Meeting Agenda
BOARD OF DIRECTORS
Lakeshore Regional Entity
March 22, 2023 – 1:00 PM
GVSU Muskegon Innovation Hub
200 Viridian Dr, Muskegon, MI 49440

1. Welcome and Introductions –
   New Board Members:
   - Ms. Susan Meston (Ottawa)
   - Mr. Jon Campbell (Kent)
   - Mr. James Storey (Allegan)

2. Roll Call/Conflict of Interest Question –
3. Public Comment (Limited to agenda items only)
4. Consent Items:
   Suggested Motion: To approve by consent the following items.
   - March 22, 2023, Board of Directors meeting agenda *(Attachment 1)*
   - January 25, 2023, Board of Directors meeting minutes *(Attachment 2)*

5. Community Advisory Panel (*Attachment 3*)
6. Reports –
   a. LRE Leadership *(Attachment 4, 5, 6)*

7. Chairperson's Report – Mr. DeYoung
   a. February 15, 2023, Executive Committee *(Attachment 7)*
   b. March 15, 2023, Executive Committee (*Attachment 8*)

8. Action Items –
   Suggested Motion: To approve the LRE 2023 Quality Assessment and Performance Improvement Program (QAPIP)

9. Financial Report and Funding Distribution – Ms. Chick *(Attachment 9)*
   a. FY2023, January and February Funds Distribution *(Attachment 10)*
      Suggested Motion: To approve the FY2023, January and February Funds Distributions as presented

   b. FY23 Budget Amendment #1*(Attachment 11)* –
      Suggested Motion: To approve the FY23 Budget Amendment 1

c. FY23 SUD Budget Amendment #1*(Attachment 12)* –
Suggested Motion: To approve the FY23 SUD Budget Amendment 1

d. Statement of Activities as of 12/31/2022 and 1/31/2023 with Variance Reports *(Attachment 13)*
e. Monthly FSRs (December and January) (*Attachment 14)* –

10. CEO Report – Ms. Marlatt-Dumas
11. Board Member Comments
12. Public Comment
13. Upcoming LRE Meetings
    - April 19, 2023 – Executive Committee, 1:00PM
    - April 26, 2023 – LRE Executive Board Meeting, 1:00 PM
14. Adjourn

Meeting Minutes
BOARD OF DIRECTORS
Lakeshore Regional Entity
January 25, 2023 – 1:00 PM
GVSU Muskegon Innovation Hub, 200 Viridian Dr, Muskegon, MI 49440

WELCOME AND INTRODUCTIONS – Ms. Verduin
Ms. Verduin called the January 25, 2023, LRE Board meeting to order at 1:14 PM.

New Board member, Susan Meston.
Dawn Rodger-DeFauw has resigned from the LRE Board.

ROLL CALL/CONFLICT OF INTEREST QUESTION – Mr. DeYoung
In Attendance: Ron Bacon, Jack Greenfield, Sara Hogan, Alice Kelsey, Janet Thomas, Patricia Gardner, Ron Sanders, Stan Stek, Jane Verduin

Absent: Mark DeYoung, Linda Garzelloni, Richard Kanten

PUBLIC COMMENT
None.

CONSENT ITEMS:
LRE 23-01 Motion: To approve by consent the following items.
- January 25, 2023, Board of Directors meeting agenda
- December 15, 2022, Board of Directors meeting minutes

Moved: Stan Stek Support: Ron Sanders
MOTION CARRIED

LEADERSHIP BOARD REPORTS
LRE Leadership reports are included in packet for information.
- Will the opioid settlement impact the LRE region? A disbursement will be given to LRE and municipalities. There are no new details yet.
- BHTEDS and the submission of additional data made in January –
    - Ms. Myers reports that time frames do not always line up for when PIHPs push in data and MDHHS pulls data. There were a couple of pulls that were not synced. We are hoping that the next measurement will be in sync. LRE is looking into creating a dashboard and have asked MDHHS if they would share the algorithm that they use to utilize in our dashboard.

CHAIRPERSON'S REPORT

January 18, 2023, Executive Committee (EC) Meeting Minutes are included in packet for information.

- There is a vacancy on the Executive Committee from Ottawa County. We are waiting for a recommendation prior to filling.
- Executive Committee have vetted the policies on the agenda and recommend approval.
- The Committee has reviewed the annual evaluation of the CEO.

CEO Evaluation - CLOSED SESSION

LRE 23-02 Motion: To approve moving into a closed work session for the purpose of discussing the LRE CEOs Evaluation

Moved: Ron Sanders Support: Patricia Gardner
ROLL CALL VOTE
MOTION CARRIED

LRE Motion 23-03: To approve moving out of closed work session

Moved: Stan Stek Support: Janet Thomas
MOTION CARRIED

LRE 23-04 Motion: To approve the extension of the LRE CEO's contract for a period of 1 year with a 4% wage increase and an adjustment to the vehicle reimbursement that correlates with the federal reimbursement rate

Moved: Janet Thomas Support: Ron Sanders
MOTION CARRIED

ACTION ITEMS

LRE Motion 23-05: To approve LRE Policies:

i. 1.3 Policy Promulgation
ii. 10.6 Open Meetings Act, Freedom of Information and Reasonable Accommodation and Request form

Moved: Jack Greenfield Support: Ron Bacon
MOTION CARRIED

FINANCIAL REPORT AND FUNDING DISTRIBUTION

FY2023 December Funds Distribution

LRE 23-06 Motion: To approve the FY2023, December Funds Distribution as presented

Moved: Stan Stek Support: Sara Hogan
MOTION CARRIED

Statement of Activities as of 11/30/2022 with Variance Report-
Included in the Board packet for information.

- The region has not yet received the Performance Bonus as we do not receive that until later in the year.

Monthly FSR-
Included in the Board packet for information.

- Contact Ms. Dyga to schedule a meeting with Ms. Chick for further explanation of the FSR if needed.

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

- Dec Action: Judge Shapiro has asked for a joint glossary of definitions by February 3. The court appeared confused by the entire suit and was concerned about the impact to the communities if LRE is not allowed to pay the deficit. Legal is hoping to have a ruling by the middle of February but then there will need to be discussions regarding how the funds will be disbursed so not to leave the LRE with a 0 balance in the ISF.
    - What are our contingencies? If LRE does not win, we cannot pay out to the CMHs. The counties would lose those funds. The counties could sue LRE but even if CMHs received a judgement against LRE we are unable, according to the contract, to use those funds for that purpose.
    - Ms. Marlatt-Dumas explains that a discussion will have to take place to identify how to disburse those funds while also taking into account the risk management for the LRE. Other considerations are the effect COVID will have on enrollment and rates.
    - Another concern is with the contract language change that MDHHS is inserting regarding the inability to use funds for past liabilities. A discussion will have to take place on how to pay the deficit past one year to make sure that those funds are earmarked. It will depend on how the court rules and what buckets of funding that we can use. LRE is working with Wakely to complete an ISF analysis.
- Rate analysis for MDHHS – this has been a large project that LRE and CMH staff have worked on. LRE will present the analysis to MDHHS on the 1/27.
- LRE Audit – As of next week this will be completed. MDHHS will most likely keep the $200,000 sanction. The funds come out of the current MC payment. LRE has been granted a hearing to argue the sanction.
- Wakely – Their report shows that BHTEDS is negatively affecting our geographic factor. They are also completing our ISF analysis.

BOARD MEMBER COMMENTS

- Ms. Gardner comments that she has not resigned from the LRE Board.
- Ms. Verduin comments that there are a lot of new board members, and she is looking forward to working with them.

PUBLIC COMMENT

None.

UPCOMING LRE MEETINGS

- February 15, 2023 – Executive Committee, 1:00PM
- February 22, 2023 – LRE Executive Board Meeting, 1:00 PM

ADJOURN

Ms. Verduin adjourned the January 25, 2023, LRE Board of Directors meeting at 2:52 PM.

_____ _____

Jane Verduin, Board Secretary

Minutes respectfully submitted by:
Marion Dyga, Executive Assistant

COMMUNITY ADVISORY PANEL MEETING AGENDA

Thursday, March 9, 2023 – 1:00 PM to 3:00 PM

Virtual Teams Meeting or Call in

Attendance:

Members: Lynette B., John M., Lucinda S., Angela K., Tamara M., Sharon H., Shawnee T.

CMH: Lori Schummer (WM CMH), Sam Potter (N180), Kelly Betts (HW), Cathy Potter (OnPoint), Anna Bednarek (Ottawa CMH)

LRE: Michelle Anguiano, Mari Hesselink, Stephanie VanDerKooi

1. Welcome and Introductions.
    a. Review of the March 9, 2023, Agenda
    b. Review of the December 8, 2022, Meeting Minutes

2. Member Stories – Limit 5 minutes
    a. Member Experiences

    Kelly Betts –

    - On March 16, HW will be taking a group of staff and individuals to Lansing for suicide prevention and mental health awareness (ASFP State Capitol Day).
    - On March 7, HW took 5 individuals to the Disability Advocacy Day at the state capitol. During this event they were able to speak with local representatives and senator and took pictures with them. They spoke with them about ongoing concerns such as living wages, public bathrooms and building that do not have doors for the disabled.

3. CAP Chair
    - Each year a new chair for this group is elected. The nominees for this year are Lynette B. and Shawnee T.
    - A vote was taken with Lynette B. being voted in by a majority.

4. LRE Customer Satisfaction Review *(Attachment 3)*
    - Mari reviews the updated CS survey with the group. LRE is hoping that this will be out by May.
    - If there is any feedback, please contact Mari at marih@lsre.org
    - Question if there are any follow up surveys completed by CMHs.
        - Ottawa calls and conducts follow up surveys.
        - OnPoint sends out follow-up surveys for individuals leaving services.

