.00	7/9/2022	7/29/2022				H0018	
Allegan	23		1.00	21.00	7/9/2022	7/29/2022				H0018	
Allegan	22		1.00	14.00	9/6/2022	9/19/2022				H0018	
Allegan	23		1.00	12.00	11/4/2022	11/15/2022				H0018	
Allegan	22		1.00	14.00	2/1/2022	2/14/2022				H0018	
Allegan	23		1.00	14.00	2/1/2022	2/14/2022				H0018	
Allegan	22		1.00	3.00	4/26/2022	4/28/2022				H0018	
Allegan	23		1.00	3.00	4/26/2022	4/28/2022				H0018	
Allegan	23		1.00	5.00			4/25/2023	4/30/2023			01(
Allegan	23		1.00	11.00			12/27/2022	1/6/2023			01(
Allegan	23		1.00	12.00	6/11/2023	6/22/2023				H0018	
Allegan	22		1.00	9.00			4/28/2022	5/6/2022			09
Allegan	23		1.00	9.00			4/28/2022	5/6/2022			09
Allegan	23		1.00	7.00			5/9/2023	5/15/2023			01(
Total	**1222**										

LAKESHORE REGIONAL ENTITY

HLOC Authorization Data Integrity
Invalid Approved Units

Authorizations Refresh Date:
7/13/2023

File_FY: Multi...
- [x] 20
- [x] 21
- [x] 22
- [x] 23

CMHSP: Multi...
- [x] Allegan
- [x] HealthWest
- [x] Network 180
- [x] Ottawa
- [x] West Michigan

659
Count of Records

Count of Records include duplicate records where table below shows duplicate records once

CMHSP	File_FY	MEDICAID_ID	Approved Units Type	Date Difference	APPROVED_UNITS	Date Diff - Approved Units	LINE_EFF_DATE	LINE_EXP_DATE	ADMISSION_DATE	DISCH/
Allegan	21	[redacted]	Approved Units GT Episode	21	22.00	1			12/24/2020	1/14/2(
Allegan	21		Approved Units GT Episode	26	27.00	-1			1/23/2021	2/18/2(
Allegan	22		Approved Units GT Episode	20	21.00	1			8/2/2022	8/22/2(
Allegan	23		Approved Units GT Episode	20	21.00	-1			8/2/2022	8/22/2(
Allegan	23		Approved Units GT Episode	10	11.00	1			12/27/2022	1/6/202
Allegan	23		Approved Units GT Episode	9	10.00	-1			12/28/2022	1/6/202
Allegan	23		Approved Units GT Episode	9	10.00	1			12/28/2022	1/6/202
Allegan	23		Approved Units GT Episode	4	5.00	-1			9/19/2022	9/23/2(
Allegan	23		Approved Units GT Episode	5	6.00	1			9/9/2022	9/14/2(
Allegan	22		Approved Units GT Episode	4	5.00	-1			5/20/2022	5/24/2(
Allegan	23		Approved Units GT Episode	4	5.00	1			5/20/2022	5/24/2(
Allegan	22		Approved Units GT Episode	8	9.00	-1			2/13/2022	2/21/2(
Allegan	23		Approved Units GT Episode	8	9.00	1			2/13/2022	2/21/2(
Allegan	21		Approved Units GT Episode	17	18.00	-1			1/16/2021	2/2/202
Allegan	22		Approved Units GT Episode	4	5.00	1			4/16/2022	4/20/2(
Allegan	23		Approved Units GT Episode	4	5.00	-1			4/16/2022	4/20/2(
Allegan	22		Approved Units GT Episode	8	9.00	1			4/28/2022	5/6/202
Allegan	23		Approved Units GT Episode	8	9.00	-1			4/28/2022	5/6/202
Allegan	23		Approved Units GT Episode	8	9.00	-1			1/17/2023	1/25/2(
Total	**14329**									

LAKESHORE REGIONAL ENTITY

HLOC Authorization Data Integrity
Invalid Requested Units

Authorizations Refresh Date:
7/13/2023

File_FY: Multi...
- [x] 20
- [x] 21
- [x] 22
- [x] 23

CMHSP: Multipl...
- [x] Allegan
- [x] HealthWest
- [x] Network 180
- [x] Ottawa
- [x] West Michigan

1224
Count of Records

Count of Records include duplicate records where table below shows duplicate records once

CMHSP	File_FY	MEDICAID_ID	Requested Units Type	Date Difference	REQUEST_UNITS	Date Diff - Requested Units	LINE_EFF_DATE	LINE_EXP_DATE	ADMISSION_DATE	DISCHA
Allegan	21	[redacted]	Requested Units GT Episode	21	22.00	1			12/24/2020	1/14/20
Allegan	23		Blank or 0 Units	3	0.00	3			9/26/2022	9/29/20
Allegan	21		Requested Units GT Episode	26	27.00	1			1/23/2021	2/18/20
Allegan	22		Requested Units GT Episode	20	21.00	-1			8/2/2022	8/22/20
Allegan	23		Requested Units GT Episode	20	21.00	1			8/2/2022	8/22/20
Allegan	23		Requested Units GT Episode	9	10.00	-1			12/28/2022	1/6/202
Allegan	23		Requested Units GT Episode	9	10.00	1			12/28/2022	1/6/202
Allegan	23		Requested Units GT Episode	4	5.00	-1			9/19/2022	9/23/20
Allegan	23		Requested Units GT Episode	5	6.00	1			9/9/2022	9/14/20
Allegan	22		Requested Units GT Episode	4	5.00	-1			5/20/2022	5/24/20
Allegan	23		Requested Units GT Episode	4	5.00	1			5/20/2022	5/24/20
Allegan	22		Requested Units GT Episode	8	9.00	-1			2/13/2022	2/21/20
Allegan	23		Requested Units GT Episode	8	9.00	1			2/13/2022	2/21/20
Allegan	21		Requested Units GT Episode	17	18.00	-1			1/16/2021	2/2/202
Allegan	22		Requested Units GT Episode	4	5.00	1			4/16/2022	4/20/20
Allegan	23		Requested Units GT Episode	4	5.00	-1			4/16/2022	4/20/20
Allegan	23		Requested Units GT Episode	8	9.00	1			1/17/2023	1/25/20
Allegan	23		Blank or 0 Units	0	0.00	0			2/18/2022	2/18/20
Allegan	22		Requested Units GT Episode	0	1.00	-1			2/18/2022	2/18/20
Total	**26618**			**9886**		**-19482**				

LAKESHORE REGIONAL ENTITY

HLOC Authorization Data Integrity
Invalid Approved Amount for IP

Authorizations Refresh Date:
7/13/2023

File_FY: Multi...
- [x] 20
- [x] 21
- [x] 22
- [x] 23

CMHSP: Multi...
- [x] Allegan
- [x] HealthWest
- [x] Network 180
- [x] Ottawa
- [x] West Michigan

627

Count of Records

Count of Records include duplicate records where table below shows duplicate records once

CMHSP	File_FY	MEDICAID_ID	Approved Cost per Unit	APPROVED_UNITS	APPROVE_AMOUNT	LINE_EFF_DATE	LINE_EXP_DATE	ADMISSION_DATE	DISCHARGE_DATE	BUNDLE_COD
Allegan	21	[redacted]	$0.00	22.00	$0			12/24/2020	1/14/2021	
Allegan	22		$0.00	21.00	$0			11/1/2021	11/22/2021	
Allegan	22		$0.00	11.00	$0			8/18/2022	8/29/2022	
Allegan	21		$0.00	7.00	$0			12/21/2020	12/28/2020	
Allegan	22		$0.00	4.00	$0			5/9/2022	5/13/2022	
Allegan	22		$0.00	10.00	$0			2/5/2022	2/15/2022	
Allegan	22		$0.00	6.00	$0			2/19/2022	2/25/2022	
Allegan	22		$0.00	5.00	$0			10/6/2021	10/11/2021	
Allegan	22		$0.00	6.00	$0			12/20/2021	12/26/2021	
Allegan	22		$0.00	13.00	$0			10/23/2021	11/5/2021	
Allegan	21		$0.00	22.00	$0			1/8/2021	2/2/2021	
Allegan	21		$0.00	25.00	$0			1/8/2021	2/2/2021	
Allegan	22		$0.00	7.00	$0			7/6/2022	7/13/2022	
Allegan	22		$0.00	17.00	$0			10/17/2021	11/3/2021	
Allegan	22		$0.00	3.00	$0			7/26/2022	7/29/2022	
Allegan	22		$0.00	10.00	$0			4/1/2022	4/11/2022	
Allegan	22		$0.00	33.00	$0			10/21/2021	11/23/2021	
Allegan	22		$0.00	59.00	$0			12/31/2021	2/28/2022	
Allegan	22		$0.00	4.00	$0			10/14/2021	10/18/2021	
Total	**13642**									

LAKESHORE REGIONAL ENTITY

HLOC Authorization Data Integrity
Invalid Approved Amount for CR

Authorizations Refresh Date:
7/13/2023

File_FY: Multi...
- [x] 20
- [x] 21
- [x] 22
- [x] 23

CMHSP: Multip...
- [x] Allegan
- [x] HealthWest
- [x] Network 180
- [x] Ottawa
- [x] West Michigan

633

Count of Records

Count of Records include duplicate records where table below shows duplicate records once

CMHSP	File_FY	MEDICAID_ID	Approved Cost per Unit	APPROVED_UNITS	APPROVE_AMOUNT	LINE_EFF_DATE	LINE_EXP_DATE	ADMISSION_DATE	DISCHARGE_DATE	BUNDLE_COD
Allegan	22	[redacted]	$0.00	7.00	$0	8/24/2022	8/30/2022			
Allegan	22		$0.00	6.00	$0	10/12/2021	10/18/2021			
Allegan	22		$0.00	21.00	$0	7/9/2022	7/29/2022			
Allegan	22		$0.00	14.00	$0	9/6/2022	9/19/2022			
Allegan	21		$0.00	1.00	$0	2/7/2021	2/7/2021			
Allegan	21		$0.00	7.00	$0	1/5/2021	1/12/2021			
Allegan	21		$0.00	5.00	$0	10/18/2020	10/22/2020			
Allegan	22		$0.00	3.00	$0	3/5/2022	3/8/2022			
Allegan	22		$0.00	3.00	$0	11/4/2021	11/7/2021			
Allegan	22		$0.00	1.00	$0	11/19/2021	11/19/2021			
Allegan	22		$0.00	14.00	$0	2/1/2022	2/14/2022			
Allegan	22		$0.00	1.00	$0	7/17/2022	7/18/2022			
Allegan	22		$0.00	3.00	$0	4/9/2022	4/12/2022			
Allegan	22		$0.00	3.00	$0	10/1/2021	10/4/2021			
Allegan	22		$0.00	5.00	$0	8/18/2022	8/23/2022			
Allegan	22		$0.00	3.00	$0	4/26/2022	4/28/2022			
Allegan	22		$0.00	3.00	$0	1/11/2022	1/14/2022			
Allegan	22		$0.00	6.00	$0	10/5/2021	10/10/2021			
Allegan	22		$0.00	3.00	$0	7/11/2022	7/14/2022			
Total	**13286**									

LAKESHORE REGIONAL ENTITY

HLOC Authorization Data Integrity
Invalid Approved Amount for PHP

Authorizations Refresh Date:
7/13/2023

File_FY: Multi...
- 20
- 21
- 22
- 23

CMHSP: Multip...
- Allegan
- HealthWest
- Network 180
- Ottawa
- West Michigan

26
Count of Records

Count of Records include duplicate records where table below shows duplicate records once

CMHSP	File_FY	MEDICAID_ID	Approved Cost per Unit	APPROVED_UNITS	APPROVE_AMOUNT	LINE_EFF_DATE	LINE_EXP_DATE	ADMISSION_DATE	DISCHARGE_DATE	BUNDLE_COD
Allegan	22	[redacted]	$0.00	9.00	$0			5/20/2022	6/1/2022	
Allegan	22		$0.00	9.00	$0	5/20/2022	6/1/2022			
Allegan	22		$0.00	6.00	$0			8/1/2022	8/8/2022	
Allegan	22		$0.00	7.00	$0			3/23/2022	3/31/2022	
Allegan	22		$0.00	6.00	$0			8/19/2022	8/26/2022	
Allegan	22		$0.00	6.00	$0			5/19/2022	5/26/2022	
Allegan	22		$0.00	21.00	$0			7/27/2022	8/17/2022	
Allegan	22		$0.00	14.00	$0			1/31/2022	2/17/2022	
Allegan	22		$0.00	11.00	$0	2/3/2022	2/17/2022			
Allegan	22		$0.00	9.00	$0			4/28/2022	5/6/2022	
Allegan	22		$0.00	4.00	$0			7/28/2022	8/2/2022	
Allegan	22		$0.00	12.00	$0	5/6/2022	5/23/2022			
Allegan	22		$0.00	8.00	$0			6/30/2022	7/8/2022	
Allegan	22		$0.00	1.00	$0			8/29/2022	8/30/2022	
Allegan	22		$0.00	10.00	$0			5/27/2022	6/9/2022	
Allegan	22		$0.00	2.00	$0			7/19/2022	7/21/2022	
Allegan	22		$0.00	3.00	$0			7/19/2022	7/21/2022	
Allegan	22		$0.00	5.00	$0			8/2/2022	8/8/2022	
Allegan	22		$0.00	3.00	$0			10/22/2021	10/26/2021	
Total	**572**									

LAKESHORE REGIONAL ENTITY

HLOC Authorization Data Integrity
Admit Fiscal Year Mismatch

Authorizations Refresh Date:
7/13/2023

File_FY: Multi...
- [x] 20
- [x] 21
- [x] 22
- [x] 23

CMHSP: Multip...
- [x] Allegan
- [x] HealthWest
- [x] Network 180
- [x] Ottawa
- [x] West Michigan

359
Count of Records

Count of Records include duplicate records where table below shows duplicate records once

CMHSP	File_FY	Admit/Line Eff FY	MEDICAID_ID	LINE_EFF_DATE	LINE_EXP_DATE	ADMISSION_DATE	DISCHARGE_DATE	BUNDLE_CODE	SERVICE_PROCEDURE	REVENUE_CODE	REC
Allegan	23	2022	[redacted]			9/9/2022	9/15/2022			0100	
Allegan	23	2022				5/20/2022	6/1/2022			0912	
Allegan	23	2022		5/20/2022	6/1/2022				0913		
Allegan	23	2022				11/1/2021	11/22/2021			0100	
Allegan	23	2022				8/18/2022	8/29/2022			0124	
Allegan	23	2022				9/16/2022	9/26/2022			0100	
Allegan	23	2022				9/26/2022	9/29/2022			0100	
Allegan	23	2022				5/9/2022	5/13/2022			0100	
Allegan	23	2022				2/5/2022	2/15/2022			0100	
Allegan	23	2022				2/19/2022	2/25/2022			0100	
Allegan	23	2022				10/6/2021	10/11/2021			0100	
Allegan	23	2022		8/24/2022	8/30/2022				H0018		
Allegan	23	2022				12/20/2021	12/26/2021			0100	
Allegan	23	2022				8/28/2022	9/8/2022			0100	
Allegan	23	2022		10/12/2021	10/18/2021				H0018		
Allegan	23	2022				10/23/2021	11/5/2021			0100	
Allegan	23	2022				7/6/2022	7/13/2022			0100	
Allegan	23	2022				10/17/2021	11/3/2021			0124	
Allegan	23	2022				7/26/2022	7/29/2022			0100	
Total	**8210**										

LAKESHORE REGIONAL ENTITY

HLOC Authorization Data Integrity
Discharge Fiscal Year Mismatch

Authorizations Refresh Date:
7/13/2023

File_FY: All
- 20
- 21
- 22
- 23

978
Count of Records

Count of Records include duplicate records where table below shows duplicate records once

CMHSP	File_FY	Disch/Line Exp FY	MEDICAID_ID	LINE_EFF_DATE	LINE_EXP_DATE	ADMISSION_DATE	DISCHARGE_DATE	BUNDLE_CODE	SERVICE_PROCEDURE	REVENUE_CODE	REC
Allegan	23	2022	[redacted]			9/9/2022	9/15/2022			0100	
Allegan	23	2022				5/20/2022	6/1/2022			0912	
Allegan	23	2022		5/20/2022	6/1/2022				0913		
Allegan	23	2022				11/1/2021	11/22/2021			0100	
Allegan	23	2022				8/18/2022	8/29/2022			0124	
Allegan	23	2022				9/16/2022	9/26/2022			0100	
Allegan	23	2022				9/26/2022	9/29/2022			0100	
Allegan	23	2022				5/9/2022	5/13/2022			0100	
Allegan	23	2022				2/5/2022	2/15/2022			0100	
Allegan	23	2022				2/19/2022	2/25/2022			0100	
Allegan	23	2022				10/6/2021	10/11/2021			0100	
Allegan	23	2022		8/24/2022	8/30/2022				H0018		
Allegan	23	2022				12/20/2021	12/26/2021			0100	
Allegan	23	2022				8/28/2022	9/8/2022			0100	
Allegan	23	2022		10/12/2021	10/18/2021				H0018		
Allegan	23	2022				10/23/2021	11/5/2021			0100	
Allegan	23	2022				7/6/2022	7/13/2022			0100	
Allegan	23	2022				10/17/2021	11/3/2021			0124	
Allegan	23	2022				7/26/2022	7/29/2022			0100	
Total	**21506**										

LAKESHORE REGIONAL ENTITY

HLOC Authorization Data Integrity
Duplicate Records

Authorizations Refresh Date:
7/13/2023

File_FY: All
- 20
- 21
- 22
- 23

(Blank)
Count of Records

Count of Records include duplicate records where table below shows duplicate records once

CMHSP	File_FY	MEDICAID_ID	Duplicate Record Cnt	LINE_EFF_DATE	LINE_EXP_DATE	ADMISSION_DATE	DISCHARGE_DATE	BUNDLE_CODE	SERVICE_PROCEDURE	REVENUE_CODE	RE

Data Sources and Definitions

Data Source: LRE_DW_CorporateInfo.Fact_Authorizations

Data Set: PDS_Authorizations

Fields in the Tables available for export to EXCEL:

CMHSP, FY, MEDICAID_ID, LINE_EFF_DATE, LINE_EXP_DATE, ADMISSION_DATE, DISCHARGE_DATE, BUNDLE_CODE, SERVICE_PROCEDURE, REVENUE_CODE, REQUESTED_UNITS, APPROVED_UNITS, APPROVED_AMOUNT, PROVIDER_NPI, PROVIDER_ORG_NAME, LINE_OF_BUSINESS, *APPROVED COST PER UNIT*

Definitions:

APPROVED COST PER UNIT = APPROVED_AMOUNT/APPROVED_UNITS

INPATIENT SERVICE/REVENUE CODES: 0100 AND 0124

PARTIAL HOSPITALIZATION SERVICE/REVENUE CODES: 0912 AND 0913

CRISIS RESIDENTIAL SERVICE/REVENUE CODE: H0018

Attachment i

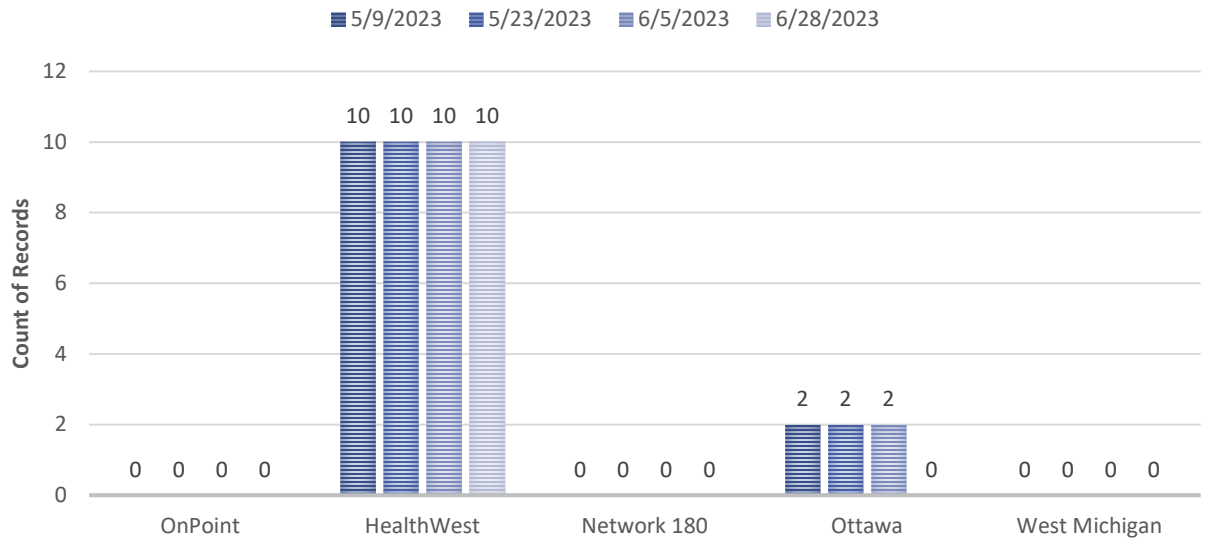
HLOC AUTHORIZATION DATA INTEGRITY DASHBOARD

PROGRESS REPORT BY CMHSP AND DATA INTEGRITY ISSUE

LRE has requested CMHSPs to address the outstanding data integrity issues outlined in the HLOC Authorization Data Integrity Dashboard **by June 30th, 2023**. This request has been communicated to IT ROAT, UM ROAT, and to the CMHSP CEOs. If areas of concern are identified which require collaboration with LRE to address, please contact the LRE CIO and Provider Network Manager to schedule a time for the LRE staff to meet one on one with CMHSP staff.

* Indicates integrity issues which directly impact the HLOC Dashboard, which should be prioritized first by CMHSPs

INVALID MEDICAID ID LENGTH*



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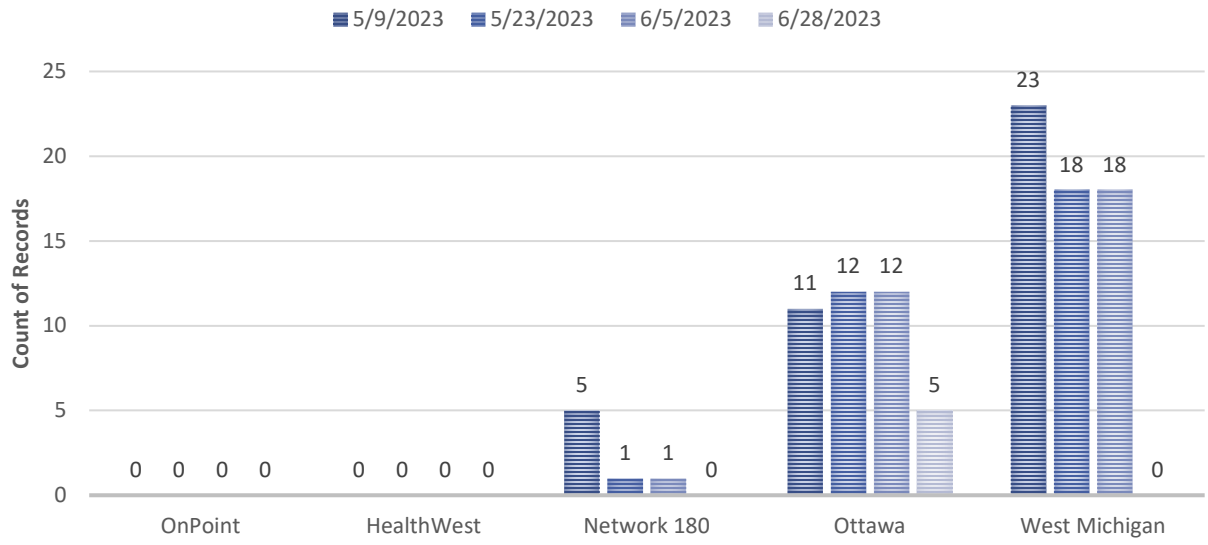
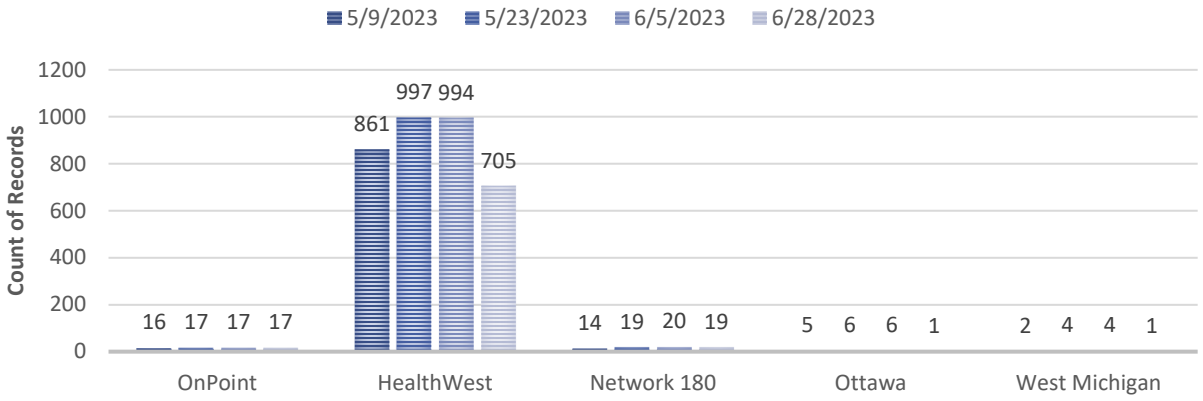


APPROVED UNITS GREATER THAN REQUESTED UNITS



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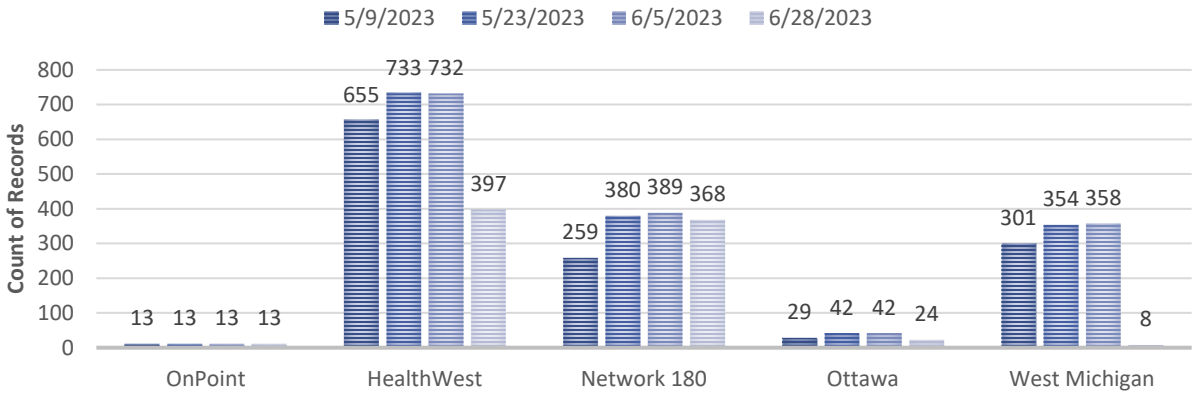

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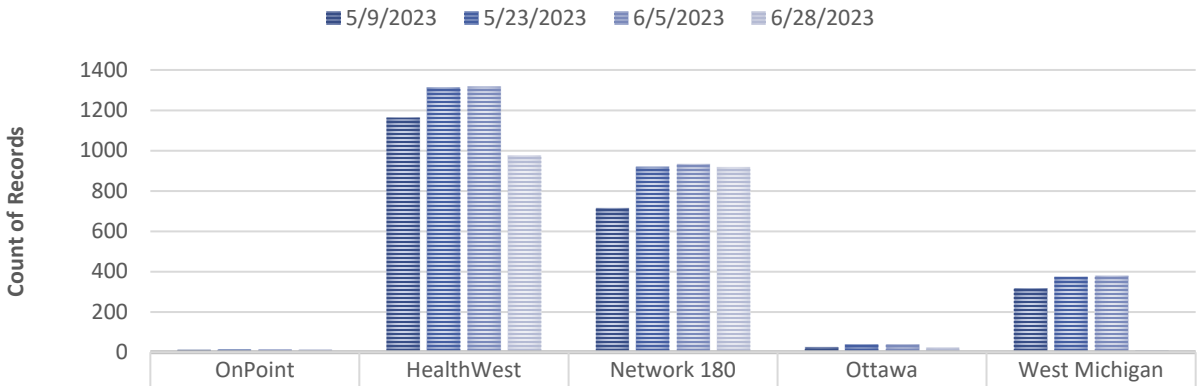

	OnPoint	HealthWest	Network 180	Ottawa	West Michigan
5/9/2023	12	1163	715	27	318
5/23/2023	13	1313	920	40	376
6/5/2023	13	1316	932	40	380
6/28/2023	13	976	918	24	9

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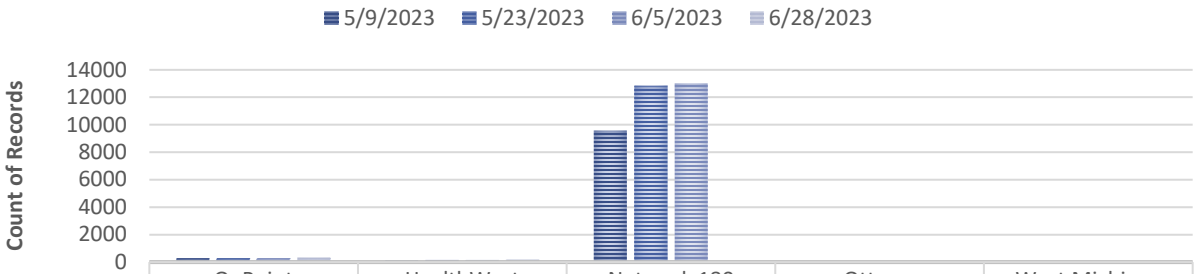
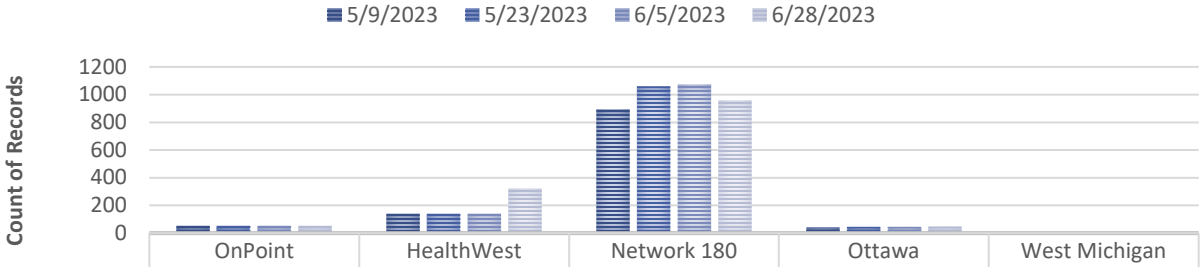


	OnPoint	HealthWest	Network 180	Ottawa	West Michigan
5/9/2023	289	149	9537	10	65
5/23/2023	291	163	12795	16	68
6/5/2023	291	163	12983	16	68
6/28/2023	291	168	3	17	36

INVALID APPROVED AMOUNT – CRISIS RESIDENTIAL*



	OnPoint	HealthWest	Network 180	Ottawa	West Michigan
5/9/2023	56	143	893	42	3
5/23/2023	56	143	1059	45	3
6/5/2023	56	143	1068	45	3
6/28/2023	56	324	957	48	8

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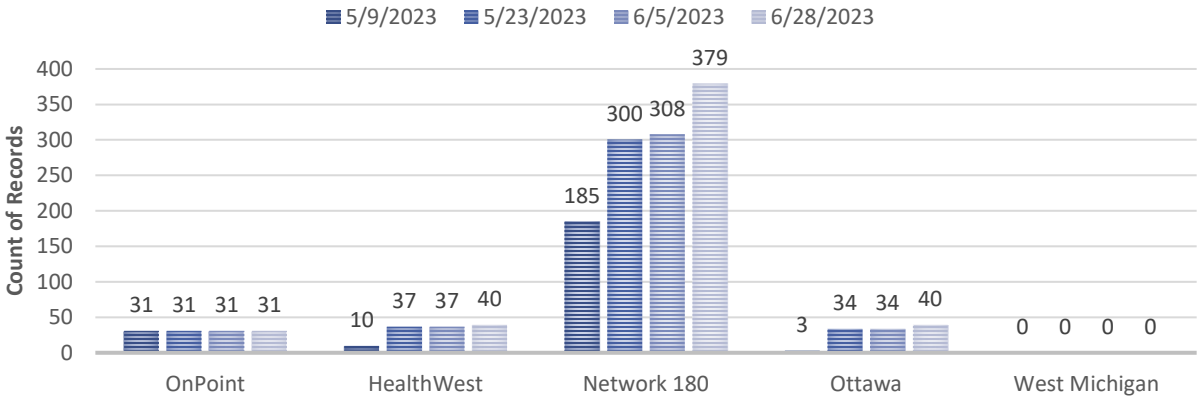
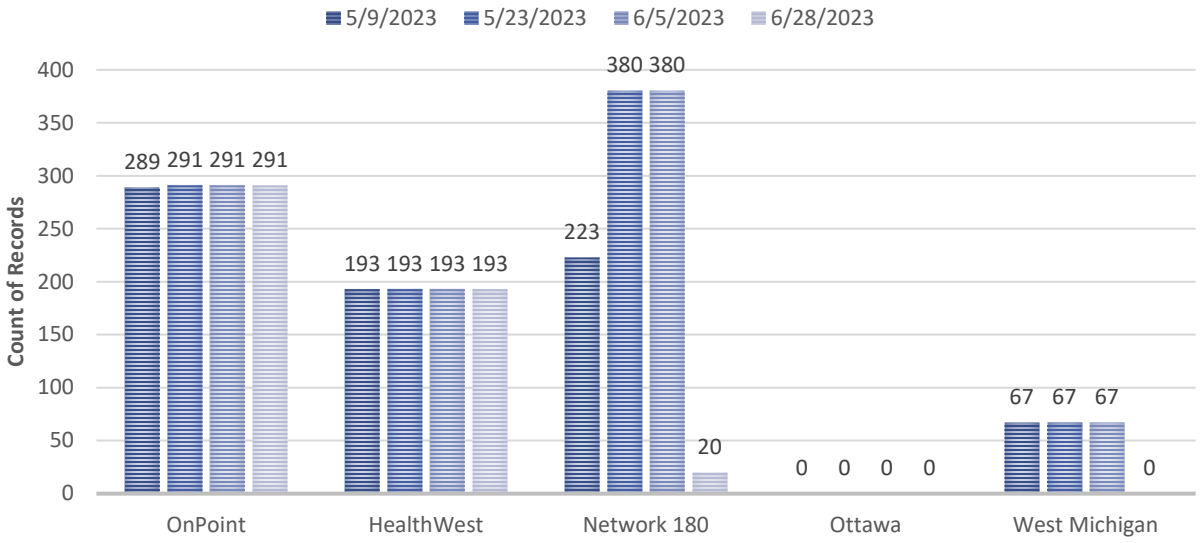


ADMIT FISCAL YEAR MISMATCH*



COMPENSATION SCHEDULE
(Facility)

SAMPLE

For medically necessary covered services rendered to Covered Persons by Provider, in accordance with the terms of the Agreement, Provider shall accept as payment in full the lesser of contracted rate or billed charges as follows:

Per Diem Payment: An all-inclusive payment made for each day of admission of a Covered Person. Such payment shall be considered as payment in full for services provided to the Covered Person for each day of admission, including but not limited to nursing care, diagnostic and therapeutic services, supplies, medications, room and board charges, physician charges. Exclusions - Electroconvulsive Therapy (ECT)

Per Treatment: An all-inclusive payment for each procedure performed per treatment of a Covered Person. Such payment shall be considered as payment in full for services provided to the Covered Person for each treatment. Including but not limited to facility charges, psychiatric charges, and anesthesiologist.

Facility Services

Services	Encounter Code	Base Rate	Payment Type
Adult Inpatient Services	0100		Per Diem
Child Inpatient Services	0100		Per Diem
Partial Hospitalization Program	0912		Per Diem
ECT Inpatient	0901		Per Treatment
ECT Outpatient	0901		Per Treatment
• Psychiatrist	90870		
• Anesthesiologist	00104 base units x minutes		

Lakeshore Regional Entity reserves the right to amend reimbursement policies with advance noticed as outlined in the Provider Contract.

Incentive Value

Based upon satisfactory performance, as described below, Provider may be awarded incentive payments each quarter based on all reimbursed claims 0100 Adult and Child Inpatient Service encounters within defined quarter. Performance shall be calculated regionally, with quarters defined as: Quarter 1, October 1- December 31; Quarter 2, January 1- March 31; Quarter 3, April 1-June 30; and Quarter 4, July 1- September 30. Payments shall be distributed among each Region 3 CMHSP based on that quarter's encounter reporting.

At regular intervals, not less than monthly, Provider shall be given the opportunity to review data reports related to progress and achievement of value-based metrics.

Indicator 1: **Increase Admissions**

Description: Provider will increase the number of Region 3 referred consumers. Only consumers directly referred to or authorized by a Region 3 CMHSP will be counted toward achieving this indicator.

Measure: Based on overall Region 3 inpatient episodes each quarter, Provider will accept 45% of Region 3 inpatient admissions, not to exceed 450 episodes, each quarter.

Available Incentive: .5%

Indicator 2a: **Consumer Supports Inclusion/Care Coordination**

Description: Between October 1, 2022, and September 30, 2023, Provider will review practices and standards to ensure inclusion, collaboration, and coordination with consumers primary and secondary supports in inpatient psychiatric treatment during key components of service delivery, including but not limited to, intake, screening and assessment, diagnosis, treatment and intervention, and discharge planning. Consumer supports are defined here as, family and/or friends, but may include, but is not limited to, primary care provider, established mental health outpatient provider, community mental health, or CCBHC.

Must Include:

- Standards for inclusion of consumer supports in assessment, care coordination, and discharge planning of all consumers.
- Resource bank and referral process for Primary Consumer Supports (Support Groups, Family Therapy, Family Psychoeducation, Education Resources).
- Process to ensure adherence to standards.
- Education for provider staff on any established or amended standards.
- Provider will present all policies and procedures which address these standards once they are determined to meet the above standards.

Measure: Quarter 1 achievement of incentive requires submission of a progress report including draft project plan. For Quarter 2, provider shall submit a project plan by the end of second quarter outlining the steps and schedule for review of current policies and procedures and subsequent plan to make any necessary institutional changes required to meet the standards outlined in the metric. The plan must include specific, measurable actions to be taken upon acceptance of this plan, provider shall become

eligible for this incentive for Quarter 2. For Quarter 3 and 4 incentives, provider shall be eligible for subsequent quarterly incentives based on satisfactory achievement of actions described in the plan.

Available Incentive: .25%

Indicator 2b: **Harm Reduction for Consumers with Co-occurring SUD**

Description: Between October 1, 2022, and September 30, 2023, Provider will review practices and standards to include harm reduction principles in psychiatric inpatient treatment to reduce risk, support engaging consumers in their current stage of change, and reduce risk of overdose deaths.

Must Include:

- Offer Naloxone education and prescription or referral to a pharmacy which participates in the Standing Naloxone Order Program to all consumers who have a history of OUD or overdose.
- Review and incorporate Harm Reduction Principles into inpatient psychiatric hospital treatment practices and policies:
    - Principle 1: Accepts, for better or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them
    - Principle 2: Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others
    - Principle 3: Establishes quality of individual and community life and well-being — not necessarily cessation of all drug use — as the criteria for successful interventions and policies
    - Principle 4: Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm
    - Principle 5: Ensures that people who use drugs and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them
    - Principle 6: Affirms people who use drugs (PWUD) themselves as the primary agents of reducing the harms of their drug use and seeks to empower PWUD to share information and support each other in strategies which meet their actual conditions of use
    - Principle 7: Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm
    - Principle 8: Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with illicit drug use

- Provider must continue any established medication treatment, as clinically indicated, for the treatment of substance use disorders, including MAT/MOUD for consumers in inpatient psychiatric treatment.
- Process to ensure adherence to standards.
- Education for provider staff on any established or amended standards.
- Provider will present all policies and procedures which address these standards once they are determined to meet the above standards.

Measure: Quarter 1 achievement of incentive requires submission of a progress report including draft project plan. For Quarter 2, provider shall submit a project plan by the end of second quarter outlining the steps and schedule for review of current policies and procedures and subsequent plan to make any necessary institutional changes required to meet the standards outlined in the metric. The plan must include specific, measurable actions to be taken upon acceptance of this plan, provider shall become eligible for this incentive for Quarter 2. For Quarter 3 and 4 incentives, provider shall be eligible for subsequent quarterly incentives based on satisfactory achievement of actions described in the plan.

Available Incentive: .25%

Indicator 3: **Discharge Appointment within 7 Days**

Description: Provider will ensure a follow up appointment is scheduled upon discharge for all psychiatric inpatient episodes.

"Discharges" are the events involving people who are discharged from a Psychiatric Inpatient Unit (community, IMD or state hospital) who meet the criteria for specialty mental health services and are the responsibility of the CMHSP/PIHP for follow-up services. In the event of multiple discharges of one person during the reporting period, count the number of discharges.

Follow up appointment or "seen for follow-up care" is defined as a face-to-face service with a professional (not exclusively psychiatrists).

"Days" are defined as calendar days.

Measure: Follow Up After Hospitalization "FUH" Reports will be utilized for measurement of scheduled appointments within seven (7) days of discharge from inpatient psychiatric treatment for 90% of all treatment episodes. At regular intervals, Provider shall be given the opportunity to review data reports on Provider-specific FUH data. Provider will be given the opportunity to dispute any discrepancies between provided FUH data reports and their own tracking. Such dispute shall be made within ten (10) business days of being provided the report. Provider data will be included in the calculation for determining earned incentive.

Available Incentive: .5%

Indicator 4: **Readmission Rates**

Description: Readmission rates shall be calculated quarterly for any consumer discharged from psychiatric inpatient treatment at seven (7) and thirty (30) days.

Readmission is defined as any authorization for inpatient psychiatric treatment at any facility within seven (7) or thirty (30) days of a prior inpatient psychiatric treatment episode.

Readmission Rate is defined as the percentage of inpatient psychiatric hospitalization encounters which are followed by an inpatient psychiatric hospitalization encounter within seven (7) and thirty (30) days of discharge.

Readmission Rate Benchmarks		
	Average	**Above Average**
7 day	3.3%	3.0%
30 day	5.7%	5.4%

Measure: "Average" Readmission Rate Benchmark is set by the average readmission rate for all Region 3 CMHSP contracted inpatient psychiatric providers. "Above Average" Readmission Rate Benchmark is set by decreasing the "Average" Readmission Rate by 0.3%. For the purposes of measurement of achievement of this indicator, only Medicaid Primary consumers will be measured due to data capabilities.

Achievement **7 Day (Average – .15%, or Above Average – .25%)**				
3.0% (or less)	3.1%	3.2%	3.3%	3.4%+

Achievement **30 Day (Average – .15%, or Above Average – .25%)**				
5.4% (or less)	5.5%	5.6%	5.7%	5.8%+

Provider may become eligible for each incentive individually, i.e. achieving "above average" for seven (7) day, yet "average" for thirty (30) day.

The eligible percentage for achieving the average performance benchmark is .15% for each of seven (7) and thirty (30) standards, or .25% for above average performance benchmark for each of seven (7) and thirty (30) day standards.

Achievement Examples: Provider achieves a seven (7) day readmission rate of 3.2% and a thirty (30) day readmission rate of 4.8% in FY23 Quarter 1. The incentive value achieved for the seven (7) day readmission rate is "Average" and holds an incentive value of .15%. The incentive value achieved for the thirty (30) day readmission rate is "Above Average" and holds an incentive value of .25%. The provider would receive a .4% increase for this indicator for FY23 Quarter 1 inpatient psychiatric services.

Provider achieves a seven (7) day readmission rate of 2.2% and a thirty (30) day readmission rate of 5.8% in FY23 Quarter 1. The incentive value achieved for the seven (7) day readmission rate is "Above Average" and holds an incentive value of .25%. No incentive is achieved for the thirty (30) day readmission rate due to not meeting the "Average" or "Above Average" benchmarks. The provider would receive a .25% increase for this indicator for FY23 Quarter 1 inpatient psychiatric services.

Available Incentive: .5%

Region 3 FY23 Value Based Contracting Tracking – SAMPLE

Indicator	FY23 – Q1	FY23 – Q2	FY23 – Q3	FY23 – Q4
Indicator 1 – Increase Admissions *** % of Total Services	**% of LRE Episodes or *** Episodes	**% of LRE Episodes or *** Episodes	**% of LRE Episodes or *** Episodes	**% of LRE Episodes or *** Episodes
Indicator 2a – Service Improvement *** % of Total Services	Develop and provide a timeline for completion, to be measured Q2, Q3, and Q4	Met goals outlined in provided timeline	Met goals outlined in provided timeline	Met goals outlined in provided timeline
Indicator 2b – Service Improvement *** % of Total Services	Develop and provide a timeline for completion, to be measured Q2, Q3, and Q4	Met goals outlined in provided timeline	Met goals outlined in provided timeline	Met goals outlined in provided timeline
Indicator 3 – Discharge Appointments *** % of Total Services	Provide evidence of a post discharge appointment scheduled for at least 98% of episodes	Provide evidence of a post discharge appointment scheduled for at least 98% of episodes	Provide evidence of a post discharge appointment scheduled for at least 98% of episodes	Provide evidence of a post discharge appointment scheduled for at least 98% of episodes
Indicator 4 – Readmission Rates Up to *** % of Total Services	7 and/or 30 Day Readmission Rate Benchmark Met – Up to *** %	7 and/or 30 Day Readmission Rate Benchmark Met – Up to *** %	7 and/or 30 Day Readmission Rate Benchmark Met – Up to *** %	7 and/or 30 Day Readmission Rate Benchmark Met – Up to *** %

Attachment K

LAKESHORE
REGIONAL ENTITY

Creating Care Pathways:

A Model for Developing Value-Based Arrangements with Inpatient Psychiatric Hospitals

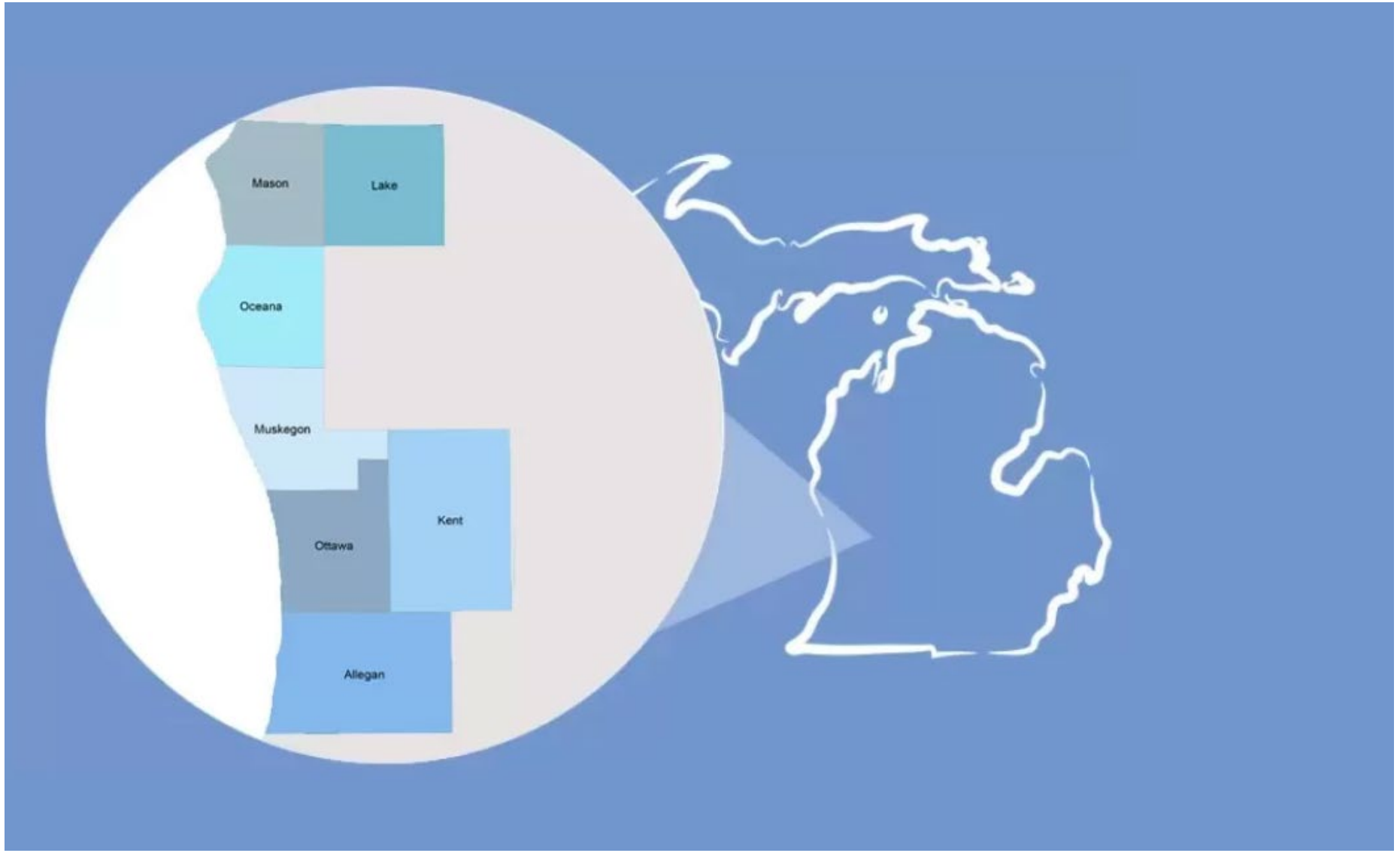
Don Avery

Jim McCormick, LMSW

Objectives

- Understand the key pillars for value-based contracting.
- Learn about using care pathways as the foundation for developing value-based care.
- Discuss implications of value-based contracting for clinical, finance, and quality teams.
- Understand how to develop and implement value-based models with inpatient psychiatric hospitals.

Regional Overview



LAKESHORE REGIONAL ENTITY

Timeline

Idea
Oct. 2021 – Dec. 2021

- Obtained buy-in from key stakeholders. Value Based contract issued for FY22.
- Contract issued an enhanced Per Diem rate, which was contingent upon the development of a mutually agreed upon Value Based Contract for FY23

Model Development
Jan. 2022 – Jun. 2022

- Development of Care Pathway and Project Timeline
- Monthly development meetings between LRE and participating Providers.
- Project was brought to LRE ROATs (Provider Network, UM, Clinical, Finance)

Contract Development
Jul. 2022 – Sep. 2022

- Contract language
- Rate negation
- Indicator Achievement Measurement
- Value Based Contract approval

What Now?
October 2022 - Present

- FY23 Value Based Contract executed.
- Continuing monthly meetings with participating providers.
- Monitoring project metrics

LAKESHORE REGIONAL ENTITY

Idea

- The “Why”
- Goals
- Foundations of Value Based Contracting

LAKESHORE REGIONAL ENTITY

The "Why"

- Siloed Treatment
- High Costs
- Lack of Accountability
- Desire to Shift the Narrative

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Goals

Quadruple Aim	Better Outcomes Better Consumer Experience Care Efficiency Improved Provider Experience
Treatment Continuum	Desire for more seamless integration of inpatient treatment into the continuum
Clinical Standards	Increase quality measures and clinical treatment standards
Relationships	Increase collaborative relationship between PIHP/CMHs and inpatient providers

Foundations of Value Based Contracting:

What it is…

A Value Based Contract is a written contractual arrangement between parties in which the payment for health care goods and services is tied to predetermined, mutually agreed upon terms that are based on clinical circumstances, patient outcomes, and other specified measures of the appropriateness and effectiveness of the services rendered.[1]

- Quality over Quantity
- Better Business, is Better Business
- Characteristics of a Value Based Contract [2]
    1. Identifies Mutually Desired Clinical Outcomes
    2. Defines the Measurement of "Good" and "Poor" Clinical Outcomes
    3. Specifies a Reimbursement Formula

Foundations of Value Based Contracting:

Reduce Burden vs. Increase Quality

- Historic Value Based Contracting – Reduction in administrative burden and increased clinician autonomy

- Regulations and requirements set by governing entities forced a different approach

Model Development

- Setting the Foundation
- Care Pathway Development
- Value Based Indicator Development

LAKESHORE REGIONAL ENTITY

Setting the Foundation

- Participating Provider Selection
- Stakeholder Buy-In
- 1 Year Value Based Contract
- Recurrent Development Meetings

LAKESHORE REGIONAL ENTITY

Creating Care Pathways

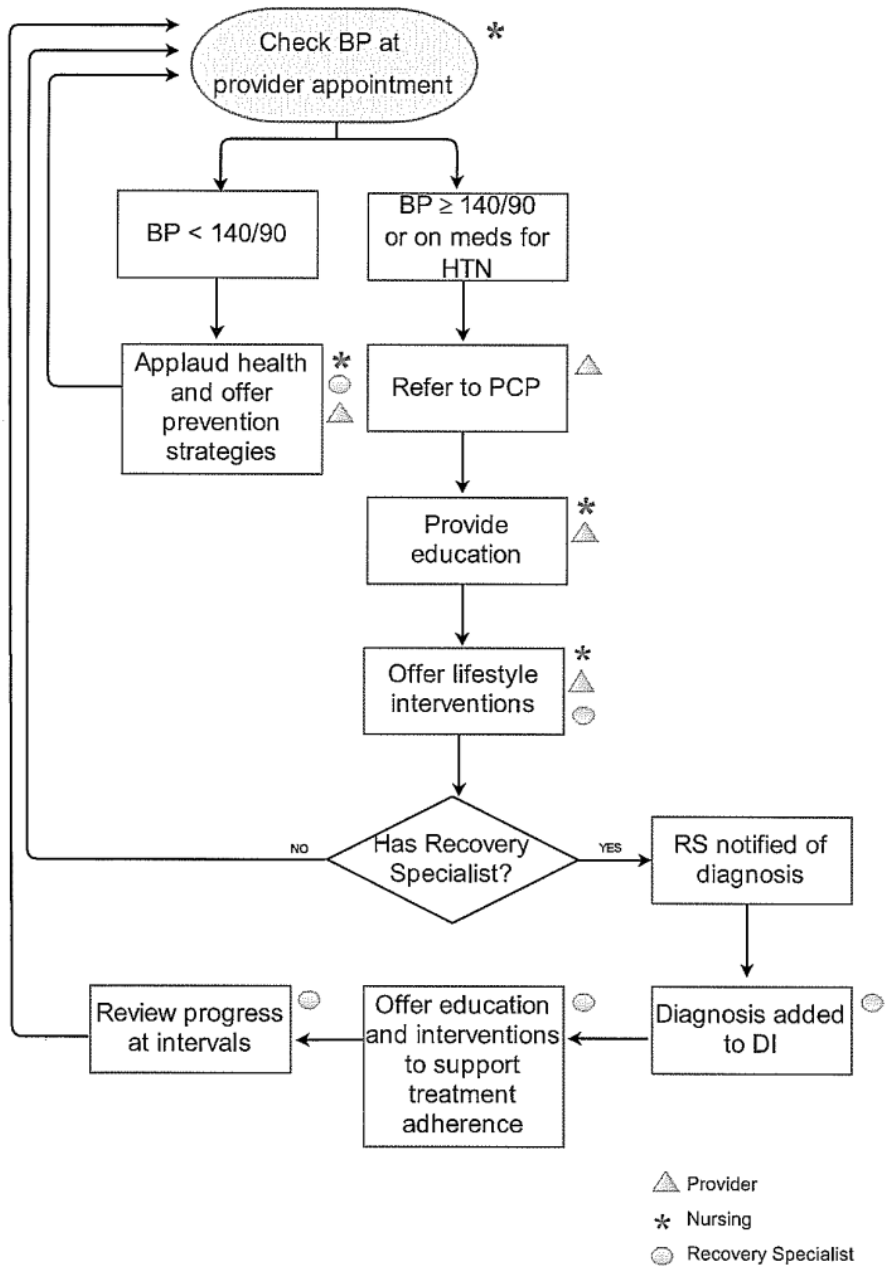
- Lack set of Behavioral Health Outcome Measures or Quality Standards
- Most Medicaid Value Based arrangements support delivery of physical health services
- Lack of established models for replication

Creating Care Pathways

- National Council for Mental Wellbeing proposed the utilization of Care Pathways for Value Based Contracting in Community Based Behavioral Health Treatment [3]
- Care Pathways are an established framework for medical treatment (diabetes, obesity, blood pressure).

[3] The National Council For Mental Wellbeing, Care Pathway Toolkit

Blood Pressure

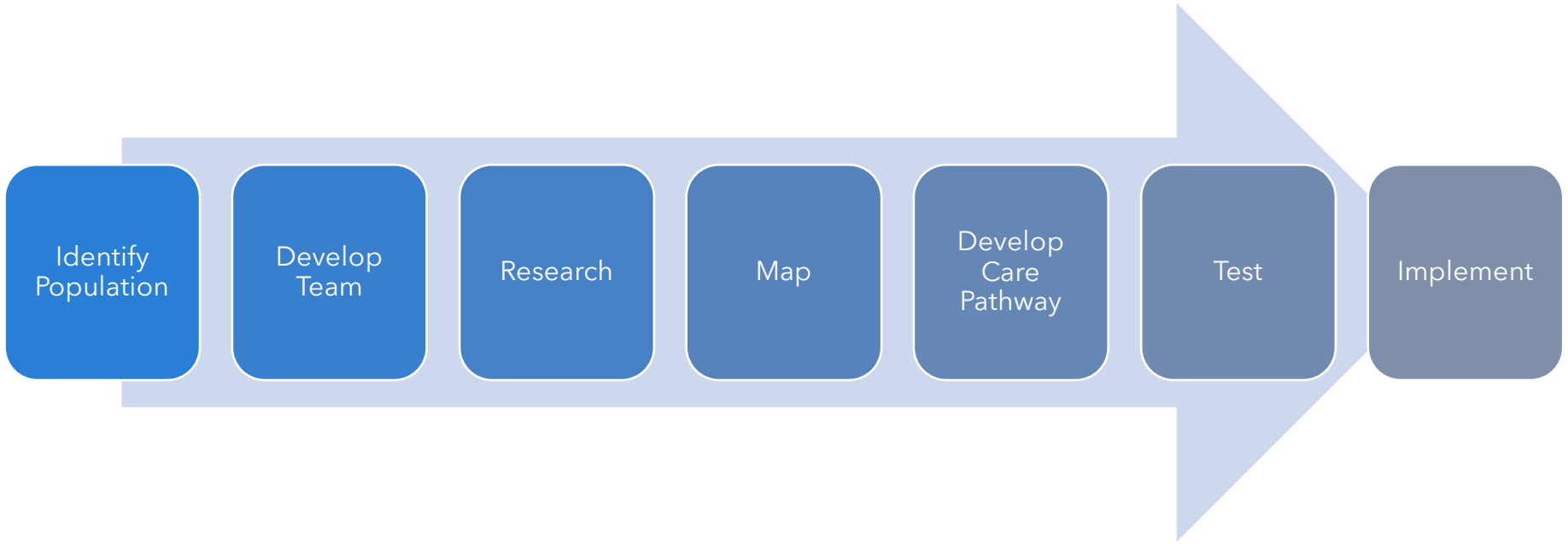


Benefits of Care Pathways

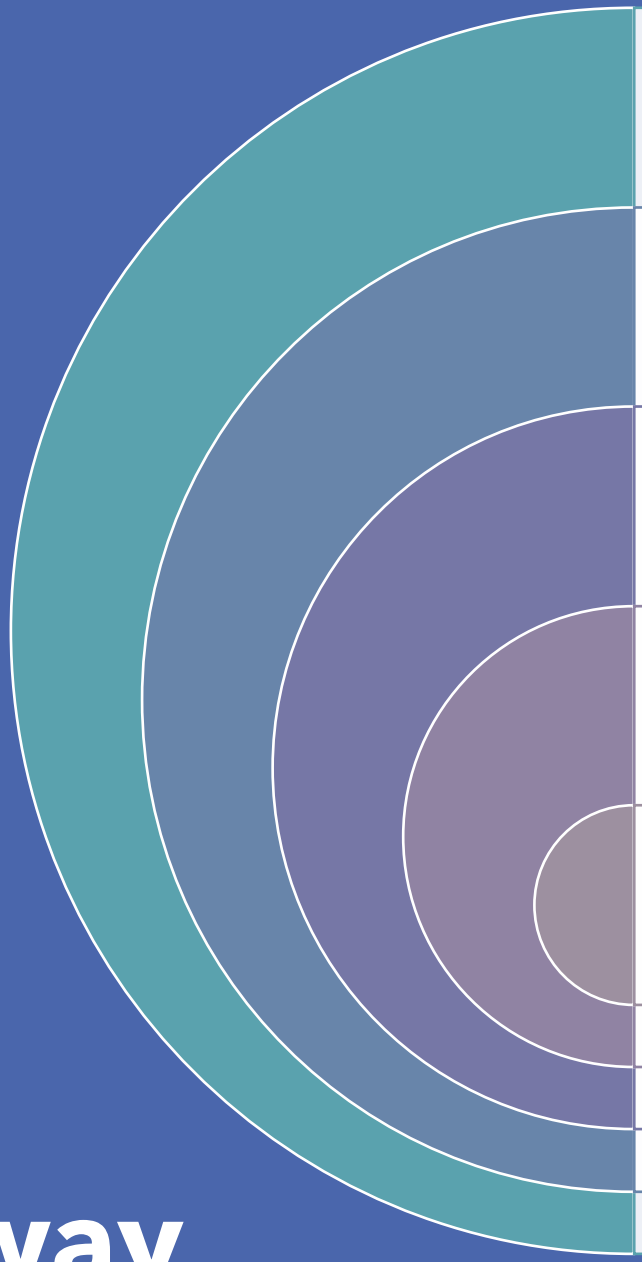
- Offers measurement-based value-proposition, service targets, and associated structures
- Measurement-based care anchored in evidence-based treatment
- Links costs to clinical process and outcome metrics
- Promotes coordination of care with and across the continuum
- Reduces confusion and variation, duplication and waste
- Improves efficiency and predictability
- Promotes continuous quality improvement
- Efficient, quality, outcomes focused care results in improved consumer satisfaction

[3] The National Council For Mental Wellbeing, Care Pathway Toolkit

Care Pathway Development



Care Pathway



Intake, Screening, Assessment, & Diagnosis	•Local Access • **24/7 Access** •Reduction of Stigma and Consumer Anxiety •SMART Medical Clearance
Treatment & Intervention	• **Evidence Based Treatments** •Trauma Informed Treatment •Zero Suicide •Psychoeducation
Care Coordination	•First Episode Psychosis •Social Determinates of Health • **LAI Access** •Case Management Contact During Admission •Standards of Care for Individuals on Multiple Antipsychotics
Discharge Planning	• **Starts at Admission** •Safety Planning •Stepdown Utilization •Harm Reduction
Post Discharge Planning	•7 Day Follow Up Post Discharge • **Readmission Rates** •Post Discharge Follow Up

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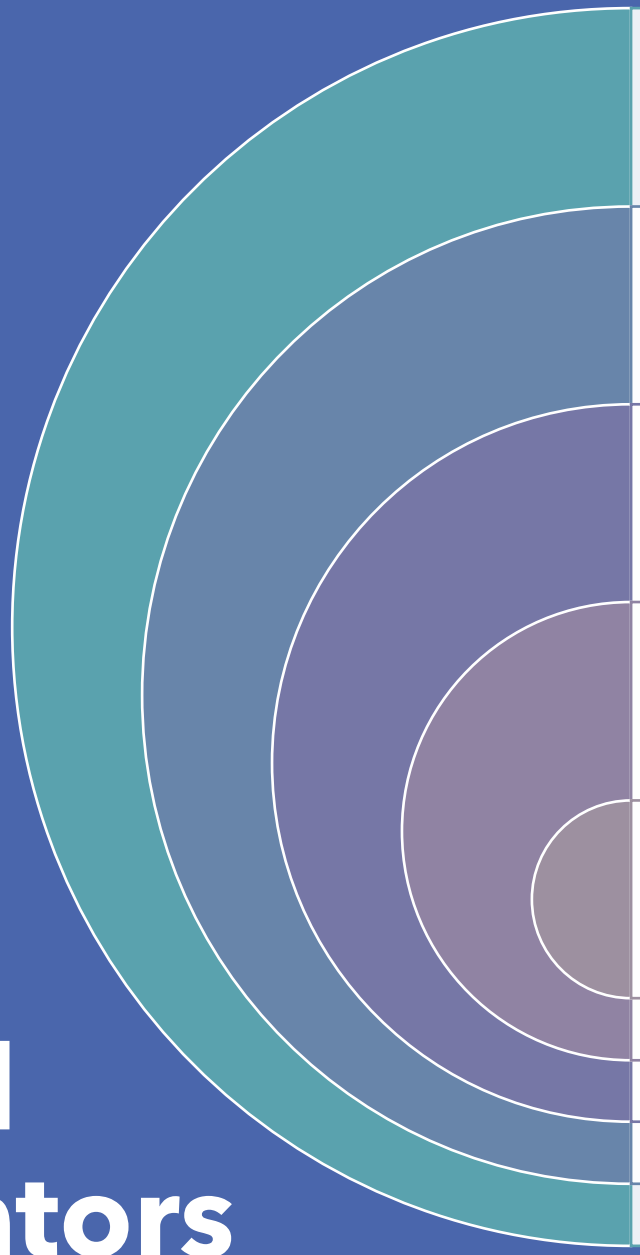
Value Based Indicators



Intake, Screening, Assessment, & Diagnosis	• **Volume Based Staffing Model** •Utilization of SMART Medical Clearance •Increased Number of LRE Admissions •Decrease Number of Denials
Treatment & Intervention	•Suboxone Induction (Availability and Increased Utilization) • **Continuation of MAT** •Consumer Supports Inclusion •LOS
Care Coordination	•Standard SDH Screening Tool with Resource Bank (CCBHC) •Psychiatry F2F • **Care Pathway for LAI Induction** •Standard Care Coordination Packet
Discharge Planning	•Access to NARCAN for every appropriate consumer at discharge •Safety planning using Zero Suicide • **Assigning and Proving Contact Info for CM at Admission**
Post Discharge Planning	•All Consumers Scheduled for a 7 Day Post Discharge Appointment • **Readmission to any crisis service (Inpt, CRU, Detox, IS, ED)** •Outpatient Psychiatric Medication Management Services Capacity

LAKESHORE REGIONAL ENTITY

Metric Development

Pathway	Indicator/Value Proposition	Metrics
Intake, Screening, and Assessment	**Volume Based Staffing Model**	**Evaluate high volume times for admission and increase staffing to meet intake needs 24/7. Implement volume-based staffing model.**
Intake, Screening, and Assessment	Utilization of SMART medical clearance	Utilize SMART Medical Clearance Process
Intake, Screening, and Assessment	Increased number of LRE referrals	Increase admissions by #%.
Treatment and Intervention	MAT (Suboxone) Induction	Offer Suboxone induction to appropriate consumers with coordination of follow up management.
Treatment and Intervention	Consumer Supports Inclusion	Referral for consumers support system for #% of admissions. - Support groups, family therapy, Family Psychoeducation
Treatment and Intervention	**Length of Stay**	**Average Length of Stay Set Benchmarks – Average and Above Average**
Care Coordination	Evaluate for EBP for FEP	Evaluate and alter standard care for FEP cases Refer #% of first episode psychosis cases to FEP Grant Program.
Care Coordination	SDOH screening tool with referral	If needed, first implement a standard SDOH Screening Tool, with resource bank (or CCBHC) referral process for appropriate consumers. Once implemented, screening #% of consumers, with referrals as appropriate.
Discharge Planning	Harm Reduction for consumers with Co-occurring SUD	All consumers with a known OD or OUD history are offered Narcan at discharge.
Discharge Planning	Safety planning using ZeroSuicide standards	Ensure/prove adherence to Zero Suicide Standards
Post Discharge Planning	Consumers scheduled for 7 day FUH at discharge	#% standard for 7 day follow up
Post Discharge Planning	Outpatient psychiatric medication mgmt.	Increase CMH access to medication management for consumers post inpatient discharge. Create standard protocol for LAI induction cases
Post Discharge Planning	**Readmission Rates**	**Readmission Rates - Standard 7/30 day readmission rates - Readmission to any crisis service (inpt, CRU, Detox, Intensive Stab, ED)**

Indicator #	Pathway	Indicator/Value Proposition	Metrics
1	Intake, Screening, and Assessment	Increased number of LRE Admissions	Increase LRE Admissions by 3%
2a	Treatment and Intervention	Consumer Supports Inclusion	Policy/Procedure Project Completion
2b	Discharge Planning	Harm Reduction for consumers with Co-occurring SUD	Policy/Procedure Project Completion
3	Post Discharge Planning	Consumers scheduled for 7 day FUH at discharge	Discharge appointment within 7 days for 90% of episodes
4	Post Discharge Planning	Readmission Rates	Achievement of “Average” or “Above Average” benchmarks

Selected Value Based Indicators - FY23

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Indicator 1:
Increase LRE Admissions by 3% in FY23

Provider 1 Utilization	LRE Total Utilization	% of Utilization	3% Increase	Episode Increase
1712	4050	42%	45%	122

Provider 2 Utilization	LRE Total Utilization	% of Utilization	3% Increase	Episode Increase
852	4050	21%	24%	137

- FY21 Utilization Data (episodes)
- Based on increase in percent of utilization, not consumer number.
- Description: Increase admission of Region 3 consumers by 3%

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Indicator 2a:

Clinical Standards Project: Consumer Supports Inclusion

Ensure inclusion, collaboration, and coordination with consumers primary and secondary supports during key components of service delivery.

- What are "consumer supports"?
  - PCP
  - Family
  - Therapist / Psychiatry
  - Home CMH/CCBHC
- Must Include:
  1. Standards for inclusion of consumer supports
  2. Resource bank
  3. Process to ensure compliance with standards
  4. Education

LAKESHORE REGIONAL ENTITY

Indicator 2b:

Clinical Standards Project: Co-occurring Treatment and Harm Reduction

Ensure incorporation of harm reduction principals into policies, procedures, and treatment protocols.

Goals - Reduce risk, support engaging consumers in their current stage of change, and reduce risk of overdose deaths.

Must Include:

1. Naloxone
2. Incorporation of “8 Harm Reduction Principals”
3. Continue MAT/MOUD
4. Process to ensure compliance with standards
5. Education

Indicator 3:

Post Discharge Appointment within 7 days

Ensure follow up appointment is scheduled upon discharge for all psychiatric inpatient episodes.

- Supports both MMBPIS Standard and FUH Reporting
- Follow up appointment is defined as a face-to-face services with a professional (not exclusively psychiatrists)
- “Days” are defined as calendar days
- Description:
  - Follow Up After Hospitalization “FUH” Reports will be utilized for measurement of scheduled appointments within seven (7) days of discharge from inpatient psychiatric treatment for 90% of all treatment episodes.

Indicator 4:
Readmission Rates

7 & 30 Day Readmission Rates – Region 3 Inpatient Providers				
	7 day (2020)	7 day (2021)	30 day (2020)	30 day (2021)
Provider 1	3.3%	2.8%	5.7%	5.2%
Provider 2	2.0%	3.1%	7.6%	7.7%
System Average	3.2%	3%	6.5%	6.3%

Readmission Rate Benchmarks		
	Average	Above Average
7 day	3.3%	3.0%
30 day	5.7%	5.4%

Contract Development

- Contract Language
- Rate Negotiation
- Value Based Contract Approval

LAKESHORE REGIONAL ENTITY

Contract Language

- Quarterly measurement for indicators
- Boilerplate contract
- Defining performance

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Rate Negotiation

- Offered several cost structures
  - Base rate inversely corresponded to incentive opportunity
- Assigned % of incentive to each indicator
- Think in terms of purchasing value, not saving money

VB Contract Approval

- Approval from MDHHS
- Cannot disincentivize access or willingness to provide a service
- Talk early, talk often

Indicator Achievement

- HLOC Dashboard – Development and Monitoring
- FUH Data
- Policy and Practice Improvement Indicators
- Tracking Mechanism
- Indicator Reimbursement

LAKESHORE REGIONAL ENTITY

HLOC Dashboard: Development and Monitoring

LAKESHORE REGIONAL ENTITY

Overview of Members

Providers: All

Data Set: Encounters

CMHSP: All

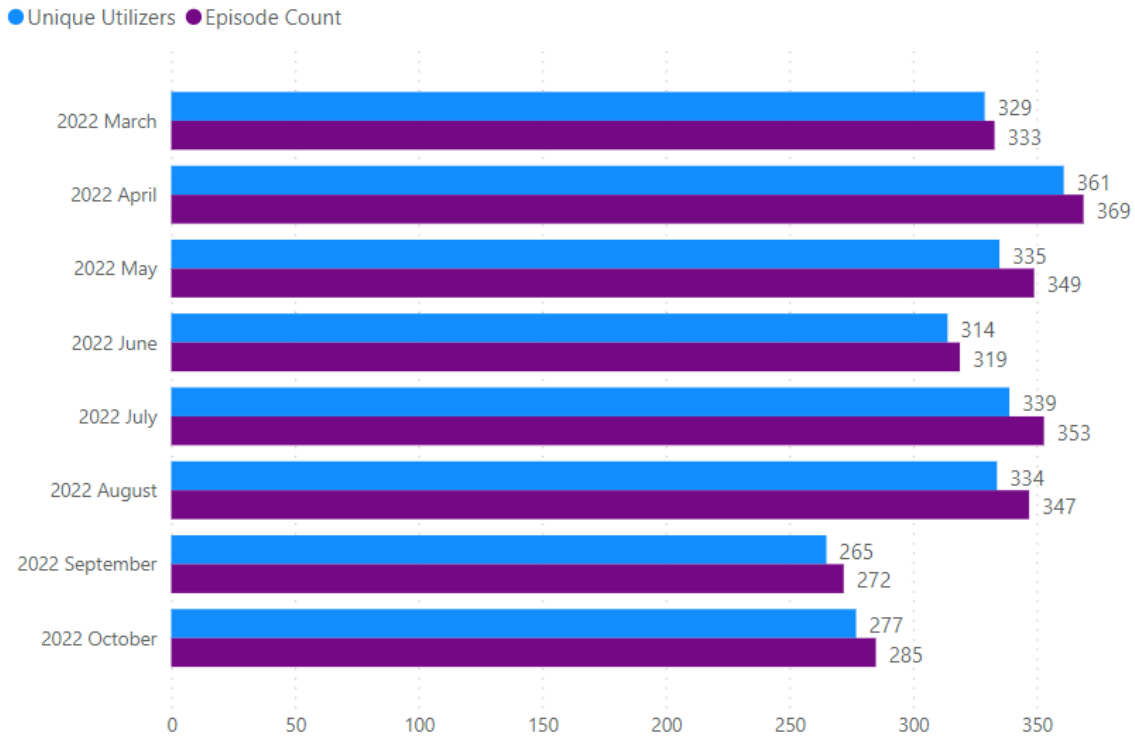
Level of Care: IP

Division: All

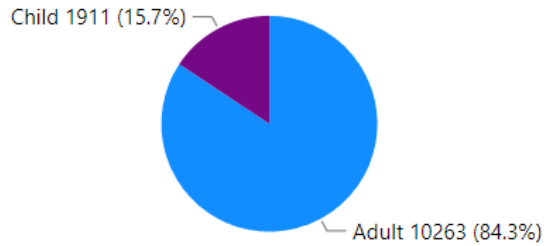
Age Category: All

Admit Dates: 10/1/2019 – 12/30/2022

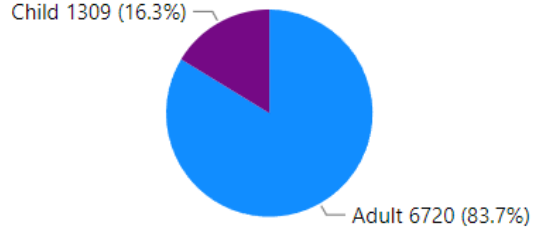
Unique Utilizers and Episode Counts by Admit Month



Episode Counts by Age Grouping



Unique Utilizer Counts by Age Grouping



Age Category	Unique Utilizers	Episode Count
Adult	6720	10263
Child	1309	1911
Total	**7984**	**12174**

LAKESHORE REGIONAL ENTITY

HLOC Dashboard: Development and Monitoring

LAKESHORE REGIONAL ENTITY

Utilization of Services

Providers: All

Data Set: Encounters

CMHSP: All

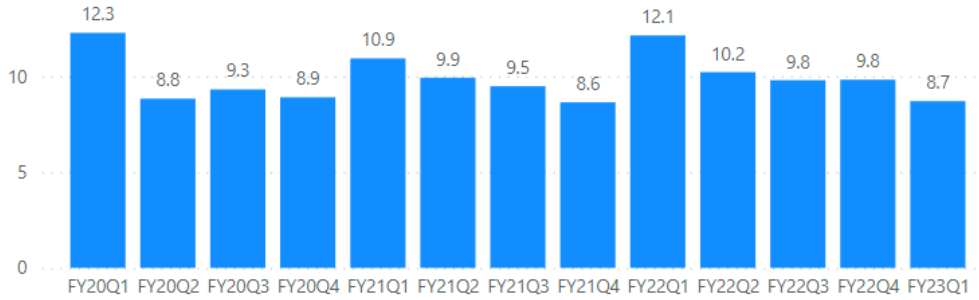
Level of Care: IP

Division: All

Age Category: All

Admit Dates: 10/1/2019 – 12/30/2022

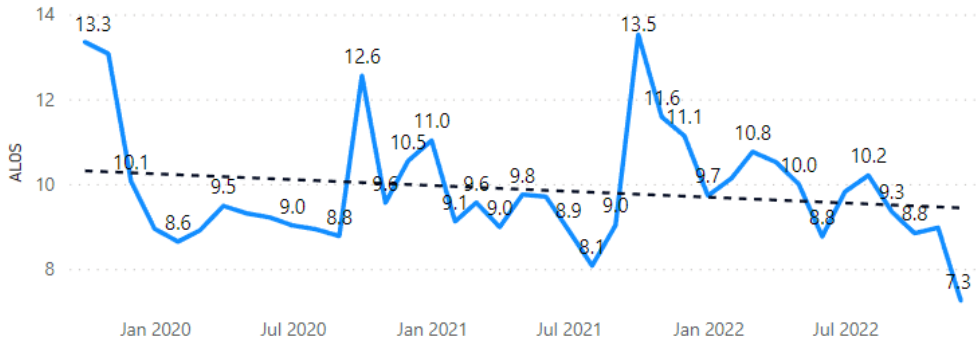
Average Length of Stay (ALOS) by Admit QTR



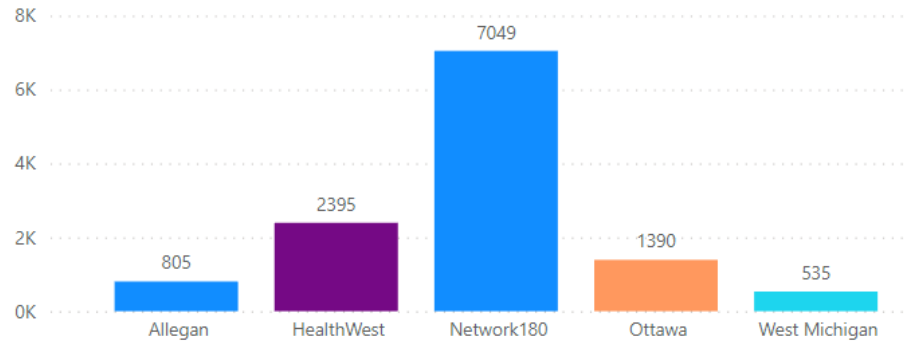
ALOS by Age Group

Age Category	ALOS	Episode Count	Units of Service
Adult	10.1	10263	103,769
Child	9.4	1911	17,881
Total	**10.0**	**12174**	**121,650**

ALOS by Admit Month



Episode Count by CMHSP



LAKESHORE REGIONAL ENTITY

HLOC Dashboard: Development and Monitoring

LAKESHORE REGIONAL ENTITY

Readmit Rates - 7 Day

Providers: All

Data Set: Encounters

CMHSP: All

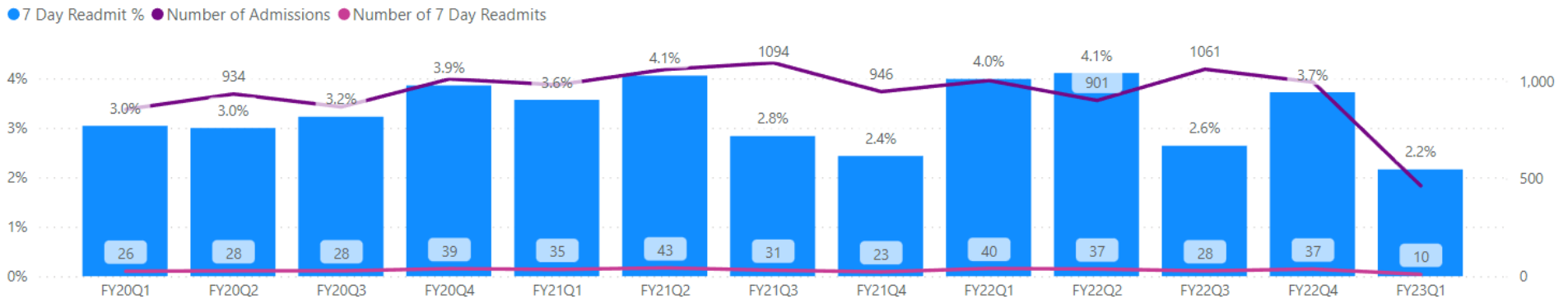
Level of Care: IP

Division: All

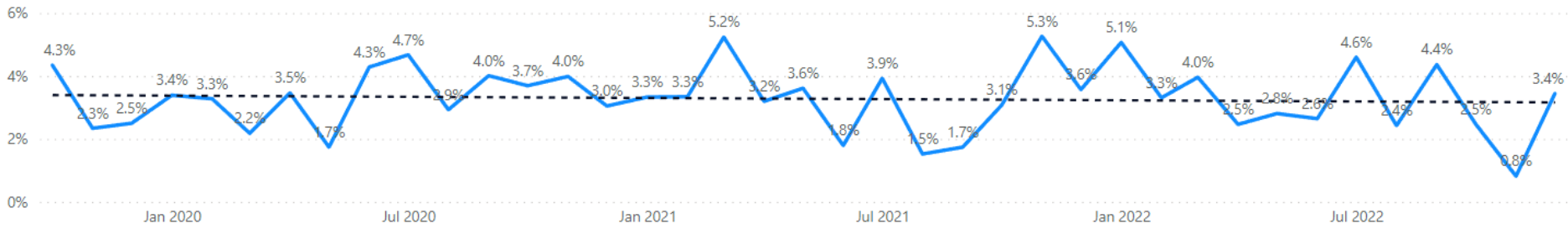
Age Category: All

Readmit Dates: 10/2/2019 – 12/30/2022

7 Day HLOC Readmit % by Fiscal Year and Qtr



7 Day HLOC Readmit % by Year and Month



LAKESHORE REGIONAL ENTITY

HLOC Dashboard: Development and Monitoring

LAKESHORE REGIONAL ENTITY

Readmit Rates - 30 Day

Providers: All

Data Set: Encounters

CMHSP: All

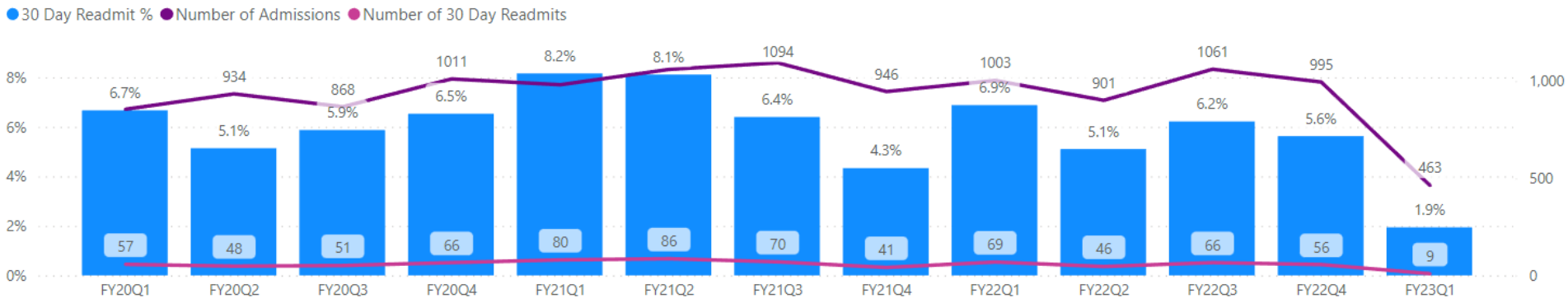
Level of Care: IP

Division: All

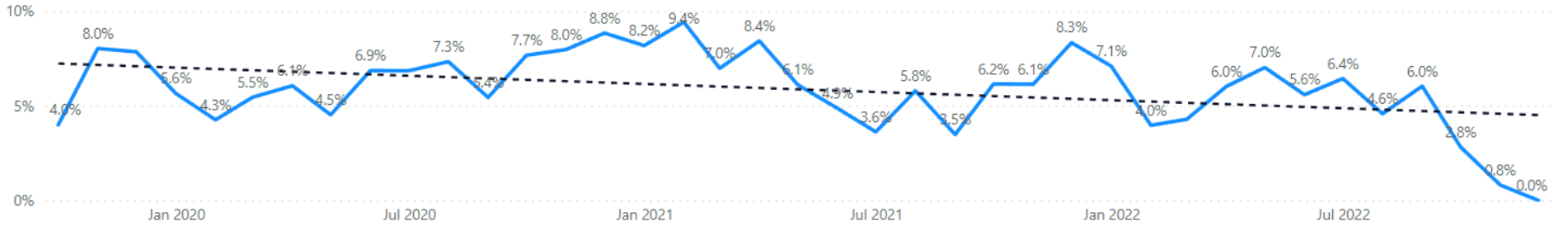
Age Category: All

Readmit Dates: 10/2/2019 – 12/30/2022

30 Day HLOC Readmit % by Fiscal Year and Qtr



30 Day HLOC Readmit % by Year and Month



LAKESHORE REGIONAL ENTITY

HLOC Dashboard: Development and Monitoring

LAKESHORE REGIONAL ENTITY

Provider Comparison Units & Cost

Comparison Providers: All

Data Set: Encounters

CMHSP: All

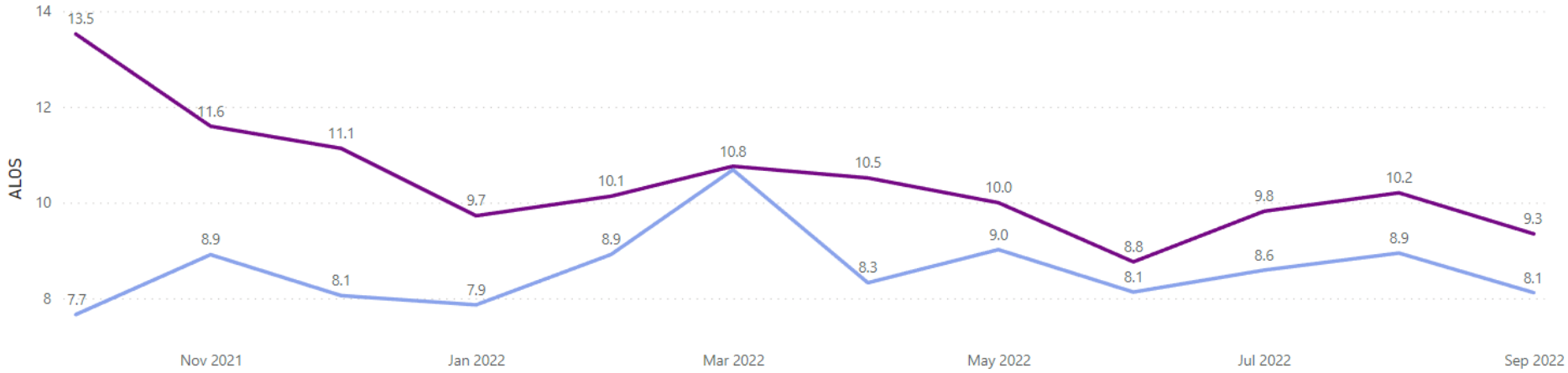
Level of Care: IP

Division: All

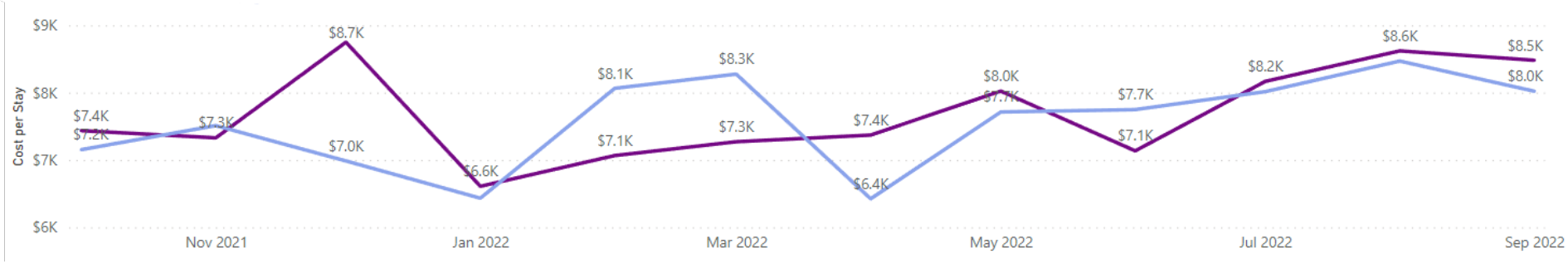
Age Category: All

Admit Dates: 10/1/2021 – 9/30/2022

Provider Comparison - Average Length of Stay



Provider Comparison - Cost per Stay



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FUH Data

- Follow up after hospitalization (FUH) data reports are used to track post-discharge follow up appointments by provider
- Tracked if > 7 days after the discharge
- Opportunity for provider review

Policy and Practice Improvement Indicators

- Quarter 1 – Submission of a Progress Report including a draft project plan
- Quarter 2 – Final Project Plan
- Quarter 3&4 – Achievement of measurable action items outlined in the project plan.