- Angela K. suggests adding an area for individuals filling out the survey to make additional comments.
    - There is an area at the bottom that contact information can be given. There is also a statement that invites a person to contact LRE to discuss their situation.
    - Another positive about this is that when a person fills this out and adds a comment or their contact information it will flag the CMH that it comes from and notify them that someone would like to have further discussion. A representative from the CMH will then contact them.

5. Consumer Advisory Panel Update *(Attachments 4)*
    i. Newsletter – if there is any artwork, poetry, stories you would like to submit for the newsletter please send those to Mari Hesselink at marih@lsre.org or Marion Dyga at mariond@lsre.org
    ii. CAP Brochure
    Mari reviews the brochure with group and informs them that it will be sent out after this CAP has reviewed it. This will be sent out after this group has reviewed it.
        - This will be posted on LRE website.
        - Ottawa logo will be fixed.

6. LRE Updates
    i. LRE Website Refresh Walk Through
        - www.lsre.org, Stephanie gives an overview of the new website explaining different areas, specifically customer service information.

    ii. LRE DEC Action Update
        - Declaratory Action – LRE has asked a judge to review information regarding the past deficit. MDHHS has stated that we are not allowed to pay it to the CMHs out of our funds. Therefore, LRE has asked for a judgement that will allow the deficit to be paid from the regional ISF (Internal Service Fund). LRE is still awaiting a judgement.

    iii. Customer Services Update
        - The CAP newsletter will be complete within the next few weeks.
        - LRE has a dashboard to review grievance and appeals data and data regarding Customer Services phone calls that LRE receives. There has been a high level of SUD calls over the last few months.
        - SUD Recipient Rights (RR) – LRE handles the second level of complaints if a provider has any. This office has just been set up at the regional level.

- SUD has a separate set of rights that are specific to substance use with a separate office that handles those. The SUD RR is directly at the provider and then LRE is the second level. CMHs handle mental health rights.

Action: Mari will send a copy of the SUD rights to the group

7. Regional Updates –
   i. LRE Strategic Planning Update
      - LRE is about halfway through the strategic planning process. The next step will be to start adding metrics or goals. The strategic plan is a 3 year plan and each year may have different metrics.

8. State Updates –
   i. Legislative Update *(Attachment 5)*
      The legislative update lists which bills have been proposed within the state and federal government that pertain to MH and SUD.
      - Items highlighted in yellow are new items.
      - Websites are also included for more information.

   ii. CMHA Impact Report *(Attachment 6)*
      - Informational

   iii. "988" National Suicide and Crisis Lifeline
      - The 988 suicide hotline has been launched. For more information or a toolkit see below link.
        - *https://988lifeline.org/?ref=w3use*

   iv. MC Enrollment and the Public Health Emergency Unwind *(Attachment 7)*
      - Renewal Month Check at newmibridges.michigan.gov
      - Market Place health coverage for those that are disenrolling in MC after the health emergency is over.
        - https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/

9. LRE Board Meeting
   March 22, 2023 – LRE Board Meeting
   GVSU Muskegon Innovation Hub, 200 Viridian Dr, Muskegon, MI 49440
   Call-in information will be posted on the LRE website

   Upcoming CAP Meetings for **2023** (2nd Thursday of every third month [Quarterly] - 1:00 pm to 3:00 pm)
   March 9, June 8, September 14, December 14

LAKESHORE REGIONAL ENTITY

Chief Operating Officer (Stephanie VanDerKooi)
Report to the Board of Directors
March 15, 2023

Oversight Policy Board (OPB): The Board met March 1st and approved several budget amendments related to Public Act 2 (PA2/Liquor Tax). The OPB's recommendations for other SUD budget amendments (specialty grants and block grant) are included in today's Board packet. Additionally, several program updates were given by SUD staff and forthcoming PA2 changes were discussed.

Officers for the coming year were elected: Patrick Sweeny will continue to serve as Chair, with Andrew Sebolt once again filling the Vice-Chair role. The Secretary seat will be voted on during the next meeting as the Board was not willing to elect the nominated individual (Sarah Sobel) while she was not in attendance.

Legislative Update: An updated report of proposed legislation at both the State and Federal Level as it relates to Behavioral Health is included with today's meeting materials. This grid will be updated monthly, and new legislation will be highlighted in yellow for ease of identification. 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): Attached is the formative evaluation for the regional activities for year 1 of this grant/program from KWB Strategies.

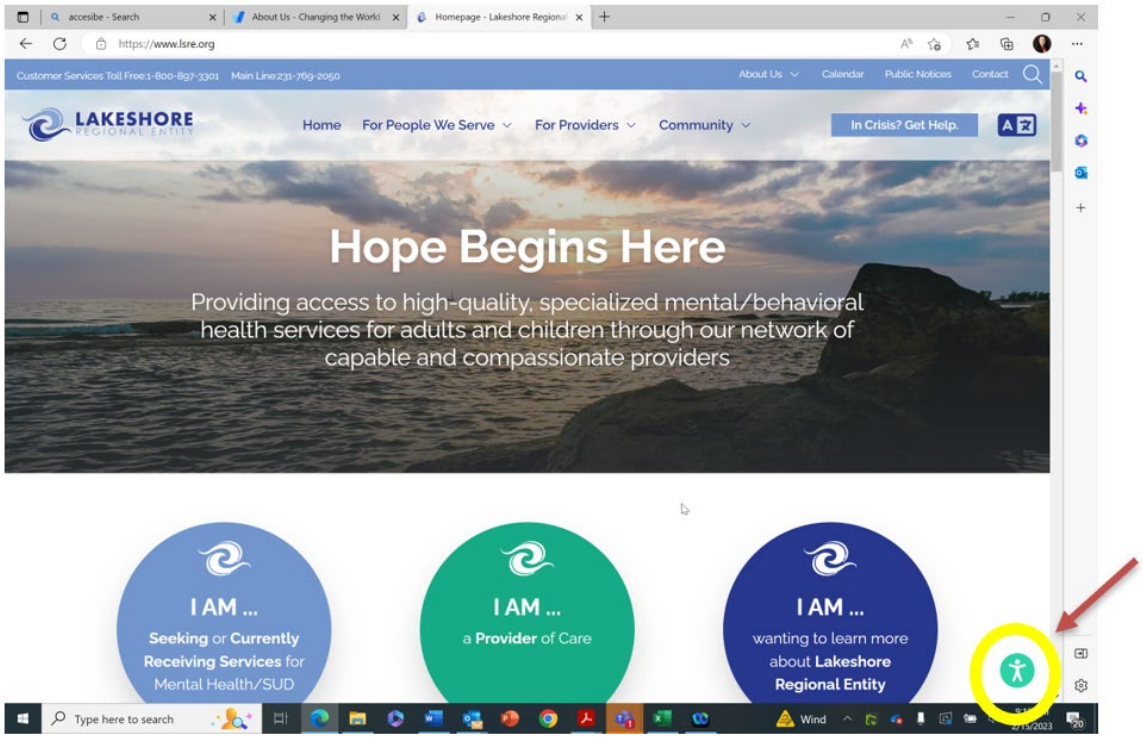
CCBHC enrollments:

- **WMCMH** assigned in February: Medicaid: 5 and non-Medicaid 19
- **HW** assigned in February: Medicaid: 114, non-Medicaid 18

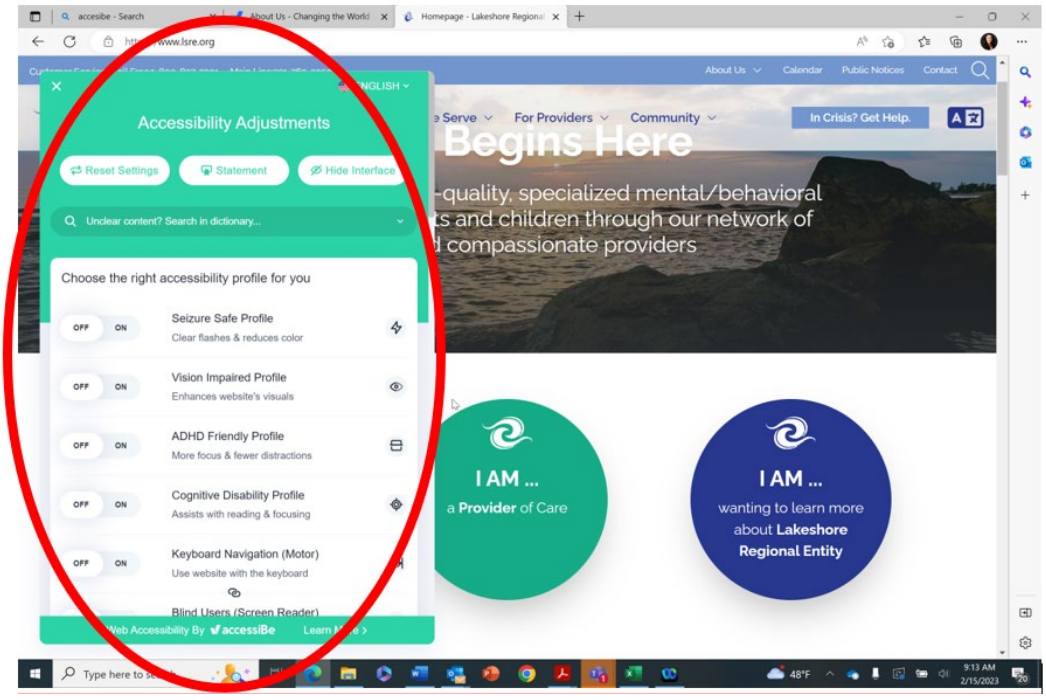
Opiate Settlement Update: Please find attached a one-pager that was recently received from MDHHS on settlement dollars. At this time, the PIHPs have not been notified of their allocation, timeline, nor the process for spending the funds. As soon as this information is made available it will be shared with the board.

FY 22 Annual Impact Report: This report is being developed with input from LRE subject matter experts (SME). The plan is for this report to be completed and presented to this Board during the May meeting.