Tracking Mechanism

PROVIDER 1 - FY23 Q1

		Indicator 1 - Increase Admissions	Indicator 2a - Consumer Supports Inclusion	Indicator 2b - Co-occurring Tx and Harm Reduction	Indicator 3 - FUH	Indicator 4 - Readmission Rates	
	metrics	45% or 450 Episodes	Draft Workplan	Draft Workplan	FUH for 90%	7 Day	30 Day
Provider 1	October	176			See "FUH Data" Chart	5.0%	3.1%
	November	38				1.6%	4.2%
	December	1				3.5%	6.3%
	Q1	480				3.4%	4.5%
All Providers	October	434					
	November	176					
	December	6					
	Q1	616					

	Metric 1	Metric 2a	Metric 2b	Metric 3	Metric 4	
Metric Achievement	78%	Indicator 2a Achieved [Draft Workplan Approved]	Indicator 2b Achieved [Draft Workplan Approved]	93%	7 Day: 3.4%	30 Day: 4.5%
% Increase Possible	1%	0.50%	0.50%	1%	0.50%	0.50%
% Increase Earned	0%	0.50%	0.50%	1%	0%	0.50%
				FY23Q1 Rate Adjustment	3%	

FUH Data - 10/1/2022 - 12/31/2022

Total number of Discharges	203
# of Missing Appointments	0
# of Appointments > 7 days post discharge	14
Total # out of compliance	14
Total % out of compliance	7%

Readmission Rate Benchmarks

	Average	Above Average
7 day	3.3%	3.0%
30 day	5.7%	5.4%

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Indicator Reimbursement

- Increase percentage provided to CMHSP Members
- Claims to be re-adjudicated
- PCE vs Other Systems

What Now?

- Expansion
- Measuring Success
- Lessons Learned: Pitfalls & Recommendations

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Expansion

- Offer to additional hospitals
- Ongoing monthly meetings with contracted hospitals to discuss performance and indicator development
- Incorporating consumer and stakeholder input
- Continue to refine the model
- Thinking about indicators for next FY

Measuring Success

Metric	Measure	Benchmark
Length of Stay	Reduce	FY 21 – 9.8 FY 22 – 10.1
Readmission Rate	Reduce	7 day – [FY21 – 3.2], [FY22 – 3.5] 30 day – [FY21 – 6.8], [FY22 – 5.6]
Out of Region Placements	Reduce %	15%
Timeliness of Admission	Reduce	TBD
Consumer Satisfaction	Measure	TBD
Cost Per Case	Reduce	Provider 1 – [FY21 - $$], [FY22 – $$] Provider 2 – [FY21 - $$], [FY22 – $$]
SDOH	Measure	MMBPIS Baseline Performance
Least Restrictive Services	Measure	TBD

Lessons Learned:
Pitfalls & Recommendations

- Bring the Right People to the Table
- The Process takes time
- **Data Lag**
- MDHHS Approval
- Adaptation is key

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Questions

LAKESHORE REGIONAL ENTITY

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References

1. Academy of Managed Care Pharmacy. AMCP Partnership Forum: Advancing value-based contracting. J Manag Care Spec Pharm. 2017;23(11):1096-1102.
2. Huron Consulting Group Inc. Value-based contracting in the U.S. Available at: www.huronconsultinggroup.com/insights/value-based-contracting-in-us. Accessed April 14, 2021.
3. Care Pathways Toolkit. (2021, December 13). The National Council For Mental Wellbeing. https://www.thenationalcouncil.org/resources/care-pathways-toolkit-2/
4. Vita A, Barlati S. The Implementation of Evidence-Based Psychiatric Rehabilitation: Challenges and Opportunities for Mental Health Services. Front Psychiatry. 2019 Mar 20;10:147. doi: 10.3389/fpsyt.2019.00147.

Attachment L

HLOC AUTHORIZATION DATA INTEGRITY DASHBOARD

PROGRESS REPORT BY CMHSP AND DATA INTEGRITY ISSUE – JULY 14, 2023

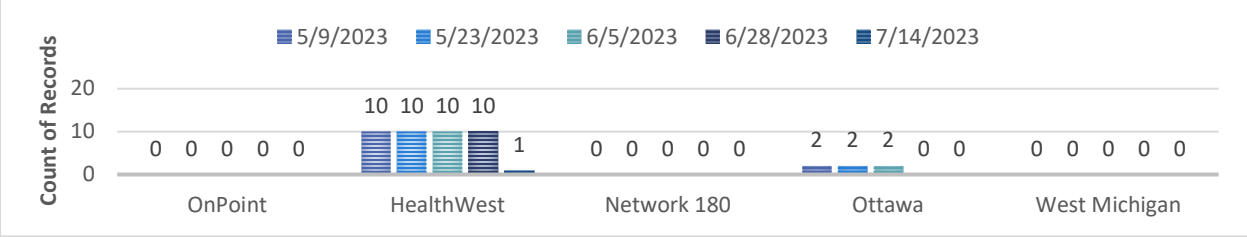
LRE has requested CMHSPs to address the outstanding data integrity issues outlined in the HLOC Authorization Data Integrity Dashboard to allow for utilization of the HLOC Dashboard. The following report outlines progress to date as well as a current status of outstanding issues by CMHSP.

Given the progress made on historic authorization data errors the LRE will not require any additional corrections to historic (FY20-22) authorization data. CMHSPs should address any outstanding FY23 authorization data errors and continue to monitor the HLOC Authorization Data Integrity Dashboard and address issues as they are identified. LRE will follow up with CMHSPs as necessary to address outstanding authorization data errors that are not corrected by the CMHSP in a timely manner. CMHSPs will address all FY23 HLOC Authorization Errors. Errors should be corrected within 30 days of error identification.

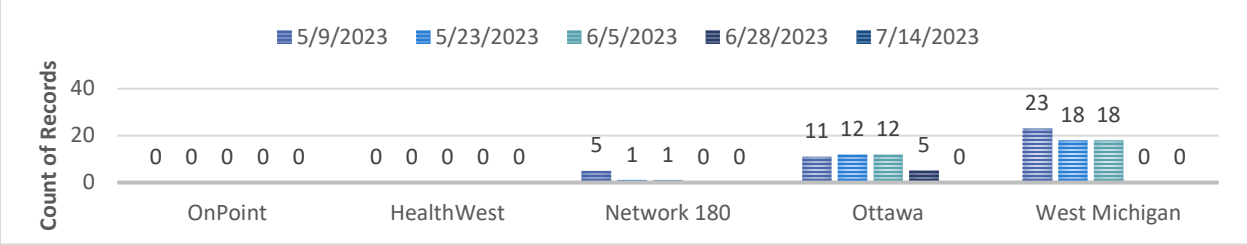
DASHBOARD CLEANUP PROGRESS REPORT

* Indicates integrity issues that directly impact the HLOC Dashboard, which should be prioritized first by CMHSPs

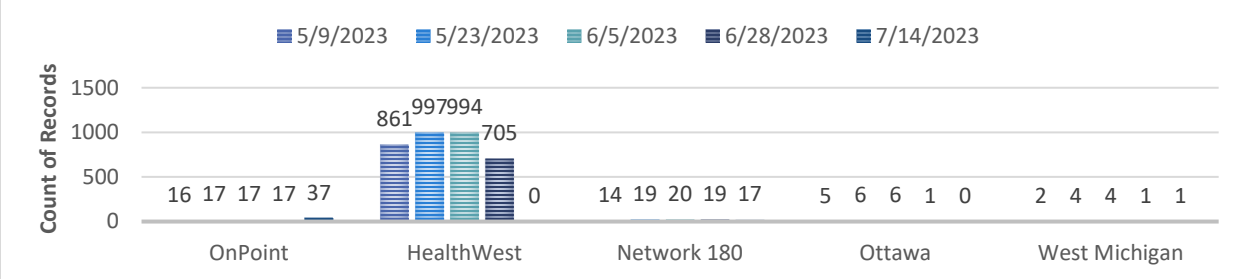
INVALID MEDICAID ID LENGTH*



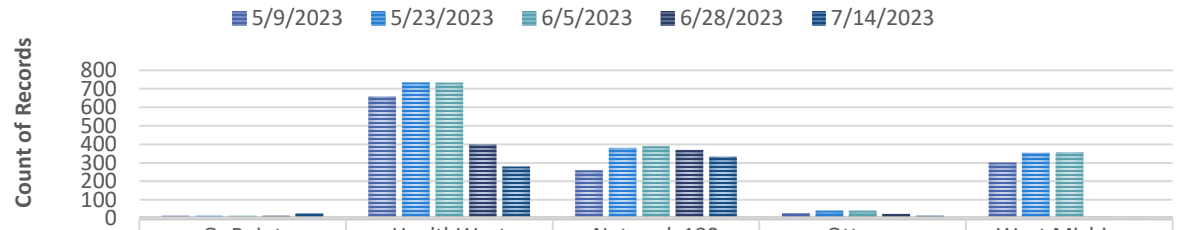
INVALID PROVIDER NPI*



APPROVED UNITS GREATER THAN REQUESTED UNITS

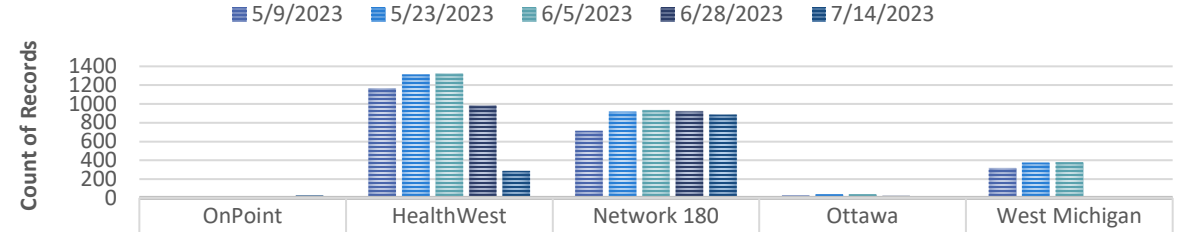


INVALID APPROVED UNITS*



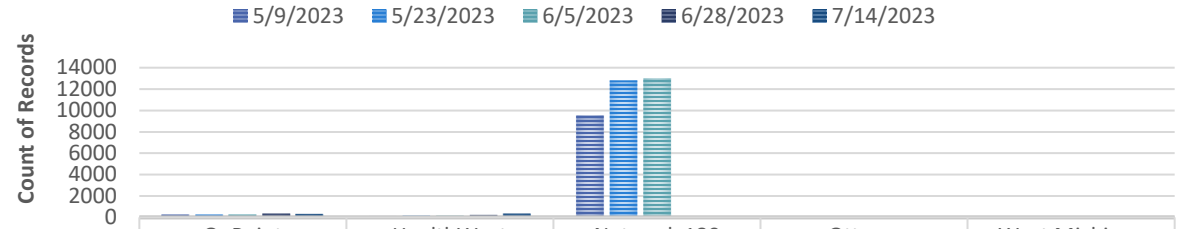
	OnPoint	HealthWest	Network 180	Ottawa	West Michigan
5/9/2023	13	655	259	29	301
5/23/2023	13	733	380	42	354
6/5/2023	13	732	389	42	358
6/28/2023	13	397	368	24	8
7/14/2023	28	278	331	14	8

INVALID REQUESTED UNITS



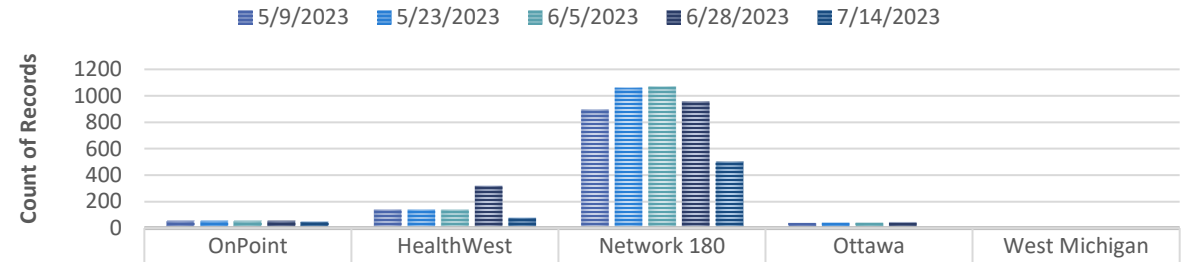
	OnPoint	HealthWest	Network 180	Ottawa	West Michigan
5/9/2023	12	1163	715	27	318
5/23/2023	13	1313	920	40	376
6/5/2023	13	1316	932	40	380
6/28/2023	13	976	918	24	9
7/14/2023	25	289	884	14	12

INVALID APPROVED AMOUNT – INPATIENT*



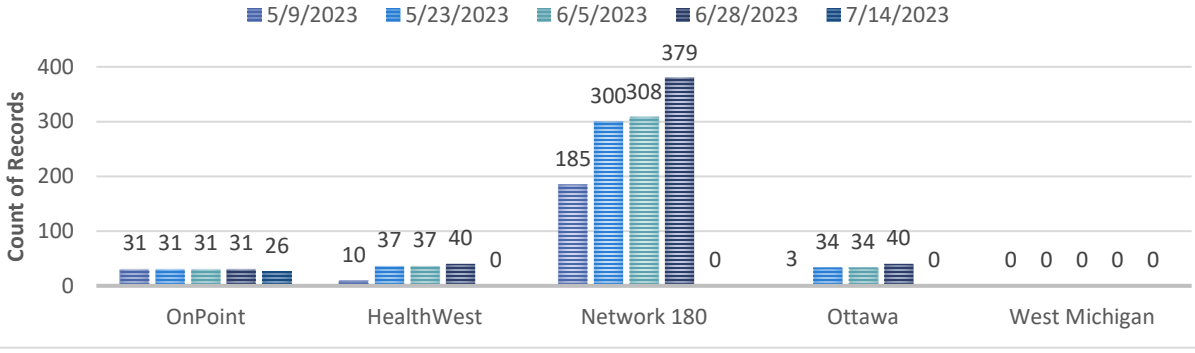
	OnPoint	HealthWest	Network 180	Ottawa	West Michigan
5/9/2023	289	149	9537	10	65
5/23/2023	291	163	12795	16	68
6/5/2023	291	163	12983	16	68
6/28/2023	291	168	3	17	36
7/14/2023	264	303	3	16	41

INVALID APPROVED AMOUNT – CRISIS RESIDENTIAL*

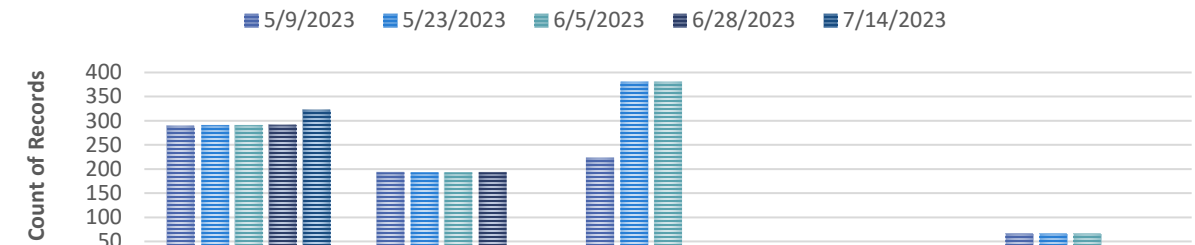


	OnPoint	HealthWest	Network 180	Ottawa	West Michigan
5/9/2023	56	143	893	42	3
5/23/2023	56	143	1059	45	3
6/5/2023	56	143	1068	45	3
6/28/2023	56	324	957	48	8
7/14/2023	51	82	500	0	0

INVALID APPROVED AMOUNT – PARTIAL HOSPITALIZATION*



ADMIT FISCAL YEAR MISMATCH*

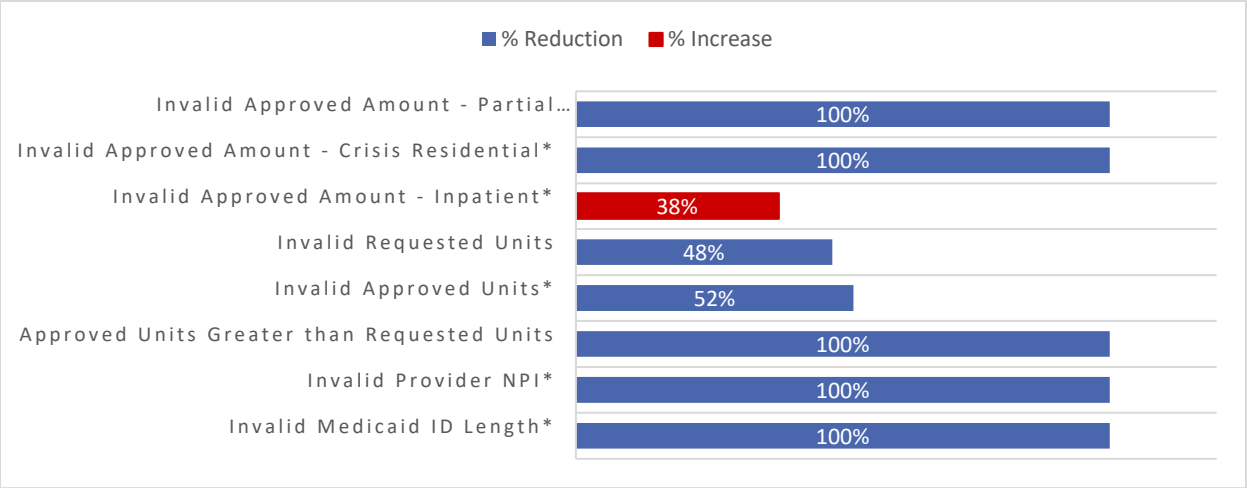


	OnPoint	HealthWest	Network 180	Ottawa	West Michigan
5/9/2023	289	193	223	0	67
5/23/2023	291	193	380	0	67
6/5/2023	291	193	380	0	67
6/28/2023	291	193	20	0	0
7/14/2023	322	17	20	0	0

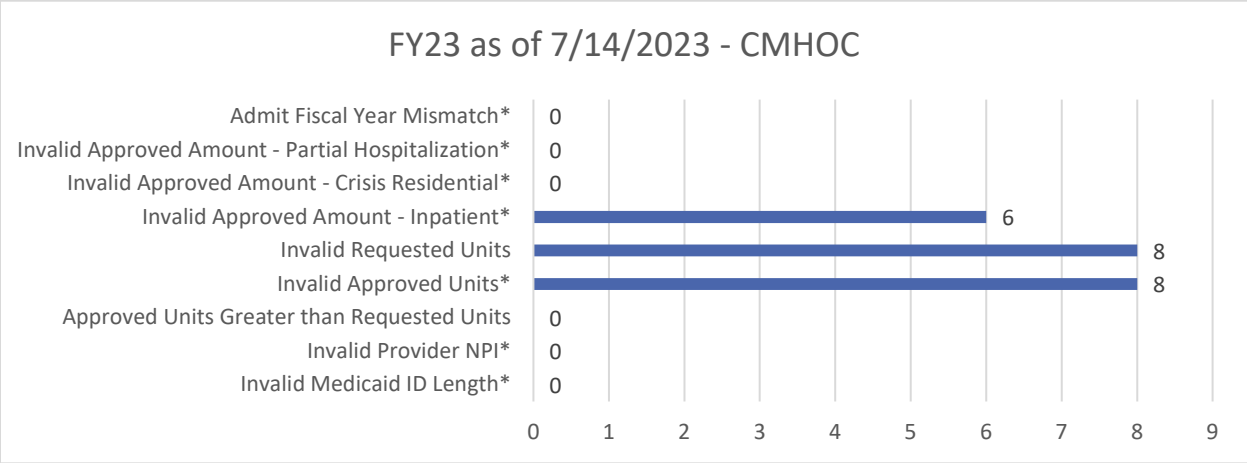
CURRENT STATUS REPORT BY CMHSP

COMMUNITY MENTAL HEALTH OF OTTAWA COUNTY

CMHOC has resolved all outstanding data integrity issues for five of the categories. CMHOC did see a 38% increase in number of episodes with an Invalid Approved Amount for Inpatient Treatment since 5/9/2023 with 16 total outstanding episode errors. The chart below outlines progress made by data error type between the dates of 5/9/2023 and 7/14/2023 for all authorizations back to FY2020.



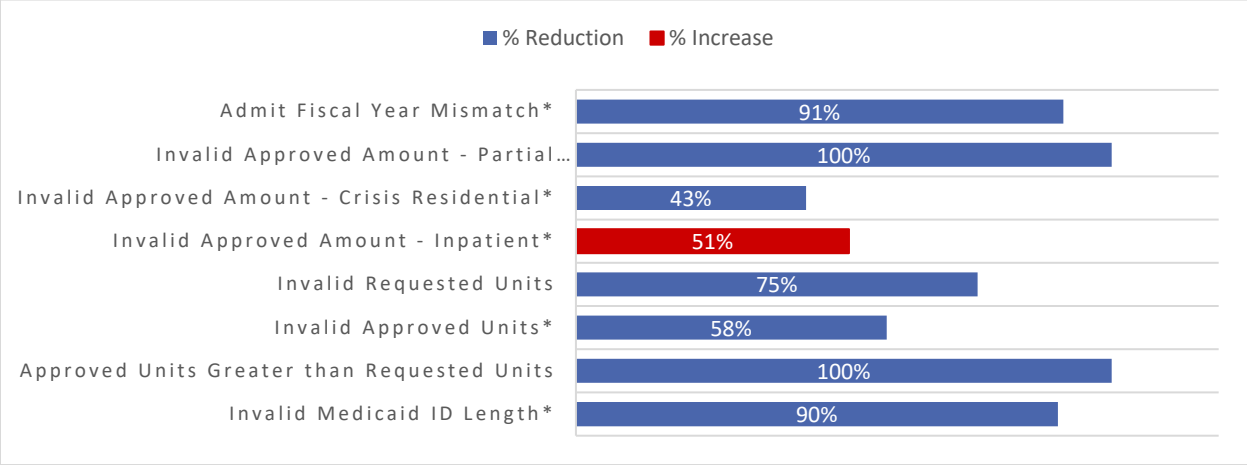
The chart below outlines the number of outstanding HLOC Authorization Data errors for FY23.



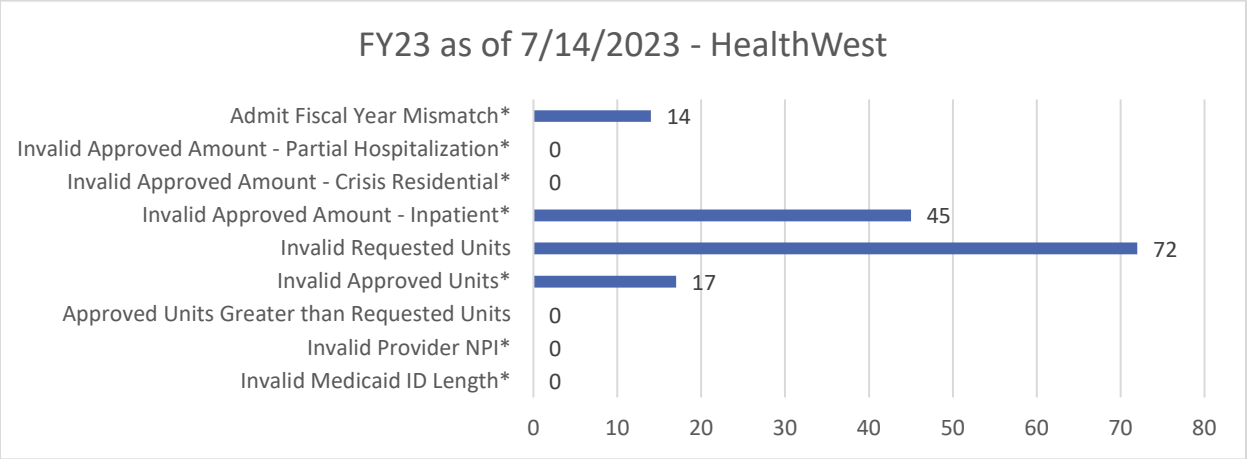
HEALTHWEST

HealthWest has resolved all outstanding data integrity issues for two of the categories. HealthWest did see a 51% increase in number of episodes with an Invalid Approved Amount for Inpatient Treatment since 5/9/2023 with 303 total outstanding episode errors. HealthWest has informed LRE of several efforts to continue to address outstanding issues.

The chart below outlines progress made by data error type between the dates of 5/9/2023 and 7/14/2023 for all authorizations back to FY2020.



The chart below outlines the number of outstanding HLOC Authorization Data errors for FY23.

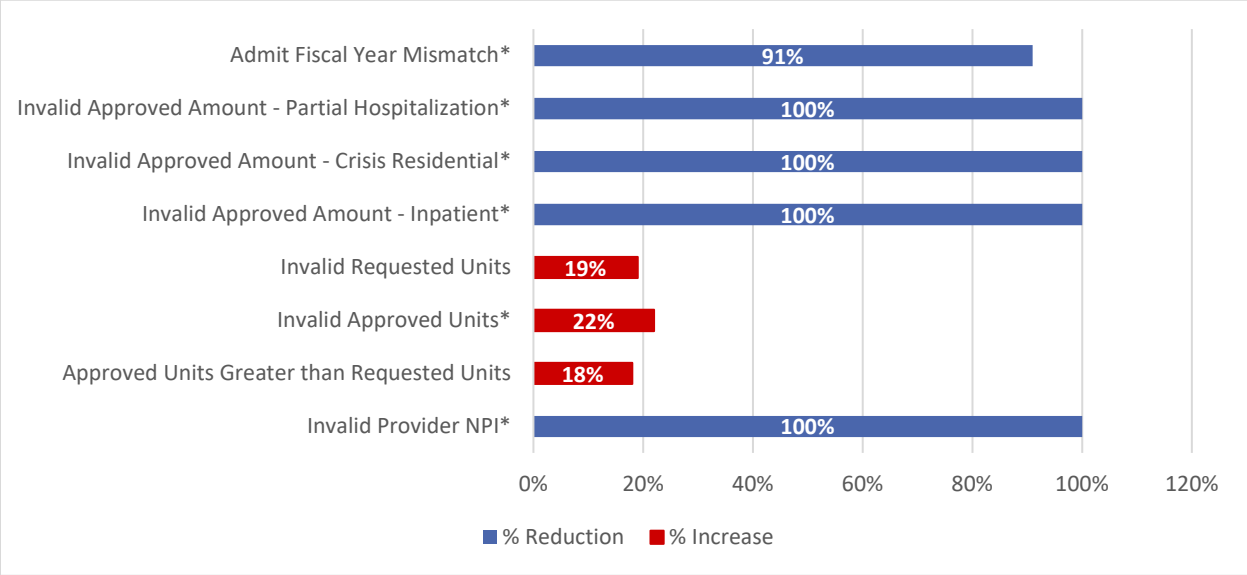


NETWORK180

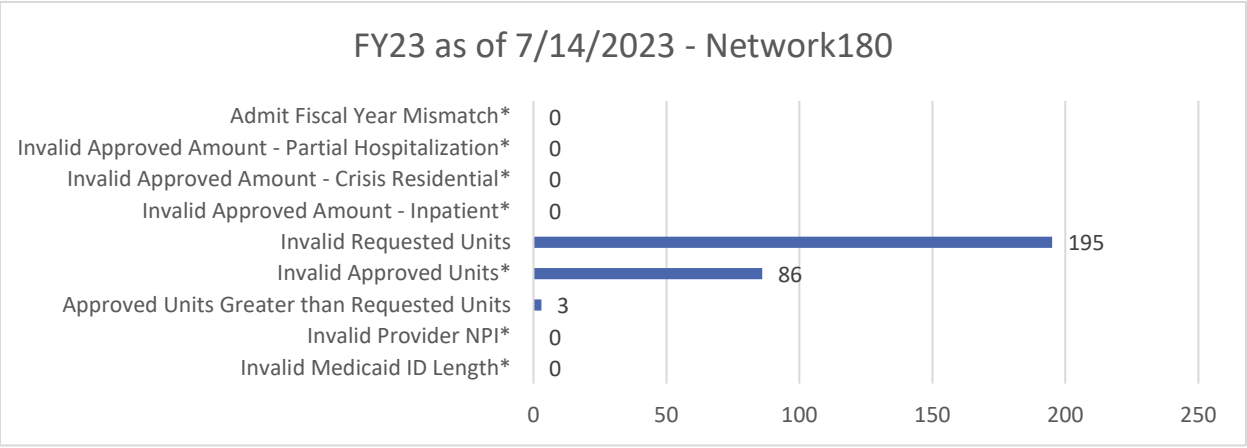
Network180 has resolved all outstanding data integrity issues for four of the categories. Network180 did see a 19% increase in number of episodes with an Invalid Requested Units, a 22% increase in number of episodes with an Invalid Approved Units, and 18% increase in Approved Units Greater than Requested Units, since 5/9/2023.

Network180 has communicated to the LRE their plan to address any outstanding issues.

The chart below outlines progress made by data error type between the dates of 5/9/2023 and 7/14/2023 for all authorizations back to FY2020.



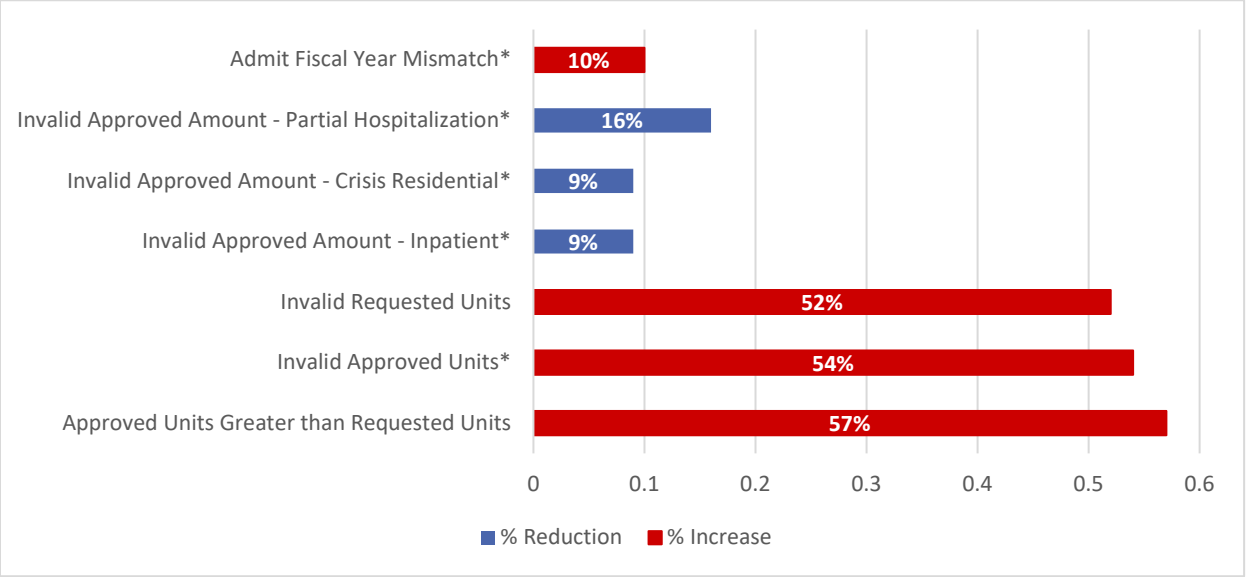
The chart below outlines the number of outstanding HLOC Authorization Data errors for FY23.



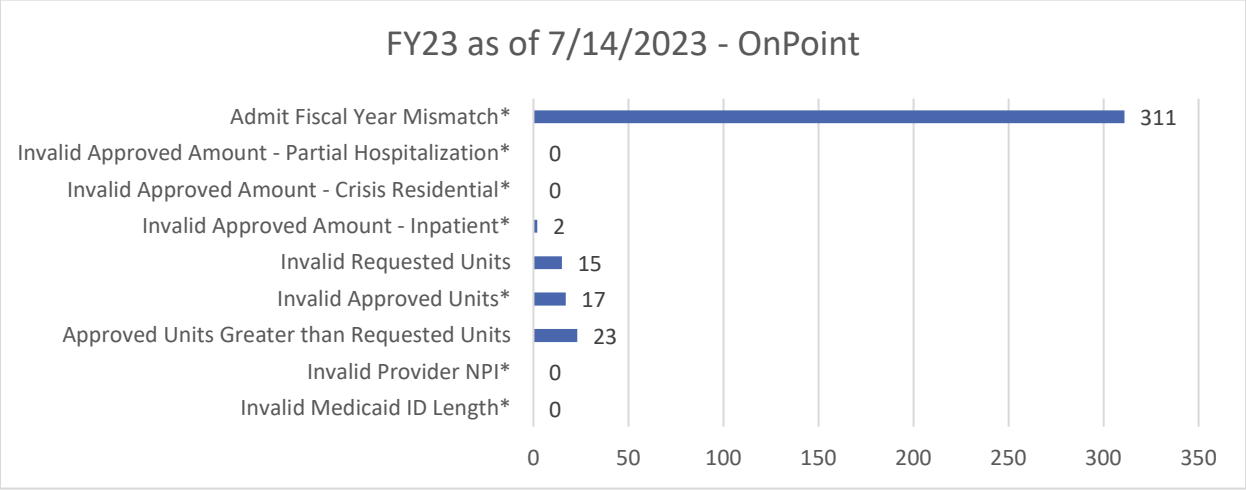
ONPOINT

OnPoint continues to work on correcting outstanding errors. OnPoint saw increases in the percentage of errors in several categories. It is important to note that OnPoint started with very few data errors when this cleanup project started and has a total of 368 FY23 episode errors with 311 of the episode errors due to Admit Fiscal Year Mismatch. LRE will continue to work with OnPoint to address these errors.

The chart below outlines progress made by data error type between the dates of 5/9/2023 and 7/14/2023 for all authorizations back to FY2020.



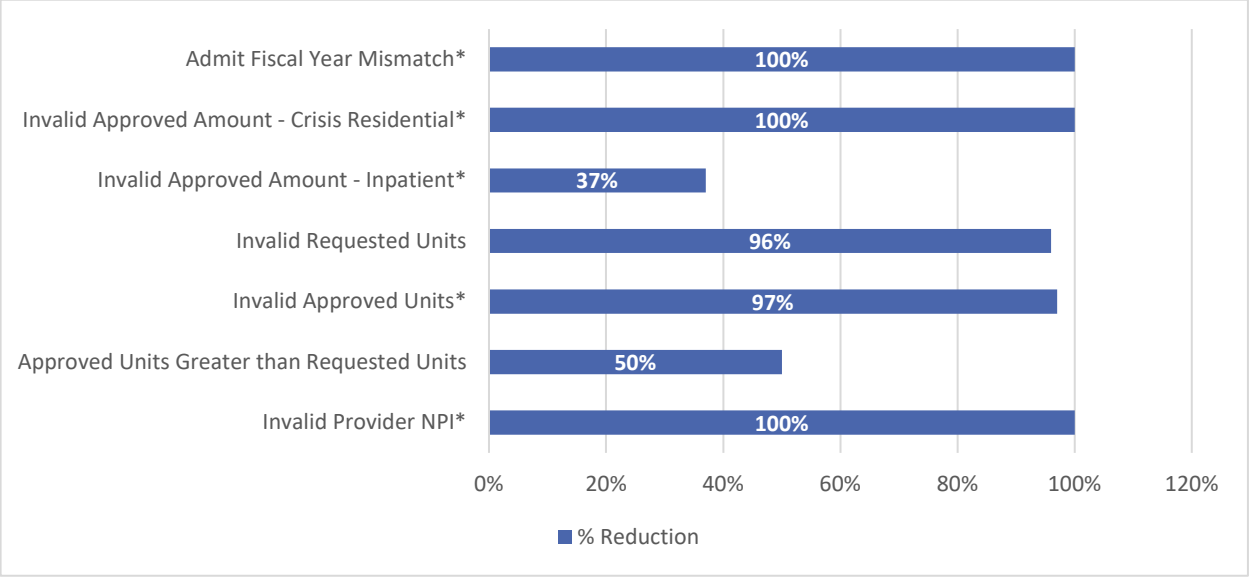
The chart below outlines the number of outstanding HLOC Authorization Data errors for FY23.



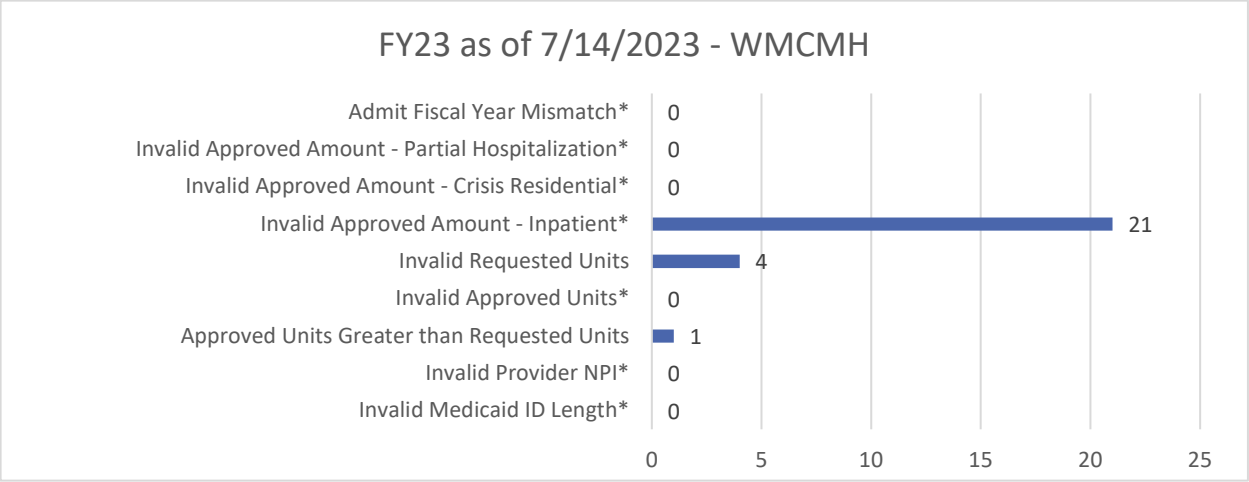
WEST MICHIGAN COMMUNITY MENTAL HEALTH

West Michigan CMH has addressed nearly all the outstanding data integrity issues identified on the HLOC Authorization Data Integrity Dashboard. Most outstanding Authorization Data errors are regarding Invalid Approved Amounts for Inpatient Treatment.

The chart below outlines progress made by data error type between the dates of 5/9/2023 and 7/14/2023 for all authorizations back to FY2020.



The chart below outlines the number of outstanding HLOC Authorization Data errors for FY23.



Introduction

Attachment M

PHI: This dashboard contains PHI.