Website: The redesigned LRE website (www.lsre.org) includes a new feature, AccessiBE, to ensure the site is ADA compliant and as inclusive as possible. When logging into the website, visitors will see an icon in the lower right corner of the main page (see below).



When the visitor clicks on this icon, a menu of options pops up to aid them in selecting accessibility adjustment:



February Report Submission Analysis:
In February, LRE completed 30 reports to MDHHS. All reports were completed on time. One report was submitted three days late, due to an inactive submission account, which took MDHHS 3 days to resolve. Hence, the report being submitted three days after the due date.

February 2023

Total Number of Reports	**30**
Number of Late Reports	1
Average Number of Days Late	3

Report Name	Report Type	Days Late	Reason
Fiscal Questionnaire	Financial Reporting	3	This report was completed on time, but the LRE's account was inactivated, and the file couldn't be uploaded on 2/10/23. State activated the account on 2/13/2023 and report was uploaded on 2/13/2023.

AUTISM SERVICES/ Behavioral Health Treatment (BHT) – Justin Persoon
Over the past month, the Autism team prepared for the upcoming CMHOC Site Review and has updated clinical review forms. Two trainings were completed with regional CMH subject matter experts and ABA providers to cover newly created forms and processes. The team continues to help facilitate discussions with Heartland Center for Autism as they try to establish contracts with regional CMHSPs to provide short term CCI residential services for children with autism. LRE is moving forward with developing a data file for ABA services to manage the service when the WSA becomes inactive in April. This will be a priority focus for the next two months. The team additionally spent significant time processing ABA service enrollments and discharges and providing technical assistance to CMHSPs.

Current Enrollments (Regional Total: 1,828)

CMHOC (Ottawa)	HealthWest (Muskegon)	Network 180 (Kent)	On Point (Allegan)	WMCMHS (Lake, Mason, Oceana)
291	168	1,178	137	54

CLINICAL/UM – Liz Totten
Parity & Inter-Rater Reliability (IRR)
February was a busy month for the UM/Clinical Departments and IRR. A great deal of time was used to prep for the first Interrater Reliability (IRR) exam in the region. Multiple meetings occurred with MCG to discuss ways to customize exam questions and ensure they were properly uploaded into the MCG Learning Management System (LMS). Significant time was also spent creating exam questions that were reviewed and approved by the UM/Clinical Team. UM Department met with CMHSP leads one week prior to the launch of the exam to provide a tutorial of how to access and take the exam. The IRR exam was launched as planned on March1, 2023. Identified CMHSP staff will have until March 31, 2023 to complete the exam.

Pre-admission screen (PAS) and continued stay review (CSR) audits for FY23 Q1 have started. Charts of consumers who were admitted/discharged during the quarter are randomly selected using the Follow-Up to Hospitalization (FUH) report. The number of charts per CMHSP will be no less than three percent nor no greater than 5 percent of the total number for the quarter (a minimum of 10 consumer charts will be audited for each CMHSP). LRE staff will use regionally approved audit tools for pre-admissions screens and continued stay reviews. LRE utilization department staff have been provided access to each CMHSP's EMR system to complete audits. Audit results will be logged in the PAS/CSR Audit Summary Tool and the report will be shared with the Utilization Management ROAT. Specific feedback on documentation will be provided to the identified CMHSPs lead.

INTEGRATED HEALTHCARE – Tom Rocheleau

Monthly joint care coordination meetings with each of the six Medicaid Health Plans that serve the LRE region continued. During the February meetings, 50 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. Four new interactive care plans were opened in February. Eighteen cases were discussed with MHPs wherein an interactive care plan was not created, but joint collaboration took place resulting in a Single Episode of Care (SEC). This is an increase in previous months indicating the CMHSPs and MHPs are working hard to identify new members for integrated care plan discussions.

CUSTOMER SERVICES/PRIORITY POPULATION– Michelle Anguiano & Mari Hesselink

The Customer Services group is currently reviewing and updating the Guide to Services, it is anticipated to be completed and ready for publication by June 1st.

Mari Hesselink is working to establish the regional SUD Office of Recipient Rights. She is compiling an accurate list of SUD providers within the region, contacting their individual rights advisors, and taking note of the needs of each (updating policies, providing updated materials, trainings, etc.). Once contact has been made with all providers, she will conduct an informal desk audit of each provider to identify any areas pertaining to SUD rights procedures and standards. This will help to ensure that the requirements set forth by the state are standardized and implemented across the region.

LRE Customer Services continues to receive numerous calls from the SAMHSA SUD hotline. Mari has again reached out to MDHHS to inform them that the issue has not been corrected. During the month of February, the CS line received 353 calls (some were multiple calls from the same individual) that were not answered by a live voice due to it being after hours or a weekend/holiday.

Customer Satisfaction Survey

The Survey Workgroup has finalized the LRE 2023 Customer Satisfaction Survey, which was presented to the CS ROAT for review in February. Customer Services team is working closely with IT to begin implementation once the draft survey is approved by all necessary administrators. A Customer Satisfaction Survey Policy and Procedure outlining the regional process and provider expectations is in development.

Priority Populations Manager
The Priority Populations Manager is a new role that MDHHS requires each PIHP have in place to help facilitate SUD treatment for individuals who are being paroled out of prison. Michelle Anguiano, LRE Customer Services Manager will add the functions of this position to her current role. LRE staff met with Michigan Department Of Corrections (MDOC) this month and gathered valuable information on how to make this position a success. The importance of communication at the forefront before problems arise and keeping everyone up to date with whom to communicate with was discussed. Provider data will be shared with MDOC to ensure the most current list of provider information is available for making referrals. This will serve as a starting tool to help transitions occur smoothly.

CREDENTIALING - Pam Bronson (Credentialing Specialist):
In February, the Credentialing Committee reviewed and approved 10 organizational providers for credentialing/re-credentialing. The Universal Credentialing project has wrapped up, and MDHHS issued (in part) the following information on March 3, 2023:

> *The Universal Credentialing process is "live" in the MDHHS BH CRM as of Wednesday, February 22, 2023. Although the Universal Credentialing process is now live in the CRM,* ***you will not be required to use the system for Universal Credentialing until after your region's scheduled training rollout.*** *Training dates are currently TBD, but are estimated to start in April or May.*

PROVIDER NETWORK MANAGEMENT (PNM) – Don Avery, Jim McCormick
PNM is currently working on revising the LRE/CMHSP Agreement to align more closely with the requirements of the MDHHS/LRE contract. Also, LRE is working with CMHSP Member contract staff to revise the regional Provider Common Contract. PNM is implementing a process for the regional collection of Disclosure of Ownership (DOO) documentation to reduce administrative burden on providers and further reduce duplicative administrative efforts across the region. Q1 of the value-based contracts with psychiatric hospitals has been completed and the performance results of each hospital have been shared with CMHSP Members.

SUD TREATMENT - Amanda Tarantowski, SUD Treatment Manager
In recent weeks, the SUD Treatment Manager participated in the Region 4 mini-series focusing on Trauma Informed Care for Perinatal Patients with a substance use disorder. Work is underway with LRE Provider Network Managers to develop the Network Adequacy Report. There is ongoing collaboration with LRE Chief Operating Officer and the Priority Populations Manager toward establishing a program that meets the needs of MDOC.

SUD/GAMBLING PREVENTION – Amy Embury
Talksooner, MDOT Team Up to "Make the Chatter Matter"
The family car may be the ideal "vehicle" to have those important "drug talk" conversations with youth/teens. Thanks to a partnership with the Michigan Department of Transportation (MDOT), Talksooner collateral materials inviting parents to "Make the Chatter Matter" will be displayed at all 77 MDOT welcome centers and rest areas – just in time for the busy Spring Break travel season. Talksooner's partnership with MDOT began in 2021, with a shared vision in fostering healthy, safe families and communities. MDOT rest areas and welcome centers serve as a

convenient venue for parents/caregivers to check out the free Talksooner.org site during their travel breaks, gleaning tips and talking points to immediately put into use. Look for these great posters, which also feature a Spanish translation, on your next family road trip.

Tobacco Sales Compliance Check 2022 Overview – Please review the attached one-page overview that provides a quick snapshot of Tobacco Retailer Compliance by each county in the LRE region along with the types of retailers who sell tobacco related products. Each county employs youth decoys tow work with the Designated Youth Tobacco Use Representatives (DYTUR) to help ensure compliance at retailers throughout the year (each DYTUR contact is listed in the attachment). During the last month, each DYTURs has all completed their review of their respective county's establishments to ensure the most up to date information for the state Master Retail List.

<u>WAIVERS</u> – Kim Keglovitz / Melanie Misiuk/Stewart Mills

Habilitation Supports Waiver (HSW)

Below 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.

	CMHOC	HW	N180	ONPPOINT	WMCMHS
Overdue Certifications	0	0	7	1	0
Overdue Guardian Consents	0	3	0	8	0
Inactive Consumers	0	1	3	1	0

The region had three open slots for February. Two children who aged off the Child Waiver (from HealthWest and Network 180) were enrolled. The 3rd slot went to an Ottawa County individual. There are six open slots for March enrollment, two of which will be assigned to individuals aging off the Children's Waiver (CMHOC and HealthWest). There are 14 complete packets and an additional 12 packets are pending due to goals, objectives, or needing updates to other required documents. Below is a chart of slot utilization in Region 3.

	10/22	**11/22**	**12/22**	**1/23**	**2/23**	**3/23**	**4/23**	**5/23**	**6/23**	**7/23**	**8/23**	**9/23**
Used	629	629	629	629	627	623						
Available	0	0	0	0	2	6						
% Used	100	100	100	100	99.7	99						

Reminder that the enrollment deadline is always the 15th of the month. If the LRE is not notified of a disenrollment right away, it may result in missing the deadline for the month (and therefore the payment) while there are individuals waiting to be enrolled.