Purpose:

To access MMBPIS results over time and investigate results by demographic factors

Data Sources:

MMBPIS Data from PCE
820/834/271 Eligibility Data & MDHHS Race/Ethnicity Fix Files

Audience:

LRE/CMHs

Data Presented:

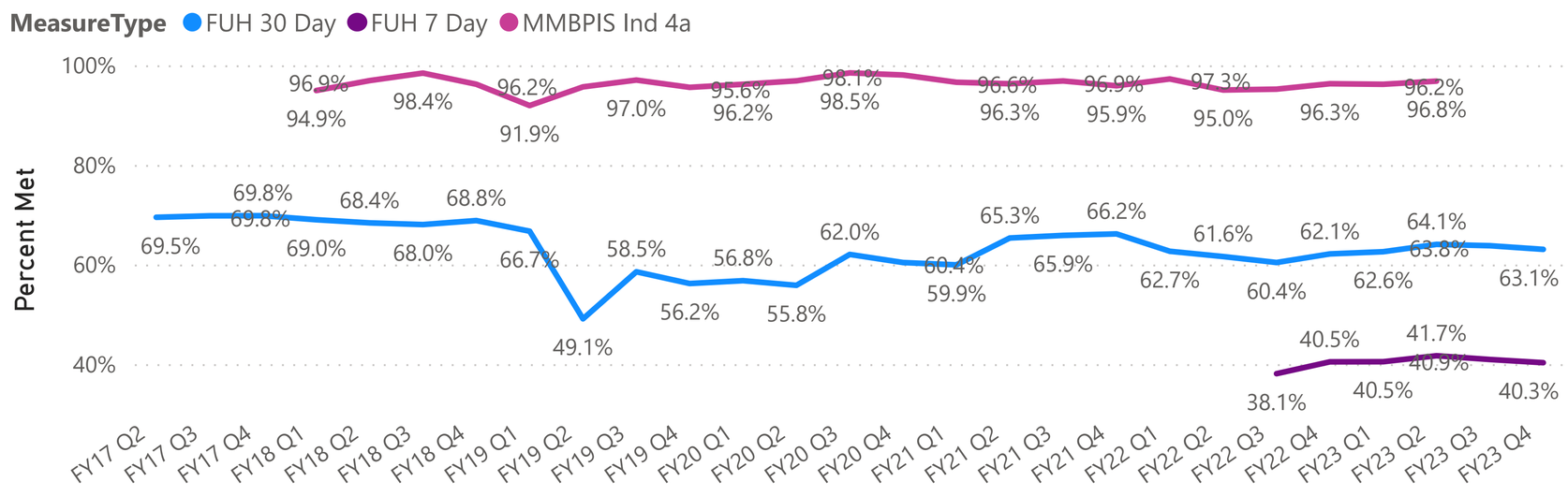
- Overview - MMBPIS Indicator Scores over time in tabular format
- CMH Comparisons - MMBPIS Indicator Scores by CMH for a single selectable fiscal quarter
- MMBPIS Volume - Shows total denominator counts over time and the distribution of counts by MMBPIS Indicator
- Indicator Volume by Race - [NCounts/Percentage] - Gives total denominator counts by race for the selected indicator
- Indicator Volume by Population - [NCounts/Percentage] - Shows total denominator counts by population for the selected indicator
- Trends - Indicator 1 [Race/Population] - Displays compliance percentages over time. Several demographic slicers are available.
- Trends - Indicator 2A [Race/Population] - Displays compliance percentages over time. Several demographic slicers are available.
- Trends - Indicator 3 [Race/Population] - Displays compliance percentages over time. Several demographic slicers are available.
- Trends - Indicator 4a [Race/Population] - Displays compliance percentages over time. Several demographic slicers are available.
- Trends - Indicator 4b Race - Displays compliance percentages over time. Several demographic slicers are available. Note: There is 1 population for this indicator, so only Race page is available.
- Trends - Indicator 10 [Race/Population] - Displays compliance percentages over time. Several demographic slicers are available.
- Exception Reasons - [NCounts/Percentage] - Tabular view of exception reason counts in each reporting period
- Exception Reasons Trend - Graphical view of exception reason counts trended over time
- FUH - MMBPIS - Trends Adult & Child Follow Up results for MMBPIS Ind 4a along with HEDIS FUH 7 day and FUH 30 day KPI results (Source: ZTS)
- Individual MMBPIS History - Shows the MMBPIS indicators where a client was included in the denominator throughout all reporting periods

Data for Internal Use Only:

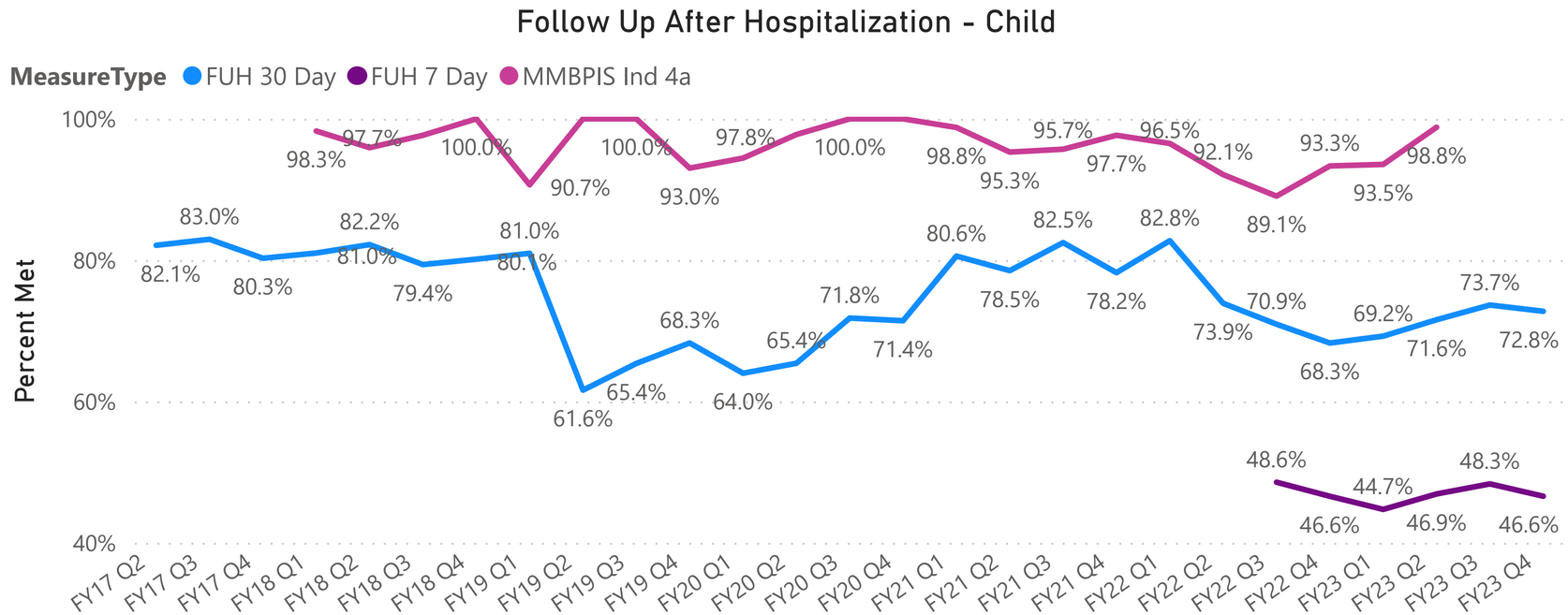
1. Prior to any external release of this information, please submit a request for approval to the LRE IT department via email at HelpDesk@LSRE.org
2. For questions, please email the IT helpdesk at: HelpDesk@LSRE.org with "MMBPIS Dashboard" in the subject line.

FUH - MMBPIS

Follow Up After Hospitalization - Adult



Follow Up After Hospitalization - Child



Race

- [x] Select all
- [x] (Blank)
- [x] American Indian or Alaskan Native
- [x] Asian
- [x] Black
- [x] Hispanic
- [x] Other
- [x] Pacific Islander
- [x] Unknown
- [x] White

CMH

- [x] Select all
- [x] OnPoint
- [x] HealthWest
- [x] Network180
- [x] Ottawa
- [x] West Michigan

Report Period

- [x] Select all
- [x] FY23 Q4
- [x] FY23 Q3
- [x] FY23 Q2
- [x] FY23 Q1
- [x] FY22 Q4
- [x] FY22 Q3
- [x] FY22 Q2
- [x] FY22 Q1
- [x] FY21 Q4
- [x] FY21 Q3
- [x] FY21 Q2
- [x] FY21 Q1
- [x] FY20 Q4
- [x] FY20 Q3
- [x] FY20 Q2
- [x] FY20 Q1
- [x] FY19 Q4
- [x] FY19 Q3
- [x] FY19 Q2
- [x] FY19 Q1
- [x] FY18 Q4

Attachment N

LAKESHORE
REGIONAL ENTITY

Improvements in MMBPIS Indicators 2a & 3 plus PIP Interventions Affecting MMBPIS 4a & HEDIS® FUH 30-day

Wendi M. Price - Chief Quality Officer

March 23, 2023

TODAY'S GOAL

- Develop a Recommendation for CEOs to consider regarding launching Region Wide Intervention to:
    1. Improve Outreach following No Show/Client Cancel
        a. Indicator 2a
        b. Indicator 3
        c. Indicator 4a
    2. Improve FUH Scheduling
        a. Indicator 4a
        b. Indicator 4b?

Current MMBPIS Exceptions

CODE	Category of Out of Compliance	Comments
CA	Client choice –to leave AMA	Use this code for client leaving Against Medical Advice (AMA) or Left Against Advice (LAA) or dropped out of treatment from Detox, Crisis Residential, or Inpatient.
CC	Client Canceled	
CD	Client Choice of date	Client chose appointment date outside timeframe, due to conflict of work schedule, school, vacation etc.
CP	Client Choice (Preference) – particular therapist or Provider Agency	Client requested a particular therapist / worker or Provider Agency.
CT	Client Canceled - transportation	
CX	Client choice not to use CMHSP/PIHP Services	Use for refused services or consumer stating they want to use another agency or their PCP for follow up
DI	Documentation Issue	Example of use: There was no documentation to explain the reason, it was not clear, or missing documentation
NR	Not scheduled due to inability to reach consumer at all	
NS	Client No Show	
OT	Other	Use this code for cases out of compliance for reasons that do not fit into other exception codes. Some examples of previous use: Incarcerated at time of request; Blizzard of 2019. We will still be able to add comment for further explanation.
RC	Rescheduled – by client	Use this code if client canceled then rescheduled.
RS	Rescheduled – by staff	Use this code if staff canceled service then rescheduled.
SC	Staff Canceled	
SI	Staffing Issue	Most records previously called “out of compliance” would be coded as this. Example not enough staff for individual to either be assessed or start ongoing services within the 14 day timeframe
SY	Systems Issue	Encompasses staff not following procedures, or problems with procedures, system failures, etc. This might be something with an EMR issue – update; maybe all staff are putting something in EMR incorrectly due to training
UR	Unable to reach client to schedule an appointment within timeframe	

Use of MMBPIS Exceptions

Indicator	1	2a	3	4a	4b	10
MDHHS Exception Allowed	No	No	No	Yes	Yes	No
LRE Exception Use as ***Best Practice***	No	***Yes***	***Yes***	***Yes***	***Yes***	No
FY22 Total Cases	7,725	5,035	4,038	1,909	592	1,928
FY22 Total # Exception Codes Used	6	1,777	1,441	740	185	15
FY22 Top Exception Codes Used	SY – 67% SI – 17%	**NS – 24%** **SI – 23%** CD – 9% **SY – 9%** RC – 8% **DI – 7%**	**SI – 26%** **NS – 19%** **DI – 10%** CD – 9% **SY – 6%** RC – 6%	**NS – 47%** CX – 24% **CC – 6%** **SY – 4%**	CA – 64% CX – 18%	OT – 73% CX – 27%

LAKESHORE REGIONAL ENTITY

LRE MMBPIS FY22

MMBPIS Indicator #	PIHP Quarterly Measures	Target	Oct-Dec 21	Q1 State Avg	Jan-Mar22	Q2 State Avg	Apr-Jun22	Q3 State Avg	July-Sept22	Q4 State Avg
Indicator #2	F/F Assessment within 14 days –MIC	N/A	71.3%	59.2%	66.9%	54.9%	63.0%	50.5%	63.8%	52.7%
	F/F Assessment within 14 days –MIA	N/A	78.9%	59.6%	64.2%	52.2%	56.4%	50.8%	57.0%	53.4%
	F/F Assessment within 14 days –DDC	N/A	73.3%	62.9%	78.5%	62.4%	75.3%	52.4%	57.8%	53.0%
	F/F Assessment within 14 days –DDA	N/A	47.2%	56.3%	56.5%	55.8%	47.1%	52.7%	62.1%	52.7%
	F/F Assessment within 14 days --LRE Total	N/A	73.4%	59.6%	66.0%	54.1%	59.5%	51.0%	59.8%	53.3%
Indicator #3	Start of Service Within 14 Days --MIC	N/A	75.6%	77.5%	60.3%	72.6%	54.8%	72.9%	62.4%	75.3%
	Start of Service Within 14 Days --MIA	N/A	70.3%	76.9%	55.6%	74.8%	64.0%	73.9%	64.5%	74.8%
	Start of Service Within 14 Days --DDC	N/A	80.0%	83.2%	65.3%	82.0%	71.7%	81.5%	60.7%	80.8%
	Start of Service Within 14 Days --DDA	N/A	79.7%	77.4%	68.4%	75.7%	67.1%	76.4%	64.7%	80.3%
	Start of Service Within 14 Days --LRE Total	N/A	74.4%	77.5%	59.8%	75.0%	60.4%	74.3%	63.3%	75.7%
Indicator #4a	% Seen Within 7 Days of Inpatient Discharge - Children	95%	96.5%	92.3%	92.1%	90.3%	89.1%	90.1%	93.3%	90.9%
	% Seen Within 7 Days of Inpatient Discharge - Adults	95%	97.3%	92.0%	95.1%	88.9%	95.2%	89.9%	96.0%	91.1%

Lakeshore Regional Entity						
Review of Indicator 2 --Reason Cases Found out of Compliance Updated 01/04/2023						
Reporting Quarter	# Reported for Indicator 2	# Cases in compliance	Percent of Cases In-compliance		# Cases found Out of	Percent of Cases found Out of Compliance
FY20 Q4	1035	848	81.9%		187	18.1%
FY21 Q1	1165	924	79.3%		241	20.7%
FY21 Q2	1336	1003	75.1%		333	24.9%
FY21 Q3	1274	953	74.8%		321	25.2%
FY21 Q4	1222	939	76.8%		283	23.2%
FY22 Q1	1286	944	73.4%		342	26.6%
FY22 Q2	1216	802	66.0%		414	34.0%
FY22 Q3	1210	720	59.5%		490	40.5%
FY22 Q4	**1316**	**787**	**59.8%**		**529**	**40.2%**

Lakeshore Regional Entity						
Review of Indicator 3--Reason Cases Found out of Compliance Updated 1/04/2023						
Reporting Quarter	# Cases Reported	# of Cases In-Compliance	Percent of Cases In-Compliance		# of Cases Out of Compliance	Percent of Cases Found Out of Compliance
FY20 Q4	667	518	77.7%		149	22.34%
FY21 Q1	849	682	80.3%		167	19.67%
FY21 Q2	985	774	78.6%		211	21.42%
FY21 Q3	952	738	77.5%		214	22.48%
FY21 Q4	946	0	75.9%		228	24.10%
FY22 Q1	1111	826	74.3%		285	25.65%
FY22 Q2	889	532	59.8%		357	40.16%
FY22 Q3	993	600	60.4%		393	39.58%
FY22 Q4	**1040**	**658**	**63.3%**		**382**	**36.73%**

MMBPIS Plans of Correction for 2a & 3

Indicators with Standards

- Indicators 1, 4a, 4b: Below 95%
- Indicator 10: Above 15%

Indicators without Standards

- POC for Indicators 2a & 3: Downward Trend for 2 Quarters in a Row

OR

- Region Wide Initiative Surrounding NS/CC Outreach and FUH Scheduling

Critical Elements for MMBPIS Plans of Correction

☑ Actionable Remediation Plans
☑ Target Remediation Completion Date
☑ Responsible Role/Person

MDHHS MMBPIS Analysis*

- **Indicator 2a**:
  - FY 2021 Statewide 50th Percentile: **65.9%**
  - FY 2021 Statewide 75th Percentile: **70.9%**
  - The denominators increased, but the numerator stay relatively stable leading to a decline in trends
  - **No quarterly percentage hit the 50th percentile in FY2021**
- **Indicator 3:**
  - FY 2021 Statewide 50th Percentile: **78.02% %**
  - FY 2021 Statewide 75th Percentile: **86.27%**
  - The denominators increased, but the numerator did not increase that much.
  - **3 out of 7 quarterly time points hit the FY2021 50th percentile, but none of them hit the 75% percentile.**
- **Indicators 4a & 4b:** Discussions to Eliminate Exceptions

*Borrowed from QIC Presentation December 7, 2022. Full presentation available upon request.

Q&A

LAKESHORE REGIONAL ENTITY

Attachment O

Meeting Agenda

Meeting Name:	LRE/Meridian FUH and FUA
Date:	6/27/2023
Time:	11:00 AM
Location:	Microsoft Teams

Attendees P = Present C = Call-in A = Absent

	Maureen Halpin		Ione Myers		Shanita McClary		
	Laura Schuyler		Stephanie VanDerKooi				
	Elizabeth Totten		Kelly Buono				
	Wendi Price		Erica Willoughby				

Agenda Topics:

Agenda Topic	Owner	Notes
Welcome/Introduction	**Maureen**	**New MHP Manager introduced**
Provider/CMH Education Discussion	**All**	**Tom will send feedback to Education Document to Meridian. Liz has completed feedback and sent back to Tom.**
FUH Discharge upload	**All**	**Discussed MHP/PIHP Meeting and FUH Upload and view days by PIHP/MHP. Workgroup does not feel a change is urgent and will table to discussion for now. Robust discussion occurred relative to making the process more timely and efficient. Man hours for workflow, when MHPs pull the information and when PIHPs Upload**
LRE Updates	**Lakeshore**	**Asked MHP if adding phone number to the FUH upload was helpful. Meridian CSM stated they were seeing a difference and been useful in more timely contacts and improved engagement. Ione Myers discussed phone number use and adherence to maintaining confidentiality.**
Questions for Meridian	**All**	**Will view data at our next month's meeting**

PIHP FUH Data Upload Schedules:

PIHP	Day of Week	Time
Detroit Wayne	Thursday	By 3:00 PM
Region 10	Thursday	Before 9:00 AM
Lakeshore	Tuesday and Fridays	Tuesday Afternoon and Friday around noon
Midstate	Fridays	N/a
Macomb	Monday	N/a
Oakland	Thursday	Before Noon
SWMBH	Friday	3:300 PM
Northern Regional Entity	Friday	Before 4:00 PM

Follow Up After Hospitalization for Mental Illness

The Follow- Up After Hospitalization for Mental Illness (FUH) Healthcare effectiveness Data and Information Set (HEDIS) measure looks at the number of discharged patients following hospital admission for treatment of selected mental illness diagnosis or intentional self-harm who had a follow up with a mental health practitioner. The measure has two rates: 7 day follow up and 30 day follow up.

Meridian and Prepaid Inpatient Health Plans (PIHPs) work in partnership to provide quality care to patients through the post discharge care transition period.

Engaging patients in appropriate discharge planning/care coordination should take place on day one of admission and always before the patient is discharged. You can help with the patient's transition by engaging in the following best practices:

Notifying LRE/member CMHSPs of an inpatient admission when member is still inpatient and upon discharge

- LRE/member CMHSPs helps coordinate behavioral healthcare services for patients and works with Meridian to help algin with necessary medical services
- Share patient's phone number and address for ongoing contact with the patient after discharge
- For any behavioral health inpatient admission after business hours, contact LRE/member CMHSPs at **Phone** the morning of the next business day
- Provide discharge documentation to LRE/member CMHSPs **via fax at Number within 24-48hrs hours of discharge**

~~Communicate with LRE utilization case manager during discharge planning process to develop appropriate plan~~

- ~~Staff can assist with discharge planning for complex cases and provide support as needed~~

Schedule follow up visit with mental health provider within seven days of discharge before the patient leaves the hospital. Telehealth visits count towards completion for measure

Importance of patients following up after hospitalization

- Increase medication adherence
- Reduce risk of readmissions
- Patients get needs met for everyday activities

If member reports problems with transportation to medical appointments, connect with Meridian's Transportation benefit **MTM Phone Number**

LAKESHORE REGIONAL ENTITY

Attachment 2

Lakeshore Regional Entity

MMBPIS Performance Indicator Dashboard

FY 2023

	Meets or exceeds target for goal
	Does not meet target for goal

MMBPIS Indicator #	PIHP Quarterly Measures	Target	Oct-Dec 22	Q1 State Avg	Jan-Mar23	Q2 State Avg	Apr-Jun23	Q3 State Avg	July-Sept23	Q4 State Avg
Indicator #1	% of Pre-Admission Screening Dispositions 3 hrs or less - Childre	95%	97.6%	98.5%	97.9%	98.9%				
	% of Pre-Admission Screening Dispositions 3 hrs or less - Adults	95%	98.2%	98.2%	98.1%	99.0%				
Indicator #2	F/F Assessment within 14 days --MIC	62%	58.9%	48.8%	67.7%	47.8%				
	F/F Assessment within 14 days --MIA	62%	55.6%	53.0%	51.7%	52.7%				
	F/F Assessment within 14 days --DDC	62%	60.6%	46.6%	52.2%	46.7%				
	F/F Assessment within 14 days --DDA	62%	66.2%	50.9%	62.2%	49.6%				
	F/F Assessment within 14 days --LRE Total	62%	57.9%	51.6%	58.7%	51.0%				
Indicator #3	Start of Service Within 14 Days --MIC	72.9%	52.6%	70.1%	54.8%	70.6%				
	Start of Service Within 14 Days --MIA	72.9%	56.3%	71.7%	60.0%	72.3%				
	Start of Service Within 14 Days --DDC	72.9%	64.1%	77.2%	62.0%	76.0%				
	Start of Service Within 14 Days --DDA	72.9%	59.5%	74.1%	63.9%	75.7%				
	Start of Service Within 14 Days --LRE Total	72.9%	55.3%	71.8%	58.0%	72.3%				
Indicator #4a	% Seen Within 7 Days of Inpatient Discharge - Children	95%	93.6%	92.2%	98.8%	92.8%				
	% Seen Within 7 Days of Inpatient Discharge - Adults	95%	96.2%	90.1%	96.9%	91.7%				
Indicator #4b	% Seen Within 7 Days of SA Detox Unit Discharge -SUD	95%	98.1%	96.6%	91.7%	96.7%				
Indicator #10	Inpatient Recidivism Rate - Children	15% or less	9.9%	6.9%	8.9%	6.1%				
	Inpatient Recidivism Rate - Adults	15% or less	8.9%	11.6%	10.4%	11.5%				
MDHHS collects and reports the following indicators										
Indicator #2e	F/F Service for Treatment Support within 14 days --SUD	75.3%	67.2%	70.0%	74.38%	69.6%				
Indicator #5	% of Area Medicaid Having Received PIHP Managed Services	MDHHS INFO	5.18%	6.4%	5.31%	6.54%				
Indicator #6	% of HSW Enrollees in Quarter who Received at Least 1 HSW Service each Month other than Support Coordination	MDHHS INFO	95.3%	94.4%	95.3%	94.2%				

Indicator	#1 - Pre-Admission Screening			#2A - 1st Request Timeliness					#3 - 1st Service Timeliness					#4a - Hospital Discharges F/U			#4b SUD - Detox Follow-Up		#10 - Inpatient Recidivism		
Threshold	≥ 95%			≥ 62%					≥ 75.3%					≥ 95%			≥ 95%		≤ 15%		
Population	Adult	Child	Total	DD / Adult	DD / Child	MI / Adult	MI / Child	Total	DD / Adult	DD / Child	MI / Adult	MI / Child	Total	Adult	Child	Total	SUD	Total	Adult	Child	Total
CMHName	Percent Met	Percent Met	Percent Met	Percent Met	Percent Met	Percent Met	Percent Met	Percent Met	Percent Met	Percent Met	Percent Met	Percent Met	Percent Met	Percent Met	Percent Met	Percent Met	Percent Met	Percent Met	Percent Met	Percent Met	Percent Met
OnPoint	100.0%	100.0%	**100.0%**	11.1%	38.7%	42.1%	54.2%	**43.4%**	42.9%	77.8%	58.0%	52.1%	**59.1%**	94.1%	100.0%	**95.5%**	100.0%	**100.0%**	4.4%	6.3%	**4.9%**
HealthWest	99.5%	99.3%	**99.4%**	85.7%	70.6%	52.2%	73.2%	**61.1%**	88.9%	61.5%	59.8%	61.7%	**61.1%**	97.4%	95.0%	**96.9%**	90.0%	**90.0%**	14.8%	3.3%	**12.7%**
Network180	97.3%	96.9%	**97.2%**	62.8%	44.4%	26.5%	62.3%	**50.0%**	57.5%	38.2%	38.8%	46.0%	**45.5%**	97.1%	100.0%	**97.8%**	89.1%	**89.1%**	9.7%	11.8%	**10.2%**
Ottawa	98.9%	99.0%	**98.9%**	57.9%	58.8%	63.6%	67.5%	**64.8%**	90.0%	66.7%	45.5%	51.0%	**52.0%**	97.2%	100.0%	**97.8%**	91.3%	**91.3%**	4.4%	7.1%	**5.1%**
West Michigan	100.0%	96.2%	**98.4%**	100.0%	66.7%	72.0%	60.5%	**69.3%**	50.0%	91.7%	89.6%	61.4%	**78.3%**	94.7%	100.0%	**96.2%**	100.0%	**100.0%**	13.6%	15.4%	**14.3%**
Total	**98.1%**	**97.9%**	**98.1%**	**62.2%**	**52.2%**	**51.7%**	**67.7%**	**58.7%**	**63.9%**	**62.0%**	**60.0%**	**54.8%**	**57.9%**	**96.9%**	**98.8%**	**97.3%**	**91.7%**	**91.7%**	**10.4%**	**8.9%**	**10.1%**

ilters:ReportPeriod is FY23 Q2

LRE FY23 CMHSP Site Review Results Report
CMH of Ottawa County
Date of Site Review: March 18-21, 2023

I. Desk Audit Results

LRE validated CMH of Ottawa County's ("Ottawa") full remediation for those Desk Audit Standards that fell below 95% during LRE's FY22 Site Review. Ottawa should be very proud of its accomplishments over the last year in these four Desk Audit Standards. LRE recognizes that Region 3 has comprised a Disclosure of Ownership Workgroup to develop standardized practices across Region 3 and that Ottawa has been instrumental in the development of these practices. LRE thanks Ottawa for its continued partnership in this endeavor.

Desk Audit & Section	Sum of Question Score	Sum of Possible Score	%
2023 Standard III Availability of Services III. Delivery Network	4	4	100%
2023 Standard III Availability of Services III. Timely Access	4	4	100%
2023 Standard IV Assurances of Adequate Capacity and Services IV. Assurances of Adequate Capacity and Services	6	6	100%
2023 Standard V Coordination and Continuity of Care V. Coordination and Continuity of Care	2	2	100%
2023 Section XXI Disclosure of Ownership Control & Criminal Conviction XXI. Disclosure of Ownership, Control, & Criminal Conviction	6	6	100%
Grand Total	**22**	**22**	**100%**

II. Program Specific Audit Results

LRE validated CMH of Ottawa County's ("Ottawa") remediation for those Program Specific Standards that fell below 95% during LRE's FY22 Site Review, except for the Children's Intensive Crisis Stabilization Services. LRE commends Ottawa in its efforts to fully remediate five of the six Program Specific Standards. LRE could not validate Ottawa's remediation efforts related to Question 9.1 in the Program Specific Standard Section|2023 CMHSP Program Specific-Non-Waiver Standards CMHSP Program Specific - Children's Intensive Crisis Stabilization Services. LRE issued a repeat citation. LRE recognizes that Ottawa has been conducting a job search for appropriately credentialed staff to lead the Children's Intensive Crisis Stabilization Services. Unfortunately, Ottawa has not been able to hire staff to do so. LRE understands the staffing crisis across not only in Ottawa County, but across the State of Michigan and the United States. LRE believes that Ottawa County will eventually fill the role and deploy the Children's Intensive Crisis

Stabilization Services in-county. LRE encourages Ottawa to continue to seek out solutions that go beyond hiring staff, such as contracting with an adjoining county to provide Children's Intensive Crisis Stabilization Services until such time as Ottawa can get its own program up and running. Ottawa has further noted complications in filling the Children's Intensive Crisis Stabilization Services position due to the insufficient utilization of this service in previous years. With the reissuance of the Systems of Care grant, Ottawa noted an intent to address this deficiency from recurrence.

Program Specific Audit & Section	Sum of Question Score	Sum of Possible Score	%
2023 CMHSP Program Specific- Non-Waiver Standards CMHSP Program Specific - Behavior Treatment Plan Review Committee V2	2	2	100%
2023 CMHSP Program Specific- Non-Waiver Standards CMHSP Program Specific - Children's Intensive Crisis Stabilizaiton Services	0	2	0%
2023 CMHSP Program Specific- Non-Waiver Standards CMHSP Program Specific - Clubhouse Psycho-Social Rehabilitation Program	4	4	100%
2023 CMHSP Program Specific- Non-Waiver Standards CMHSP Program Specific - Home-Based Services	2	2	100%
2023 CMHSP Program Specific- Non-Waiver Standards CMHSP Program Specific - Targeted Case Management	4	4	100%
2023 CMHSP Program Specific- Non-Waiver Standards CMHSP Program Specific - Trauma Informed Care	2	2	100%
Grand Total	**14**	**16**	**88%**

III. Credentialing & Training Audit Results

LRE audited Ottawa's credentialing and re-credentialing processes for internal and external providers. LRE commends Ottawa for its training, credentialing, and re-credentialing efforts. Ottawa score above 95% for all populations, except for Non-Waiver, which scored 90% for Non-Waiver credentialing – a 6% decrease over fiscal year 2022. Ottawa's credentialing of HSW providers improved 8% over fiscal year 2022.

Population	Sum of Question Score	Sum of Possible Score	%
Non-Waiver Training	130	130	100%
SEDW	116	118	98%
CWP	148	152	97%
Autism	554	570	97%
HSW	705	734	96%
Non-Waiver Credentialing	202	224	90%
Grand Total	1855	1928	96%

Overall, Ottawa scored 96% in Credentialing and Training, which is similar to Ottawa's FY22 performance.

	% of Indicators Met		
Population/Audit Type	**FY22**	**FY23**	**Change**
HSW Training/HR	88%	96%	8%
SEDW Training/HR	95%	98%	3%
Autism Training/HR	96%	97%	2%
Non-Waiver/Non-Autism Staff Training	100%	100%	0%
Non-Waiver/Non-Autism Staff Credentialing	96%	90%	-6%

Autism. LRE determined that Ottawa's IPOS training compliance rate improved to 100% compliance for Autism providers. Autism providers have the opportunity to improve credentialing processes by completing background checks prior to hire and completing the necessary First Aid/CPR courses in the required timeframes along with obtaining the necessary proofs.

Non-Waiver/Non-Autism. LRE found that Ottawa's internal credentialing showed much improvement regarding completing annual performance appraisals within the required timeframes. Ottawa elected to re-credential all staff in unison, which appears to have delivered positive results. Ottawa's training for internal staff continues to be excellent but a barrier for external providers. External providers have the opportunity to improve initial credentialing processes by verifying primary source documents, conducting timely performance appraisals, and completing professional liability checks.

Population	Question / Sub Title	Question Score	Possible Score	Percent
Non-Waiver	1.6k Performance Appraisal presented annually (dates of last two)	0	2	0%
Non-Waiver	1.6g.i NPDB/HIDBP query or in lieu of query all of the following must be verified: Minimum 5-year history of professional liability claims resulting in judgement or settlement.	0	2	0%
Non-Waiver	1.6g.i NPDB/HIDBP query or in lieu of query all of the following must be verified: Minimum 5-year history of professional liability claims resulting in judgement or settlement.	0	2	0%
Non-Waiver	1.6a Primary source Verification - State Licensure or certification	0	2	0%
Non-Waiver	1.6a Primary source Verification - State Licensure or certification	0	2	0%
Non-Waiver	1.1a Application includes Education	0	2	0%
Non-Waiver	1.1a Application includes Education	0	2	0%
Non-Waiver	1.10 Credentialing approved by qualified credentialed practitioner and/or credentialing committee. (date of approval)	0	2	0%
Non-Waiver	1.10 Credentialing approved by qualified credentialed practitioner and/or credentialing committee. (date of approval)	0	2	0%
Non-Waiver	1.6g.i NPDB/HIDBP query or in lieu of query all of the following must be verified: Minimum 5-year history of professional liability claims resulting in judgement or settlement.	1	2	50%
Non-Waiver	1.6d Primary Source Verification of most recent Criminal Background Check (indicate type/date) (ICHAT)	1	2	50%
Non-Waiver	1.6c Primary Source Verification - Documentation of graduation from an accredited school.	1	2	50%
Non-Waiver	1.6b Primary source Verification - Board certification, or highest level of credentials attained, if applicable, or completion of any required internships/residency programs or other postgraduate training.	1	2	50%

Waiver. LRE concluded that Ottawa's credentialing and recredentialing efforts improved over FY22. Specifically, LRE found improvements in IPOS trainings. One external HSW provider has

the opportunity to improve credentialing processes by documenting hire dates and completing staff training within the required timeframe.

IV. Clinical Audit Results

LRE reviewed clinical charts for all populations listed in the table below.

Population	Sum of Question Score	Sum of Possible Score	%
IDD ADULT	266	268	99%
MI CHILD	541	552	98%
HSW	482	500	96%
CWP	448	468	96%
SEDW	411	432	95%
MI ADULT	1139	1238	92%
Autism	669	748	89%
IDD CHILD	194	222	87%
Grand Total	4150	4428	94%

Ottawa excelled in its IDD Adult and MI Child charts scoring 99% and 98%, respectively. Ottawa also scored 95% or higher on the HSW, CWP, and SEDW charts.

Ottawa fell below the 95% compliance rate for the MI Adult, Autism, and IDD Child populations. LRE provides the score for each question that did not meet 100% compliance on pages 6 – 8 of this report.

Ottawa's overall clinical audit improved to 94%, which is an almost 9% over FY22 results driven by SEDW, improving 32%, and CWP, improving 6%, charts.

	% of Indicators Met		
Population/Audit Type	FY22	FY23	Change
SEDW Charts	63%	95%	32%
CWP Charts	90%	96%	6%
HSW Charts	94%	96%	2%
Non-Waiver/Non-Autism Clinical Charts	95%	94%	-1%
Autism Charts	90%	89%	-1%

For FY23, MI Adult and IDD Child drove the decline of 1%, 95% to 94%, in Non-Waiver Clinical chart results over FY22 and Autism chart results were down from 90% to 89% over FY22.

Autism. LRE determined that Ottawa demonstrated improvements in biopsychosocial assessments and other assessments overall. LRE found Ottawa's documentation appropriate in most cases. LRE also applauds Ottawa in achieving a 100% compliance rate for Autism testing documentation and ensuring supervision by BCBAs when necessary. LRE also notes that Ottawa

demonstrated a significant improvement in providing consumers/guardians copies of IPOSs within 15 days following the completing the person-centered planning process.

Ottawa has the opportunity to improve clinical charts by improving all aspects of SMART goal writing, enhancing documentation of progress towards goals, increasing the opportunity for consumers to have more input into the PCP process, including risk factors in IPOSs, and ensuring pre-plans are included in all charts.

LRE also notes that Ottawa delivery of ABA services in the amount authorized was not compliant in any charts reviewed. LRE acknowledges that this is a systemic issue and that LRE has created an Autism Workgroup to identify barriers related to improving the delivery of ABA services in the amount authorized.

NON-WAIVER. LRE determined that Ottawa excelled in coordinating care between and among service providers and engaging families/caregivers for children served. LRE also appreciates Ottawa's ongoing leveraging of technology to improve clinical charts; specifically, Ottawa's ability to capture digital signatures.

Ottawa has the opportunity to improve clinical charts by improving all aspects of SMART goal writing, ensuring all details are included in the biopsychosocial assessment and IPOSs, enhancing documentation of progress towards goals, including estimated costs of services in the chart, documenting whether a consumer did or did not achieve goals/objectives, including target dates for all objectives and goals, ensuring previous year's goals and objectives are not "carried over" into new year, including medication consents in the chart, and ensuring pre-plans are included in all charts. Ottawa also has the opportunity to improve timeliness for periodic IPOS reviews.

Waiver. LRE determined that Ottawa's charts were complete, comprehensive, and organized in most aspects of the review.

Ottawa has the opportunity to improve clinical charts by improving all aspects of SMART goal writing and ensuring goals and objectives are written in the consumer's/guardian's words instead of "Client will do …" or "Clients want to…"

A. MI Adult – 92%

Audit Question	Sum of Question Score	Sum of Possible Score	%
1.10 Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool?	13	16	81%
1.2 Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	14	16	88%
1.6 Substance use (current and history) included in assessment?	21	22	95%
1.8 Current healthcare providers are identified? Name and Address must be identified for each healthcare provider	21	22	95%
1.9 Previous behavioral health treatment and response to treatment identified?	21	22	95%
2.2 Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan? If done on same day, documentation reflects reasoning and/or client's request	15	22	68%
2.3 Pre-planning addressed when and where the meeting will be held.	18	22	82%
2.4 Pre-planning addressed who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).	18	22	82%
2.5 Consumers hopes, dreams, and desires are documented. (Strengths and concerns)	20	22	91%
2.6 Pre-planning identified any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and plan for how to address them.	10	12	83%
2.7 The consumer was offered a choice of external facilitator.	18	22	82%
2.8 Pre-planning addressed what accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).	0	2	0%
2.9 Pre-planning addressed who will facilitate the meeting.	18	22	82%
3.16 The estimated/prospective cost of IPOS services and supports authorized by the CMHSP must be available.	20	22	91%
3.17 The IPOS is signed by the person and/or representative, case manager or supports coordinator, and the support broker/agent (if one is involved).	18	22	82%
3.2 The timeframe between the initial Psycho-social assessment and the IPOS was in acceptable limits (for new intakes only).	2	4	50%
3.21 If applicable, identified history of trauma is addressed as part of PCP.	9	10	90%
3.23 Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	16	20	80%
3.9a The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured. The IPOS focuses not just on activities, but also results. Goals/objectives are: Specific	21	22	95%
3.9b Measurable	14	22	64%
3.9e Time-Bound	10	22	45%
3.9f Strength-based (not compliance based)	19	22	86%
6.1b Amount	20	22	91%
6.2 Service documentation references goals and objectives (progress notes, data sheets, logs)	20	22	91%
6.3 Progress toward goal/objective is included in service documentation (progress notes, data sheets, logs)	20	22	91%
6.4 Are periodic reviews occurring according to time frames established in plan?	19	22	86%
6.5 Periodic reviews provide a summary of progress toward goals and objectives?	17	22	77%
7.3 Release of Information for Primary Care Physician and relevant healthcare providers listed in the assessment are obtained. Releases must contain an individual's name and Address. Names of clinics/practices are not acceptable.	19	22	86%
7.5 If not, is there evidence of a referral to a Primary Care Physician? If consumer declined referral, there is documentation.	2	4	50%
7.6a For medication services: a. Informed consent was obtained for all psychotropic medications.	16	20	80%
9.1 The CMHSP encourages all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services.	20	22	91%

B. Autism – 89%

Audit Question	Sum of Question Score	Sum of Possible Score	%
1.1 The IPOS must address risk factors identified for the child and family, specify how the risk factor may be minimized and describe the backup plan for each identified risk. For example, a risk factor might be how to ensure consistent staff in the event a staff did not show up. The backup plan is that the agency has a staff who is already trained in the child's IPOS and that staff person can be sent in the event a staff does not show up to provide a service.	8	10	80%
1.10 Beneficiaries average range of ABA therapy hours were within the suggested range for the intensity of service plus or minus a variance of 25%. Time period is the annual review period	0	10	0%
2.2 Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan? If done on same day, documentation reflects reasoning and/or client's request	16	20	80%
2.3 Pre-planning addressed when and where the meeting will be held.	16	20	80%
2.4 Pre-planning addressed who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).	16	20	80%
2.5 Consumers hopes, dreams, and desires are documented. (Strengths and concerns)	16	20	80%
2.6 Pre-planning identified any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and plan for how to address them.	16	20	80%
2.7 The consumer was offered a choice of external facilitator.	16	20	80%
2.8 Pre-planning addressed what accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).	16	20	80%
2.9 Pre-planning addressed who will facilitate the meeting.	16	20	80%
3.7 The IPOS includes A description of the individual's strengths, abilities, plans, hopes, interests, preferences, and natural supports.	8	10	80%
3.9a The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured. The IPOS focuses not just on activities, but also results. Goals/objectives are: Specific	5	10	50%
3.9b Measurable	7	10	70%
3.9c Attainable	7	10	70%
3.9d Reasonable	8	10	80%
3.9e Time-Bound	8	10	80%
6.1b Amount	5	10	50%
6.2 Service documentation references goals and objectives (progress notes, data sheets, logs)	9	10	90%
6.3 Progress toward goal/objective is included in service documentation (progress notes, data sheets, logs)	6	10	60%
6.4 Are periodic reviews occurring according to time frames established in plan?	6	10	60%
6.5 Periodic reviews provide a summary of progress toward goals and objectives?	6	10	60%

C. IDD Child – 87%

Audit Question	Sum of Question Score	Sum of Possible Score	%
1.2 Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	3	4	75%
2.2 Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan? If done on same day, documentation reflects reasoning and/or client's request	2	4	50%
2.3 Pre-planning addressed when and where the meeting will be held.	2	4	50%
2.4 Pre-planning addressed who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).	2	4	50%
2.5 Consumers hopes, dreams, and desires are documented. (Strengths and concerns)	2	4	50%
2.6 Pre-planning identified any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and plan for how to address them.	0	2	0%
2.7 The consumer was offered a choice of external facilitator.	2	4	50%
2.8 Pre-planning addressed what accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).	0	2	0%
2.9 Pre-planning addressed who will facilitate the meeting.	2	4	50%
3.22 For children's services: The plan is family-driven, and youth guided.	2	4	50%
3.3 Current IPOS was completed within 365 days of previous IPOS.	1	2	50%
3.6 The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	3	4	75%
3.7 The IPOS includes A description of the individual's strengths, abilities, plans, hopes, interests, preferences, and natural supports.	3	4	75%
3.9a The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured. The IPOS focuses not just on activities, but also results. Goals/objectives are: Specific	3	4	75%
3.9b Measurable	3	4	75%
3.9e Time-Bound	3	4	75%
6.4 Are periodic reviews occurring according to time frames established in plan?	3	4	75%
6.5 Periodic reviews provide a summary of progress toward goals and objectives?	2	4	50%

LAKESHORE REGIONAL ENTITY

LRE FY23 CMHSP Site Review Results – Final Results

West Michigan CMH

Date of Site Review: April 18-21, 2023

Draft Report: May 5, 2023

Final Report: May 11, 2023

I. Desk Audit Results

Lakeshore Regional Entity ("LRE") audited West Michigan CMH's ("West Michigan") remediation for those Desk Audit Standards that fell below 95% during LRE's FY22 Site Review or those required by regulation or contract. In FY22, West Michigan scored above 95% for all Desk Audit Standards. Therefore, LRE only audited West Michigan under the Health Information System Desk Audit Standard, which is required by regulation or contract. LRE determined that West Michigan was 100% compliant with the Health Information Systems Standard, which is unprecedented. LRE appreciates West Michigan for its efforts and notes that West Michigan should be proud of this accomplishment.