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

On February 21 the LRE submitted the CAP responses for the MDHHS Waiver audit. MDHHS accepted all responses except two. Responses not accepted were returned to MDHHS on March

3. MDHHS accepted one of those plans, and we are currently working through a response with the department and the CMHSP. The response will be returned to MDHHS the week of March 13.

Children's Waiver Program (CWP)

85 children are open and enrolled in the Children's Waiver Program for March. Two children, both from Network180, have been invited to enroll on the Children's waiver for a March start date. Two prescreens were submitted to MDHHS in February (OnPoint, CMHOC). All 569 CWP slots in the state are currently filled, and MDHHS has continued to use the weighing list for selecting new enrollments. LRE currently has ten scored prescreens on the weighing list but have not yet been invited to join the CWP. Six of the prescreens on the list are from Network 180, two are from CMHPC, and two are from On Point.

	CMHOC (Ottawa)	**HealthWest (Muskegon)**	**Network 180 (Kent)**	**On Point (Allegan)**	**WMCMHS (Lake, Mason, Oceana)**
# Enrolled	10	6	64	4	1

<u>1915(i)SPA:</u>

MDHHS Updates:

MDHHS's deadline for iSPA compliance is 10/1/2023; it is the expectation that all iSPA cases are enrolled in the WSA by that date.

The final Policy Bulletin was released on 11/1/22. MDHHS reports that these bulletins will be included in the April MPM updates.

The MDHHS iSPA Specialist, Monica Erickson, attended the Regional iSPA meeting in February to offer Technical Assistance and answer any questions related to the iSPA. MDHHS gave a presentation on the iSPA and upcoming updates to the WSA and program. CMSHP representatives were able to ask questions and provide feedback to the State. This meeting was well attended. Feedback was mixed, due to some questions still being unanswered, including how data is being analyzed by MDHHS. The LRE has requested a meeting with MDHHS to discuss how the data is being used to ensure appropriate monitoring of regional data.

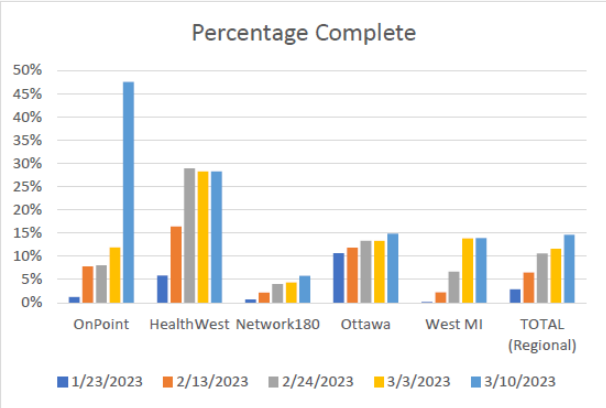
Regional Updates:

The Regional iSPA Workgroup has been meeting monthly, with representation from each CMHSP. Workgroup members also attend 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.

Time and staffing seem to be the most reported roadblocks to CMHSPs being able to identify cases and enter data into the WSA. Last month, the CMHSPs were sent a memorandum detailing the work being done on the iSPA and the need for a compliance plan in order to reach the enrollment benchmarks laid out by MDHHS. All CMHSPs responded and have a plan in place to work towards meeting the enrollment goals.

See the attached graphs for more details on enrollment progress in the Region.

1915(I)SPA ENROLLMENT PROGRESS



GOAL: 50% Enrollment by April 1, 2023

75% by July 1, 2023

100% by October 1, 2023

CMHSP	2/13/2023	2/24/2023	3/3/2023	3/10/2023
OnPoint	8%	8%	12%	48%
HealthWest	16%	29%	28%	28%
Network180	2%	4%	4%	6%
Ottawa	12%	13%	13%	15%
West MI	2%	7%	14%	14%
TOTAL (Regional)	**6%**	**11%**	**12%**	**15%**

CMHSP	Total Potential Cases in WSA - 3/3/23	Total Potential Cases in WSA - 3/10/23	Currently Enrolled - 3/3/23	Currently Enrolled - 3/10/23	Withdrawn - 3/3/23	Withdrawn - 3/10/23
OnPoint	529	534	61	64	2	190
HealthWest	1810	1813	160	160	352	352
Network180	4740	4735	197	225	10	11
Ottawa	1040	1041	125	131	14	14
West MI	828	826	113	113	2	2
TOTAL (Regional)	**8947**	**8949**	**656**	**693**	**380**	**569**

SEDW (Series Emotional Disturbance Waiver)

There are currently 80 open SEDW cases.

- Allegan – 6
- HealthWest – 15
- Network180 – 40
- Ottawa – 17
- West MI – 2

The SEDW program continues to run smoothly. Cases are being submitted on time and are recertified or disenrolled when appropriate. Enrollments continue to increase slightly, with several new cases being enrolled in the last month.

At the statewide SEDW Meeting this month, MDHHS again highlighted the use of therapeutic activities for SEDW services. MDHHS would like to see this service utilized more where possible, as they feel it is an under-utilized service statewide. Suggested places to look for services were provided and discussed.

Lakeshore Regional Entity's Legislative Update – 3/14/2023

This document contains a summary and status of bills in the House and Senate, and other political and noteworthy happenings that pertain to both mental and behavioral health, and substance use disorder in Michigan and the United States.

Prepared by Melanie Misiuk, SEDW & 1915(i)SPA Specialist & Stephanie VanDerKooi, Chief Operating Officer

Highlight = new updates
Highlight = old bill, no longer active

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

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*	*Wayne Schmidt*	*12/29/22 – signed by the Governor*

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

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*	*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 |

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
		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 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.		Congress.gov | Library of Congress
	HR 9221	***Bruce's Law:*** *This bill reauthorizes certain grants through FY2027 and sets out other activities to address drug overdoses, with a particular focus on contamination with fentanyl or other synthetic opioids.*	*David Trone*	*10/20/22-Introduced and referred to House Committee on Energy and Commerce* *10/24/22 – Referred to the Subcommittee on Health*
	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	1/17/22-Introduced and referred to Committee on Energy and Commerce & Committee on the Judiciary
	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.
	SR 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

LEGISLATIVE CONCERNS

LOCAL THREATS AND CHALLENGES			
ISSUE	**SUMMARY**	**COUNTY**	**ADDITIONAL INFORMATION/LINKS**
State Medicaid Redeterminations	Emergency Medicaid coverage protection extended during the COVID-19 pandemic is set to expire April 1st. This could result in up to 400,000 Michigan residents losing Medicaid coverage.		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
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	Recently, the Director of the Office of National Drug Control Policy (ONDCP), Dr. Rahul Gupta,		A disappointing report card for primary care -

ISSUE	SUMMARY	COUNTY	ADDITIONAL INFORMATION/LINKS
to Use Medicaid for Incarcerated Substance Use Treatment	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		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)

LAKESHORE REGIONAL ENTITY

Certified Community Behavioral Health Clinics

Formative Evaluation Report

A foundational review of the purpose, requirements, and funding structures for Certified Community Behavioral Health Clinics (CCBHC), the status of CCBHC development in the region, and progress in year one of the CCBHC Demonstration project.

PREPARED BY

KWB Strategies

January 2023

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Introduction

As one of ten Prepaid Inpatient Health Plans (PIHP) in Michigan, the LRE is responsible for managing behavioral health services under contract with the Michigan Department of Health and Human Services (MDHHS).[1] Beginning in FY22 the LRE became responsible for the management and oversight of Certified Community Behavioral Health Clinics (CCBHCs) funded as Demonstration sites through MDHHS's CMS CCBHC Demonstration Grant. Demonstration sites in the LRE region include West Michigan Community Mental Health Services (WMCMHS) and HealthWest.

Background Information

State-Level CCBHC Infrastructure:

The intention of SAMHSA working with states under the Demonstration Project is for state departments, such as MDHHS, to develop the structures necessary to implement a new funding model to support CCBHCs that provide the resources and flexibility to:

1. Expand the scope of mental health and substance use disorder (SUD) treatment services.
2. Increase access to serve anyone who needs care, regardless of insurance or ability to pay, as required for CCBHC certification.

During the Demonstration Project, participating PIHPs are charged with developing the capabilities to implement the new funding model and provide the required oversight and management of CCBHC sites.

The state's CCBHC Demonstration Grant was originally scheduled to end 9.30.23 but was recently extended by at least two years. Staff at MDHHS have verbally indicated that following the Demonstration Project, there is an intention to sustain the model as an alternative approach to funding behavioral health services.

Local CCBHC Development:

Due to the commitment and innovation of Member CMHSPs, the LRE is the only PIHP region in the state with certified CCBHCs in place for their entire region.

HealthWest and WMCMHS were among the first in the state to transform their behavioral health systems under SAMHSA CCBHC Expansion grants beginning in FY19. Since then, they have supported others in the region to pursue CCBHC development.

Network180, OnPoint, and Community Mental Health of Ottawa County (CMHOC) have each successfully applied and been awarded funding under SAMHSA CCBHC Expansion grants with SAMHSA funding each organization directly. The Expansion grant is designed to support organizations in achieving CCBHC certification. MDHHS and the LRE have no direct involvement in Expansion grants.

1. To simplify terminology, the term "behavioral health" when used in this document, refers to services for persons with mental illness, emotional disturbance, intellectual/developmental disabilities, or substance use disorders.

Purpose of Report

During FY22, the LRE began efforts under the Demonstration Project to establish the mechanisms necessary to oversee and provide funds to CCBHCs. In anticipation of the CCBHC model becoming the future approach for behavioral health services in Michigan, the LRE is committed to the establishment of sustainable CCBHCs throughout the region, not just those supported by the Demonstration Project. To support this aim, the focus of this report is not limited to the Demonstration Project.