Desk Audit and Section	Sum of Question Score	Sum of Possible Score	Percent Compliant
2023 Standard XII Health Information Systems	150	150	100%

II. Program Specific Audit Results

LRE audited West Michigan's remediation for those Program Specific Standards that fell below 95% during LRE's FY22 Site Review, except for the Self-Directed Services, which was not scored in FY22. LRE validated West Michigan's remediation efforts of the Fiscal Management Services and Trauma Informed Care Standards. LRE elected to review the Self-Direction Standard in FY23. LRE determined that West Michigan is fully compliant in the Self-Direction Standard. LRE commends West Michigan remediation efforts for these Program Specific Standards.

Desk Audit and Section	Sum of Question Score	Sum of Possible Score	Percent Compliant
CMHSP Program Specific - Fiscal Management Services (FMS) Monitoring)	12	12	100%
CMHSP Program Specific - Self-Direction	12	12	100%

CMHSP Program Specific - Trauma Informed Care	2	2	100%

III. Credentialing & Training Audit Results

LRE audited West Michigan's credentialing and re-credentialing processes for internal and external providers. Overall, West Michigan scored 91.3% for the Credentialing and Training audits. LRE determined that West Michigan scored above 95% for the Children's Waiver Program ("CWP") and Severe Emotional Disturbance Waiver ("SEDW") audits for professional staff. LRE commends West Michigan for its remediation efforts for CWP, which increased 26% over FY22, and SEDW, which improved 13% over FY22.

LRE found that West Michigan scored below 95% for all other credentialing and training audits. LRE determined that West Michigan scored an average of 12% lower for the non-waiver/non-autism training and credentialing audits and 6% lower for autism credentialing and training than FY22 which are areas for improvement both externally and internally.

Desk Audit and Section	Sum of Question Score	Sum of Possible Score	Percent Compliant
2023 Autism Staff Training-Credentialing Tool	219	238	92%
2023 CMH Credentialing Personnel File	88	104	85%
2023 CMHSP Staff Training Tool	131	148	86%
2023 CWP Professional Qualifications	31	32	97%
2023 HSW Aide Level Credentialing and Training	477	516	92%
2023 HSW Professional Qualifications Review	56	62	90%
2023 SEDW Professional Qualification	46	48	96%

Desk Audit and Section	FY22	FY23	Change
Autism Training/HR	98%	92%	-6%
CWP Training/HR	71%	97%	26%
HSW Training/HR	89%	92%	3%
SEDW Training/HR	83%	96%	13%
Non-Waiver/Non-Autism Training	97%	86%	-11%
Non-Waiver/Non-Autism Credentialing	98%	85%	-13%

Non-Waiver/Non-Autism. LRE found that West Michigan's internal credentialing process showed an improvement in performance appraisals and required training for internal staff. While this improvement showed positive change, there were remarkable decreases in the overall year-to-year percentages. LRE determined that the decline can be attributed to missing trainings, lack of sanction checks, incomplete applications – including lack of education on applications, and lack of primary source verification of credentialing documents.

Waiver/Autism LRE concluded that West Michigan's credentialing and recredentialing efforts improved over fiscal year 2022, except for Autism. For Waiver, LRE found improvements in

background checks prior to the date of hire. For Autism, LRE determined that the decline can be attributed to missing trainings and lack of appropriate first-aid certifications.

Below are the missed questions on credentialing/training audits during the West Michigan Site Review:

AuditSection	AuditQuestion	QuestionRes
Autism	2.1 Appeals and Grievances	Not Met
Autism	2.2 Corporate Compliance	Not Met
Autism	2.3 Cultural Competency	Not Met
Autism	2.4 First Aid Certification	Partially Met
Autism	2.5 Health Insurance Portability and Accountability Act (HIPAA)	Not Met
Autism	2.6 Limited English Proficiency (LEP)	Not Met
Autism	2.7 Person-Centered Planning and Self-Determination	Partially Met
Autism	2.8 Recipient Rights	Not Met
Autism	2.9 Standard Precautions (Blood Borne Pathogens/Infection Control)	Not Met
CWP	1.2 Qualified Intellectual Disability Professional (Transcript needed if not Licensed)	Partially Met
HSW	1.1 Qualified Intellectual Disability Professional (Transcript needed if not Licensed)	Partially Met
HSW	1.3 Criminal background check is completed prior to hire.	Not Met
HSW	1.3 Criminal background prior to hire	Not Met
HSW	2.10 Medication Series including • Medication Administration and Monitoring (online) • Health and Wellness (online) • Medication & Health Skills Demonstration (classroom) • Medications: Types, Uses & Effects (online) HSW - Specialized Residential Only	Partially Met
HSW	2.11 Nutrition and Food Safety HSW - Specialized Residential Only	Partially Met
HSW	2.12 Person-Centered Planning and Self-Determination	Partially Met
HSW	2.15 Trauma informed Care	Partially Met
HSW	2.16 CPR and First Aid Certification HSW – Specialized Residential Only	Not Met
HSW	2.17 Beneficiary Specific IPOS Training • Date of the IPOS training: • Staff was trained by the appropriate professional. • The IPOS training document must include the following: a. The name and credentials of the individual who conducted the training. b. The date the IPOS training occurred. c. The name of the client. d. The date of the IPOS. e. The subject matter of the training. f. The name of the staff receiving the training. Required for Choice Voucher/Self Determination	Partially Met
HSW	2.4 Emergency Preparedness HSW – Specialized Residential Only	Partially Met
HSW	2.7 Introduction to Human Services HSW – Specialized Residential Only	Partially Met
Non-Waiver/Non-Autism	1.1 Appeals and Grievances • Not required for Fiscal Intermediary • Not required for Administrative Staff	Partially Met
Non-Waiver/Non-Autism	1.10 Credentialing approved by qualified credentialed practitioner and/or credentialing committee. (date of approval)	Not Met
Non-Waiver/Non-Autism	1.1a Application includes Education	Not Met
Non-Waiver/Non-Autism	1.2 Corporate Compliance	Partially Met
Non-Waiver/Non-Autism	1.2 Required Attestations: Lack of present illegal drug use	Not Met
Non-Waiver/Non-Autism	1.3 Cultural Competency (Not required for Fiscal Intermediary)	Partially Met
Non-Waiver/Non-Autism	1.4 Standard Precautions (Blood Borne Pathogens/Infection Control) Not required for: • Fiscal Intermediary • Administrative staff	Partially Met
Non-Waiver/Non-Autism	1.5 Health Insurance Portability and Accountability Act (HIPAA)	Partially Met
Non-Waiver/Non-Autism	1.6 Limited English Proficiency (LEP)	Partially Met
Non-Waiver/Non-Autism	1.6g.i NPDB/HIDBP query or in lieu of query all of the following must be verified: Minimum 5-year history of professional liability claims resulting in judgement or settlement.	Partially Met
Non-Waiver/Non-Autism	1.6h Primary Source Verification - If the individual practitioner undergoing credentialing is a physician, the physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements for licensure, board certification, and graduation from an accredited school.	Not Met
Non-Waiver/Non-Autism	1.6i Initial Sanction Checks- Office of Inspector General (OIG), System for Award Management (SAM), and Michigan Sanctioned Provider List. (service used/frequency)	Partially Met
Non-Waiver/Non-Autism	1.6j Evidence of monthly Sanction Checks completed. If service is used, which service? (service used/frequency)	Not Met
Non-Waiver/Non-Autism	1.6l Education/Internship/Residency (Physicians, NP, PA, etc.)	Not Met
Non-Waiver/Non-Autism	1.7 Recipient Rights	Partially Met
Non-Waiver/Non-Autism	2.1 Complete Application (Signed, dated, appropriate attestations)	Not Met
Non-Waiver/Non-Autism	2.1 Person-Centered Planning and Self-Determination (all Clinical Staff)	Not Met
SEDW	2.1 Criminal background prior to hire	Not Met

IV. Clinical Audit Results

LRE reviewed clinical charts for all populations listed in the table below. Overall, West Michigan scored 96.3% for the Clinical audits. LRE determined that West Michigan scored above 95% on all Clinical audit types, except for CWP and SEDW, which scored 92% and 89%, respectively.

Audit Type	Sum of Question Score	Sum of Possible Score	Percent Compliant
2023 CMH Clinical Chart Review Autism	402	412	98%
2023 CMH Clinical Chart Review CWP	147	160	92%
2023 CMH Clinical Chart Review HAB	842	882	95%
2023 CMH Clinical Chart Review IDD Adult	918	956	96%
2023 CMH Clinical Chart Review IDD Child	124	128	97%
2023 CMH Clinical Chart Review MI Adult	792	806	98%
2023 CMH Clinical Chart Review MI Child	439	446	98%
2023 CMH Clinical Chart Review SEDW	227	256	89%
2023 HSW Clinical Chart Review	129	130	99%

LRE determined that West Michigan's clinical charts improved or remained similar from the previous fiscal year. Most notable changes that drove compliance were waiver charts. LRE applauds West Michigan's efforts to improve quality of care.

Population/Audit Type	FY22	FY23	Percent Change
Non-Waiver/Non-Autism Charts	97%	97%	0%
Autism Charts	88%	98%	10%
SEDW Charts	90%	89%	-1%
CWP Charts	81%	92%	11%
HSW Charts	79%	96%	17%

Autism. LRE determined that West Michigan demonstrated improvements in biopsychosocial assessments and other assessments overall. LRE found West Michigan's assessments to be comprehensive. LRE acknowledges West Michigan's efforts in providing BCBA supervision at the standard of 10%. It should also be noted that LRE commends West Michigan for incorporating parent and caregiver goals into ABA plans.

West Michigan has the opportunity to improve clinical charts by ensuring that discharge from services is incorporated into the arch of treatment.

Waiver. LRE determined that West Michigan's charts were complete, comprehensive, and organized in most aspects of the review. Every chart that was reviewed showed very good coordination of care with the client's PCP and it was obvious that West Michigan staff work on keeping the PCP up to date on the progress of the client.

West Michigan has a few opportunities to improve clinical charts in several areas. First by ensuring that all progress notes track back to a goal or objective and show progress towards these goals. Also, by ensuring that SMART goal principles are written into every IPOS objective. The final area for improvement is to make sure that all evaluations for specialty services are not only happening, but happening in a timely manner once the family is authorized for that service.

Non-Waiver/Non-Autism. LRE reviewed charts across the service array at West Michigan and determined that consumers transitioned well throughout treatment. LRE determined that West Michigan clinicians assist individuals into less restrictive treatment settings. LRE noted that multiple charts demonstrated SMART goals and well documented outreach and care coordination.

West Michigan can improve by ensuring that IPOSs are completed within 364 days of the previous plan's completion, as well as ensuring that the plan is written in "person first" language.

A. CWP - 92%

Audit Question	Question Result
7.1b The prescription has a beginning and end date.	Partially Met
3.9b Measurable	Partially Met
3.9e Time-Bound	Partially Met
6.2 Service documentation references goals and objectives (progress notes, data sheets, logs)	Partially Met
6.3 Progress toward goal/objective is included in service documentation (progress notes, data sheets, logs)	Partially Met
13.3 Service documentation supports how the CLS intervention was completed (assisting, prompting, reminding, cueing, observing, guiding, and/or training).	Not Met
19.1 An evaluation for each therapy is completed by the appropriate professional and present in the record.	Not Met
3.25 There is documentation that direct care staff were in-serviced on the IPOS.	Not Met
3.3 Current IPOS was completed within 365 days of previous IPOS.	Not Met

B. SEDW - 89%

Audit Question	Question Result
5.3 Reasons for decisions are clearly documented and available to the recipient.	Partially Met

3.17 The IPOS is signed by the person and/or representative, case manager or supports coordinator, and the support broker/agent (if one is involved).	Partially Met
4.1 Consumer was provided written information related to Recipient Rights?	Partially Met
4.3 Consumer was given accurate information about the Grievance and Appeal Process?	Partially Met
6.1b Amount	Partially Met
1.2 Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	Not Met
2.2 Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan? • If done on same day, documentation reflects reasoning and/or client's request	Not Met
2.3 Pre-planning addressed when and where the meeting will be held.	Not Met
2.4 Pre-planning addressed who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).	Not Met
2.5 Consumers hopes, dreams, and desires are documented. (Strengths and concerns)	Not Met
2.6 Pre-planning identified any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and plan for how to address them.	Not Met
2.7 The consumer was offered a choice of external facilitator.	Not Met
2.8 Pre-planning addressed what accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).	Not Met
2.9 Pre-planning addressed who will facilitate the meeting.	Not Met
3.6 The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	Not Met
3.9b Measurable	Not Met
3.9e Time-Bound	Not Met

LAKESHORE REGIONAL ENTITY

LRE FY23 CMHSP Site Review Results – Final Report

network180

Date of Site Review: May 22-25, 2023

Draft Report: June 8, 2023

Final Report: July 17, 2023

I. Desk Audit Results

Lakeshore Regional Entity ("LRE") audited N180's remediation for those Desk Audit Standards that fell below 95% during LRE's FY22 Site Review or those required by regulation or contract. LRE audited Desk Audit Standard III Availability of Services and Standard XXI Disclosure of Ownership Control & Criminal Conviction, which network180 (n180) scored below 95% in FY22. Further, LRE audited Health Information Systems Desk Audit Standard, which is required by regulation or contract. LRE determined that n180 was 100% compliant in all areas of the desk audit, except for Health Information Systems, which scored 99.3%. LRE applauds n180 for the areas of improvement of this past year.

Desk Audit and Section	Sum of Question Score	Sum of Possible Score	Percent Compliant
2023 Standard III Availability of Services	8	8	100.0%
2023 Section XXI Disclosure of Ownership Control & Criminal Conviction	4	4	100.0%
2023 Standard XII Health Information Systems	149	150	99.3%

LRE analyzed n180's Desk Audit performance at the Audit Question level to identify specific areas of improvement year over year as well as opportunities for continued improvement. Overall, n180 improved its compliance rate from 0% in FY22 to 100% in FY23 for six of the Audit Questions, which are represented in green highlight below. n180 received a ***repeat citation*** for Standard XII Health Information Systems|Question 12.58 due to its non-compliance with BH-TEDS reporting.

n180 CMHSP SITE REVIEWS: DESK AUDIT RESULTS BY AUDIT QUESTION FY22 vs. FY23:

Audit Type	Audit Section	Audit Question	FY22	FY23
2023 Standard III Availability of Services	III. Access System Standards	3.27 Access staff follow up with individuals who made contact within two (2) business days to ensure service needs have been met or to re-engage if referral connections have not been met.	0%	100%
2023 Standard III Availability of Services	III. Access System Standards	3.22 Individuals with routine needs are screened or other arrangements made within 30 minutes.	0%	100%
2023 Standard III Availability of Services	III. Access System Standards	3.21 All non-emergent callbacks occur within one business day of initial contact.	0%	100%
2023 Standard III Availability of Services	III. Access System Standards	3.20 For non-emergent calls, a person's time on-hold awaiting a screening does not exceed 3 minutes without being offered an option for callback or talking with a non-professional in the interim.	0%	100%
2023 Section XXI Disclosure of Ownership Control & Criminal Conviction	XXI. Disclosure of Ownership, Control, & Criminal Conviction	21.4a Reporting Criminal Convictions: The CMHSP has a policy and process to identify and notify the PIHP (who notifies MDHHS BHDDA Division of Program Development, Consolation and Contracts) when any disclosures are made by providers with regard to: Any staff member, director, or manager of the CMHSP, individual with beneficial ownership of five percent or more, or an individual with an employment, consulting or other arrangement with CMHSP has been convicted of a criminal offense described under sections 1128(a) and 1128(b)(1)(2), or (3) of the social security Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act.	0%	100%
2023 Section XXI Disclosure of Ownership Control & Criminal Conviction	XXI. Disclosure of Ownership, Control, & Criminal Conviction	21.4 Reporting Criminal Convictions: The CMHSP has a policy and process to identify and notify the PIHP (who notifies MDHHS BHDDA Division of Program Development, Consolation and Contracts) when any disclosures are made by providers with regard to: The ownership or control by a person that has been convicted of a criminal offense described under sections 1128(a) and 1128(b)(1)(2), or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act.	0%	100%
2023 Standard XII Health Information Systems	XII. Contractual Obligations	12.58 The CMHSP submits BH-TEDS files and QI files to LRE monthly in accordance with the CMHSP's responsibilities outlined in the LRE/CMHSP delegation grid.	50%	50%

II. Program Specific Audit Results

LRE audited n180's remediation for those Program Specific Standards that fell below 95% during LRE's FY22 Site Review. LRE validated n180's remediation efforts of the Children's Intensive Crisis Stabilization Services. LRE determined that n180 is fully compliant in this service area. LRE commends n180 for remediation efforts for this Program Specific Standard.

Program Specific Audit Section	Sum of Question Score	Sum of Possible Score	Percent Compliant
CMHSP Program Specific - Children's Intensive Crisis Stabilization Services	2	2	100.0%

III. Credentialing & Training Audit Results

LRE audited n180's credentialing and re-credentialing processes for internal and external providers. Overall, n180 scored 96.9% for the Credentialing and Training audits, which is an increase of 3.2% over FY22. LRE determined that n180 scored above 95% for all audit types, apart from CMH Credentialing Personnel File and the CMH Staff Training Tool, which scored 94.5%, and 94.8%, respectively, in FY23.

Audit Type
2023 Autism Staff Training-Credentialing Tool
2023 CMH Credentialing Personnel File
2023 CMHSP Staff Training Tool
2023 CWP Aide Level Credentialing and Training
2023 CWP Professional Qualifications
2023 HSW Aide Level Credentialing and Training
2023 HSW Professional Qualifications Review
2023 SEDW Professional Qualification

LRE commends n180 for its credentialing and training remediation efforts for the Waiver programs throughout FY22. n180's remediation efforts resulted in significant improvements in Waiver Credentialing and Training compliance rates for CWP Aide (+7.1%), CWP Professional (+6.1%), and HSW Aide (+4.8%) Audits.

LRE found that n180 performed lower in CMHSP Staff Training by -4%.

Audit Type	FY22 % Compliant	FY23 % Compliant	Year over Year Change
2023 Autism Staff Training-Credentialing Tool	96.3%	97.2%	0.9%
2023 CMH Credentialing Personnel File	94.0%	94.5%	0.5%
2023 CMHSP Staff Training Tool	98.8%	94.8%	-4.0%
2023 CWP Aide Level Credentialing and Training	93%	100.0%	7.1%
2023 CWP Professional Qualifications	93.9%	100.0%	6.1%
2023 HSW Aide Level Credentialing and Training	92.8%	97.6%	4.8%

2023 HSW Professional Qualifications Review	94.2%	96.6%	2.4%
2023 SEDW Professional Qualification	100%	100.0%	0.0%

Non-Waiver/Non-Autism. LRE found that n180's internal credentialing and training processes to be like years in the past, which is excellent. LRE determined that while n180 internally performed well, missing external training (see the below chart) attributed to the 4% decline in CMHSP Staff Training.

Waiver/Autism. LRE concluded that n180's credentialing and recredentialing efforts improved over fiscal year 2022. Specifically, Waiver Credentialing and Training compliance rates improved significantly for CWP Aide (+7.1%), CWP Professional (+6.1%), and HSW Aide (+4.8%) Audits, which can be attributed to overall improvements in IPOS trainings.

Audit Type	Audit Question	Question Result
2023 Autism Staff Training-Credentialing Tool	3.5 Beneficiary Specific IPOS Training • Date of the IPOS training: • Staff was trained by the appropriate professional. • The IPOS training document must include the following: a. The name and credentials of the individual who conducted the training. b. The date the IPOS training occurred. c. The name of the client. d. The date of the IPOS. e. The subject matter of the training. f. The name of the staff receiving the training. Only required for Behavior Technicians	Partially Met
2023 Autism Staff Training-Credentialing Tool	2.4 First Aid Certification	Partially Met
2023 CMHSP Staff Training Tool	5.1 Behavioral Treatment/Crisis Intervention (MANDT series)	Partially Met
2023 CMHSP Staff Training Tool	1.5 Health Insurance Portability and Accountability Act (HIPAA)	Partially Met
2023 Autism Staff Training-Credentialing Tool	3.2 Working under the supervision of an ABA supervisor (BCBA, BCaBA, QBHP)	Partially Met
2023 Autism Staff Training-Credentialing Tool	1.1 Appeals and Grievances • Not required for Fiscal Intermediary • Not required for Administrative Staff	Partially Met
2023 Autism Staff Training-Credentialing Tool	1.2 Criminal background check is completed prior to hire.	Partially Met
2023 Autism Staff Training-Credentialing Tool	6.2 Working under the supervision of a licensed BCBA.	Not Met

2023 CMHSP Staff Training Tool	1.4 Standard Precautions (Blood Borne Pathogens/Infection Control) Not required for: • Fiscal Intermediary • Administrative staff	Not Met
2023 Autism Staff Training-Credentialing Tool	5.4 Health & Wellness	Not Met
2023 Autism Staff Training-Credentialing Tool	5.7 Nutrition & Food Safety	Not Met
2023 Autism Staff Training-Credentialing Tool	5.1 Minimum one-year experience in diagnosing / treating children with ASD based on the principles of ABA	Not Met
2023 Autism Staff Training-Credentialing Tool	5.3 Documented course work at graduate level from an accredited university in at least 3 of the following 6 areas: • Ethical Considerations • Definitions & characteristics & principles, process, concepts of behavior • Behavior assessment & selecting interventions, outcomes, and strategies • Experimental evaluation of interventions • Measurement of behavior & developing & interpreting behavior data • Behavioral change procedures and system supports	Not Met
2023 Autism Staff Training-Credentialing Tool	5.4 Scheduled to become a BCBA by 9/30/2025 and is certified and licensed as a BCBA within two years of completing ABA coursework if QBHP.	Not Met
2023 Autism Staff Training-Credentialing Tool	3.1 Able to communicate expressively and receptively	Not Met
2023 Autism Staff Training-Credentialing Tool	3.3 BACB approved training outlined in the RBT Task List	Not Met
2023 Autism Staff Training-Credentialing Tool	3.4 Proof individual is age 18 or older.	Not Met
2023 Autism Staff Training-Credentialing Tool	1.3 Last criminal background check was completed within the last two years.	Not Met
2023 Autism Staff Training-Credentialing Tool	2.1 Appeals and Grievances	Not Met
2023 CMHSP Staff Training Tool	2.2 Corporate Compliance	Not Met
2023 CMHSP Staff Training Tool	2.3 Cultural Competency	Not Met
2023 CMHSP Staff Training Tool	2.5 Health Insurance Portability and Accountability Act (HIPAA)	Not Met
2023 CMHSP Staff Training Tool	2.6 Limited English Proficiency (LEP)	Not Met
2023 Autism Staff Training-Credentialing Tool	2.7 Person-Centered Planning and Self-Determination	Not Met
2023 Autism Staff Training-Credentialing Tool	2.8 Recipient Rights	Not Met

2023 Autism Staff Training-Credentialing Tool	2.9 Standard Precautions (Blood Borne Pathogens/Infection Control)	Not Met
2023 Autism Staff Training-Credentialing Tool	2.1 Person-Centered Planning and Self-Determination (all Clinical Staff)	Not Met
2023 Autism Staff Training-Credentialing Tool	2.2 Trauma informed Care (all clinical staff)	Not Met
2023 Autism Staff Training-Credentialing Tool	1.2 Corporate Compliance	Not Met
2023 Autism Staff Training-Credentialing Tool	1.3 Cultural Competency (Not required for Fiscal Intermediary)	Not Met
2023 Autism Staff Training-Credentialing Tool	1.6 Limited English Proficiency (LEP)	Not Met
2023 Autism Staff Training-Credentialing Tool	1.7 Recipient Rights	Not Met
2023 Autism Staff Training-Credentialing Tool	6.1 Knowledge of First Aid training	Not Met
2023 Autism Staff Training-Credentialing Tool	6.1 Current Certification through the BACB	Not Met
2023 Autism Staff Training-Credentialing Tool	4.0 Current License	Not Met
2023 Autism Staff Training-Credentialing Tool	8.1 Minimum one-year experience in diagnosing / treating children with ASD based on the principles of ABA.	Not Met
2023 Autism Staff Training-Credentialing Tool	8.2 Must be one of the following professions: • a physician with a specialty in psychiatry or neurology. • a physician with a subspecialty in developmental pediatrics, developmental-behavioral pediatrics • or a related discipline; a physician with a specialty in pediatrics or other appropriate specialty with training, experience or expertise in ASD and/or behavioral health; • a psychologist; • an advanced practice registered nurse with training, experience, or expertise in ASD and/or behavioral health; • a physician assistant with training, experience, or expertise in ASD and/or behavioral health; • a clinical social worker, working within their scope of practice, and is qualified and experienced in diagnosing ASD.	Not Met

IV. Clinical Audit Results

LRE reviewed clinical charts for all non-SUD populations. Overall, n180 scored 95.7% for the Clinical audits, which is a 0.3% decrease over FY22. LRE determined that n180 scored above 95% on all Clinical audit types, except for CWP and SEDW, which scored 94.7%, 94.5%, and 91.8%, respectively.

Audit Type	Sum of Question Score	Sum of Possible Score	Percent Compliant
2023 CMH Clinical Chart Review Autism	1663	1720	96.9%
2023 CMH Clinical Chart Review CWP	445	470	94.7%
2023 CMH Clinical Chart Review HAB	648	676	95.9%
2023 CMH Clinical Chart Review IDD Adult	510	536	95.1%
2023 CMH Clinical Chart Review IDD Child	206	212	97.2%
2023 CMH Clinical Chart Review MI Adult	447	466	95.9%
2023 CMH Clinical Chart Review MI Child	395	410	96.3%
2023 CMH Clinical Chart Review SEDW	391	426	91.8%

LRE determined that n180's clinical charts remained similar from the previous fiscal year, except for Autism clinical charts, which improved by 4.8% over FY22 and Non-Waiver IDD Adult charts and Non-Waiver MI Child charts, which decreased by 3.4% and 2.8%, respectively, over FY22.

Audit Type	FY22 % Compliant	FY23 % Compliant	Year over Year Change
2023 CMH Clinical Chart Review Autism	92.1%	96.9%	4.8%
2023 CMH Clinical Chart Review CWP	95.8%	94.7%	-1.1%
2023 CMH Clinical Chart Review HAB	95.9%	95.9%	No Change
2023 CMH Clinical Chart Review IDD Adult	98.5%	95.1%	-3.4%
2023 CMH Clinical Chart Review IDD Child	97.9%	97.2%	-0.7%
2023 CMH Clinical Chart Review MI Adult	97.3%	95.9%	-1.4%
2023 CMH Clinical Chart Review MI Child	99.1%	96.3%	-2.8%
2023 CMH Clinical Chart Review SEDW	91.4%	91.8%	0.4%

Autism. LRE determined that n180 and providers demonstrated improvements in assessments, diagnostic evaluations and the LRE applauds n180 Autism staff/providers for well written goals.

n180 can improve Autism charts by ensuring discharge planning occurs at each stage of treatment and services are authorized at the appropriate amount for the individual served.

Waiver. LRE determined that n180's charts were complete, comprehensive, and organized in most aspects of the review.

n180 can improve clinical charts by ensuring primary care physicians are listed in person center planning documents and SMART principles are utilized when writing goals and objectives.

Non-Waiver/Non-Autism. LRE reviewed charts across the service array at n180 and determined that biopsychosocial assessments clearly explained treatment history and IPOS objectives were recovery focused. Internal and externally provided services coordinate care well, which should be applauded.

n180 can improve clinical charts by ensuring that services are delivered as authorized in the plan of service and service note narrative clearly relates to a goal or objective in the plan of service. n180 can also ensure that SMART principles of goal writing are implemented internally and externally for best quality of care.

A. IDD Adult – 95.1% showing a decline of 3.4% over FY22 Audit.

Audit Question	Question Result
1.10 Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool?	Partially Met
1.3 Are consumer's needs & wants are documented?	Partially Met
1.9 Previous behavioral health treatment and response to treatment identified?	Partially Met
19.3 Progress toward IPOS goals and objectives is present in the service documentation.	Partially Met
2.5 Consumers hopes, dreams, and desires are documented. (Strengths and concerns)	Partially Met
3.16 The estimated/prospective cost of IPOS services and supports authorized by the CMHSP must be available.	Partially Met
3.24 Consumer has ongoing opportunities to provide feedback on satisfaction with treatment, services, and progress towards valued outcomes?	Partially Met
3.9b Measurable	Partially Met
3.9e Time-Bound	Partially Met
6.1b Amount	Partially Met
6.2 Service documentation references goals and objectives (progress notes, data sheets, logs)	Partially Met
6.3 Progress toward goal/objective is included in service documentation (progress notes, data sheets, logs)	Partially Met
6.4 Are periodic reviews occurring according to time frames established in plan?	Partially Met
7.1a There is a physician prescription or referral for each specialized service (PT, OT, Speech etc.): a. The date of the prescription is on the prescription.	Partially Met
7.1b The prescription has a beginning and end date.	Partially Met

7.1c The prescription indicated which service is being prescribed.	Partially Met
7.1d The prescription has the doctor's signature	Partially Met
7.3 Release of Information for Primary Care Physician and relevant healthcare providers listed in the assessment are obtained. • Releases must contain an individual's name and Address. • Names of clinics/practices are not acceptable.	Partially Met
16.2 There is a copy of the SD Agreement	Not Met
19.1 An evaluation for each therapy is completed by the appropriate professional and present in the record.	Not Met
2.2 Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan? • If done on same day, documentation reflects reasoning and/or client's request	Not Met
3.21 If applicable, identified history of trauma is addressed as part of PCP.	Not Met
3.23 Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	Not Met
3.25 There is documentation that direct care staff were in-serviced on the IPOS.	Not Met
3.3 Current IPOS was completed within 365 days of previous IPOS.	Not Met
4.3 Consumer was given accurate information about the Grievance and Appeal Process?	Not Met
6.1a Services are being delivered consistent with plan: Scope	Not Met
7.4 There is evidence of coordination with Primary Care Physician in the record.	Not Met
9.1 The CMHSP encourages all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services.	Not Met

B. CWP – 94.6%

Audit Question	Question Result
1.10 Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool?	Not Met
1.2 Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	Not Met
1.8 Chart contains a narrative for the determination of the Category of Care/Intensity of Care and decision guide.	Partially Met
1.8 Current healthcare providers are identified? • Name and Address must be identified for each healthcare provider	Partially Met
13.3 Service documentation supports how the CLS intervention was completed (assisting, prompting, reminding, cueing, observing, guiding, and/or training).	Not Met
19.1 An evaluation for each therapy is completed by the appropriate professional and present in the record.	Not Met
3.12a The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system. The following are identified for each authorized service in the IPOS: Amount	Partially Met
3.21 If applicable, identified history of trauma is addressed as part of PCP.	Not Met
3.25 There is documentation that direct care staff were in-serviced on the IPOS.	Partially Met
3.3 Current IPOS was completed within 365 days of previous IPOS.	Not Met
3.6 The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	Partially Met
3.8 The plan addresses need/issues identified in the assessment (or clear documentation of why issue is not being addressed) and builds upon the strengths	Partially Met
3.9b Measurable	Partially Met
3.9e Time-Bound	Partially Met
3.9f Strength-based (not compliance based)	Partially Met
6.1b Amount	Partially Met
6.1c Duration	Partially Met
6.2 Service documentation references goals and objectives (progress notes, data sheets, logs)	Partially Met
6.3 Progress toward goal/objective is included in service documentation (progress notes, data sheets, logs)	Partially Met
7.1b The prescription has a beginning and end date.	Partially Met
7.1c The prescription indicated which service is being prescribed.	Partially Met
7.1d The prescription has the doctor's signature	Partially Met

C. SEDW – 91.8%

Audit Question	Question Result
1.2 Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	Not Met
1.8 Current healthcare providers are identified? • Name and Address must be identified for each healthcare provider	Not Met
2.2 Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan? • If done on same day, documentation reflects reasoning and/or client's request	Not Met
2.3 Pre-planning addressed when and where the meeting will be held.	Not Met
2.4 Pre-planning addressed who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).	Not Met
2.5 Consumers hopes, dreams, and desires are documented. (Strengths and concerns)	Not Met
2.6 Pre-planning identified any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and plan for how to address them.	Not Met
2.7 The consumer was offered a choice of external facilitator.	Not Met
2.8 Pre-planning addressed what accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).	Not Met
2.9 Pre-planning addressed who will facilitate the meeting.	Not Met
3.16 The estimated/prospective cost of IPOS services and supports authorized by the CMHSP must be available.	Not Met
3.17 The IPOS is signed by the person and/or representative, case manager or supports coordinator, and the support broker/agent (if one is involved).	Partially Met
3.2 The timeframe between the initial Psycho-social assessment and the IPOS was in acceptable limits (for new intakes only).	Partially Met
3.6 The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	Not Met
3.8 The plan addresses need/issues identified in the assessment (or clear documentation of why issue is not being addressed) and builds upon the strengths	Partially Met
3.9b Measurable	Partially Met
3.9e Time-Bound	Partially Met
3.9f Strength-based (not compliance based)	Partially Met
4.1 Consumer was provided written information related to Recipient Rights?	Partially Met
4.3 Consumer was given accurate information about the Grievance and Appeal Process?	Partially Met
5.3 Reasons for decisions are clearly documented and available to the recipient.	Partially Met

6.1b Amount	Partially Met
6.2 Service documentation references goals and objectives (progress notes, data sheets, logs)	Partially Met
6.3 Progress toward goal/objective is included in service documentation (progress notes, data sheets, logs)	Partially Met
7.3 Release of Information for Primary Care Physician and relevant healthcare providers listed in the assessment are obtained. • Releases must contain an individual's name and Address. • Names of clinics/practices are not acceptable.	Partially Met
8.2a Does the discharge/transfer documentation include: a. Statement of the reason for discharge; and Individual's status and condition at discharge	Not Met
9.1 The CMHSP encourages all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services.	Partially Met

D. MI Child – 95.1% showing a decline of 3.4% over FY22 Audit.

Audit Question	Question Result
3.12a The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system. The following are identified for each authorized service in the IPOS: Amount	Partially Met
3.12b Scope	Partially Met
3.12c Duration	Partially Met
3.16 The estimated/prospective cost of IPOS services and supports authorized by the CMHSP must be available.	Not Met
3.8 The plan addresses need/issues identified in the assessment (or clear documentation of why issue is not being addressed) and builds upon the strengths	Not Met
3.9b Measurable	Partially Met
3.9e Time-Bound	Partially Met
3.9f Strength-based (not compliance based)	Partially Met
1.8 Current healthcare providers are identified? • Name and Address must be identified for each healthcare provider	Partially Met
3.17 The IPOS is signed by the person and/or representative, case manager or supports coordinator, and the support broker/agent (if one is involved).	Partially Met
3.23 Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	Partially Met
6.1b Amount	Partially Met
2.2 Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan? • If done on same day, documentation reflects reasoning and/or client's request	Partially Met

LAKESHORE REGIONAL ENTITY

LRE Medicaid Verification FY23 Quarter 1 (October -December 2022)

Medicaid Verification was completed for FY23 Quarter 1.
The overall results were high scores for all CMHSP's with an average of 99.95% to 100%. There were no concerns noted during this audit.
There was a recoupment of Medicaid funding completed by one of the CMHSP's totaling $5,094.23.

Number of Encounters completed by Population Group		Number of Consumers completed by Population Group	
MI Adult	1013	MI Adult	151
MI Child	493	MI Child	85
I/DD Adult	925	I/DD Adult	126
I/DD Child	287	I/DD Child	46
SUD Adult	7	SUD Adult	2
Total Reviewed	2725	***Total Reviewed***	410

Number of Reviews Completed by Service Type										
Service	**Claims**	**Units**		**Service**	**Claims**	**Units**		**Service**	**Claims**	**Units**
Outpatient Services	384	384		Wrap Around	29	94		CLS (H2015)	319	5386
Psychiatric Services	182	182		Supports Coord/ Case Management	537	1090		Skill Building	31	279
Treatment Planning	125	125		Home Based	98	370		Supported Employment	31	238
Clinical Assessments	37	37		Family Training	31	31		Residential CLS	110	370
Peer Support	31	119		Autism	200	1757		Personal Care	110	366
Screening for Inpatient	16	16		Therapy: OP other	4	16		Respite	34	675
ACT	156	375		Crisis Residential Hospitalization	17	17		Med Injections	56	56

Services	Claims	Units		Services	Claims	Units		Services	Claims	Units
Nursing Services	11	15		Behavior Treat	15	15		Crisis Assessments	31	57
CCBHC	108	108		Fiscal Intermed	14	14		Clubhouse	1	21
Transport	6	6		Overnight CLS	4	76				

Providers Reviewed

Provider	Service	Provider	Service
ACORN	Autism	Harbor House Ministries	Residential
Agnus Dei AFC	Residential	Hope Network	Autism, OP, CM. Psych
American Homestead	Residential	Indian Trails	CLS
Arbor Circle	OP	Kelly's Kare	CLS, Residential
Beacon Specialized	Residential	MOKA	CLS, Residential
Bethany Christian	OP	Naile Boshnjaku	Residential
BHT Gusco	FI	Norma Jeans AFC	Residential
Brightside Living	Residential	North Kent Guidance Services	OP
Centria	Autism	Pine Rest	OP, CM,Psych
Cherry Health	OP, CM,SUD	Pioneer	CLS, Residential
Chrysalis Services	CLS	Positive Behavioral Supports	Autism
Community Alliance	CLS	Preferred Employment/Community	CLS, SE
Community Living Services	Case Management	Real Life Living Services	CLS
Cornerstone AFC	Residential	Second Story	OP
Covenant Ability	Residential	Sparks Behavioral Health	Psychology
DA Blodgett	OP, CM, Home Based	Spectrum Community Services	OP, CM
David's House Ministries	Residential	Stuart Wilson	FI
Daybreak Adult Services	CLS	Thresholds	CLS, Residential
Developmental Enhancements	Autism	Toni Ann Keglovitz	Health Services
Evas AFC	Residential	Turning Leaf	Residential
Family Outreach	OP, CM	Warren Sakshaug Group Home	Residential
Flatrock Manor	Residential	Wedgwood	OP, CM, wrap around
Goodwill Industries	SB, SE	West MI Psych Services	OP
Guardian Trac	FI		

LAKESHORE REGIONAL ENTITY

LRE Medicaid Verification FY23 Quarter 1 (Sept-Dec2022)

						Does the service informationin				Does the documentation include the			
	Is the provided service eligible for payment under Medicaid?	The Benficiary was eligble for Medicaid on the date of service?	Was the service delivered by a staff person qualified to provide the	Was the IPOS in effect for the date of service, available for review?	Was the provided service identified in the Plan of Service?	Identified Amount	Identified Scope	Identified Duration	Is there documentation indicating the service was provided on the date billed?	Signatures and Credentials of Service Provider	Unit based services have start and stop times	Documentation supports the services as reported	The billed services amount / units match provided documentati
Allegan													
Yes	525	525	525	509	509	509	509	509	525	273	276	521	525
No	0	0	0	0	0	0	0	0	0	0	0	0	0
N/A				16	16	16	16	16		252	249	4	
% of Yes	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Allegan Overall % of Yes			**100.00%**										
HealthWest													
Yes	476	476	476	404	352	352	351	352	474	374	205	462	474
No	0	0	0	0	0	0	0	0	2	0	0	0	2
N/A				72	124	124	125	124		102	271	14	
% of Yes	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.58%	100.00%	100.00%	100.00%	99.58%
HealthWest Overall % of Yes			**99.95%**										
Network180													
Yes	791	791	791	754	727	727	727	727	791	657	504	789	791
No	0	0	0	0	0	0	0	0	0	0	0	0	0
N/A				37	64	64	64	64		134	287	2	
% of Yes	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Network180 Overall % of Yes			**100.00%**										
Ottawa													
Yes	370	370	370	346	319	319	319	319	370	310	159	370	370
No	0	0	0	0	0	0	0	0	0	0	0	0	0
N/A				24	51	51	51	51		60	211	0	
% of Yes	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Ottawa Overall % of Yes			**100.00%**										
West Michigan CMH													
Yes	563	563	563	544	477	477	477	477	563	357	329	560	563
No	0	0	0	0	0	0	0	0	0	0	0	0	0
N/A				19	86	86	86	86		206	234	3	
% of Yes	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
West Michigan CMH Overall % of Yes			**100.00%**										
Lakeshore Regional Entity Totals													
Yes	2725	2725	2725	2557	2384	2384	2383	2384	2723	1971	1473	2702	2723
No	0	0	0	0	0	0	0	0	2	0	0	0	2
N/A				168	341	341	342	341		754	1252	23	
% of Yes	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.93%	100.00%	100.00%	100.00%	99.93%
Lakeshore Regional Entity Overall % of Yes					**99.99%**								

Provider Information

Population of Providers	See Chart Above
Number of Providers Reviewed	47
Number of Providers put on Corrective Action Plans	0
Number of Providers on Correction Action for repeat/continuing issues	0
Number of Providers taken off Correction Action Plans	0

Medicaid Claims Verification Data Information

Review Period	Total Medicaid Dollars	Amount Recouped
FY 23 Quarter 1	$628,151	$5,094.23

LAKESHORE REGIONAL ENTITY

EXECUTIVE COMMITTEE SUMMARY
Wednesday, June 21, 2023, 1:00 PM

Present: Ron Bacon (online), Richard Kanten (online)
Absent: Jack Greenfield, Linda Garzelloni
LRE: Mary Marlatt-Dumas, Stacia Chick

WELCOME and INTRODUCTIONS

i. Review of July 19, 2023, Meeting Agenda
ii. Review of June 21, 2023, Meeting Minutes

The July 19, 2023, agenda and the June 21, 2023, meeting minutes are accepted as presented.

Welcome Mr. Jim Storey to the meeting. The OnPoint Board has recommended Mr. Storey to be placed on the LRE Executive Committee. This recommendation will be brought to the July Board for approval.

MDHHS UPDATES

- Ms. Marlatt-Dumas updates that she is attending the Directors Forum and highlights:
  - Alan Bolter reviewed the FY24 state budget which is the largest in the Michigan history of a budget.
    - Ms. Marlatt-Dumas will breakout the amounts for this region and put in her Board report when that information is released.
  - Discussed the newly appointed MDHHS staff. Kristen Jordan has taken the place of Jeff Wieferich.
  - Discussion on MDHHS initiatives such as Standard Cost Allocation and Conflict Free Access and Planning.
  - Discussion about CCBHC PIHPs will be receiving a 1.5% cut off the top of their capitated rate on top of the 5% rate reduction that.
  - Discussion about MDHHS efforts on how they are addressing the workforce shortage in the behavioral health field.
  - The State hospital's reduction in capacity due to Hawthorne being torn down.
  - A year in review document about the 988 project will be shared with the Board.