Through this report the LRE seeks to:

- Achieve a clear and shared understanding of the CCBHC model, including current and future funding structures.
- Assess the LRE's progress in establishing the necessary mechanisms to oversee and monitor CCBHCs during year one of the Demonstration project.
- Provide an overview for stakeholders on the status of local CCBHC development throughout the region, including those not yet receiving CCBHC funds through the LRE. Please note that this report only seeks to evaluate regional effort of the LRE. This information is provided solely to assist stakeholders in understanding the current context of CCBHC development.
- Identify opportunities for how the LRE can assist local efforts of CCBHCs in the region as they establish CCBHCs.

Throughout this report underlined text indicates a hyperlink to additional information. When viewing this report electronically, clicking on the underlined text will direct you to another portion of the report or an external resource for more information.

Because of the hard work of so many of our community partners, our mental health care and addiction initiative is a proven success story. In Michigan and across our country, we are finally transforming the way we deliver high-quality services in our communities and the results are clear. Now more people who are struggling with mental health issues or addiction will get the treatment they need close to home. [2]

Senator Debbie Stabenow

2. https://www.stabenow.senate.gov/news/senator-stabenow-announces-1-million-in-funding-to-expand-mental-health-and-addiction-services-at-west-michigan-community-health

Methodology

To inform development of this report the following activities were conducted:

LRE Progress Updates

The evaluator developed a form that is completed bi-annually by LRE staff and provided to the evaluator. Updates include:

- Status and efforts related to fulfillment of each of the LRE's required responsibilities for management and oversight of the Demonstration Grant as defined by the CMS CCBHC Demonstration Handbook published in February 2022. This document has since been revised and the most recent version can be found here.
- Efforts by the LRE to support and enhance CCBHC development, sustainability, and regional collaboration.
- Enhancements and successes at Demonstration sites.
- Status of service providers for each required service, including the number of Designated Care Organizations contracted by each Demonstration site.

Interviews

Interviews were conducted with representatives from each Member CMHSP to discuss their progress and successes and to identify opportunities for how the LRE could best support their local efforts. Although these interviews were optional, each Member CMHSP chose to participate.

Document Review

A review of meeting minutes, documents related to CCBHC published by state and national behavioral health related organizations, and data reports generated by the LRE.

CCBHC 101

Rationale

According to the National Council for Mental Wellbeing, the behavioral health system has long needed significant investment and transformation to meet the true needs of communities. After decades of underfunding, ongoing struggles to recruit and retain staff, and dual mental health and substance use crises nationwide, the Certified Community Behavioral Health Clinic (CCBHC) model provides the resources and flexibility necessary to address these challenges and transform how care is delivered.

Structural changes implemented to support this transformation of the behavioral health system include:

Funding

Flexible funding to expand the scope of mental health and substance use services available in the community. The flexible funding model supports development of a comprehensive integrated service array. In addition to traditional therapeutic services, the service array includes physical health screenings, crisis intervention and management, medication assisted treatment, and care coordination.

Expanded Eligibility

CCBHCs serve anyone who walks through the door, regardless of their diagnosis, insurance coverage, place of residence, or age. CCBHCs restructure the way that outpatient care is provided to enhance services and increase access to care for people with unmet needs. Any person with a mental health or substance use disorder (SUD) ICD-10 diagnosis code is eligible for CCBHC services. The mental health or SUD diagnosis does not need to be the primary diagnosis. Individuals with a dual diagnosis of intellectual disability/developmental disability are also eligible for CCBHC services.[3]

Certification

SAMHSA has established criteria for CCBHCs to achieve certification. By meeting these standards, SAMHSA seeks to ensure that CCBHCs provide comprehensive and high-quality services in a manner reflecting evidence based and best practices in the field. CCBHCs must meet specific standards for the range of services they provide and are required to get people into care quickly.

3. https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/ccbhc/consumer

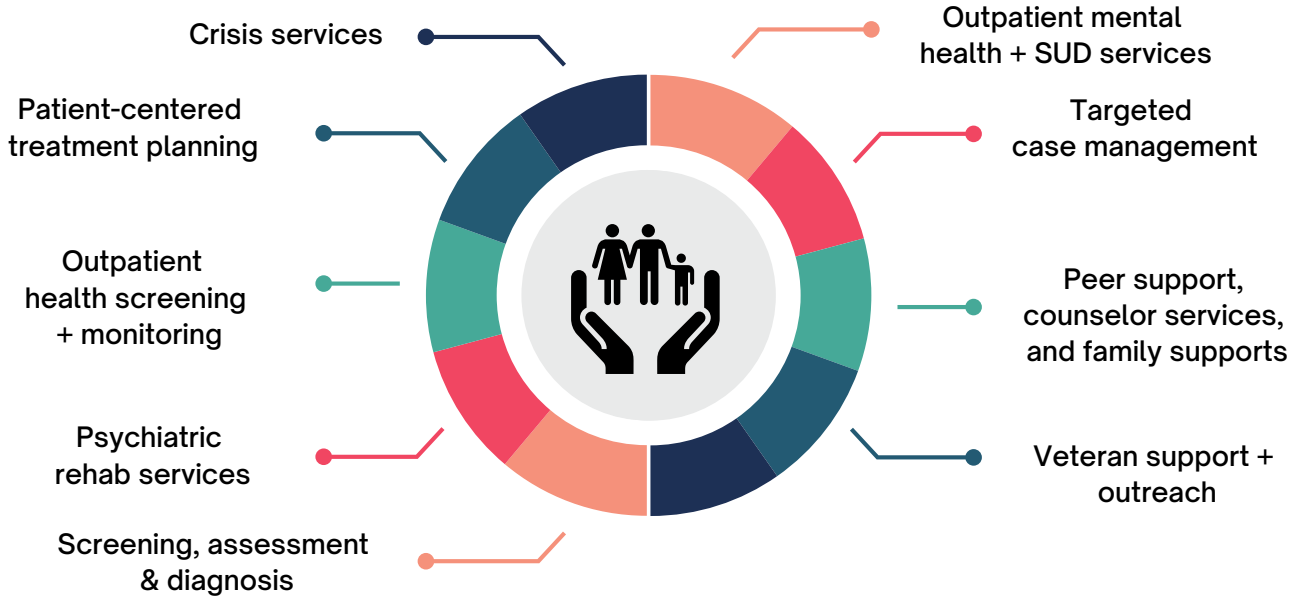
CCBHC Services

A recent national evaluation found that CCBHCs served 23% more people on average, provided much faster access to mental health services, and increased access to certain forms of substance use disorder (SUD) treatment than non-CCBHCs. They were also better able to hire and retain staff and develop integrated care partnerships with other organizations such as federally qualified health centers (FQHCs), schools, hospitals, and law enforcement.[4]

Required Services:

CCBHCs are required to provide a set of nine comprehensive services and meet federally defined criteria. Services can be provided directly by the CCBHC or through designated collaborating organizations (DCOs).[5]

Required services include:



> *In some ways, it feels like the world is our oyster. This grant allows for a lot of creativity to figure out how to better serve consumers.*
>
> Community Mental Health of Ottawa County

4. https://www.thenationalcouncil.org/wp-content/uploads/2022/10/2022-CCBHC-Impact-Report.pdf
5. https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

Service Standards:

The following standards are expected for services provided by a CCBHC:[6]

Comprehensive

A comprehensive array of behavioral health services so that people who need care are not caught trying to piece together the behavioral health support they need across multiple providers.

Timely

Immediate screening and risk assessment for mental health, addictions, and basic primary care needs.

Easy access to care with criteria to assure a reduced wait time so those who need services can receive them when they need them, regardless of ability to pay or location of residence.

Coordinated

Care coordination to help people navigate behavioral & physical health care, social services, and the other systems in which they are involved. Expanded care coordination with primary care, hospitals, other health care providers, social service providers, and law enforcement. Focus on whole health and access to a full range of medical, behavioral & supportive services.

Staffing

CCBHC staffing will include providers who adequately address the needs of the population served. Credentialed, certified, and licensed professionals with adequate training in person-centered, family-centered, trauma-informed, culturally competent, and recovery-oriented care.

Peer & Family

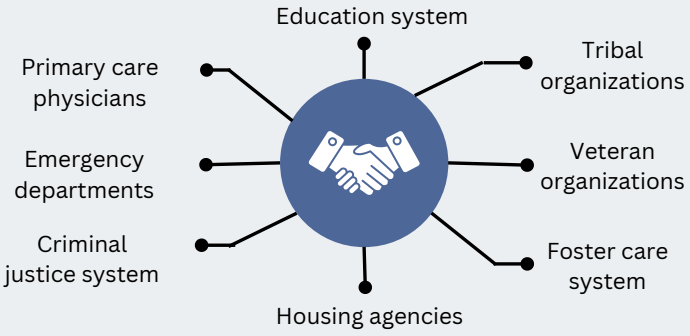
Commitment to peers and family, recognizing that their involvement is essential for recovery and should be fully integrated into care.

Military & Veterans

Tailored care for active-duty military and veterans to ensure they receive the unique health support essential to their treatment.

Key Partnerships

To provide holistic treatment, it is imperative that CCBHCs have strategic partnerships with organizations that coordinate outreach to specific subsets of the population.



Section 223 (a)(2)(C) of PAMA

6. Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (samhsa.gov)

CCBHC Funding

There are two primary federal programs through the Substance Abuse and Mental Health Services Administration (SAMHSA) that currently support CCBHC development within the LRE region, including the CCBHC Expansion Grant and the CCBHC Medicaid Demonstration Grant.

SAMHSA EXPANSION

A competitive federal grant awarded directly to behavioral health providers to transform their system and achieve CCBHC certification.

The intention is to support expansion of CCBHCs throughout the country that pursue sustainability under other funding sources following the grant period.

CMS Demonstration

Federal funds are provided to state's development of funding mechanisms and oversight to support CCBHCs. The intention is for states to develop an implementation model and then make CCBHCs a central and permanent part of the behavioral health system following the grant.

In Michigan, the grant supports 13 CCBHCs identified in the state's original application.

SAMHSA CCBHC Expansion Grant

Since 2018 this federal grant has awarded funds to local clinics to support development of CCBHCs. Eligible organizations include clinics that are CCBHC certified or self-report that they meet certification criteria and can expect to achieve certification within 4-months of award.

The intention for these grants is to support development of the organization's infrastructure and serve as a foundation for establishing a CCBHC. This grant is not designed to provide long-term funding to sustain a CCBHC.

As an Expansion Grantee, clinics must provide all CCBHC required services and meet service standards.

States do not have any direct role in these grants. CCBHC Expansion Grantees are eligible for a SAMHSA Expansion Grant while receiving funds through their state's Demonstration Grant.

Both HealthWest and WMCMHS were awarded Expansion grants in FY19 and were two of only four Michigan grantees awarded funds that year. WMCMHS was recently awarded another Expansion grant that began in FY23. Since FY21, OnPoint, Network180, and CMHOC have each successfully applied and been awarded SAMHSA Expansion grants and each has achieved their CCBHC certification.

In 2021, SAMHSA awarded funds to the National Council for Mental Wellbeing to provide technical assistance and advocacy for CCBHC expansion grantees. Under this grant, a mentorship program is available to clinics in Michigan that are moving from expansion into their state's Demonstration grant. For more information about this resource visit the National Council for Mental Wellbeing.

CMS CCBHC Demonstration Grant:

This SAMHSA grant allocates funding to state agencies to support existing certified CCBHCs. Michigan applied to become a Demonstration state in 2016, identifying the 14 local CCBHCs to receive support under this grant which included WMCMHS and HealthWest in the LRE region. Initially in 2017, 8 other states were selected and in 2020 Michigan and one other state were approved to join, with the project beginning October 1st, 2021.

Under this grant states are responsible for overseeing the funded CCBHC sites, including clinic certification, payment, and compliance with federal reporting requirements. The Michigan Department of Health and Human Services (MDHHS) relies on the regional PIHPs to provide oversight. The intention for these grants is for states to cement the comprehensive benefit within the Medicaid system following the Demonstration Project to create a long-term sustainable approach to maintaining the expanded CCBHC service array.

Under this grant, Demonstration sites are required to provide a robust set of coordinated, integrated, and comprehensive services to all persons with any mental illness or substance use disorder diagnosis, not just those with Medicaid.

Reimbursement Model:

Through this grant CCBHCs are funded using a Prospective Payment System (PPS) rate for qualifying encounters provided to Medicaid beneficiaries. The PPS system pays CCBHCs a fixed daily rate for all services provided on any given day to a Medicaid beneficiary. To account for the expanded service requirements, the state's PPS rate must provide an enhanced payment rate to properly cover costs and offer greater financial predictability and viability. The PPS is integral to sustaining expanded services, investments in the technological and social determinants of care, and serving all eligible Michiganders regardless of insurance or ability to pay.

The Demonstration grant may only reimburse the PPS rate for Medicaid beneficiaries. However, consumers with no insurance, private insurance, or Medicare must be served and the Demonstration sites must pursue reimbursement from private insurance or Medicare.

To offset the costs of serving non-Medicaid recipients, additional funds were allocated to support Demonstration sites including funding approved under the federal American Recovery Plan Act (ARPA) and General Funds dedicated by MDHHS.

To request reimbursement through APRA funds, Demonstration sites submit CCBHC qualifying daily visits (encounters) for non-Medicaid recipients. These encounters are multiplied by the CCBHC's PPS rate minus any fees, collections or other sources of funds received. The Demonstration site can request reimbursement for the remaining amount from the LRE. The PIHP reimburses the Demonstration site when funds are available. For FY22, MDHHS allocated a total of $315k in ARPA funds to the LRE region this purpose. These funds were entirely drawn down in only a 3-month period. ARPA funds are expected to continue through FY25 with decreasing allocations for the region (FY23 - $210k, FY24 - $17k, and FY25 - $15k).

A total of $5M in General Funds were allocated for this by MDHHS in FY22 with the LRE region receiving $694k. MDHHS determined the allocation for each Demonstration site based on the proportion of non-Medicaid daily visits reported on the Milliman CCBHC Drive Dashboard between October and March of 2022 by each Demonstration site in the state.

Funding Sustainability

At the end of Michigan's CCBHC Demonstration grant, the MDHHS website states that they will evaluate the program's impact and assess the potential to continue or expand the initiative under the CMS State Plan option.[7] The Demonstration grant was originally scheduled to expire on September 30, 2023 but has been extended. The Bipartisan Safer Communities Act, passed in June 2022, extends the grant until September 30, 2025.[8] However, MDHHS has indicated to PIHPs that they anticipate an additional four years under the Demonstration grant which would extend the grant to September 30, 2027.

Currently, only the CCBHC sites listed in Michigan's original 2016 application are eligible to participate in the state's Demonstration program which includes only HealthWest and WMCMHS in the region.[9] LRE staff report that MDHHS has submitted a request to SAMHSA to allow for the state to expand the Demonstration grant to additional CCBHC sites. The results of this request were unknown at the time of this report.

To ensure long-term viability of CCBHC sites in the region, it is imperative that two things occur:

- Michigan must make CCBHCs a permanent component of the behavioral health system following the Demonstration Project. States can do so through a Medicaid State Plan Amendment (SPA) or via legislation.[10]
- CCBHCs that are not currently supported by the Demonstration grant must be supported as their SAMHSA Expansion grants end. This could be addressed temporarily through the Demonstration grant if the state's request to allow additional sites is approved, or by making CCBHC permanent as discussed in the previous item.

The Community Mental Health Association of Michigan (CMHAM) indicates that there is some level of certainty that CCBHCS will become a central and permanent part of Michigan's behavioral health system. As the Bipartisan Safer Communities Act demonstrates, CCBHCs are considered to be an emerging cornerstone of the system by national policy makers.

> “If CCBHCs are not made a permanent component of Michigan’s mental health system, there will be a substantial loss of access to care by a significant number of Michiganders.”
>
> CMHAM

7. https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/ccbhc

8. https://www.congress.gov/bill/117th-congress/senate-bill/2938/text

9. CCBHC Demonstration Handbook

10. https://www.ncsl.org/research/health/the-value-of-certified-community-behavioral-health-clinics-magazine2022.aspx

LRE Role & Responsibilities

Demonstration Grant Oversight

The Michigan Department of Health and Human Services (MDHHS) relies on the regional PIHPs to provide management and oversight of Demonstration funds. To fulfill this role, the LRE provides reimbursement and coordinates data collection and reporting to MDHHS. In addition, the LRE seeks to enhance collaboration between grantees in the region.

A summary of LRE progress in fulfilling the required responsibilities related to management of this grant during year one are provided below. For more information refer to Attachment A.

Oversight & Support

Status

- Agreements have been established with each Demonstration site to fulfill requirements. Training and and technical assistance (TA) are provided during regular meetings to monitor progress and provide support.
- Each Demonstration site has established the necessary care coordination and required services.
- A primary focus in FY22 was establishing the necessary data collection, sharing and reporting capabilities to fulfill requirements.

Next Steps

- Continue working to improve SUD service data to support enhanced coordination of care. Work with MI Health Information Network to develop via LRE software.
- Finish development of dashboard to monitor whether individuals who have been admitted to an Emergency Department for drug/alcohol issue have initiated or engaged in SUD treatment using data collected through the CC360 data system.
- Develop a training on Waiver Support Application (WSA) enrollment to ensure clients are assigned accurately.

Enrollment & Engagement

Status

- LRE has established procedures to use the WSA tool for CCBHC assignment activities and distributed monthly to CCBHC sites.
- Consistent collection of consent forms has been incorporated into audits and was reviewed during September 2022 audits.

Next Steps

In FY23, assess the need for policy and procedure for the following & develop if necessary:

- WSA info collection for non-Medicaid recipients receiving services under CCBHC.
- Verification of diagnostic criteria for recipients not automatically CCBHC enrolled.

Coordination and Outreach

Status

- Demonstration sites provide each of the required services, ensuring service availability. In addition, DCOs can be contracted to provide additional services and expand capacity. One DCO has been contracted to provide outpatient services by HealthWest. Statewide staffing shortages have made it challenging to establish additional DCOs due to lack of capacity. Each site has established working relationships with healthcare providers.
- The LRE offers technical assistance and holds regular meetings with Demonstration sites to identify challenges and provide support related to outreach and coordination.

Next Steps

- Ongoing support and technical assistance as necessary.

Payments

Status

- The LRE has established the necessary reimbursement mechanisms and provides payments to each site at their PPS rate for each encounter as required, up to the amount paid to the LRE by MDHHS.
- The LRE has established the mechanisms and tracks encounters and daily visits with PowerBI reports, updated twice per month and accessible by Demonstration sites.

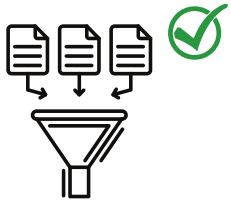
Next Steps

- Once reconciliation templates are provided by MDHHS, the LRE will implement a reconciliation process to determine whether the amounts that have been paid are appropriate.

Reporting

Status

- The LRE collects and reports all access and quality data to MDHHS as required.



PIHP collects & reports access data

PIHP reviews and submits CCBHC cost + quality metric reports

PIHPs must monitor, collect, & report grievances, appeals and fair hearing information

PIHPs must submit other MDHHS reports to MDHHS

Next Steps

- LRE will ensure processes are in place to collect and report on grievances, appeals, and fair hearing information.

Regional Support

In addition to requirements related to oversight of the Demonstration grant, the LRE seeks to foster regional innovation and collaboration to support CCBHC development at all Member CMHSPs.