DEFICIT PAYMENT/MOTION 23-23 UPDATE

1. Ms. Marlatt-Dumas updates that the motion reads "The CMH's owed money will be paid 20% of funds to be held in an escrow restricted account at the CMH which shall be returned to the LRE under any of the following conditions…". An escrow account involves 3rd party which then adds additional cost. Network180 would hold est. $2 million in the escrow which would accrue an est. $1,500 per month in charges.

- LRE and LRE legal are recommending amending the language in the motion to state that the CMHs will hold the 20% in a restricted account directly at the CMH. Mary reiterates the 2 options:
    i. The CMHs can set up an escrow with a 3rd party or
    ii. Amend the motion 23-23 to allow the CMHs to hold the 20% in their own restricted account instead of a 3rd party escrow.
- Ms. Marlatt-Dumas asks which CMHs would like the Motion 23-23 to be amended to say the CMHs are to hold the 20%:
    - WM agrees to ratify the motion,
    - HW agrees to ratify the motion,
    - Network180 will communicate through their attorney on what their recommendation is.
- Mr. Bacon and Mr. Kanten agree that a recommendation should be made to the Board to amend Motion 23-23.
    - Ms. Marlatt-Dumas will follow up with Ms. Garzelloni and Mr. Greenfield and N180.
    - If N180 legal does not recommend changing the language that will be communicated to the EC.
- LRE legal will send the updated language to amend the motion.

COMPLIANCE AUDIT UPDATE

- LRE received a letter from the state about the FY20 audit. There were numbers that were not reconciling with what was submitted. LRE will work with the state to address these concerns.
- MDHHS denied LRE's FSR revisions that were submitted. MDHHS gave us 7 days to resubmit the information and if that was done the $200 thousand sanction will be waived. LRE legal has informed the state that we will be unable to turn that around that quickly.
- LRE is continuing to work toward a resolution of all the compliance audits.

WAKELY RATES/ISF ANYALYSIS UPDATE

- There are 2 meetings scheduled that will include LRE staff and CMH CEOs/CFOs. The plan is to have this completed and brought to the Board for a presentation in August.
- Ms. Marlatt-Dumas comments that the analysis will have to be revised due to the state not approving the previous year's FSRs.

LRE POLICIES

- 10.4 LRE Board Governance Policy
    - Mr. Bacon and Mr. Kanten agree that this should be moved forward to the Board for review and recommended approval.
    - Ms. Marlatt-Dumas will check with Mr. Greenfield.
- 10.22/10.22a New Board member Orientation Policy/Procedure
    - Mr. Bacon comments that he would like the content of the orientation packet discussed during the in-person orientation meeting with the CEO.

- Mr. Bacon and Mr. Kanten agree that this should be moved forward to the Board for review and recommended approval.

- LRE Board Member Conduct and Board Meetings.
  - Add language under COI that "when declaring a conflict, the conflict has to be stated".
  - Mr. Bacon and Mr. Kanten agree that this should be moved forward to the Board for review and recommended approval.

BOARD MEETING AGENDA ITEMS

i. Motion 23-23 - Escrow Account
ii. Before staff reports add the action to appoint Mr. Storey.
iii. Directly after EC appointment add discussion/appointment of Chair.
iv. December Board meeting date.

BOARD WORK SESSION AGENDA

Mr. Bob Sheehan will be presenting at the Work Session.

LRE CEO EVALUATION PROCESS/TOOL

- When the process is approved, policy 10.19 will be updated to reflect the new process.
- The questions that will be included in the new tool will be sent to the Board for review. The questions are specific to LRE Board members, LRE staff and CMH CEOs
- Mr. Bacon and Mr. Kanten agree to move forward with building the tool.

LRE CEO ANNUAL PERFORMANCE PLAN

- Under Section 4 there are 2 options: Regional and LRE Leadership – Question 5
  i. CEO will utilize effective conflict resolution skills to improve relationships with member CMHs.
  ii. Find solutions to conflict and work effectively with the Board and the Executive Committee.
    - Mr. Bacon and Mr. Kanten agree that the second option should be included.

OTHER

- LRE received a letter regarding the SUD FY23 Review stating no exceptions and that LRE complied with all requirements.

UPCOMING MEETINGS

- July 26, 2023 – LRE Executive Board Meeting, 1:00 PM
  GVSU, Muskegon Innovation Hub, 200 Viridian Dr, Muskegon, MI 49440
- August 16, 2023 – Executive Committee, 1:00PM
- August 23, 2023 – LRE Executive Board Meeting, 1:00 PM
  GVSU, Muskegon Innovation Hub, 200 Viridian Dr, Muskegon, MI 49440

ADJOURN

Lakeshore Regional Entity
Chief Executive Officer Performance Evaluation & Compensation Process

Policy:

It is the practice of the Lakeshore Regional Entity to compensate all employees with a salary that is market competitive and performance based. Our compensation program will protect the financial integrity of the organization and will drive organizational performance toward excellence. The compensation system for the Chief Executive Officer will be determined by the Governing Board.

Performance Evaluation & Compensation Process:

The timeline and process for evaluation of the performance of the Chief Executive Officer and determining compensation follows.

Meeting	Date	Action	Responsibility
Executive Committee Meeting	December meeting	The committee will be notified of the upcoming review cycle. Review form will be distributed for reference. If changes are needed, the Executive Committee will provide the feedback to Director of HR.	Director of Human Resources
Board of Directors Meeting	December meeting	Instructions on the annual performance evaluation will be shared with all Board Members.	Board Chair
	January 10th	Performance Evaluation Due back from Board Members to HR	Board Members
Executive Committee Meeting	January meeting	The Director of HR will distribute a summary report to Executive Committee and CEO.	Director of Human Resources
Board of Directors Meeting	January meeting	The Executive Committee will present the performance evaluation summary to the Governing Board.	Board Chair
Executive Committee Meeting	February meeting	Salary data will be distributed to Executive Committee	Director of Human Resources
		The Executive Committee and CEO will finalize salary agreement for the next calendar year per the contract.	Executive Committee & CEO

		The Executive Committee will develop a recommendation for the Board of Directors to review and approve.	Executive Committee
Board of Directors Meeting	February meeting	The Executive Committee will present the recommendation to the Board.	Board Chair

2023 CEO Annual Appraisal (Board)

1. Key LRE Performance Indicators

Please check the rating that reflects your assessment of the CEO's performance on each of these important responsibility areas of Executive leadership.

	Below Expectations (1)	(2)	Meets Expectations (3)	(4)	Exceeds Expectations (5)
Agency Fiscal Status	◯	◯	◯	◯	◯
Financial Audit Status	◯	◯	◯	◯	◯
Executive Limitations Status	◯	◯	◯	◯	◯
CMH Relationship Status	◯	◯	◯	◯	◯
LRE Strategic Goal Completion Status	◯	◯	◯	◯	◯

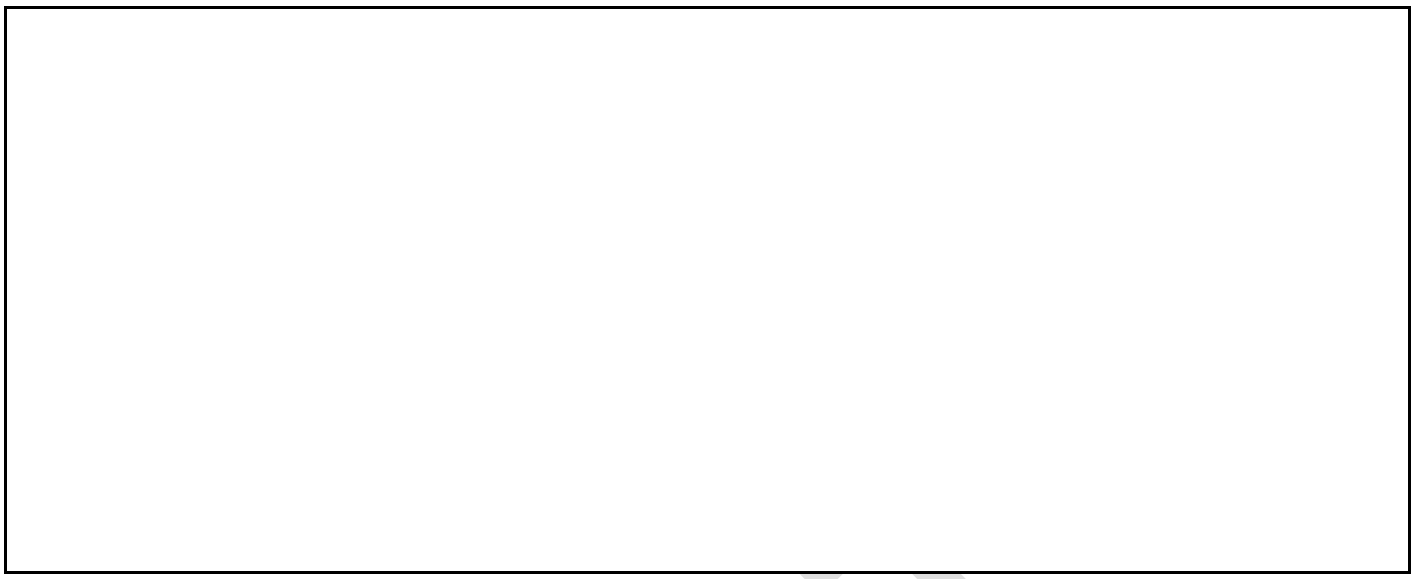
Comments on the above areas

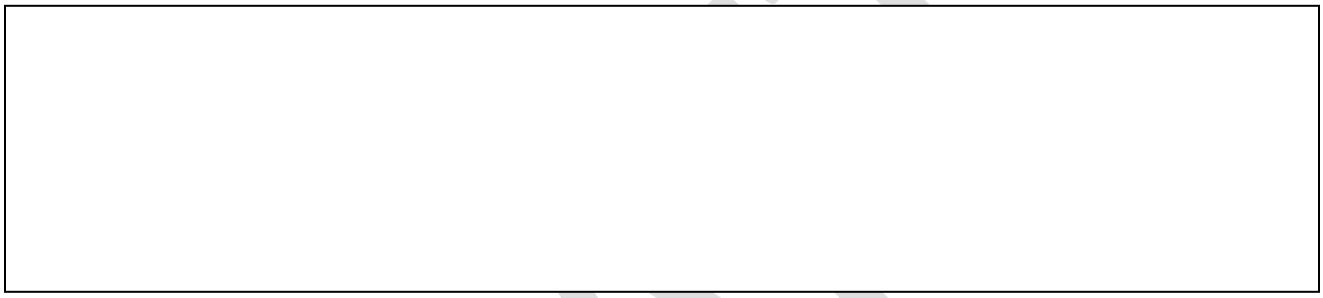
2. Job Specific Duties and Responsibilities

Please check the rating that reflects your assessment of the CEO's performance on each of these important responsibility areas of Executive leadership.

	Below Expectations (1)	(2)	Meets Expectations (3)	(4)	Exceeds Expectations (5)
Governing Board	◯	◯	◯	◯	◯
Provides staff leadership to the Board - Keeps Board Informed – Operations, affiliations, and regulatory/political matters					
Community Connection Consumer Advocacy	◯	◯	◯	◯	◯
Spokesperson for the LRE/Region. Executive champion for consumer advocacy, partnership and empowerment					
Affiliations Relations	◯	◯	◯	◯	◯
Evaluate affiliation options in order to ensure the most appropriate alignment to secure services, funding, resources, and collaboration opportunities					
Political advocacy	◯	◯	◯	◯	◯
Actively participates in MDHHS, MACMHB and other relevant organizations to advocate on behalf of the needs of the Consumers. Actively participates in political and regulatory activity – locally, across the region, region and state level					

Comments on the above areas





3. Overall Performance Rating

	Below Expectations (1)	(2)	Meets Expectations (3)	(4)	Exceeds Expectations (5)
Overall Performance Rating for the Past Year	◯	◯	◯	◯	◯

Comments

CEO Strengths

Opportunities for improvement

LRE CEO Performance Evaluation - January 2024 DRAFT for CMH Directors and LRE Leadership	CMH Directors	LRE Leadership
Q1. Prepares timely and understandable reports and materials.		
Q2. Responds to requests from the Board in a timely way.		
Q3. Offers input to the Board, when needed, on issues requiring Board action and makes appropriate recommendations when needed or requested based on thorough study and analysis of the situation.		
Q4. Finds solutions to conflict and works effectively with the Board and Executive Committee.		
Q5. Practices fair, objective, and direct communication with the Board.		
Q6. Communicates well with the Board, providing appropriate information at and between meetings about issues, needs, and the overall operation of the organization.		
Q7. Works as an advocate for the organization before the government, consumers, members, and the general public.	X	X
Q8. Adequately manages and monitors delegated functions.	X	X
Q9. Seeks to build and maintain positive relationships with state and local governments.	X	X
Q10. Understands the needs of the organization/ consumers/members, and seeks to fill those needs with the organization's programs and services.	X	X
Q11. Finds solutions to conflict and works effectively with the Operations Committee	X	
Q12. Stays up to date on current trends and new ideas among CMHSPs (Community Mental Health Service Providers) and PIHPs (Prepaid Inpatient Health Plans).	X	X
Q13. Employs and utilizes quality personnel.		X
Q14. Fosters creativity and self-direction in staff.		X
Q15. Helps to define team roles to maximize output.		X
Q16. Mentors and encourages staff development and offers technical support when needed.		X
Q17. Seeks staff input, feedback, and technical support.		X
Q18. Able to forecast financial needs of the organization and reports periodically on the state of the budget.	X	X
Q19. Monitors implementation of the budget within Board approved policy, law, and state contract requirements.	X	
Q20. Assures that cost effective contracts are negotiated.	X	X
Q21. Promotes the strategic outcomes for consistent regional benefits of standard services, efficiency, integration of care, and data analytics.	X	X
Q22. Ensures the organization funds are spent appropriately and in the best interest of those we serve.	X	X
Q23. Demonstrates the leadership, initiative, and persistence needed to accomplish goals and objectives of the organization.	X	X
Q24. Ensures culture for a high standard for service.	X	X
Q25. Manages multiple tasks and responsibilities, utilizing good organizational skills.	X	X
Q26. Establishes clear vision and direction for the organization, including development of a strategic plan.		X
Q27. Demonstrates commitment and enthusiasm for the job.	X	X
Q28. Maintains standards of ethics, honesty, and integrity in professional relationships.	X	X
Q29. Please use this space for any additional feedback you would like to share with the CEO and other Board members that might prove helpful in completing a meaningful evaluation.	X	X

UTILIZATION MANAGEMENT PLAN

FY2024

LAKESHORE REGIONAL ENTITY
FY2024 UTILIZATION MANAGEMENT PLAN

Lakeshore Regional Entity (LRE) is the public behavioral health plan for individuals with mental illness, developmental disability, and substance use disorders in Allegan, Kent, Lake, Mason, Muskegon, Oceana and Ottawa counties. As one of 10 Prepaid Inpatient Health Plans (PIHP) in Michigan, LRE manages the Medicaid and Block Grant services provided under a contract with the State of Michigan's Department of Health and Human Services (MDHHS) to residents in the region.

The LRE UM Program is designed to utilize mechanisms to detect and correct under-and over-utilization of services as well as procedures for conducting prospective, concurrent and retrospective reviews. The LRE's Utilization Management (UM) Program must ensure the delivery of high quality, medically necessary care through appropriate utilization of resources in a cost effective and timely manner. The UM program provides the framework for the region to ensure services and UM activities are conducted in compliance with federal law and MDHHS contract requirements.

LRE has adopted Utilization Management and Service Delivery Polices and Procedures that guide regional UM functions and effective oversight. The polices and procedures comply with 42 CFR 441.301(c)(4) requirements for home and community-based settings.

UTILIZATION MANAGEMENT POLICIES:

- 5.0 Utilization Management
  - 5.0a UM Procedure
  - 5.0b Application of Milliman Care Guidelines
- 5.1 Person Centered Planning
  - 5.1a Person Centered Planning Procedure
  - 5.1b Community Living and Housing Preferences
  - 5.1c Self Determination Procedure
- 5.2 Assessments and Screens
- 5.6 Integrated Care Coordination
  - 5.6a Care Coordination with Medicaid Health Plans
- 5.15 Adoption of Clinical Practice Guidellines and Evidence Based Practices

SERVICE DELIVERY POLICIES

- 13.1 Habilitation Supports Waiver Administration
  - 13.1a HSW Initial Application and Eligibility Process
  - 13.1b HSW Annual Recertification Procedure
  - 13.1c HSW Disenrollment and Transfer
  - 13.1d HSW Prior Review and Approval
- 13.2 Children's Home and Community Based Services Waiver (CWP)
  - 13.2a CWP Prior Review Authorization Request Procedure
- 13.3 Seriously Emotionally Disturbed Waiver (SED)
- 13.4 Out of State Placements
  - 13.4a Out of State Placements Procedure
- 13.5 Trauma Informed Systems of Care
- 13.6 Autism Services
- 13.7 Inpatient Psychiatric Hospitalization Standards
  - 13.7a Continued Stay Review Process

The LRE UM Program must meet the following core objectives:

- Improve the consumer's experience of car
- Ensure effective and efficient provision of services across the region
- Use of common tools and/or protocols to consistently evaluate medical necessity for services
- Ensure regional capacity for all Utilization Management functions to control costs and minimize risk while assuring quality care.
- Ensure that all services conform to accepted clinical practice guidelines

UM PROGRAM OVERVIEW

LRE must ensure regional access to public behavioral health services in accordance with its contract with MDHHS and relevant Michigan Medicaid Provider Manual (MMPM) and Michigan Mental Health Code (MMHC) requirements. LRE has adopted the American Psychiatric Association Clinical Practice Guidelines as the established practice guideline for all Medicaid covered services. In addition, Milliman Care Guidelines (MCG) were adopted in 2020 and are utilized as an additional factor/criteria for decision-making and service authorization for inpatient, partial hospitalization, and crisis residential determinations

LRE currently provides oversight and monitoring of all delegated regional UM functions,

Over the past several years, LRE has engaged in significant redesign of its regional program to standardize UM functions across the region, including:

- Standardization of access to higher levels of care, including psychiatric inpatient, crisis residential, and partial hospitalization treatment
- Development of a regional policy and procedure to standardize continued stay review for inpatient, partial inpatient, and crisis residential placements.
- Methodologies to improve processes and reporting that assists CMHSPs with service eligibility determinations
- Standardized report sharing for higher level of care initial authorizations, continuing stay reviews, discharge reporting, multi-morbidity/high complexity case identification, and high-cost service reviews.
- Developed a regional auditing process to ensure Inter-Rater Reliability
- Created utilization data reports for higher level of care, for example:

    - Psychiatric Inpatient ALOS
    - Crisis Residential ALOS/Units
    - Partial Inpatient ALOS
    - Inpatient Admits/1000 and Inpatient Days/1000
    - Readmission Rates – 7/30 Days

The LRE will continue to focus on standardization of utilization management activities. Regardless of where these activities and functions occur, LRE retains responsibility to recommend and ensure improvement strategies across its service delivery network, particularly if adverse utilization trends are detected within the region.

In addition to continued standardization of regional UM functions, there will be continued efforts toward data integrity processes including identification of overlapping services and coding errors. LRE and CMHPSs continue collaborative work on authorization and claims files to provide greater visibility into real time medical expense via reporting tools and improved claims data exports/extracts to LRE from CMHSPs.

OVERSIGHT STRUCTURE

The LRE's UM Program operates under the oversight of the LRE CEO, Regional Operations Committee, and LRE UM Regional Operations Advisory Team (UM ROAT) and Clinical ROAT

LRE has delegated UM related activities to th Member CMHSPs. LRE staff manage the overall UM Plan as well as the direction and focus of the LRE UM and Clinical ROATs to achieve the strategic outcomes of the Lakeshore Regional Entity. Collaboratively, LRE and CMHSP designated staff are responsible to:

- Provide oversight to ensure that each CMHSP has policies and procedures that comply with State and federal requirements related to UM.
- Develop, monitor and track key performance indicators to include identification of over/under utilization patterns and/or deviation from expected results across the region
- Implement policies and systems to ensure consistency with the Mental Health Parity and Addiction Equity Act of 2008
- Engage in studies of specific populations or sets of services based on identified factors or criteria. These may include populations or services with high risk, high costs, and presence of negative outliers or outcomes, or significant variance in utilization patterns
- Act as the representative for the region on any Utilization Management initiatives across the state

The LRE UM ROAT is the primary body responsible for evaluating the utilization of LRE services and making UM recommendations to the LRE Operations Committee.The UM ROAT is comprised of one Subject Matter Expert (SME) from each member CMHSP and the LRE UM/Clinical Manager. Other SME's may be invited by the Clinical ROAT for a specific agenda topic.

The responsibilities and duties of the UM ROAT include the following:

- Develop and monitor a regional utilization management plan.
- Set utilization management priorities based on the LRE strategic plan and/or contractual/public policy expectations.
- Recommend policy and practices for access, authorization and utilization management standards that are consistent with requirements and represent best practices.
- Participate in the development of access, authorization and utilization management monitoring criteria and tools to assure regional compliance with approved policies and standards.
- Support development of materials and proofs for external quality review activities.
- Establish improvement priorities based on results of external quality review activities.
- Recommend regional medical necessity and level of care criteria.
- Perform utilization management functions sufficient to analyze and make

recommendations relating tocontrolling costs, mitigating risk and assuring quality of care; review and monitor utilization patterns andanalysis to detect and recommend remediation of over/under or inappropriate utilization.

- Recommend improvement strategies where adverse utilization trends are detected; and
- Implement policies and systems to ensure consistency with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
- Ensure UM ROAT coordination and information sharing to address continuity and efficiency of PIHPprocesses.

PROGRAM STRUCTURE

As required by the MDHHS contract, the UM Program must include the following:

- Ensuring a welcoming, responsive access system available 24 hours per day, 7 days per week. Member CMHSPS are responsible to manage all requests for services with prompt, consistent screening/assessment for services.
- Adoption of consistent regional access policies and procedures to assure compliance with LRE standards related to service eligibility and crisis response capacity.
- Mechanisms to identify and correct under and/or over utilization.
    a. The LRE UM ROAT is responsible for reviewing aggregated and trend data related to services delivered across the region.
    b. The LRE UM ROAT is responsible for identification of over and underutilization trends and identifying opportunities/interventions to correct significant variances.
- Procedures to outline utilization review work including UM authorization and denial decisions made by qualified and credentialed professionals. UM reviews are supervised by qualified and credentialed professionals.
- Efforts are made to obtain all necessary clinical information to render a decision. The rationale for all utilization review decisions are clearly documented and available to the LRE, CMHSP, provider, or the individual.
- Well publicized and accessible appeal mechanisms are available for both the providers and individuals receiving services. Notification of denials should include a copy of how to file an appeal.
- Appeals and Fair Hearings is a contracted function managed by Beacon Health Options from LRE. Appeals and Fair Hearing decisions will be made in a timely manner as required by the MDHHS contract.

SERVICE ACCESS AND ELIGIBILITY DETERMINATION

Initial access to care and authorization of medically necessary services occurs at the CMHSPs and in some instances (SUD Services) at other provider sites. Initial service eligibility, continued stay review activities and ongoing utilization management for all mental health and substance use disorder services must be based on common standardized screening and assessment protocols consistent with the Medicaid Provider Manual and criteria/service selection guidelines specified by MDHHS contract. The LRE has delegated these activities to the 5 CMHSPs.

- The determination of medically necessary supports, services and/or treatments must be:
- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals who know the beneficiary; and

- Based on clinical information from the beneficiary's primary care physician or health care professional who have evaluated the beneficiary; and
- Based on person-centered or individualized treatment planning
- Made by appropriately trained and credentialed mental health and/or substance use disorder professionals
- Made within federal and state standards for timeliness
- Sufficient in amount, scope and duration to reasonably achieve its purpose
- Documented in the individual's record.

Intake assessments have an established uniformity across the region using common screening and assessment tools that are validated and standardized per the Michigan Medicaid Provider Manual.The LRE and regional Member CMHSPs adopted MCG medical necessity criteria for psychiatric inpatient, crisis residential and partial hospitalization levels of care. MCG criteria does not replace the Michigan Medicaid Provider Manual, rather it is supplemental criteria used to support the individualized plan of service.

Eligibility for services will be documented in the clinical record and specific data elements submitted to the PIHP as required by the PIHP/CMHSP sub-contract.

All screening decisions will be documented and shall include:

- Presenting problem and need for service and supports
- Initial identification of the population group that qualified the person for services and supports
- Legal eligibility and priority criteria (where applicable)
- Urgent and emergent needs including linkages to crisis services
- Screening disposition
- Rationale for admission or denial
- Ongoing service(s) required

LRE retains responsibility to ensure that screening and eligibility determinations are consistently made across the region.

AUTHORIZATION/UTILIZATION REVIEW

LRE and CMHSPs shall establish guidelines and utilization monitoring procedures in accordance with the Michigan Medicaid Provider Manual. LRE shall not use any medical necessity criteria that are more restrictive than those specified by MDHHS and/or the Medicaid Provider Manual to place appropriate limits on any service.

Level of care criteria shall be sufficient to address the severity of illness and intensity of services required by the individual. Some services that fall within established parameters may be "presumptively authorized" to expedite care (i.e., initial assessment)

LRE, and CMHSPs and contract providers shall not deny services based solely on preset limits of the cost, amount, scope, or duration of services. Instead, determination of the need for services shall be conducted on an individualized basis using established medical necessity criteria.

Decisions regarding the type, scope, duration and intensity of services to authorize or deny must be:

- Accurate and consistent with medical necessity criteria
- Consistent with established guidelines (ie: Medicaid Provider Manual, MDHHS contract)
- Adjusted appropriately as beneficiary's needs, status, and/or service requests change
- Timely
- Provided to the consumer in writing
- Accompanied by the appropriate notice to the beneficiary regarding their appeal rights.

Crisis services including pre-admission screening for and/or diversion from intensive services (Inpatient psychiatric, crisis residential, partial hospitalization services, SUD detox) and/or crisis stabilization services remain the responsibility of the CMHSP/Provider.

UTILIZATION MANAGEMENT /OUTLIER MANAGEMENT

Consistent with the Balanced Budget Act (BBA) and MDHHS contract requirements, the LRE, CMHSPs and contracted provider entities will ensure mechanisms are in place to detect over and under-utilization of services. This includes:

- Developing, monitoring, and tracking key performance indicators to detect patterns or trends
- Specific studies of certain populations or particular sets of services based on established factors or criteria. These may include populations or services with high risk, high cost,
- and/or presence of negative outliers or outcomes, or significant variation in utilization patterns.
- Conducting data-driven analysis of regional utilization patterns
- Requiring corrective action when necessary

DATA REPORTING AND ANALYSIS

UM activities delegated to Member CMHSPs, as contracted entities, collect, aggregate, and analyze data related to service utilization, costs, timeliness, and outcomes for all delegated UM activities. Data collected includes, but is not limited to:

- Service utilization and costs by service code
- Over / under utilization trends
- Denials of authorization
- Access and availability of services
- Population trends
- Penetration rates
- Readmission rates

LRE continues to develop, redesign and review reporting mechanisms via Power Bi Dashboards

OPERATIONAL GOALS

The activities described below identify how Lakeshore Regional Entity will achieve its Utilization Management Program goals.

1. Continue to develop standardized utilization management protocols & functions across the region. This will include review of the following functions.
    - Access and service eligibility determination
    - Authorization for services
    - Re-authorizations
    - Admissions and continuing stay reviews for intensive services.

2. Continue with development and review of a regional Utilization Management framework that includes common screening and assessment, UM procedures (where appropriate) as well as continued development of enhanced data reporting (Power Bi Reports) which will be reviewed for trends and potential areas of growth.

3. Continue development and implementation of regionally uniform, standard processes across the region for determining service eligibility, level of care guidelines, standard assessment protocols, and regular monitoring and oversight to assure ensure effective use of resources.

    The Michigan Department of Health and Human Services (MDHHS) requires the use of standardized assessments or level of care determination tools during the initial assessment phase for specific clinical populations. Minimally, the tools are used to inform, and in some instances, guide decision making regarding the appropriate level of care. No one assessment shall be used to determine the care an individual receives, rather it is part of a set of assessments, clinical judgment, and individual input that determine level of care. The following assessments/tools will be utilized in the Lakeshore region:

    Substance Use Disorder Services:
    - ASAM (American Society of Addiction Medicine) Continuum Assessment for adults (18 and older)
    - ASAM Patient Placement Criteria (ASAM-PPC) for level of care determination

    Children and Adolescents with Serious Emoitional Distrubance
    - DECA (Devereaux Early Childhood Assessment, ages birth-47 months)
    - CAFAS (Child and Adolescent Functional Assessment Scale (for ages7-17)
    - PECFAS (Preschool and Early Childhood Functional Assessment Scale (for ages 46
    - GAIN (Global Appraisal of Individual Needs) comprehensive biopsychosocial assessment for adolescents (17 and under)

    Adults with Mental Illness
    - LOCUS (Level of Care Utilization System) for Psychiatric and Addiction

    Adults with Intellectual/Developmental Disabilities

    MDHHS is in the process of determining a standardized assessment tool for this population (expected in FY2024). LRE will implement this assessment tool regionally when identified.

4. At least annually, conduct a review (including an onsite monitoring) with each CMHSP to ensure Members are compliant with MDHHS and Balanced Budget Act (BBA) requirements related to utilization management

5. Analyze regional ability to increase authorization process consistency to monitor over/under utilization of services

6. Analyze regional ability to apply Interrater Reliability processes to specialized residential/CLS medical necessity criteria

7. Identify high risk populations for focused analysis (e.g. using MDHHS data extract, Care Connect 360 or local data) and ongoing monitoring toward improved coordination of care

8. Based on review of regional utilization data or results of oversight and monitoring activities, determine specific areas or services for focused review or improvement. This may include monitoring and trending of regional claims and encounters

9. Participate on statewide work groups related to UM functions and share relevant information with LRE UM & Clinical ROATs and Operations Committee

10. Ensure LRE and Member CMHSPs are represented on cross regional UM related work groups

APPENDIX I: DEFINITIONS

These terms have the following meaning throughout this Utilization Management Plan

CMHSP Member: refers to one of the five-member Community Mental Health Services Program (CMHSP) participants in the Lakeshore Region.

Concurrent Review: During the course of service delivery (i.e. point of care), ensuring an appropriate combination of services is authorized; concurrent review occurs within the context of philosophical frameworks governing decision making regarding services (e.g., consumer self-determination, person centered planning and trauma informed and recovery oriented care); may include re-measurement(s) of need utilizing standardized assessment tools; for Medicaid enrollees, concurrent UM decision making includes Advance Notice to the consumer.

Crisis Residential: Services that are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries (adult or child) experiencing an acute psychiatric crisis when clinically indicated. Services must be provided to beneficiaries in licensed crisis residential foster care or group home settings not exceeding 16 beds in size.

Crisis Stabilization: Structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services. Can be stabilized and served in the consumer's usual community environments.

Intellectual/Developmental Disability (I/DD): Developmental disability means If applied to an individual older than 5 years of age, a severe, chronic condition that meets all of the following requirements: Is attributable to a mental or physical impairment or a combination of mental and physical impairments, is manifested before the individual is 22 years old, is likely to continue indefinitely, results in substantial functional limitations in three or more of the following areas of major life activity, self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency; reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated. If applied to a minor from birth to 5 years of age, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability. Intellectual disability means a condition manifesting before the age of 18 years that is characterized by significantly sub average intellectual functioning and related limitations in 2 or more adaptive skills and that is diagnosed based on the following assumptions: valid assessment considers cultural and linguistic diversity, as well as differences in communication and behavioral factors, the existence of limitation in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the individual's particular needs for support, specific adaptive skill limitations often coexist with strengths in other adaptive skills or other personal capabilities, and with appropriate supports over a sustained period, the life functioning of the individual with an intellectual disability will generally improve.

Prospective Review: Determination of the appropriateness of a level of care or service setting before services are initiated; associated with admission to a program, agency or facility and the application of medical necessity, benefit eligibility or access/admission criteria; may include

baseline measurements of need utilizing standardized assessment tools; for Medicaid enrollees, prospective UM decision making includes Adequate Notice to the consumer.

Provider Network: Refers to LRE CMHSP Members and Substance Use Disorder Service Providers (SUDSP) directly under contract with the CMHSP/ PIHP to provide/arrange for behavioral health services and/or supports. Services and supports may be provided through direct operations or through the subcontract arrangements.

Retrospective Review: After service delivery, evaluation of whether the scope, duration and frequency of services received met consumer need; includes determination of whether or not intended outcomes were achieved; may include post-discharge measurement of health outcomes or re-measurement of need utilizing standardized assessment tools; retrospective review may occur specific to a service, program or facility.

Serious Emotional Disturbance (SED): As described in Section 330.1100c of the Michigan Mental Health Code, a serious emotional disturbance is a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental
disorders published by the American Psychiatric Association and approved by the MDHHS, and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities.

Serious Mental Illness (SMI): As described in Section 330.1100c of the Michigan Mental Health Code, a serious mental illness is a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDHHS and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbances, but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness.

Staff: Refers to an individual directly employed and/or contracted with a CMHSP Members or SUD Service Provider.

Stakeholder: A person, group, or organization that has an interest in an organization, including consumer, family members, guardians, staff, community members, and advocates.

Substance Use Disorder (SUD): The taking of alcohol or other drugs as dosages that place an individual's social, economic, psychological, and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.

Appeal: A process to have an authorization decision that adversely affects services provided to an individual or a denial of services to an individual reviewed by a licensed professional, not involved in the original decision, to evaluate the medical needs of the individual for possible decision reversal.

Authorization: Approval of level of care and/or specific services

Denial: A determination that a specific service is not medically / clinically appropriate, necessary to meet needs, consistent with the individual's diagnosis, symptoms and functional impairments, the most cost-effective option in the least restrictive environment, and/or consistent with clinical standards of care.

Medical Director: Physician, psychiatrist, addictionologist serving in a leadership capacity for the LRE or Member CMHSP's.

Medically Necessary: A determination that a specific service is clinically appropriate, necessary to meet an individual's needs, consistent with the diagnosis, symptoms and functional impairments, is the most cost-effective option in the least restrictive environment. Medically Necessary Services are intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness or substance use disorder, arrest or delay the progression of illness, and/or designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his/her goals of community inclusion and participation, independence, recovery or productivity.

Medical Necessity Criteria: Criteria used to determine which services, equipment, and/or treatment protocols are required for the diagnosis or severity of illness that meets accepted standard of practice.

Utilization Management: The LRE's managed care system that ensures eligible recipients receive clinically appropriate / medically necessary, high quality, and cost effective services.

Utilization Review: The LRE's review process established to ensure that the UM Program's service standards, protocols, practice guidelines, and documentation standards are adhered to by all Member CMHSP's.

Policy

POLICY TITLE: Board Governance Policy	POLICY # 10.4	REVIEW DATES	
Topic Area: LRE Board Policies	**ISSUED and APPROVED BY:** Board of Directors	11/18/21	
Applies to: Board Of Directors			
Developed and Maintained by: LRE CEO or Designee			
Supersedes: N/A	**Effective Date:** 9/17/2016	**Revised Date:** 6/24/2023	

I. PURPOSE

This policy is intended to clarify the Lakeshore Regional Entity (LRE) Board's policy governance role; to keep the Board focused upon its philosophy, accountability and the specifics of its role.

II. POLICY

The Board shall carry out its responsibilities using a governing style consistent with policy governance.

1. Governance Process

1. Governance Commitment

On behalf of the Members named in its Bylaws, the Board, engaging in a continual refinement of its values, mission, and vision, guarantees the accountability of NMRE by assuring that:

A. It achieves appropriate results for appropriate persons at appropriate costs and avoids unnecessary risks; and that
B. Governance decisions are made after full and fair consideration of the views of diverse stakeholders.

Commented [MMD1]: Newly drafted section

2. Governance Style

The Board will govern with an emphasis on:

A. Encouragement of diversity in viewpoints;
B. Outward vision rather than internal preoccupation;
C. Strategic leadership rather than administrative detail;
D. Clear distinction of Board and CEO roles;
E. Collective rather than individual decisions;
F. Future goals rather than past or present programs; and
G. Proactivity rather than reactivity.

Commented [MMD2]: Language from Policy 10.4 Board Goverance

3. Board Job Descriptions

A. Establishing the link between the Board and the Members; and

B. Writing governing policies which at the broadest level address:
   i. Organizational Goals: Organizational products, impacts, benefits, outcomes, recipients, and their relative worth (what good for which recipients at what cost;
   ii. Executive Limitations: Constraints on executive authority that establish the prudence and ethics boundaries within which all executive authority and decisions must take place;
   iii. Governance Process: Specification of how the Board conceives, carries out, and monitors its own task;
   iv. Board – CEO linkage: How power is delegated, and its proper use monitored; the CEO role, authority, and accountability.

C. Assurance of successful CEO performance.
~~C.~~ Annually, the Entity Board of Directors will have a formal evaluation of the Entity CEO.

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4. Board Chair Functions

The Chair ensures the integrity of the Board's governance process as the Board carries out its governance obligations.

A. Powers of the Chair – The Chair
   i. Reviews Agendas for meetings of the Board with the CEO;
   ii. Limits consideration of issues to those properly before the Board and within the scope of its authority as set forth in the Board Governance Policies;
   iii. Ensures that Board deliberation is fair, open, thorough, timely, orderly, and on task;
   iv. Exercises the procedural authority accorded the position of the Chair by Roberts Rules of Order;
   v. Subject to the Bylaws, names and charges ad hoc committees as needed;
   vi. When and to the extent authorized by the Board to do so, serves as spokesperson for the Board to the media and the public concerning the positions taken by the Board as a whole.

B. Limits of the Powers of the Chair – The Chair shall not exercise the powers granted to the Chair hereunder for any of the following purposes:
   i. To preclude Board consideration of a decision to employ or terminate a CEO;
   ii. To unilaterally amend or modify a Board Governance Policy;
   iii. To supervise or direct the CEO; ~~or~~
   ~~iii.~~iv. To exercise authority over Entity staff; or
   ~~iv.~~v. To publicly represent a personal position on an issue as that of the Authority.

Commented [MMD4]: Newly drafted language

5. The Role of the Executive Committee

The Executive Committee shall consist of the Board Chairperson, Vice Chairperson, Secretary and two others; one each from the two Members that do not have an elected official on the entity Board. The Executive Committee:

A. Shall have the authority:

i. To act as an Advisory Committee to the CEO;
ii. To assist in development of the Board Agenda;
iii. To discuss major concerns or trends to support in strategy development;
iv. To propose possible methods of resolution on major concerns; subject to any prior limitation imposed by the Board and with the understanding that all matters of major importance be referred to the Board;
v. To call special board meetings when necessary;
vi. To provide guidance to shape and form the Board of Directors;
vii. To provide collective leadership; and
~~A.~~viii. To act as a consultation group between regular scheduled meetings ~~to advise the CEO during the period between the meetings of the Board, subject to any prior limitation imposed by the Board and with the understanding that all matters of major importance be referred to the Board.~~

B. Shall not exercise the powers granted to the Executive Committee hereunder for any of the following purposes:

i. To preclude Board consideration of a decision to employ or terminate a CEO;
ii. To unilaterally amend or modify a Board Governance Policy;
iii. To supervise or direct the CEO; ~~or~~
iv. To exercise authority over Entity staff; or ~~iii.~~
~~iv.~~v. To publicly represent a personal position on an issue as that of the Authority.

6. Annual Board Planning Cycle

The Board shall accomplish its job with a governance style consistent with its policies and follow an annual agenda which:

A. Completes a re-exploration of goals, policies annually; and
B. Continually improves its performance through attention to Board education to enrich input and deliberations.

2. Board – Staff Relationship

1. CEO Role

Commented [MMD5]: Added language from the original Policy 10.2 Committees Structure.

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The CEO is accountable to the Board acting as a body. The Board shall instruct the CEO through written governance policies, delegating to him or her interpretation and implementation of those governance policies. Development and approval of operational policies will be delegated to the CEO.

2. Delegation to the CEO
   All Board authority delegated to the staff is delegated through the CEO, so that all authority and accountability of staff is considered to be the authority and accountability of the CEO.

3. CEO Job Description
   As the Board's single official link to the operating organization, the CEO's performance will be considered to be synonymous with organizational performance in:
   A. Organizational accomplishment of established goals as monitored annually; and
   B. Organizational operation within the boundaries of prudence and ethics established in Board Policies on Executive Limitation as monitored annually.

3. Executive Limitations

1.General Executive Constraint

Commented [MMD6]: Language is from Policy 10.17

The CEO shall not cause or allow any practice, activity, decision, or organizational circumstance which is either illegal, imprudent, or in violation of commonly accepted business and professional ethics or resulting in contractual sanctions.

2. Treatment of Clients

Commented [MMD7]: Policy 10.17

With respect to interactions with clients or stakeholders, the CEO shall not cause or allow conditions or decisions which are unsafe, disrespectful, undignified, intrusive, or which fail to provide appropriate confidentiality and privacy. Accordingly, he or she may not:

A. Use forms or procedures that elicit information for which there is no clear necessity;
B. Use methods of collecting, reviewing, or storing client information that fail to protect against improper access to the information elicited;
C. Fail to provide procedural safeguards for the transmission of information; D. Fail to have client services that reflect the diversity found in the community.

3. Treatment of Staff

Commented [MMD8]: Policy 10.17

With respect to treatment of staff, the CEO may not cause or allow conditions which are unfair, undignified, or unsafe. Accordingly, he or she may not:

A. Operate without approved procedures which clarify personnel rules for staff, provide for effective handling of compliance, and protect against wrongful conditions;
B. Discriminate against any staff member for expressing an ethical dissent;
C. Fail to acquaint staff with their rights under this policy; or
D. Fail to consider human diversity in all dealings with staff.

4. Budgeting

Budgeting any fiscal year or the remaining part of any fiscal year shall not deviate materially from Board goal priorities, risk financial jeopardy, or fail to be derived from a multi-year plan. Accordingly, he or she may not cause or allow budgeting that:

A. Contains too little information to enable projection of revenues and expenses, separation of capital and operational items, and cash flow;
B. Plans the expenditure in any fiscal year of more funds than are conservatively projected to be available.
C. Provide less than is sufficient for Board prerogatives, such as costs of fiscal audit, Board development, Board and committee meetings, and Board legal fees; or
D. Endangers the fiscal soundness of future years or ignores the building of organizational capability sufficient to achieve Board goals in future years.
E. Results in unbudgeted expenditures greater than $50,000 without Board approval.

Commented [MMD9]: Language from policy 10.12 Budget & 10.17 Delegation of Authority Section

5. Financial Condition

With respect to the actual, ongoing condition of the organization's financial health, the CEO may not cause or allow the development of fiscal jeopardy or a material deviation of actual expenditures from Board priorities established in Board Goals Policies. Accordingly, he or she may not:

A. Expend more funds than are available in the fiscal year to date;
B. Use any designated reserves other than for established purposes;
C. Conduct inter-fund shifting in amounts greater than can be restored to a condition of discrete fund balances by certain unencumbered revenues within the fiscal period;
D. Fail to settle payroll and debts in a timely manner;
E. Allow any payments to be overdue or inaccurately filed; or
F. Acquire, encumber, or dispose of real property.

Commented [MMD10]: Policy 10.17 Management Delegation and Executive Limitations

6. Asset Protection

The CEO shall not allow assets to be unprotected, inadequately maintained or unnecessarily risked. Accordingly, he or she may not:

A. Fail to insure against theft and casualty losses to one-hundred (100) percent replacement value less any reasonable deductible and against liability losses to Board members, staff, or the organization itself in an amount greater than the average for comparable organizations;
B. Allow unbonded personnel access to material amounts of funds;
C. Unnecessarily expose the organization, its Board, or staff to claims of liability;
D. Make any purchase wherein normally prudent protection has not been given against conflict of interest, or that requires competitive procurement pursuant to Circular A-87;
E. Fail to protect intellectual property, information, and files from loss or significant damage;
F. Receive, process, or disburse funds under controls insufficient to meet auditor's standards;
G. Invest or hold operating capital in insecure instruments, including uninsured checking accounts, and bonds of less that "AA" rating, or in non-interest-bearing accounts except where necessary to facilitate ease in operational transactions; or
H. Endanger the organization's public image or credibility, particularly in ways that would hinder its accomplishment of mission, including changing the name of the organization.

Commented [MMD11]: Newly drafted language, however supports language in financial policy 2.3 INvestments

7. Compensation and Benefits

With respect to employment, compensation, and benefits to employees, consultants, contract workers, and volunteers, the CEO may not cause or allow jeopardy to fiscal integrity or public image. Accordingly, he or she may not:

A. Change his or her own compensation and benefits;
B. Promise or imply permanent or guaranteed employment;
C. Establish current compensation and benefits which:

    i. Deviate materially from the geographic or professional market for the skills employed; or
    ii. Create obligations over a longer term than revenues can be safely projected, in no event, longer than one year with the exception of labor contracts and in all events, subject to loss of revenue; or

D. Establish or change pension benefits so the pension provisions:

i. Cause unfunded liabilities to occur or in any way commit the organization to benefits which incur unpredictable future costs;
ii. Provide less than some basic level of benefits to all fulltime employees, though differential benefits to encourage longevity in key employees are not prohibited;
iii. Allow any employee to lose benefits already accrued from any foregoing plan; iv. Treat the CEO differently from other comparable key employees;
iv. Are instituted without a prior monitoring of those provisions.

8. Executive Succession

In order to protect the Board from sudden loss of chief executive services, the CEO shall not have less than one (1) other executive familiar with Board and CEO issues and processes.

9. Community Resources

With respect to the attainment of the Board's goals, the CEO shall not fail to take advantage of collaboration, partnerships, and innovative relationships with agencies and other community resources.

Commented [MMD12]: Newly drafted language.

10. Communication and Counsel to the Board

With respect to providing information and counsel, the CEO shall not permit the Board to be uninformed. Accordingly, he or she may not:

A. Neglect to submit monitoring data required by the Board in a timely, accurate, and understandable fashion, directly addressing provisions of the Board Policies being monitored.
B. Let the Board be unaware of relevant trends, anticipated adverse media coverage, material external and internal changes, particularly changes in the assumptions upon which any Board Policy has previously been established.
C. Fail to advise the Board if, in the CEO's opinion, the Board is not in compliance with its own Policies on Governance Process and Board-Staff Relationship, particularly in the case of Board behavior which is detrimental to the work relationship between the Board and CEO.
D. Fail to marshal for the Board as many staff and external points of view, issues, and options, as needed for fully informed Board choices.
E. Present information in unnecessarily complex or lengthy forms;

F. Fail to provide a mechanism for official Board, officer, or committee communications;
G. Fail to deal with the Board as a whole except when fulfilling individual requests for information.
H. Fail to report in a timely manner an actual or anticipated noncompliance with any policy of the Board.

Commented [MMD13]: Policy 10.13

4. Goals

Focusing on goals ensures the Board tackles the difficult questions by mobilizing Board time, mechanics, and concern around what good is to be done for whom and at what cost. To this end, the Board will annually review and adopt Goals Policies.

Commented [MMD14]: Newly drafted language

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to the Entity Board of Directors.

IV. MONITORING AND REVIEW

The CEO and designees will review the policy on an annual basis.

V. DEFINITIONS

N/A

VI. REFERENCES AND SUPPORTING DOCUMENTS

1. Board Policies and Procedures
2. Board of Directors By-Laws
3. Operating Agreement

VII. REFERENCES/LEGAL AUTHORITY

N/A

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
11/18/2021	Language from 10.1 Annual Planning Cycle, Updated Title, added language from policy 10.9	CEO and Designees
6/13/2023	Revised Language in 10.4, combined language from 10.2, 10.12, 10.13, and 10.17.	CEO and Designees

Attachment 12

POLICY TITLE: NEW LRE Board of Director's Orientation	POLICY # 10.22	REVIEW DATES	
Topic Area: 10 LRE Board Policies	**ISSUED BY:** Chief Executive Officer		
Applies to: LRE Board of Directors, LRE CEO			
Developed and Maintained by: LRE CEO or Designee	**APPROVED BY:** Chief Executive Officer		
Supersedes: N/A	**Effective Date:** 6/28/2023	**Revised Date:**	

I. PURPOSE

In order that newly appointed Board members may cast informed votes and function effectively as Lakeshore Regional Entity (LRE) Board members, the Board and Chief Executive Officer (CEO) will extend to them the fullest measures of courtesy and cooperation and will make every reasonable effort to orient newly appointed Board members to the organizations purpose, strategic direction and Board functions, policies, procedures and current issues.

II. POLICY

The Board, through the CEO, will provide new members with copies of or access to appropriate publications, such as the LRE policy manual, the region's Operating Agreement, the Board Bylaws, its Strategic Plan and current fiscal year budget.

The Board Chairperson, CEO and Deputy Director will schedule and arrange for an orientation session for new Board members as soon as practicable after appointment. A reasonable amount of time will be provided for discussion of the following possible topics:

1. The roles, responsibilities and conduct of the Board and individual members;
2. The Board fiduciary responsibility and integrity obligations;
3. Basic operational procedures of the Board;
4. Placement of items on the agenda;
5. The role of councils, committees, subcommittees and advisory committees;
6. Conflict of Interest;
7. Appropriate responses of an individual member when a request or complaint is made directly to him/her by a regional stakeholder, consumer, provider or community member;
8. How Board members, in fulfilling their duties, may request information concerning the organizations operations, finances and personnel; 9. Protocol for interacting with the media; and
10. Other relevant topics.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to the Entity Board of Directors.

IV. MONITORING AND REVIEW

This policy is reviewed by the CEO and designees on an annual basis.

V. DEFINITIONS

CEO: Chief Executive Officer
LRE: Lakeshore Regional Entity
SUD: Substance Use Disorder

VI. REFERENCES AND SUPPORTING DOCUMENTS

PIHP-MDCH Contract
Open Meetings Act

VII. RELATED POLICIES AND PROCEDURES

Board Governance
Board Member Conduct
Conflict of Interest

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
June 28, 2023	NEW	Chief Executive Officer

PROCEDURE # 10.22a	EFFECTIVE DATE	REVISED DATE
TITLE: NEW LRE Board of Directors Orientation	6/28/2023	
ATTACHMENT TO POLICY #: 10.21 POLICY TITLE: NEW LRE Board of Directors Orientation CHAPTER: 10 LRE Board Policies	REVIEW DATES	

I. Purpose

The purpose of this procedure is to provide a means to orient new members of the Northern Michigan Regional Entity (LRE) Board of Directors and Substance Use Disorder (SUD) Policy Oversight Board.

II. Application

All new members of the LRE Board of Directors as appointed by the CMHSP Board of Directors or Substance Use Disorder Policy Oversight Board Members as appointed by his or her County's Board of Commissioners.

III. PROCEDURES

LRE BOARD OF DIRECTORS

1. When appointed, the CMHSP Director will forward contact information to the LRE CEO and Executive Assistant.
2. The CEO will arrange a meeting with the newly appointed Board Member and one of the other representatives from that CMHSP, if possible.
3. During the meeting, the CEO will provide the following information:
   a. LRE ByLaws
   b. LRE Operating Agreement
   c. LRE Mission and Vision Statements
   d. LRE Organizational Chart
   e. List of LRE Board Members and Committee Members
   f. Contact Information for LRE CEO and Executive Assistant
   g. LRE Board Governance Policy
   h. LRE Conflict of Interest Policy
   i. Acronym List
   j. LRE Member Handbook
4. The CEO will also explain the Board meeting schedule, per diem policy, and provide necessary paperwork relating to these payments.
5. At the New Member's first Board meeting:

a. The LRE Chairperson will introduce the New Board Member.
b. New Board Member will be given an opportunity to share background, interest, etc. with the Board.
c. Other Board Members will introduce themselves to the new Board Member.

SUD POLICY OVERSIGHT BOARD

1. When notified by a County that a new member has been appointed, the LRE CEO will contact the individual to schedule a meeting, prior to the next SUD Policy Oversight Board meeting, if possible.
2. The LRE CEO and the LRE COO will meet with the new Board Member. During the meeting, the following information will be provided:
   a. PA 500 of 2012
   b. LRE SUD Policy Oversight Board ByLaws
   c. LRE Mission and Vision Statements
   d. LRE Organizational Chart
   e. List of LRE SUD Policy Oversight Board Members
   f. Contact information for the LRE CEO and Executive Assistant
   g. LRE SUD Conflict of Interest Policy and related forms
   h. Acronym list
   i. LRE Member Handbook
   j. Current FY Budget for SUD Services
3. The CEO will also explain the SUD Policy Oversight Board meeting schedules, per diem policy, and provide necessary paperwork relating to these payments.
4. At the new Member's First SUD Policy Oversight Board Meeting:
   a. The COO will introduce the new Board Member
   b. The New Board Member will be given an opportunity to share background, interest, etc. with the SUD Policy Oversight Board
   c. Other SUD Policy Oversight Board Members will introduce themselves to the new Board Member.

IV. CHANGE LOG

Date of Change	Description of Change	Responsible Party

Policy #10.23

POLICY TITLE: Board Member Conduct and Board Meetings	POLICY # 10.232	REVIEW DATES	
Topic Area: LRE Board Policies	**ISSUED BY:** Chief Executive Officer		
Applies to: LRE Board of Directors, LRE CEO			
Developed and Maintained by: LRE CEO or Designee	**APPROVED BY:** Chief Executive Officer		
Supersedes: N/A	**Effective Date:** 6/28/2023	**Revised Date:**	

I. PURPOSE

The Lakeshore Regional Entity (LRE) Board exists to represent and make decisions in the best interest of the entire organization and its regional stakeholders. The Board is established to assure development and approval of effective policies that provide for compliance with the approved strategic direction, the LRE Corporate Compliance Plan, the Board's fiduciary responsibility, approved policies, and authorized contracts.

Each Board Member is expected to adhere to a high standard of ethical conduct and to act in accordance with LRE's Mission and Core Values. The good name of LRE depends upon the way Board Members conduct business and the way the public perceives that conduct.

II. POLICY

It is the policy that each Lakeshore Regional Entity (the "Entity") Board of Directors member represent the interests of the Entity. This accountability supersedes any potential conflicts of loyalty to other interests including advocacy or interest groups, membership on other boards, relationships with other's or personal interests of any Board Director.

Each of the Entity Board of Directors may not attempt to exercise individual authority over the organization except as explicitly set forth in the Entity Board of Directors policies.

a. Each of the Entity Board of Directors interaction with the Entity Chief Executive Officer (CEO) or with the Entity staff must recognize the lack of authority vested in individuals except when explicitly the Entity Board of Directors-authorized.
b. Each Entity Board Director's interaction with public, press or other entities must recognize the same limitation and the inability of any Entity Board of Director to speak for the Entity Board of Directors.
c. Each Entity Board Director commenting on the agency and the Entity CEO performance must be done collectively and as regards to explicit Entity Board of Directors policies. Any comments regarding the Entity and/or the Entity CEO performance must be done collectively as related to the policies.

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Each Entity Board Director will be properly prepared for the Entity Board of Directors deliberation.

~~II.~~

A. LRE Board members shall be guided by the following principles in carrying out their responsibilities:

Board Interaction with Payers, Regulators, the Community and Media: The Board recognizes that payers/regulators, members of the media, LRE's stakeholder groups and the public at large have significant interests in the organization's actions and governance, therefore the Board seeks to ensure appropriate communication, subject to concerns about confidentiality. The Board designates the Chief Executive Officer as the primary point of contact and spokesperson for LRE.

- If comments from the LRE Board are appropriate, they should be reviewed and discussed by the Board in advance, and, in most circumstances, come from the Chairperson of the Board.

Compliance with Laws, Rules and Regulations: Board members shall comply with all laws, rules and regulations applicable to LRE.

Confidentiality: Board members shall maintain the confidentiality of information entrusted to them by or about LRE its business, consumers, or providers, contractors except when disclosure is authorized or legally mandated.

Conflicts of Interest: Board members must act in accordance with the Conflicts of Interest Policy adopted by the LRE Board, and as amended from time to time. When declaring a conflict of interest, the conflict must be clearly stated.

Delegation of Authority: The Entity Board of Directors will use due care not to delegate substantial discretionary authority to individuals whom they know, or should have known through due diligence, have a propensity to engage in illegal activities.

Duty of Care: Board members shall apply themselves with seriousness and diligence to participating in the affairs of LRE and shall act prudently in exercising management oversight of the organization. Board Members are expected to be familiar with LRE's business and the environment in which the organization operates, and understand LRE's policies, strategies and core values.

Duty of Loyalty: Board members shall act so as to protect LRE's interests and those of its employees, assets and legal rights, and Board Members shall serve the interests of LRE, its beneficiaries, partner Community Mental Health Service Programs and the consumers they serve. If an individual Board member disagrees with a decision made by the Board, he/she

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shall identify if speaking on the matter after the meeting that they are speaking as an individual and not for the Board.

Duty to Disclose: Each Covered Person has a duty to disclose to the Board the Existence of a Financial Interest and all related material facts.

Excluded Individuals: Persons who have been excluded from participation in Federal Health Care Programs may not serve as an Entity Board Director. Each Entity Board Director becomes responsible for notifying the Entity Corporate Compliance Department if they believe they will become an excluded individual. Each Entity Board Director is responsible for providing information necessary to monitor possible exclusions. The Entity shall periodically review the Entity Board Director's names against the excluded list per regulatory and contractual obligations.

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Inquiry: Board members shall take steps necessary to be sufficiently informed to make decisions on behalf of LRE and to participate in an informed manner in Board activities.

Integrity of Records and Public Reporting: Board members shall promote accurate and reliable preparation and maintenance of LRE's financial and other records to assure full, fair, accurate, timely, understandable, open and transparent disclosure.

Observance of Ethical Standards: Board members must adhere to the highest of ethical standards in the conduct of their duties. These include honesty, fairness and integrity. Unethical actions, or the appearance of unethical actions, are not acceptable.

B. **Enforcement**: Board members will discuss with the Board Chairperson any questions or issues that may arise concerning compliance with this policy. Breaches of this policy, whether intentional or unintentional, shall be reviewed in accordance with the LRE Operating Agreement (Article 5 - Section 5.1) "Dispute Resolution Process." Action to remove a Board member shall occur in accordance with approved bylaws (Section 4.4) "Removal."

III. Board Meeting Procedures:

A. LRE Board Meetings shall be conducted in accordance with the board bylaws and parliamentary procedures. Specifically, the process of decision and order of procedures shall occur as outlined in the bylaws section 4.6-4.12.

B. Agenda(s)

1. DEVELOPMENT: BOD agendas shall be managed by the CEO in conjunction with the BOD Chairperson and LRE Executive Assistant.

2. AGENDA ITEM(S) FOR CONSIDERATION: With the exception of the BOD members (see Section III.A.2.a) agenda items must be submitted to LRE Executive Assistant not less than ten (10) business days prior to the next scheduled Regular Meeting for placement on the agenda. The submission shall include all necessary supporting documentation/information requisite to the BOD's full consideration.

    a. A BOD member's intent to add an item or amend/rescind a previous item shall be introduced to the BOD during the "future agenda items" portion of a preceding meeting. The BOD shall not add items to an agenda if said item has been previously acted upon by the BOD unless approved in advance by the BOD and/or the provisions of Section D.3 (Voting,Rescind/Amend) have been met.

    b. All agenda items for consideration shall be submitted with complete documentation. The CEO shall review the request and take one of the following actions:
        i. Request additional information as needed before making recommendations or taking action.
        ii. Approve or deny items under the authority of the CEO. Items denied may be appealed in writing to the Chairperson of the BOD detailing specific reasons why an item should be considered. Requests for consideration/appeal must be received within 10 business days from the receipt of the denial.
        iii. Report items requiring action to the BOD with recommendation/resolutions on disposition of action.

    c. AGENDA FORMAT FOR REGULAR MEETINGS:
        i. Call to Order/Welcome
        ii. Roll call/Determination of Quorum/Conflict of Interest Question
        iii. Public Comment (Limited to agenda items only)
        iv. Consent Items: Agenda/Minutes
        v. Staff Reports
        vi. Chairperson's Report
        vii. Action Items
        viii. Financial Report and Funding Distribution
        ix. Statement of Activities with variance reports
        x. Monthly FSR
        xi. CEO Report
        xii. Board Member Comments
        xiii. Public Comment

xiv. Upcoming LRE Meetings
xv. Adjourn

d. INFORMATIONAL FLOW TO THE BOD:

i. REGULAR MEETING PACKETS: In general, on the Friday before each BOD meeting, LRE Executive Administrative Assistant will provide the BOD with a written materials and reports for the upcoming meeting. Any questions or additional information needed by the BOD should be director to the CEO by the Monday prior to the meeting, and that information shall be provided back to all BOD before the meeting.

ii. CHANGES TO THE PUBLISHED AGENDA: at the discretion of the CEO and/or BOD Chairperson, agenda items (except those under Scetion III.A.2.a) may be changed (including but not limited to additions, deletions, and order) prior to the close-of-business on the Tuesday prior to the scheduled BOD meeting. Challenges shall be for a substantial reasons i.e. urgency, lack of supporting materials, availability of presenter. The BOD shall receive a revised final agenda at the close of business that same day, reflecting any changes to the agenda with appropriate revision number noted. If no changes have been made, the meeting packet previously sent shall be considered the final agenda unless changed by the BOD during the meeting.

a. Any changes to the final agenda by the BOD after noon on Tuesday must be accomplished at the beginning of the meeting by a two-thirds (2/3) majority vote of those elected and serving.

iii. AGENDA ITEMS: LRE Directors may add agenda items for discussion only to any regularly scheduled meeting of the Board by contacting the Chair or, in the absence of the Chair, the vice chair, up to noon on the Tuesday preceding the scheduled meeting.

iv. DISCUSSION ITEMS: Items may be of a specific nature on which action will be required at a future meeting and/or a broader nature requiring discussion on subsequent agendas. Following the discussion of each item, the BOD Chairperson should clarify the intent of further action or discussion needed. Generally, items requiring BOD action shall start as discussion items and be moved to a future agenda for

action. However, routing and time-sensitive items may be moved for immediate action.

v. CONSENT ITEMS: The purpose of the consent items portion of the agenda is to expedite business by grouping non-controversial items together to be considered by a single motion without discussion and debate. Any member of the BOD may ask that any consent item be placed elsewhere on the agenda for the item to be considered separately. Such requests will automatically be granted.

C. RULES OF FORM

1. SPEAKING TO A QUESTION: Every BOD member, previous to speaking upon a question shall address the chair. When two or more BOD members speak at once, the chair shall designate the BOD member who shall speak first. On matters involving questions about an item presently before the Board, there shall be no limit on board member questions or other inquiry.

2. CALL TO ORDER: When a BOD member is speaking on any question before the BOD, the member shall not be interrupted except to be called to order. A member called to order shall immediately be silent unless permitted to explain, and the BOD, if appealed to, shall decide the case. If there is no appeal, the decision of the BOD chair shall stand.

3. SUBMISSION OF MOTION: No motion shall be debated or put in the minutes unless the same is seconded It shall be stated by the Chairperson before debate, and any such motion shall be reduced to writing if any members desire it, or at the request of the Chairperson or the Administrative Executive Assistant.

4. WITHDRAWAL OF MOTION: After a motion is stated by the Chairperson, it shall be deemed to be in possession of the BOD, but my be withdrawn by the member who made the motion, with the concurrence of the member seconding the motion, if there is no objection by any other member of the BOD. All BOD decisions shall be entered in the record of the BOD proceedings.

5. MOTIONS DURING DEBATE: On matters of debate involving significant differences in views among board members about an item presently before the Board, the Board Chair may designate a timeframe within which the debate is to occur. The Board, by motion duly seconded and adopted, may extend the period for debate. Any member can motion to close debate, which motion must be seconded and is not debatable. If the motion passes, such debate shall

terminate. When a question is under debate, no motions shall be received but to adjourn to call the previous question, to table, to postpone indefinitely, to postpone to a day certain, to refer, and/or to amend…

6. MOTION TO ADJOURN: The motion to adjourn shall always be in order, and the motion to table shall be decided without debate. A motion simply to adjourn shall be understood to mean for the day only.

7. PREVIOUS QUESTION: When moved, and seconded, a 2/3rds affirmative vote ends all discussion/debate and the BOD shall proceed immediately to any related amendments and then the main motion (as amended).

8. DIVISON OF QUESTION: If the question being discussed contains two or more points, any BOD member may request to have it divided for separate considerations.

9. RECORDING: In all cases, every written report, resolution, or motion shall bear the name of the originating committee or workgroup, and the names of the BOD member moving and the BOD member seconding shall be entered into the record of the BOD's proceedings.

10. COMMENTS ENTERED INTO THE RECORD: A BOD member, wishing to have his/her comment(s) entered into the record of the BOD's proceedings, shall submit the comment(s) in writing to the LRE Executive Administrative Assistant.

11. SPECIAL ORDERS: Any measure or motion having been placed on special orders for some future time shall be taken up prior to that time except by unanimous consent of the BOD members present.

D. VOTING

1. ROLL CALL:
   a. The names and votes of the BOD members shall be recorded on board actions to adopt final measures as ordinances and the appointment or election of officers, etc [MCLA 46.3a]

   b. Conflicts of Interest: BOD members may not "engage in any transaction, arrangement, or proceedings of other matter or undertake positions with other organizations that involve a Conflict of Interest, except in compliance" with the Conflict of Interest Policy. "covered Persons should avoid not only actual but he appearance of Conflicts of Interest as well;" and shall make

such declarations of real or perceived conflict of interest at the time appropriately prior to any final, related action by the BOD.

c. A roll call vote will be taken when requested by any BOD member.

d. When a roll call vote is taken, no member present shall abstain from voting "yes" or "no".

e. For the voting of the BOD at each session, the LRE Executive Administrative Assistant shall vary the order of the calling the role.

f. During the roll call vote, members of the BOD shall be given an opportunity to vote. Each BOD member's vote shall be presented as follows and so recorded by the LRE Executive Administrative Assistant:
   i. "Yes" – representing any response in the affirmative
   ii. "No" – representing any response in the negative
   iii. "Abstaining" – only in the instance of a conflict of interest as defined in D.1.b above, and
   iv. "Absent" – BOD members was not present at the time of the vote.

2. TIE VOTES: In the event of a tie bote of the BOD upon any matter presented to them for consideration, the motion or proposal does not pass for lack of a majority approval; the matter, however, may be proposed to the BOD for reconsideration in the identical, similar or revised form at any time, to be voted on by the same number of BOD members, or more, present at the time of the tie vote.

3. RESCIND/AMEND: A motion to rescind or amend any question previously acted upon may be made on any day of any session under the following conditions:

   a. The action caused by the original question has not already been carried out to the point that it cannot be undone.
   b. The motion to rescind or amend must be moved and seconded by the BOD members who voted with the majority, but there must be at least as many BOD members present as there was when the matter to be rescinded was first voted upon.

E. MISCELLANEOUS RULES

1. On matters of general comment or comments of a personal nature, after being recognized by the Chairperson, each Board member may speak on items presently before the Board twice, for up to three (3) minutes each time. The

Chairperson may extend an additional (3) minute speaking period at the request of the individual board member or if duly authorized by board action. Any member can make a motion to suspend the rule, which motion must be seconded. If the motion passes, the rule shall be suspended for the duration of consideration of the item before the Board.

IV. APPLICABILITY AND RESPONSIBILITY

This policy applies to the Entity Board of Directors.

V. MONITORING AND REVIEW

The CEO and designees will review this policy on an annual basis.

VI. DEFINITIONS

Boardsmanship: Describes the competencies and skills necessary to be an effective Board member.
CEO: Chief Executive Officer
LRE: Lakeshore Regional Entity
MDHHS: Michigan Department of Health and Human Services
PIHP: Pre-Paid Inpatient Health Plan

VII. REFERENCES AND SUPPORTING DOCUMENTS

LRE Corporate Compliance Plan
LRE Operating Agreement
LRE Board By-Laws
SUD Intergovernmental Agreement

VIII. REFERENCES/LEGAL AUTHORITY

LRE Operating Agreement
LRE Board Bylaws
MDHHS-PIHP contract section, Observance of State and Federal Laws and Regulations, 1Q.(10) Ethical Conduct, 1.Q(11) Conflict of Interest

IX. CHANGE LOG

Date of Change	Description of Change	Responsible Party
6/14/2023	NEW (combined 10.5 Code of Conduct with new language and changed title). Rescind 10.5	Chief Executive Officer

LAKESHORE REGIONAL ENTITY

Attachment 15

POLICY TITLE: COMMITTEES STRUCTURE	**POLICY # 10.2**	
Topic Area: Board of Directors **Applies to:** Board of Directors **Review Cycle:** Annually **Developed and Maintained by:** CEO	**Issued By and Approved By:** Board of Directors	**REVIEW DATES** 11/18/21
Supersedes: N/A	**Effective Date:** 9/17/16	**Revised Date:** 11/18/21

I. PURPOSE

To define the roles and functions of the Entity Board of Directors and Committees.

II. POLICY

A Committee is established as a Lakeshore Regional Entity (the "Entity") Board of Directors Committee only if its existence and charge is directed by the Entity Board of Directors, regardless of whether the Entity Board of Director's members sit on the committee. Unless otherwise stated, a committee ceases to exist as soon as its work is complete.

Committee Structure

A. The Entity Board of Directors will create Committees, as needed to address specific areas of concern.
B. A written charge for each Committee will be developed. The charge will include a written statement of the scope, purpose, and obligation of the Committee as well as details regarding committee makeup, member terms, and defined time frames for completion of the Committee's charge.

Committee Principles

Committees shall:

1. Assist the Entity Board of Directors by preparing policy alternatives and implications for the Entity Board of Directors deliberation. In keeping with the broader focus, the Entity Board of Directors committees will normally not have direct dealings with current staff operations.
2. Not speak or act for the Entity Board of Directors except when formally given such authority for specific and time-limited purposes.
3. Not exercise authority over the Entity staff.
4. Be developed sparingly and ordinarily in an ad hoc capacity.
5. The Member CEOs will assign staff resources necessary for committee support

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to any group that is formed by the Entity Board of Directors action, whether or not it is called a committee and regardless of whether the group includes the Entity Board of Directors members. It does not apply to committees formed under the authority of the Entity CEO.

IV. MONITORING AND REVIEW

This policy is reviewed by the CEO on an annual basis.

V. DEFINITIONS

N/A

VI. RELATED POLICIES AND PROCEDURES

A. Board of Directors By-laws
B. Operating Agreement

VII. REFERENCE/LEGAL AUTHORITY

N/A

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
11/18/21	Merged 10.2 and 10.3, formatted. Renamed policy	CEO

Attachment 16

POLICY TITLE: CODE OF CONDUCT	POLICY # 10.5	
Topic Area: Board of Directors **Applies to:** Board of Directors **Review Cycle:** Annually **Developed and Maintained by:** CEO and Designees	**Issued By and Approved By:** Board of Directors	**REVIEW DATES** 11/18/21
Supersedes: N/A	**Effective Date:** 9/17/16	**Revised Date:** 11/18/21

I. PURPOSE

The Entity Board of Directors commits itself to ethical, lawful, and businesslike conduct including proper use of authority and appropriate decorum when acting as an Entity Board Director.

II. POLICY

It is the policy that each Lakeshore Regional Entity (the "Entity") Board of Directors member represent the interests of the Entity. This accountability supersedes any potential conflicts of loyalty to other interests including advocacy or interest groups, membership on other boards, relationships with other's or personal interests of any Board Director.

1. Each of the Entity Board of Directors will follow the Entity Conflict of Interest Policy
2. Each of the Entity Board of Directors may not attempt to exercise individual authority over the organization except as explicitly set forth in the Entity Board of Directors policies.
    a. Each of the Entity Board of Directors interaction with the Entity Chief Executive Officer (CEO) or with the Entity staff must recognize the lack of authority vested in individuals except when explicitly the Entity Board of Directors-authorized.
    b. Each Entity Board Director's interaction with public, press or other entities must recognize the same limitation and the inability of any Entity Board of Director to speak for the Entity Board of Directors.
    c. Each Entity Board Director commenting on the agency and the Entity CEO performance must be done collectively and as regards to explicit Entity Board of Directors policies. Any comments regarding the Entity and/or the Entity CEO performance must be done collectively as related to the policies.
3. Each Entity Board Director will respect the confidentiality appropriate to issues of a sensitive nature including, but not limited, to those related to business or strategy.
4. Confidentiality: Each Entity Board Director shall comply with the Michigan Mental Health Code, Section, 330.1748, & 42 CFR Part 2 relative to substance abuse services,

and any other applicable privacy laws (Materials can be found by contacting the Entity Compliance Department)

5. Each Entity Board Director will be properly prepared for the Entity Board of Directors deliberation.
6. Each Entity Board Director will support the legitimacy and authority of the final determination of the Entity Board of Directors on any matter, without regard to the Entity Board Director's personal position on the issue.
7. Delegation of Authority: The Entity Board of Directors will use due care not to delegate substantial discretionary authority to individuals whom they know, or should have known through due diligence, have a propensity to engage in illegal activities.
8. Excluded Individuals: Persons who have been excluded from participation in Federal Health Care Programs may not serve as an Entity Board Director. Each Entity Board Director becomes responsible for notifying the Entity Corporate Compliance Department if they believe they will become an excluded individual. Each Entity Board Director is responsible for providing information necessary to monitor possible exclusions. The Entity shall periodically review the Entity Board Director's names against the excluded list per regulatory and contractual obligations.
9. Each Entity Board Director will read and seek to understand the Entity Compliance Plan and Code of Conduct.
    a. The Entity Board of Directors have a duty to report to the Entity Chief Compliance Officer any alleged or suspected violation of the Entity Board of Directors Code of Conduct or related laws and regulations by themselves or another Entity Board Director.
    b. The Entity Board of Directors may seek advice from the Entity Board of Directors Chairperson or the Entity Chief Compliance Officer concerning appropriate actions that may need to be taken to comply with the Code of Conduct or Compliance Plan.
    c. Reporting Suspected Fraud: The Entity Board of Directors must report any suspected "fraud, abuse or waste" (consistent with the definitions as set forth in the Compliance Program Plan) of any Entity funding streams.
    d. Failure to comply with the Entity Compliance Plan and the Entity Board of Directors Code of Conduct may result in the recommendation to a participant CMHSP Board the member's removal from the Entity Board of Directors.
    e. The Entity Board Directors will participate in required Entity Board of Directors compliance trainings.
    f. The Entity Board of Directors will establish and encourage throughout its region, cultures that promote prevention, detection, and resolution of instances of misconduct in order to conform to applicable laws and regulations.
    g. The Entity Board of Directors shall cooperate fully in any internal or external Medicaid or other LRE funding stream compliance investigation.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to the Entity Board of Directors.

IV. MONITORING AND REVIEW

This policy is reviewed by the CEO and designees on an annual basis.

V. DEFINITIONS

Conflict of Interest: Any actual or proposed direct or indirect financial relationship or ownership interest between each individual director and any entity with which the Entity has or proposes to have a contract, affiliation, arrangement, or other transaction.

VI. RELATED POLICIES AND PROCEDURES

A. Conflict of Interest Policy
B. Compliance Plan
C. Board By-Laws

VII. REFERENCES/LEGAL AUTHORITY

A. MDHHS Medicaid Specialty Supports and Services Contract
B. 42 CFR Part 2
C. Michigan Mental Health Code

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
11/18/21	Add references	CEO and Designees

Attachment 17

POLICY TITLE: BUDGET	POLICY #: 10.12	
Topic Area: Board of Directors **Applies to:** Chief Executive Officer, Board of Directors **Review Cycle**: Annually **Developed and Maintained by:** CEO and Designees **Supersedes:** N/A	**Issued By and Approved By:** Board of Directors	**REVIEW DATES** 11/18/21 **Effective Date:** 9/16/17 **Revised Date:** 11/18/21

I. PURPOSE

To ensure the Board of Directors, in its governance role, is provided accurate information to ensure fiscal accountability and oversight.

II. POLICY

Budgeting any fiscal year or the remaining part of any fiscal year shall not deviate from Lakeshore Regional Entity (the "Entity") Board of Directors accomplishments/results/outcomes priorities, risk fiscal jeopardy, or fail to be derived from multi-year plan.

Accordingly, the Entity CEO will provide appropriate budgeting which:

1. Contains adequate information and includes information which enables credible projection of revenues and expenses, separation of capital and operational items, cash flow, and disclosure of planning assumptions.
2. Plans for the expenditures in any fiscal year of funds that are conservatively projected to be available for that period.
3. Provides detail that is sufficient for the Entity Board of Directors prerogatives, such as costs of fiscal audit, the Entity Board of Directors development, the Entity Board of Directors and committee meetings, and the Entity Board of Directors legal fees.
4. Ensures the fiscal soundness of future years and builds organizational capability sufficient to achieve future ends.
5. Can be shared with the Entity Board of Directors on a monthly basis.
6. Adheres to generally accepted accounting practices and standards.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to the Entity Chief Executive Officer (CEO).

IV. MONITORING AND REVIEW

This policy is reviewed by the CEO and designees on an annual basis.

V. DEFINITIONS

N/A

VI. RELATED POLICIES AND PROCEDURES

A. Financial Policies and Procedures
B. Board Policies and Procedures

VII. REFERENCES/LEGAL AUTHORITY

N/A

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
11/18/21	Added Purpose	CEO and Designees

Attachment 18

POLICY TITLE: COMMUNICATION AND COUNSEL TO THE BOARD OF DIRECTORS	POLICY #: 10.13	
Topic Area: Executive Responsibility	**Issued By and Approved By:** Board of Directors	**REVIEW DATES** 11/18/21
Applies to: Chief Executive Officer, Chief Compliance Officer, Chief Financial Officer		
Developed and Maintained by: CEO and Designees	**Effective Date:** 9/17/16	**Revised Date:** 11/18/21
Supersedes: N/A		

I. PURPOSE

To make appropriate decisions, the Entity Board of Directors must be informed of relevant information by the Entity Executive staff.

II. POLICY

Chief Executive Officer

The Lakeshore Regional Entity (the "Entity") Chief Executive Officer (CEO) shall ensure that the Entity Board of Directors is informed and supported in its work.

The Entity CEO must:

1. Submit monitoring data required by the Entity Board of Directors in in a timely, accurate, and understandable fashion, directly addressing provisions of Entity Board of Directors policies being monitored and including the Entity CEO interpretations as well as relevant data.
2. Ensure that the Entity Board of Directors is aware of any noncompliance actual or anticipated of Entity Board of Directors policies regardless of monitoring policy schedule.
3. Ensure that the Entity Board of Directors has adequate information to be aware of relevant trends, regardless of monitoring policy schedule.
4. Inform the Entity Board of Directors of any significant information on impending media coverage, threatened or pending lawsuits, and material internal and external changes.
5. Ensure that the Entity Board of Directors is aware that, in the Entity CEO's opinion, the Entity Board of Directors is not in compliance with its own policies, particularly in the case of the Entity Board of Directors behavior that is detrimental to the work relationship between the Entity Board of Directors and the Entity CEO.
6. Refrain from presenting information in unnecessarily complex or lengthy form or in a form that fails to differentiate among information of three types: monitoring, decision preparation, and other.

7. Ensure that the Entity Board of Directors will have a workable mechanism for official Entity Board of Directors, officers, or committee's communications.
8. Not deal with individual Entity Board of Directors in a way that favors or privileges certain the Entity Board of Directors members over others, except when fulfilling individual requests for information or responding to officers or committees duly charged by the Entity Board of Directors.
9. Submit to the Entity Board of Directors a consent agenda containing items delegated to the Entity CEO required by law, regulation, or contract to be approved by the Entity Board of Directors, along with applicable monitoring information.

Chief Financial Officer and Chief Compliance Officer

The Financial Officer and Chief Compliance Officer shall have direct access to the Entity Board of Directors.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to the Entity Board of Directors, Entity CEO, Entity Chief Compliance Officer, and the Entity Chief Financial Officer.

IV. MONITORING AND REVIEW

The CEO and designees will review this policy on an annual basis.

V. DEFINITIONS

N/A

VI. RELATED POLICIES AND PROCEDURES

A. Compliance Policies and Procedures
B. Board Policies and Procedures
C. Board By-Laws

VII. REFERENCE/LEGAL AUTHORITY

N/A

CHANGE LOG Date of Change	**Description of Change**	**Responsible Party**
11/18/21	Moved procedure to policy section. Added language from 10.17	CEO and Designees

POLICY TITLE: MANAGEMENT DELEGATION AND EXECUTIVE LIMITATIONS	POLICY #: 10.17	
Topic Area: Board of Directors **Applies to:** CEO, CFO, Compliance Officer **Review Cycle**: Annually **Developed and Maintained by:** CEO and Designees **Supersedes:** N/A	**Issued By and Approved By:** Board of Directors	**REVIEW DATES** 11/18/21
	Effective Date: 9/17/16	**Revised Date:** 11/18/21

I. PURPOSE

All Entity Board authority delegated to staff is delegated to the CEO. The CEO shall execute the delegated authority of the Entity Board within defined executive limitations.

II. POLICY

The Lakeshore Regional Entity (the "Entity") Board of Directors sole official connection to the operational organization, its achievements and conduct will be through its chief executive, titled Chief Executive Officer (CEO).

The Entity CEO shall have the authority delegated to that position from time to time by the Entity Board of Directors. The Entity CEO may not simultaneously hold another position (employee, board member or contractor) with any Member.

Delegation of Authority

Contracts

A. For funds included in the Entity Board's approved budget, the CEO is authorized to enter into purchase-of-service agreements such as maintenance contracts, printing contracts, television advertising, clinical service contracts, and other contracts that implement functions of the Entity system administration. This also includes entering into contracts with consultants and contracts for professional services.
B. For items not included in the Entity Board's approved budget, the CEO is authorized to enter into purchase-of-service agreements and contracts whose total cost does not exceed $50,000. Such contracts will be reported to the Entity Board in a timely manner as specified by Policy 2.2 – Cash Management- Disbursements.

Executive Limitations

A. Decisions or instructions of individual Entity Board of Directors officers, or committees are not binding on the CEO except in instances when the Entity Board of Directors has specifically authorized such exercise of authority.

B. In the case of individual Entity Board of Directors or committees requesting information or assistance without the Entity Board of Directors authorization, the Entity CEO can refuse such requests that require, if in the Entity CEO's opinion, a material amount of staff time or funds are required or are disruptive.

C. The CEO shall not cause or allow any practice, activity, decision, or organizational circumstance, which is either illegal, imprudent or in violation of commonly accepted business and professional ethics or in violation of contractual obligations.

D. With respect to the actual, ongoing condition of the Entity's financial health, the Entity Chief Executive Officer (CEO) may not cause or allow the development of fiscal jeopardy or the material deviation of actual expenditures from board priorities established in policies.

   The Entity CEO may not:

   1. Expend more funds than have been received in the fiscal year to date (including carry forward funds from prior year) unless the Entity Board of Directors debt guideline is met as defined in the LRE Operating Agreement under Section 4.8 Debt-Thresholds.
   2. Incur debt in an amount greater than can be repaid by certain and otherwise unencumbered revenues in accordance with the LRE Entity Board of Directors approved schedule.
   3. Use any designated reserves other than for established purposes.
   4. Conduct inter-fund shifting in amounts greater than can be restored to a condition of discrete fund balances by certain and otherwise unencumbered revenues within ninety days.
   5. Fail to settle payroll and debts in a timely manner.
   6. Allow tax payments or other government-ordered payments of filings to be overdue or inaccurately filed.
   7. Fail to adhere to applicable generally acceptable accounting standards.
   8. Make a single purchase or commitment of greater than $ 50,000.00 in a fiscal year, except for participant CMHSP and direct-contracted prevention or treatment provider contracts. Splitting orders to avoid this limit is not acceptable.
   9. Purchase or sell real estate in any amount absent the Entity Board of Directors authorization.
   10. Fail to aggressively pursue receivables after a reasonable grace period.

E. Treatment of Staff

   The Entity CEO may not:

   1. Operate without written personnel rules that:
      i. Articulate federal and state work rules
      ii. Clarify these rules for staff
      iii. Provide effective handling of grievances
      iv. Protect against wrongful conditions such as nepotism and grossly preferential treatment for personal reasons.

2. Retaliate against any staff member for expression of dissent.
3. Fail to acquaint staff with the Entity CEO interpretation of their protections under this policy.
4. Allow staff to be unprepared to deal with emergency situations.

F. Treatment of Plan Members

The Entity CEO may not:

1. Use forms or procedures that elicit information for which there is no clear necessity.
2. Use methods of collecting, reviewing, or storing plan member information that fail to protect against improper access to the information elicited.
3. Fail to inform the Entity Board of Directors of the status of uniform benefits across the region or fail to assist Participant CMHSPs towards compliance.
4. Fail to provide procedural safeguards for the secure transmission of Plan members' protected health information.
5. Fail to establish with people served by the Entity a clear contract of what may be expected from the Entity including but not limited to their rights and protections.
6. Fail to inform people served by the Entity of this policy or to provide a grievance process to those plan members who believe that they have not been accorded a reasonable interpretation of their rights under this policy.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to the Entity CEO and the Entity Board of Directors.

IV. MONITORING AND REVIEW

The CEO and designees will review this policy on an annual basis.

V. DEFINITIONS

N/A

VI. RELATED POLICIES AND PROCEDURES

A. Board By-Laws
B. Financial Policies and Procedures
C. Board Policies and Procedures
D. Compliance Plan

VII. REFERENCES/LEGAL AUTHORITY

N/A

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party

11/18/21	Added language from 2.1, 10.11, 10.15, 10.16, 10.20 10.21	CEO and Designees

LAKESHORE REGIONAL ENTITY

Lakeshore Regional Entity Board
Financial Officer Report for July 2023
7/26/2023

- **Disbursements Report** – A motion is requested to approve the June 2023 disbursements. A summary of those disbursements is included as an attachment.