To identify opportunities, each Member CMHSP was asked how the LRE could best provide assistance. Based on the input provided, the LRE should consider the following:

Sustainability

If the state has not made CCBHCs a permanent part of the behavioral health system prior to the Demonstration grant ending, sustainability of CCBHCs in the LRE region is in danger.

As noted by one local CCBHC, "It is critical that the PIHP achieves a high level of understanding of what it means to be a CCBHC and uses that knowledge to effectively advocate with MDHHS." Local CMHSP members that are not a Demonstration site noted that this advocacy must include ongoing funding to support their CCBHCs in a timely manner.

If MDHHS's request to expand Demonstration sites is approved, advocacy may be necessary to ensure OnPoint, Network180, and CMHOC are added. In addition, the LRE must ensure these sites are able to access Demonstration Project funds in a timely manner upon addition. If the state's request for expansion of Demonstration sites is not approved, advocacy to accelerate the state's timeline for making CCBHC a permanent part of the behavioral health system may be necessary.

Regional Forum

Provide ongoing opportunities for all CCBHCs in the region to learn and support their peers, including:

- Share local approaches to implementation, best-practices and processes, and emerging evidence regarding effective CCBHC services and structures.
- Support Member CMHSPs that are not currently a Demonstration sites to prepare for transition to CCBHC funding through the LRE, with the assumption that Michigan will continue and expand support for CCBHCs following the Demonstration Project.
- Coordinate regional efforts to advocate for timely process by MDHHS to sustain CCBHCs and prevent the discontinuation of sites due to lack of funds. This must ensure that Member CMHSPs that are not currently a Demonstration site are supported as their SAMHSA Expansion grants end, and that structures are in place to sustain all CCBHCs beyond the Demonstration Project.

Promotion

Promote and advocate for the value and benefits of the CCBHC model in general. With such a high concentration of CCBHCs in one area the LRE is in a unique position to celebrate and promote the benefits and successes possible with a CCBHC model.

Local Successes & Learnings

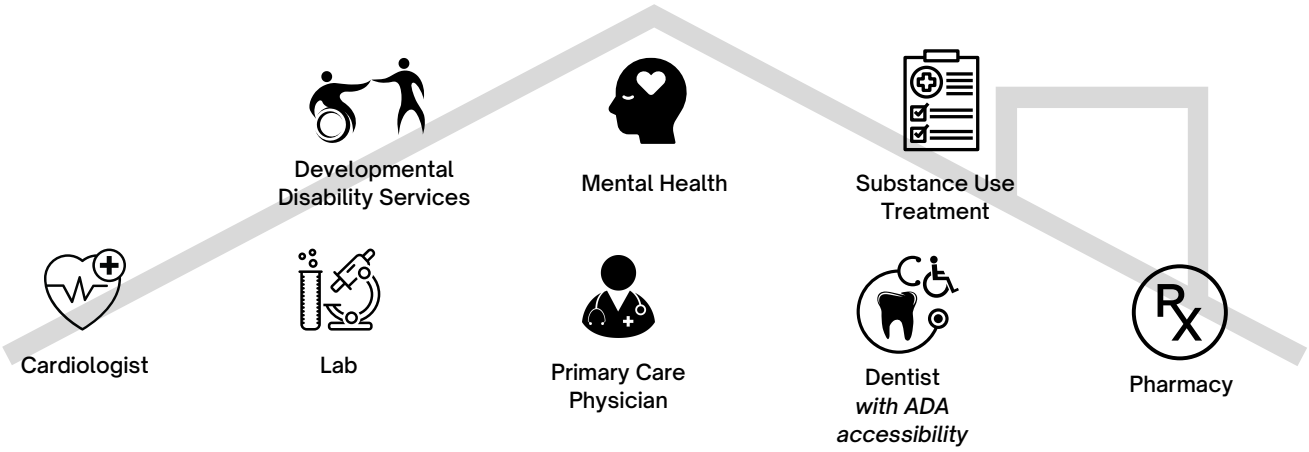
HealthWest

Subject matter experts: Cyndi Blair and Linda Closz

HealthWest began their journey toward integrated care in 2014 when they participated in SAMHSA's Primary and Behavioral Health Care Integration Grant. This grant assisted to create a framework for CCBHC.

To reflect the transformation that the organization went through to provide integrated care, they changed their name to HealthWest in 2015. Their vision was to become a leader in integrated healthcare, inspiring hope and wellness among residents, and making the region more inclusive through innovation and collaboration.[11] HealthWest now provides mental health, disability, substance use disorder treatment, and physical health services to all populations who seek them.

What does integrated care look like at HealthWest?



HealthWest partnered with Hackley Community Care Center to provide physical health services onsite including a lab, primary care physician, cardiologist, dentist with ADA accessibility and a pharmacy.

HealthWest has observed incredible benefits to providing holistic care. As Cyndi Blair highlighted, "To have our staff be a part of this transition and experience the goodness of having everything in one system - it changed the way we operate. All of the needs of our clients became our needs. It helped our staff to see the importance and feasibility of coordinating care."

Having everything in one space, and a team that interacts across specialties, allows for interdisciplinary problem solving which puts the client's needs first. An example of this was a consumer who lost their medications in a house fire. Because of the integration of health services, the case management team was able to coordinate with the onsite pharmacy to work with their insurance to provide an emergency medication refill in 24 hours. A process that typically takes weeks was accomplished in one day. This coordination of care allowed for the consumer to seamlessly continue their medication while they navigated challenges following a house fire.

11. https://www.mlive.com/news/muskegon

Innovative Solutions:

CCBHC provides flexibility for organizations to think creatively about how to engage consumers and provide holistic care. At HealthWest, some of these innovations include:

- Stationary bikes installed in the lobby to encourage people to use them as they wait for their appointments.
- Wellness Wednesdays to provide cooking classes, making smoothies, or other activities with consumers. The team has found that this can be a good introduction to topics like WRAP (Wellness Recovery Action Plan). Providing information in brief snippets has been successful as it doesn't require an initial commitment for a multi-session course.
- Prize closet: To help individuals celebrate small victories and create incremental change, consumers receive a stamp for activities like checking in with healthcare providers. Once they achieve a certain number of stamps, they can pick something out of the prize closet. Prizes are all wellness based and HealthWest reports that consumers are excited about this program.
- The pharmacy works closely with the care team to communicate individuals that missed picking up medications so that reminders and conversations between the consumer and care team can occur.
- Have established a Care Coordination Subcommittee that is developing a Care Coordination Model and have a Care Coordination Document available within our electronic health record.
- Have added Referral Specialists at the front door to discuss what services individuals are eligible for within HealthWest and at other providers.

Key Learnings:

Based on their experience, HealthWest would share the following lessons learned with others:

- To successfully transform into a CCBHC, it is important to understand that this is an opportunity not just for your organization, but to better serve your community.
- Challenge yourself to think outside the box. For example, HealthWest has struggled to find a space for the crisis stabilization team. In other communities, crisis stabilization teams are connected to the emergency department, which isn't possible in their community. As an alternative they are in discussion with an alternative school that provides housing about potentially hosting the crisis stabilization space. The school is looking to provide wrap around care for their students and because of the shared goal of providing holistic care for the community, the two organizaition may be able to work together to meet both needs.
- CCBHC will encourage collaboration across teams within your organization and with other organizations.
- It is important to understand that providing holistic care requires more than one organization. Believing that we are all in this together has shifted HealthWest's approach to problem solving.
- Learn from others. Reach out to other CCBHCs to see what they have done for programming and reporting.
- Change management is not just about bringing your staff along, it's also about bringing your consumers along.

West Michigan CMH Services (WMCMHS)

Subject Matter Experts: Lisa Williams, Josh Snyder, and Julie Sherlock

WMCMHS serves Lake, Mason, and Oceana Counties. They began the expansion to CCBHC in 2018 with a SAMHSA CCBHC Expansion Grant. In 2021, WMCMHS began receiving funds through the state's CCBHC Demonstration Grant. Since 2018, they have increased access to care by 14%.[12] WMCMHS reports that their unique strength is in change management. In conversation, it was obvious that transforming into a CCBHC required strategy, resources, communication, and growth. As Josh Snyder highlighted, "It often feels like you are taking a master's level class in CCBHC and change management. But stick with it, the change is worth it."

Transforming into a CCBHC

Change was an operational and cultural shift that required restructuring several aspects of the agency. The team invested in LEAN processing to identify improvements necessary to evolve into a CCBHC.

The way things have always been done	LEAN framework for data driven operations
Serving consumers with Medicaid or no insurance	Serving anyone with any type of insurance
Only providing services for "severe" cases	Expansion to serving mild & moderate diagnosis
Assigned a team based on population	Clinicians see clients with a variety of diagnoses

A few of the biggest changes are listed below:

- The entire agency was restructured so that all clinicians now provide all services, including substance use, mental health, and developmental disabilities. Prior to this, consumers were assigned to a team based on diagnosis, which is the traditional approach.
- Expansion of services into mild and moderate populations felt like a tipping point for change. Ongoing feedback was required after implementation so the leadership team could remove structural barriers encountered and to adjust and pivot as challenges arose.
- Transitioning into data driven operation requires consistent collection of data. SAMHSA requires collection of National Outcome Measures (NOMS). However, agencies that seek to improve processes will use this data internally to drive client outcomes which results in an organization and staff that recognize the value of meaningful data collection.
- Serving anyone, regardless of insurance type, required a change in clinical and hiring processes to ensure clinicians can bill private insurance as well as Medicaid.
- CCBHC allowed the organization to become more trauma-informed as an agency and therapists are now trained in a trauma specialty area within six months of hire.

WMCMH's focus on changing well has paid off. They report that people in the community who would never have approached the agency before now receive services through their organization. Staff report that it has been rewarding to expand services and provide the best care possible for anyone seeking services.