- **Statement of Activities** – Report through May is included as an attachment. This is a preliminary report. Figures will change based on the final FY2022 financial statements due to accruals, other year-end entries, the external audit, and the CMHSP final FSRs.

- **LRE Combined Monthly FSR –** The May LRE Combined Monthly FSR Report is included as an attachment for July's meeting. Expense projections, as reported by each CMHSP, are noted. An actual surplus through May of $10.7 million, a projected annual surplus of $7 million and a budgeted surplus of $10.9 million regionally (Medicaid and HMP, excluding CCBHC) is shown in this month's report. All CMHSPs have an actual surplus, except Network180 with an actual deficit of $3 million. All CMHSPs have a projected surplus, except Network180 with a projected deficit of $1.9 million and West Michigan with a projected deficit of $91 thousand. All CMHSPs have a budgeted surplus.

  CCBHC activity is included in this month's report showing no actual, projected or budgeted surplus or deficit. The CCBHC activity is for the LRE only and does not reflect the activity at the CCBHC level due to different reporting requirements for the PIHP versus the CCBHC. This report was reviewed by Finance ROAT on July 19, 2023, and reviewed by Operations Advisory Council on July 19, 2023. This reporting template is still a work in progress and changes throughout the year are anticipated.

- **Cash Flow Issues –** No Member CMHSP has reported any cash flow issues.

- **ISF/Medicaid Savings Estimate –** On July 14, 2023, the State Attorney General's office sent communication to the LRE's legal team indicating that the amended FSR submissions on March 7, 2022 will not be accepted nor approved by the Department.

  On July 20, 2023, the LRE received communication from MDHHS regarding the FY20 Compliance Examination. MDHHS indicated several discrepancies with the FSR from FY20 that was included in the Compliance Examination that was filed by the LRE's auditors June 2021.

  The LRE is in the process of working with auditors and legal to determine what options are available and what impact this will have on the previously reported ISF/Medicaid Savings.

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- **FY 2023 Revenue Projections** – Updated revenue and membership projections by program and CMHSP are below. The FY23 June revenue projection includes an overall increase of approximately $4.3 million from the May projections. About $2.8 million of the increase is attributable to revised assumptions about the impact of Medicaid redeterminations. In the FY24 Draft Capitation Rate setting materials, Milliman estimated that 60% of the pandemic related growth in enrollments would drop off due to redeterminations and 40% of people added during the pandemic would remain Medicaid eligible. Our original projections assumed that enrollment would return to pre-pandemic levels. Additionally, although redeterminations resumed in July, most disenrollments have been delayed until August, and are expected to continue through August 2024. Our previous projections assumed that disenrollments would begin in July. The remaining $1.5 million of the increase is primarily due to an increase in the number of eligibles who are not currently enrolled in a Medicaid Health Plan. This population tends to have both physical and behavioral health conditions, requiring more complex care management and a greater cost of care. As a result, the capitation rates for unenrolled individuals are typically greater than those enrolled in Medicaid Health Plans.

FY 2023 Revenue Projection

Total LRE

	FY 22 Budget Projection	FY 23 Initial Budget Projection	FY22 to FY23 Initial Change	FY22 to FY23 Initial % Change	FY23 Current Budget Projection	FY22 to FY23 Current Change	FY22 to FY23 Current % Change	FY23 Intitial to Current Change	FY23 Intitial to Current %Change
MCD - MH	$ 213,135,026	$ 230,503,748	$ 17,368,722	8.15%	$ 231,864,791	$ 18,729,765	8.79%	$ 1,361,043	0.59%
MCD - SUD	$ 8,189,247	$ 8,922,063	$ 732,815	8.95%	$ 10,022,016	$ 1,832,768	22.38%	$ 1,099,953	12.33%
HMP - MH	$ 32,718,689	$ 35,267,839	$ 2,549,150	7.79%	$ 38,907,706	$ 6,189,016	18.92%	$ 3,639,867	10.32%
HMP - SUD	$ 18,646,066	$ 20,373,667	$ 1,727,601	9.27%	$ 19,422,446	$ 776,380	4.16%	$ (951,221)	-4.67%
Autism	$ 41,587,466	$ 44,763,182	$ 3,175,717	7.64%	$ 43,805,177	$ 2,217,712	5.33%	$ (958,005)	-2.14%
Waiver	$ 41,989,313	$ 46,509,162	$ 4,519,850	10.76%	$ 44,506,093	$ 2,516,780	5.99%	$ (2,003,070)	-4.31%
LRE Admin	$ 12,451,370	$ 8,451,024	$ (4,000,346)	-32.13%	$ 13,922,556	$ 1,471,186	11.82%	$ 5,471,532	64.74%
ISF	$ 28,393,407	$ -	$ (28,393,407)	-100.00%	$ -	$ (28,393,407)	-100.00%	$ -	
IPA	$ 4,711,498	$ 4,902,840	$ 191,342	4.06%	$ 5,050,551	$ 339,053	7.20%	$ 147,711	3.01%
Total Region	**$ 401,822,082**	**$ 399,693,525**	**$ (2,128,557)**	**-0.53%**	**$ 407,501,336**	**$ 5,679,254**	**1.41%**	**$ 7,807,811**	**1.95%**

Total CMHSPs

	FY 22 Budget Projection	FY 23 Initial Budget Projection	FY22 to FY23 Initial Change	FY22 to FY23 Initial % Change	FY23 Current Budget Projection	FY22 to FY23 Current Change	FY22 to FY23 Current % Change	FY23 Intitial to Current Change	FY23 Intitial to Current %Change
Allegan	$ 31,638,150	$ 34,101,811	$ 2,463,661	7.79%	$ 34,338,471	$ 2,700,321	8.54%	$ 236,660	0.69%
Healthwest	$ 70,438,581	$ 80,471,573	$ 10,032,992	14.24%	$ 80,718,982	$ 10,280,401	14.59%	$ 247,409	0.31%
Network180	$ 180,590,423	$ 190,822,853	$ 10,232,430	5.67%	$ 191,930,058	$ 11,339,635	6.28%	$ 1,107,205	0.58%
Ottawa	$ 49,281,634	$ 53,873,029	$ 4,591,395	9.32%	$ 54,559,480	$ 5,277,846	10.71%	$ 686,451	1.27%
West Michigan	$ 24,317,020	$ 27,070,395	$ 2,753,376	11.32%	$ 26,981,238	$ 2,664,219	10.96%	$ (89,157)	-0.33%
Total CMHSPs	**$ 356,265,807**	**$ 386,339,661**	**$ 30,073,854**	**8.44%**	**$ 388,528,229**	**$ 32,262,422**	**9.06%**	**$ 2,188,568**	**0.57%**

Average PMPM

	FY 22 Budget Projection	FY 23 Initial Budget Projection	FY23 Current Budget Projection	Change
Allegan	$ 97.34	$ 100.97	$ 98.31	$ (2.67)
Healthwest	$ 92.56	$ 101.53	$ 100.18	$ (1.35)
Network180	$ 89.80	$ 91.31	$ 89.19	$ (2.11)
Ottawa	$ 87.08	$ 90.89	$ 87.33	$ (3.57)
West Michigan	$ 89.29	$ 95.99	$ 94.24	$ (1.75)
Total CMHSPs	**$ 90.53**	**$ 94.34**	**$ 92.11**	**$ (2.23)**

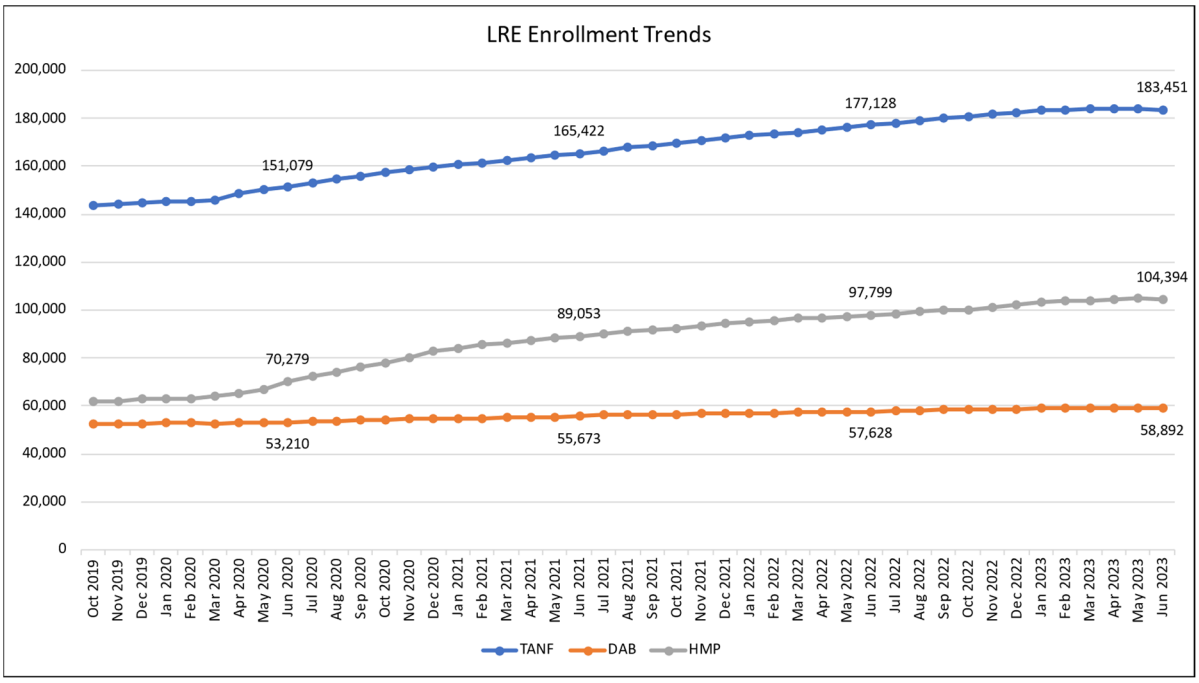
Member Month Projection

	FY 22 Budget Projection	FY 23 Initial Budget Projection	FY23 Current Budget Projection	Change
Allegan	325,041	337,728	349,302	11,574
Healthwest	761,004	792,624	805,759	13,135
Network180	2,010,987	2,089,944	2,151,915	61,971
Ottawa	565,936	592,704	624,782	32,078
West Michigan	272,333	282,012	286,315	4,303
Total Member Months	**3,935,299**	**4,095,012**	**4,218,073**	**123,061**

CMHSPs Breakdown

	FY 22 Budget Projection	FY 23 Initial Budget Projection	FY23 Current Budget Projection	Change
MCD - MH				
Allegan	$ 18,459,689	$ 18,969,153	$ 19,159,123	$ 189,970
Healthwest	$ 43,665,225	$ 46,816,052	$ 46,901,761	$ 85,709
Network180	$ 106,890,686	$ 117,079,439	$ 117,734,686	$ 655,247
Ottawa	$ 28,593,576	$ 30,887,650	$ 31,420,199	$ 532,549
West Michigan	$ 15,525,850	$ 16,751,454	$ 16,649,023	$ (102,431)
Total MCD - MH	**$ 213,135,026**	**$ 230,503,748**	**$ 231,864,791**	**$ 1,361,043**
MCD - SUD				
Allegan	$ 671,848	$ 730,726	$ 811,838	$ 81,112
Healthwest	$ 1,749,475	$ 1,897,354	$ 2,128,595	$ 231,242
Network180	$ 4,108,629	$ 4,481,652	$ 5,040,635	$ 558,983
Ottawa	$ 1,038,301	$ 1,138,491	$ 1,284,640	$ 146,149
West Michigan	$ 620,994	$ 673,840	$ 756,308	$ 82,468
Total MCD - SUD	**$ 8,189,247**	**$ 8,922,063**	**$ 10,022,016**	**$ 1,099,953**
HMP - MH				
Allegan	$ 2,508,410	$ 2,697,512	$ 2,950,448	$ 252,935
Healthwest	$ 6,590,924	$ 7,106,018	$ 7,706,048	$ 600,030
Network180	$ 16,644,528	$ 17,910,233	$ 19,869,119	$ 1,958,885
Ottawa	$ 4,645,779	$ 5,066,277	$ 5,678,389	$ 612,112
West Michigan	$ 2,329,049	$ 2,487,798	$ 2,703,702	$ 215,903
Total HMP - MH	**$ 32,718,689**	**$ 35,267,839**	**$ 38,907,706**	**$ 3,639,867**
HMP - SUD				
Allegan	$ 1,412,762	$ 1,541,824	$ 1,467,295	$ (74,530)
Healthwest	$ 3,868,962	$ 4,222,890	$ 3,985,140	$ (237,750)
Network180	$ 9,498,255	$ 10,362,966	$ 9,881,316	$ (481,650)
Ottawa	$ 2,525,248	$ 2,794,857	$ 2,701,135	$ (93,722)
West Michigan	$ 1,340,839	$ 1,451,130	$ 1,387,560	$ (63,569)
Total HMP - SUD	**$ 18,646,066**	**$ 20,373,667**	**$ 19,422,446**	**$ (951,221)**
Autism				
Allegan	$ 3,522,099	$ 3,937,779	$ 3,889,531	$ (48,248)
Healthwest	$ 4,686,111	$ 9,028,145	$ 8,983,295	$ (44,850)
Network180	$ 25,577,745	$ 22,522,287	$ 21,938,741	$ (583,546)
Ottawa	$ 6,155,560	$ 6,591,085	$ 6,431,267	$ (159,818)
West Michigan	$ 1,645,950	$ 2,683,886	$ 2,562,343	$ (121,543)
Total Autism	**$ 41,587,466**	**$ 44,763,182**	**$ 43,805,177**	**$ (958,005)**
Waiver				
Allegan	$ 5,063,342	$ 6,224,816	$ 6,060,237	$ (164,579)
Healthwest	$ 9,877,884	$ 11,401,115	$ 11,014,143	$ (386,972)
Network180	$ 17,870,579	$ 18,466,274	$ 17,465,561	$ (1,000,713)
Ottawa	$ 6,323,169	$ 7,394,670	$ 7,043,850	$ (350,820)
West Michigan	$ 2,854,338	$ 3,022,287	$ 2,922,302	$ (99,985)
Total Waiver	**$ 41,989,313**	**$ 46,509,162**	**$ 44,506,093**	**$ (2,003,070)**

- **Financial Data/Charts** – Below, this chart contains an annual and monthly comparison of the number of individuals in our region who are eligible for each program. The number of eligible individuals in our region determines the amount of revenue the LRE receives each month. Data is shown for October 2019 – June 2023. The LRE also receives payments for other individuals who are not listed on these charts but are eligible for behavioral health services (i.e. individuals enrolled and eligible for the Habilitation Supports Waiver (HSW) program).



- **FY 2024 Rate Setting Update –** On July 14, 2023, MDHHS provided draft rates for FY24. Those rates do not yet include the impact of enrollment redetermination, entity specific factors, or complete CCBHC rate information. The State's actuarial firm indicated at the July 10, 2023 Rate Setting Meeting that they are assuming a 60% decrease in pandemic-related growth due to redetermination.

- **FY 2024 Revenue Projections –** Based on the rate setting information above, the LRE has drafted FY2024 Initial Revenue Projections. Those projections were shared at Finance ROAT on July 19, 2023. Those projections show a $22.5 million or 5.57% reduction in revenue from the FY2023 June Revenue Projections. Member CMHs will be utilizing these projections for their FY2024 Proposed Spending Plans/Budgets, which are due to the LRE on August 11, 2023.

FY 2024 Revenue Projection

Total LRE

	FY23 Budget Projection (June)	FY24 Current Budget Projection	FY23 to FY24 Current Change	FY23 to FY24 Current % Change
MCD - MH	$ 230,682,442	$ 217,030,117	$ (13,652,325)	-5.92%
MCD - SUD	$ 9,945,521	$ 9,155,470	$ (790,051)	-7.94%
HMP - MH	$ 38,121,691	$ 30,245,020	$ (7,876,671)	-20.66%
HMP - SUD	$ 19,029,661	$ 17,026,563	$ (2,003,098)	-10.53%
Autism	$ 43,511,376	$ 43,905,852	$ 394,477	0.91%
Waiver	$ 44,494,732	$ 46,287,054	$ 1,792,323	4.03%
LRE Admin	$ 13,922,556	$ 13,922,556	$ -	0.00%
ISF	$ -	$ -	$ -	
IPA	$ 4,992,129	$ 4,584,582	$ (407,547)	-8.16%
Total Region	**$ 404,700,107**	**$ 382,157,214**	**$ (22,542,893)**	**-5.57%**

Total CMHSPs

	FY23 Budget Projection (June)	FY24 Current Budget Projection	FY23 to FY24 Current Change	FY23 to FY24 Current % Change
Allegan	$ 34,117,609	$ 32,060,166	$ (2,057,443)	-6.03%
Healthwest	$ 80,178,452	$ 75,503,802	$ (4,674,651)	-5.83%
Network180	$ 190,530,282	$ 179,585,887	$ (10,944,394)	-5.74%
Ottawa	$ 54,166,835	$ 51,318,561	$ (2,848,274)	-5.26%
West Michigan	$ 26,792,243	$ 25,181,659	$ (1,610,584)	-6.01%
Total CMHSPs	**$ 385,785,422**	**$ 363,650,076**	**$ (22,135,346)**	**-5.74%**

Average PMPM

	FY23 Budget Projection (June)	FY24 Current Budget Projection
Allegan	$ 98.80	$ 101.10
Healthwest	$ 100.65	$ 103.13
Network180	$ 89.58	$ 91.93
Ottawa	$ 87.73	$ 90.34
West Michigan	$ 94.67	$ 97.23
Total CMHSPs	**$ 92.53**	**$ 94.95**

Member Month Projection

	FY23 Budget Projection (June)	FY24 Current Budget Projection
Allegan	325,041	317,100
Healthwest	761,004	732,131
Network180	2,010,987	1,953,488
Ottawa	565,936	568,063
West Michigan	272,333	259,003
Total Member Months	**3,935,299**	**3,829,785**

CMHSPs Breakdown

	FY23 Budget Projection (June)	FY24 Current Budget Projection	Change
MCD - MH			
Allegan	$ 19,060,871	$ 17,628,958	$ (1,431,913)
Healthwest	$ 46,671,010	$ 43,773,040	$ (2,897,970)
Network180	$ 117,130,277	$ 110,639,408	$ (6,490,869)
Ottawa	$ 31,254,347	$ 29,409,075	$ (1,845,272)
West Michigan	$ 16,565,937	$ 15,579,636	$ (986,301)
Total MCD - MH	**$ 230,682,442**	**$ 217,030,117**	**$ (13,652,325)**
MCD - SUD			
Allegan	$ 805,478	$ 740,224	$ (65,254)
Healthwest	$ 2,112,903	$ 1,938,957	$ (173,946)
Network180	$ 5,002,302	$ 4,596,526	$ (405,776)
Ottawa	$ 1,274,149	$ 1,185,378	$ (88,771)
West Michigan	$ 750,690	$ 694,385	$ (56,305)
Total MCD - SUD	**$ 9,945,522**	**$ 9,155,470**	**$ (790,052)**
HMP - MH			
Allegan	$ 2,890,725	$ 2,304,985	$ (585,740)
Healthwest	$ 7,550,762	$ 5,943,486	$ (1,607,276)
Network180	$ 19,467,786	$ 15,458,082	$ (4,009,704)
Ottawa	$ 5,562,833	$ 4,458,463	$ (1,104,370)
West Michigan	$ 2,649,585	$ 2,080,005	$ (569,580)
Total HMP - MH	**$ 38,121,691**	**$ 30,245,020**	**$ (7,876,671)**
HMP - SUD			
Allegan	$ 1,437,717	$ 1,287,401	$ (150,316)
Healthwest	$ 3,904,827	$ 3,485,931	$ (418,896)
Network180	$ 9,681,267	$ 8,661,120	$ (1,020,147)
Ottawa	$ 2,646,045	$ 2,378,104	$ (267,941)
West Michigan	$ 1,359,805	$ 1,214,006	$ (145,799)
Total HMP - SUD	**$ 19,029,661**	**$ 17,026,563**	**$ (2,003,098)**
Autism			
Allegan	$ 3,864,060	$ 3,888,638	$ 24,578
Healthwest	$ 8,927,596	$ 8,956,110	$ 28,514
Network180	$ 21,787,577	$ 22,048,431	$ 260,854
Ottawa	$ 6,387,440	$ 6,448,522	$ 61,082
West Michigan	$ 2,544,703	$ 2,564,151	$ 19,448
Total Autism	**$ 43,511,376**	**$ 43,905,852**	**$ 394,476**
Waiver			
Allegan	$ 6,058,758	$ 6,209,961	$ 151,203
Healthwest	$ 11,011,355	$ 11,406,278	$ 394,923
Network180	$ 17,461,073	$ 18,182,321	$ 721,248
Ottawa	$ 7,042,021	$ 7,439,019	$ 396,998
West Michigan	$ 2,921,524	$ 3,049,476	$ 127,952
Total Waiver	**$ 44,494,731**	**$ 46,287,054**	**$ 1,792,323**

- **Legal Expenses –** Below, this chart contains legal expenses of the LRE that have been billed to the LRE to date for FY2022 and FY2023.

LAKESHORE REGIONAL ENTITY LEGAL EXPENSES REPORT June 30, 2023		
4/30/2022	BYLAWS/OPERATING AGREEMENT	5,700.00
7/28/2022	BYLAWS/OPERATING AGREEMENT	6,500.00
	BYLAWS/OPERATING AGREEMENT T	**12,200.00**
11/30/2021	CCHBC SUPPORT	812.50
	CCHBC SUPPORT TOTAL	**812.50**
2/11/2022	GENERAL/OTHER	325.00
1/16/2023	GENERAL/OTHER	10,000.00
2/3/2023	GENERAL/OTHER	250.00
	GENERAL/OTHER TOTAL	**10,575.00**
10/31/2021	HEALTHWEST LIGITATION	5,368.74
3/31/2022	HEALTHWEST LIGITATION	2,016.00
4/30/2022	HEALTHWEST LIGITATION	9,388.80
6/24/2022	HEALTHWEST LIGITATION	13,782.40
3/31/2023	HEALTHWEST LIGITATION	6,992.00
4/30/2023	HEALTHWEST LIGITATION	3,640.00
	HEALTWEST LITIGATION TOTAL	**41,187.94**
10/31/2021	MANAGED CARE/MDHHS CONTRACT	17,058.00
11/30/2021	MANAGED CARE/MDHHS CONTRACT	9,992.00
12/31/2021	MANAGED CARE/MDHHS CONTRACT	5,202.00
1/25/2022	MANAGED CARE/MDHHS CONTRACT	23,501.31
2/17/2022	MANAGED CARE/MDHHS CONTRACT	9,280.00
2/17/2022	MANAGED CARE/MDHHS CONTRACT	17,125.00
2/28/2022	MANAGED CARE/MDHHS CONTRACT	20,051.20
2/28/2022	MANAGED CARE/MDHHS CONTRACT	6,312.50
3/31/2022	MANAGED CARE/MDHHS CONTRACT	4,032.00
4/11/2022	MANAGED CARE/MDHHS CONTRACT	421.50
6/24/2022	MANAGED CARE/MDHHS CONTRACT	2,863.57
7/25/2022	MANAGED CARE/MDHHS CONTRACT	6,788.23
8/22/2022	MANAGED CARE/MDHHS CONTRACT	4,437.50
8/25/2022	MANAGED CARE/MDHHS CONTRACT	16,806.40
9/29/2022	MANAGED CARE/MDHHS CONTRACT	20,832.00
9/30/2022	MANAGED CARE/MDHHS CONTRACT	23,104.65
10/31/2022	MANAGED CARE/MDHHS CONTRACT	9,307.00
11/30/2022	MANAGED CARE/MDHHS CONTRACT	33,792.00
11/30/2022	EARLY PAYMENT DISCOUNT	(5,068.80)
12/31/2022	MANAGED CARE/MDHHS CONTRACT	31,494.10
1/31/2023	MANAGED CARE/MDHHS CONTRACT	25,683.40
2/28/2023	MANAGED CARE/MDHHS CONTRACT	7,472.60
3/31/2023	MANAGED CARE/MDHHS CONTRACT	3,371.20
4/30/2023	MANAGED CARE/MDHHS CONTRACT	16,328.80
5/31/2023	MANAGED CARE/MDHHS CONTRACT	2,212.00
5/31/2023	MANAGED CARE/MDHHS CONTRACT	3,716.00
	MANAGED CARE/MDHHS CONTRACT	**316,116.16**
2/28/2023	NETWORK 180 LITIGATION	2,674.00
3/31/2023	NETWORK 180 LITIGATION	29,167.33
4/30/2023	NETWORK 180 LITIGATION	103.20
5/31/2023	NETWORK 180 LITIGATION	2,274.40
	NETWORK 180 LITIGATION TOTAL	**34,218.93**
	GRAND TOTAL	**$ 415,110.53**

LAKESHORE REGIONAL ENTITY

BOARD ACTION REQUEST
Subject: May 2023 Disbursements
Meeting Date: July 26, 2023

RECOMMENDED MOTION:

To approve the June 2023 disbursements of $50,111,295.09 as presented.

SUMMARY OF REQUEST/INFORMATION:

Disbursements:	
Allegan County CMH	$2,814,250.91
Healthwest	$16,551,915.64
Network 180	$22,849,947.08
Ottawa County CMH	$4,562,818.08
West Michigan CMH	$1,894,893.23
SUD Prevention Expenses	$100,462.44
SUD Public Act 2 (PA2)	$194,813.46
Administrative Expenses	$1,142,194.25
Total:	**$50,111,295.09**

97.71% of Disbursements were paid to Members and SUD Prevention Services.

I affirm that all payments identified in the monthly summary above are for previously appropriated amounts.

STAFF: *Stacia Chick* **DATE: 7/19/2023**

LAKESHORE REGIONAL ENTITY

Statement of Activities - Actual vs. Budget
Fiscal Year 2022/2023
As of Date: 5/31/23

Change in Net Assets	Year Ending 9/30/2023	5/31/2023		
	FY23 Budget *Amendment 1*	Budget to Date	Actual	Actual to Budget Variance
Operating Revenues				
Medicaid, HSW, SED, & Children's Waiver	285,537,018	190,358,012	195,723,019	5,365,007
Autism Revenue	43,517,457	29,011,638	30,361,299	1,349,661
DHS Incentive	471,247	314,165	123,901	(190,264)
Healthy Michigan	62,732,364	41,821,576	40,219,101	(1,602,475)
Peformance Bonus Incentive	2,819,234	1,879,489	-	(1,879,489)
Hospital Rate Adjuster (HRA)	9,518,432	6,345,621	5,814,732	(530,889)
Local Match Revenue (Members)	1,007,548	671,699	503,774	(167,925)
CCBHC Supplemental Revenue	13,064,253	8,709,502	6,062,712	(2,646,790)
CCBHC General Funds	693,898	462,599	493,278	30,679
MDHHS Grants	13,155,178	8,770,119	4,318,337	(4,451,782)
PA 2 Liquor Tax	3,249,131	2,166,087	1,985,148	(180,940)
Non-MDHHS Grants: DFC	125,000	83,333	83,146	(188)
Interest Revenue	299,487	199,658	174,658	(25,000)
Miscellaneous Revenue	15,500	10,333	-	(10,333)
Total Operating Revenues	**436,205,747**	**290,803,831**	**285,863,104**	**(4,940,728)**
Expenditures				
Salaries and Fringes	3,871,353	2,580,902	2,715,038	134,136
Office and Supplies Expense	259,630	173,087	106,589	(66,497)
Contractual and Consulting Expenses	888,445	592,297	441,454	(150,842)
Managed Care Information System (PCE)	305,200	203,467	196,800	(6,667)
Legal Expense	242,153	161,435	155,135	(6,301)
Utilities/Conferences/Mileage/Misc Exps	8,355,776	5,570,517	196,969	(5,373,548)
Grants - MDHHS & Non-MDHHS	989,860	659,907	237,605	(422,302)
Taxes, HRA, and Local Match	15,503,880	10,335,920	9,928,869	(407,051)
Prevention Expenses - Grant & PA2	3,034,456	2,022,971	2,231,010	208,039
Contribution to ISF/Savings	-	-	-	-
Member Payments - Medicaid/HMP	356,798,513	237,865,675	239,632,149	1,766,473
Member Payments - CCBHC Capitation	20,545,519	13,697,013	13,330,840	(366,173)
Member Payments - CCBHC Supplemental	13,064,253	8,709,502	3,906,229	(4,803,273)
Member Payments - CCBHC General Fund	693,898	462,599	493,278	30,679
Member Payments - PA2 Treatment	2,001,942	1,334,628	517,242	(817,386)
Member Payments - Grants	9,650,869	6,433,913	4,233,523	(2,200,390)
Total Expenditures	**436,205,747**	**290,803,831**	**278,322,731**	**(12,481,101)**
Total Change in Net Assets	**-**	**-**	**7,540,373**	**7,540,373**

Statement of Activities
Budget to Actual Variance Report

For the Period ending May 31, 2023

As of Date: 5/31/23

Operating Revenues

Medicaid/HSW/SED/CWP	N/A - Closely aligned with the current budget projections.
Autism Revenue	N/A - Closely aligned with the current budget projections.
DHS Incentive	This revenue will be received quarterly beginning in April. Amounts are based on encounter data that supports services to Foster Care and CPS children.
Healthy Michigan	N/A - Closely aligned with the current budget projections.
Peformance Bonus Incentive	Revenue is received after the end of the fiscal year if health plan performance metrics are met.
Hospital Rate Adjuster	Revenue is received quarterly. Third quarter payment is expected in quarter four.
Local Match Revenue	Local match requirement for FY23 was reduced.
CCBHC Supplemental Revenue	Rates are expected to decrease for FY23. Will be monitored for adjustments during the next amendment when MDHHS provides the new rates.
CCBHC General Funds	Funds received were less than projected. Adjustments to be made during next amendment.
MDHHS Grants	SUD grant payments changed to quarterly in FY23. Recent allocation increases will be drawn down as the year goes on.
PA 2 Liquor Tax	PA2 revenues are received after the Department of Treasury issues payments to the counties. More payments are expected for the 3rd quarter.
Non-MDHHS Grants: DFC	Budget amendment is expected to carry lapsed FY22 funds over for use in FY23.
Interest Revenue	Interest earned on savings, including the LRE's CD, is trending higher than expected. Recent budget amendment adjusted for this increase.
Miscellaneous Revenue	No miscellaneous funds received as of this report. Funds are expected periodically throughout the year for trainings and Talksooner subscriptions.

Expenditures

Salaries and Fringes	N/A - Closely aligned with the current budget projections.
Office and Supplies	N/A - Closely aligned with the current budget projections.
Contractual/Consulting	Spending is under but some budgeted expenditures are planned for later in the year.
Managed Care Info Sys	N/A - Closely aligned with the current budget projections.
Legal Expense	N/A - Closely aligned with the current budget projections.
Utilities/Conf/Mileage/Misc	This line item includes the LRE's contingency fund and will be monitored for adjustments during the next amendment.
Grants - MDHHS & Non-MDHHS	Most of these payments are billed to the LRE and paid by MDHHS 45-60 days in arrears. In addition, as noted above, some grants are being paid quarterly.
Taxes/HRA/Local Match	N/A - Closely aligned with the current budget projections.
Prevention Exps - Grant/PA2	Proposed amendments will result in a closer alignment of budget to actual in this category.
Contribution to ISF	N/A - Spending will be monitored per LRE's Risk Management Plan
Member Med/HMP Payments	N/A - Closely aligned with the current budget projections.
Member CCBHC Capitation	Due to recent rate changes, this line item will be monitored for a possible budget amendment.
Member CCBHC Supplemental	CCBHC PPS-1 Supplemental Payments are based on actual eligible daily visits reported. PPS-1 rates were decreased retroactively for FY23. A budget amendment is likely needed.
Member CCBHC GF	Last fiscal year MDHHS did not allow billings against this category until quarter four.
Member PA2 Tx Payments	Billings against this line item typically occur after other grant funding is applied. Spending will be monitored to assess deferrals for future use.
Member Grant Payments	Proposed amendments will result in a closer alignment of budget to actual in this category.

Includes Medicaid, Autism and Healthy Michigan activity only.
Does not inlcude Grant, General Funds, Local or other funding..

LAKESHORE REGIONAL ENTITY

Lakeshore Regional Entity Combined Monthly FSR Summary
FY 2023
May 2023 Reporting Month
Reporting Date: 07/19/2023

ACTUAL:	HealthWest	Network180	OnPoint	Ottawa	West Michigan	LRE	Total
Distributed Medicaid/HMP Revenue							
Medicaid	30,655,754	89,737,366	16,872,585	25,226,746	9,837,980	2,972,218	175,302,649
Autism	6,215,394	15,160,594	2,693,174	4,388,500	1,769,973	385,140	30,612,775
Healthy Michigan	5,974,696	19,922,743	2,955,601	5,488,204	3,405	484,617	34,829,266
Total Distributed Medicaid/HMP Revenue	42,845,844	124,820,703	22,521,360	35,103,450	11,611,358	3,841,975	240,744,690
Capitated Expense							
Medicaid	29,883,742	95,210,403	17,152,553	22,990,037	9,782,775	2,972,218	177,991,727
Autism	1,518,307	16,064,365	1,387,442	3,182,344	526,593	385,140	23,064,191
Healthy Michigan	5,106,113	16,574,138	2,737,558	3,079,802	1,039,126	484,617	29,021,354
Total Capitated Expense	36,508,161	127,848,906	21,277,553	29,252,183	11,348,494	3,841,975	230,077,273
Actual Surplus (Deficit)	6,337,683	(3,028,203)	1,243,807	5,851,267	262,864	-	10,667,418
% Variance	14.79%	-2.43%	5.52%	16.67%	2.26%	0.00%	
Information regarding Actual (Threshold: Surplus of 5% and deficit of 1%)	Spending is in line with our initial spending plan and planned positive variance.	Deficit projected in previous months' reporting is now showing in actuals due to MAT reconsiderations that occurred in May. This resulted in higher YTD claims expenses.	Spending is in line with board approved budget and initial spending plan. Surplus is consistent with prior month, as expected.	April and May revenue payments were booked in May and the last 2 weeks of payroll and provider payables posted on 6/2.	Less than threshold for explanation		

PROJECTION:	HealthWest	Network180	OnPoint	Ottawa	West Michigan	LRE	Total
LRE Revenue Projections as of:							
May							
Medicaid	47,846,083	139,270,937	25,989,107	39,469,724	13,682,294	14,573,351	280,831,496
Autism	8,914,849	21,676,909	3,847,356	6,363,428	2,533,303	1,966,125	45,301,970
Healthy Michigan	8,470,272	28,666,331	4,253,035	8,069,973	1,558,639	2,312,486	53,330,736
Total Projected Medicaid/HMP Revenue	65,231,204	189,614,177	34,089,497	53,903,125	17,774,236	18,851,963	379,464,202
	(0)	-	-	-	-	-	
Expense Projections							
Medicaid	47,825,613	143,255,092	26,758,264	40,534,844	15,015,013	14,573,351	287,962,177
Autism	3,075,184	23,805,748	2,297,237	6,352,937	1,352,427	1,966,125	38,849,658
Healthy Michigan	7,785,618	24,459,396	3,925,366	5,712,953	1,497,756	2,312,486	45,693,575
Total Capitated Expense Projections	58,686,415	191,520,237	32,980,867	52,600,734	17,865,195	18,851,963	372,505,410
Projected Surplus (Deficit)	6,544,789	(1,906,060)	1,108,630	1,302,391	(90,959)	-	6,958,792
% Variance	10.03%	-1.01%	3.25%	2.42%	-0.51%	0.00%	
Information regarding Projections (Threshold: Surplus of 5% and deficit of 1%)	Spending is 2% higher than the surplus that we are aiming for. HealthWest's spending plan has a planned 5.8% positive variance built in for last minute items due to historical swings and expected revenue reductions. We anticipate expense will continue to go up and remain within our 5.8% goal.	See explanation on SUD rate increases and projected impact for the remainder of FY23.	OnPoint does a full projection update quarterly, this update has been completed based on known actual and authorization data through June 30, 2023.	Less than threshold for explanation	Less than threshold for explanation		

PROPOSED SPENDING PLAN:	HealthWest	Network180	OnPoint	Ottawa	West Michigan	LRE	Total
Submitted to the LRE as of:	12/8/2022	9/19/2022	10/18/2022	6/9/2023	6/9/2023		
Medicaid/HMP Revenue							
Medicaid	50,592,580	138,477,148	26,226,787	37,997,693	13,748,030	14,637,966	281,680,204
Autism	8,877,222	21,807,343	3,848,342	6,663,994	2,533,303	1,962,200	45,692,404
Healthy Michigan	9,801,631	28,885,568	4,320,883	8,381,507	1,583,863	2,239,706	55,213,158
Total Budgeted Medicaid/HMP Revenue	69,271,433	189,170,059	34,396,012	53,043,194	17,865,195	18,839,873	382,585,766
Capitated Expense							
Medicaid	52,832,547	136,680,342	26,869,897	40,534,844	15,015,013	14,637,966	286,570,609
Autism	2,409,949	22,686,387	1,961,305	6,002,636	1,352,427	1,962,200	36,374,903
Healthy Michigan	8,177,941	27,916,973	3,063,222	5,878,693	1,497,756	2,239,706	48,774,291
Total Budgeted Capitated Expense	63,420,437	187,283,702	31,894,424	52,416,174	17,865,195	18,839,873	371,719,804
	-	-	-	-	-	-	
Budgeted Surplus (Deficit)	5,850,996	1,886,358	2,501,588	627,021	0	-	10,865,962
% Variance	8.45%	1.00%	7.27%	1.18%	0.00%	0.00%	
Information regarding Spending Plans (Threshold: Surplus of 5% and deficit of 1%)	Based on Board approved budget.	Less than threshold for explanation	Based on Board approved budget.	Less than threshold for explanation	Less than threshold for explanation		

Variance between Projected and Proposed Spending Plan	693,793	(3,792,417)	(1,392,958)	675,371	(90,959)	-	(3,907,171)
% Variance	1.00%	-2.00%	-4.05%	1.27%	-0.51%	0.00%	
Explanation of variances between Projected and Proposed Spending Plan (Threshold: Surplus of 5% and deficit of 1%)	Less than threshold for explanation	Spending Plan expenses match N180 FY23 Board Approved Budget on 9/19/22, plus increase for H0020 to $19 per unit and 3% SUD Rate increase. Projection matches LRE revenue projection, which was finalized after the N180 Board approved budget	Budget was prepared at the beginning of the year before SUD rate changes were known. OnPoint has also added a number of positions based on increased utilization, and worked with contracted service providers to supplement staffing vacancies, resulting in current projections being higher than initial spending plan.	Less than threshold for explanation	Less than threshold for explanation		

CCBHC Activity is for LRE activity only. Does not reflect the activity at the CCBHC level due to different reporting requirements for the PIHP vs. the CCBHC.

Lakeshore Regional Entity Combined Monthly FSR Summary
FY 2023
May 2023 Reporting Month
Reporting Date: 07/19/2023

CCBHC ACTIVITY

ACTUAL:	HealthWest	Network180	OnPoint	Ottawa	West Michigan	LRE	Total
Distributed Medicaid/HMP CCBHC Revenue							
Medicaid CCBHC Base Capitation	7,963,984				4,352,832		12,316,817
Medicaid CCBHC Supplemental	2,824,408				1,235,235		4,059,642
Healthy Michigan CCBHC Base Capitation	1,872,483				1,590,399		3,462,882
Healthy Michigan CCBHC Supplemental	879,157				473,262		1,352,419
Total Distributed Medicaid/HMP CCBHC Revenue	13,540,031	-	-	-	7,651,728	-	21,191,760
Capitated CCBHC Expense							
Medicaid CCBHC	10,788,392				5,588,067		16,376,459
Healthy Michigan CCBHC	2,751,639				2,063,661		4,815,301
Total Capitated CCBHC Expense	13,540,031	-	-	-	7,651,728	-	21,191,760
Actual CCBHC Surplus (Deficit)	-	-	-	-	-	-	-
% Variance	0.00%				0.00%		
Information regarding CCBHC Actual (Threshold: Surplus of 5% and deficit of 1%)	Less than threshold for explanation				Less than threshold for explanation		

PROJECTION:	HealthWest	Network180	OnPoint	Ottawa	West Michigan	LRE	Total
LRE CCBHC Revenue Projections *							
Medicaid CCBHC Base Capitation	11,945,977				6,529,249		18,475,225
Medicaid CCBHC Supplemental	4,236,611				1,852,852		6,089,464
Healthy Michigan CCBHC Base Capitation	2,808,724				2,385,599		5,194,323
Healthy Michigan CCBHC Supplemental	1,318,735				709,893		2,028,628
Total Projected Medicaid/HMP CCBHC Revenue	20,310,047				11,477,593	-	31,787,640
Capitated CCBHC Expense Projections							
Medicaid CCBHC	16,182,588				8,382,101		24,564,689
Healthy Michigan CCBHC	4,127,459				3,095,492		7,222,951
Total Capitated CCBHC Expense Projections	20,310,047	-	-	-	11,477,593	-	31,787,640
Projected CCBHC Surplus (Deficit)	-	-	-	-	-	-	-
% Variance	0.00%				0.00%		
Information regarding CCBHC Projections (Threshold: Surplus of 5% and deficit of 1%)	Less than threshold for explanation				Less than threshold for explanation		

PROPOSED SPENDING PLAN:	HealthWest	Network180	OnPoint	Ottawa	West Michigan	LRE	Total
Submitted to the LRE as of:	12/8/2022	9/19/2022	10/18/2022	6/9/2023	6/9/2023		
Medicaid/HMP Revenue							
Medicaid CCBHC Base Capitation	9,239,326				6,463,513		15,702,839
Medicaid CCBHC Supplemental	4,126,582				1,978,533		6,105,115
Healthy Michigan CCBHC Base Capitation	1,747,430				2,360,375		4,107,805
Healthy Michigan CCBHC Supplemental	1,369,610				731,510		2,101,120
Total Budgeted Medicaid/HMP CCBHC Revenue	16,482,949				11,533,930	-	28,016,879
Capitated Expense							
Medicaid CCBHC	13,365,909				8,442,045		21,807,954
Healthy Michigan CCBHC	3,117,041				3,091,885		6,208,925
Total Budgeted Capitated CCBHC Expense	16,482,949				11,533,930	-	28,016,879
Budgeted Surplus (Deficit)	-				-	-	-
% Variance	0.00%				0.00%		
Information regarding CCBHC Spending Plans (Threshold: Surplus of 5% and deficit of 1%)	Less than threshold for explanation				Less than threshold for explanation		
Variance between CCBHC Projected and Proposed Spending Plan	-				-	-	-
% Variance	0.00%				0.00%		
Explanation of variances between CCBHC Projected and Proposed Spending Plan (Threshold: Surplus of 5% and deficit of 1%)	Less than threshold for explanation				Less than threshold for explanation		

***CCBHC Projected Revenue is based on the State's projections in the FY22 Rate Certification Letter.**