12. https://www.wmcmhs.org/news/west-michigan-cmh-receives-provisional-state-designation-to-increase-access-to-integrated-health-care-services/

Innovative Solutions:

CCBHC provides flexibility for organizations to think creatively about how to engage consumers and provide holistic care. At WMCMHS, some of these innovations include:

- All therapists are trained in a trauma specific, evidenced-based practice within 6 months of hire to ensure that the past trauma many consumers have experienced is addressed effectively.
- To continue quality improvement efforts related to coordination of care, WMCMHS is embedding tools, processes, training, and practices within their processes that support care coordination activities.
- To increase therapy capacity WMCMHS contracted a full-time tele-health therapist.
- Expanded the service array for individuals with mild to moderate mental health needs to add basic care management, peer group, and individual services. This provides ongoing services for those who are stable, who continue on medications, or who need additional support following a higher level of care (Level 3 or 4) or from therapy services, potentially decreasing the need for higher-level, high-cost services.
- Hold a monthly integrated care case consultation meeting for staff to discuss cases with both behavioral health and physical healthcare needs to discuss with the agency RN care managers, and nurse practitioners.
- Quality Bonus Payment Measures (QBPMs) and CCBHC-reported quality measures are reviewed regularly by the teams who do the work. Teams have received training to understand the data and related workflows. Data reports include out-of-compliance cases so teams can conduct targeted interventions to bring these cases into compliance.

Key Learnings:

Based on their experience, WMCMHS would share the following lessons learned with others:

- Change is slow. The leadership team believed that transforming into a CCBHC would take 1 year when it actually took 3-4 years for the culture shift to take place.
- When restructuring the vision and process, the leadership team's style has to change and requires working with staff individually and as a group.
- Behavior proceeds belief. Communication of the *why* driving the change is important, but there will still be resistance to change. After communicating, implement the new way of doing business. Belief will follow, and you adjust as feedback is received which drives continuous improvement.
- CCBHC requires a lot of change that results in large scale impacts for the front-line staff. Leadership should be careful not to push too hard, too quickly because staff who are implementing changes will feel immense pressure.
- Celebrate successes along the way - even small ones!

What's next?

WMCMHS will focus on education and outreach to primary care, schools, and emergency departments to ensure access for an additional 575 individuals from specific underserved populations (uninsured, underinsured, and Hispanic/Latino and LGBTQIA+). CCBHC has fundamentally changed how we deliver services in our rural communities, making evidence-based treatment and recovery possible for everyone." [13]

Lisa Williams, CEO WMCMH

13. https://www.stabenow.senate.gov/news/senator-stabenow-announces-1-million-in-funding-to-expand-mental-health-and-addiction-services-at-west-michigan-community-health

Network180

Subject Matter Experts: Kristin Spykerman and Beverly Ryskamp

Network180 was awarded the SAMHSA Expansion Grant in 2020 and began receiving funds during FY21. At the time of the award, leadership of Network180 expressed excitement about the expansion of services to anyone needing mental health and substance use disorder treatment, regardless of their insurance, and expansion of mobile crisis services. Since then, the Network180 team has worked hard to expand crisis services, to collaborate closely with community partners, and to adjust operations to expand the scope of who receives services.[14]

Transforming into a CCBHC:

Beverly and Kristin highlighted the following changes:

- Change in Access Center procedures to allow for expanded eligibility for services. As a CCBHC Network180 can now provide services for anyone who seeks therapy, whether that is short or long term. For example, if someone is going through a divorce and wants short term support, Network180 can now provide those services.
- Establishing the operations necessary to bill private insurance; including considerations such as hiring clinicians that can bill multiple payers.
- Streamlining documentation requirements during intake. The substantial amount of documentation required for Medicaid services can be stigmatizing. As an organization, Network180 considered how to reduce this burden for mild and moderate cases. By only collecting the necessary information consumers are able to start services faster and staff report that the reduced paperwork allows them to provide therapy to more consumers.
- For mobile crisis services, Network180 now works closely with dispatch in Kent County to pair a clinician with an officer to co-respond to calls involving a behavioral health crisis so the clinician can provide support in stabilizing the individual and connections to community resources or services.

Key Learnings:

Based on their experience, Network180 would share the following lessons learned with others:

- CCBHC provides the opportunity to expand services. In doing so it was necessary to consider how to reform and streamline operations to best serve consumers.
- Recognize as an agency that providing holistic care takes time. Leadership has to work closely with staff to share the vision and what that looks like. Provide consistent messaging for change and work with teams to provide feedback for process improvement.
- Communication is key. Communication with staff, community members, and your Board of Directors. It is important to ensure that people understand the shift in care, why that shift is occurring, and how it better serves our community.
- "Culture eats strategy for lunch." This is a paradigm shift for people who have spent most of their career working at a Community Mental Health. If staff don't understand the why, they will feel like you are just adding more work to their plate.
- The organizations must buy into the model of care because grant funding will not cover all expenditures needed to become a CCBHC.

14. https://grbj.com/news/health-care/network180-wins-2m-grant-to-expand-mental-health-services-in-kent-county/

OnPoint

Subject Matter Expert: Leanne Kellogg

OnPoint was awarded a two-year CCBHC Expansion Grant from SAMHSA in 2021 to begin their journey toward becoming a CCBHC in Allegan County. At the time of the award, their director Mark Witte stated that “SAMHSA funds will support access to care (including mobile response) for those previously ineligible for services, identify and treat trauma, and integrate physical care for those with mental illness and/or substance use issues. There are a lot of needs in Allegan County that we care a lot about. This grant will go a long way toward meeting those needs." [15]

During their first year of funding, OnPoint was able to enhance capacity in several areas including:

- Staffing of both clinical and operational teams to create an integrated health system.
- Clinical staff received a variety of Evidence Based Practice trainings.
- Services were expanded for substance use disorder treatment to provide intensive outpatient services for individuals who would have been eligible previously.
- Procedural change for access and assessment processes to streamline assessments and services.

Development of their CCBHC has also resulted in a strengthening of their community partnerships and referral relationships, including:

- Referral relationships and partnerships with a variety of community stakeholders established and increased coordination.
- Mobile crisis team partnering closely with local school districts.
- Public Health has become a close partner for referring consumers to STD/STI testing and treatment when appropriate.

OnPoint is especially proud of their progress related to data collection and tracking. They established an evaluation team that researched CCBHCs across the country to learn about best practices for data collection and evaluation. Following this, a dashboard was created, based on the Thread concept, to allow staff to track progress and outcomes for individual clients in real-time. In addition, data collection has allowed them to track individuals throughout the continuum of care to ensure consumers don't "fall through the cracks".

Key Learnings:

Based on their experience, OnPoint would share the following lessons learned with others:

- Learn from others. Find out what other CCBHCs are doing across the country; take their work and make it your own. The OnPoint evaluation team did this by taking the best of what they learned and used it to create a custom data tracking system for them to use.
- Educate yourself and your team about how to communicate about change. Consider how feedback is received and what should be done with that feedback. A lot of people instinctively do not like change, and they need to understand that the change will occur regardless of negative opinions.
- The culture change that accompanies CCBHC is equal to, or even more important than, the clinical and process changes that need to be made.

15. https://www.mlive.com/news/kalamazoo/2021/07/4m-awarded-to-improve-access-to-mental-health-and-substance-abuse-services-in-allegan-county.html

CMH of Ottawa County (CMHOC)

CMHOC was awarded a two-year CCBHC Expansion Grant from SAMHSA in 2021 with funding beginning in FY22. CMHOC reports they are excited to approach care with the whole person in mind. The Expansion Grant has allowed CMHOC to expand their infrastructure to better integrate care for the people we serve.

What does integrated care look like at CMHOC?

CMHOC has enhanced capacity in several areas including:

- Health and wellness initiatives provided both at CMHOC and through partnering organizations.
- Medical assistants are embedded on each team at CMHOC to better integrate physical care.
- Increased support at the front door to meet the needs of community members walking in with questions and resource needs.
- Short term navigation team to provide short term case management and therapy services to individuals and families who do not qualify for the full array of services.
- Peer recovery coach assists with coordinating care at sober living facilities and outpatient treatment providers.
- Facilitation of co-occurring groups to provide support and resources to individuals experiencing both SUD and mental health diagnosis.

Key Partnerships:

Based on their experience, CMHOC reports that establishing partnerships to better meet community needs has been very effective during CCBHC development, including the following examples:

The crisis intervention team has been an investment through CCBHC that has been invaluable. This program allows for therapists to accompany law enforcement on calls to assist with crisis situations. Since October 2021, the CIT team has had over 400 calls. Each of these calls provide an opportunity to connect an individual with resources or support. [16]

Local partnership with Intercare to improve care coordination and working with Genoa, the CMHOC onsite pharmacy, to provide education opportunities for staff and consumers.

Enhancements to the electronic health record has allowed for increased collaboration with contract agencies and improved data collection and analysis.

Established a partnership with Nottawaseppi Huron Band of the Potawatomi, a local tribe, to improve services and to connect individuals who identify as Native American with tribal resources. This partnership resulted in improvements of the assessment process to ask about tribal affiliation during a person's initial assessment. In addition, site visits have been mutually beneficial in helping them best serve Native Americans within the community.

Cooking Demonstrations & food access membership are provided through partnership with local nonprofit.

16. https://www.secondwavemedia.com/lakeshore/features/Ottawa_County_CIT_team_bridge_to_mental_health_resources.aspx

Conclusions & Next Steps

LRE Role

Demonstration Grants Management

During FY22 the LRE successfully established the necessary mechanisms and processes to oversee and reimburse CCBHCs under the state Demonstration Grant. In addition to maintaining these processes and responding to MDHHS ongoing changes in requirements, the LRE will address the following:

- Determine necessity of policy development related to WSA data tracking for non-Medicaid recipients of CCBHC services and verification of diagnostic criteria for recipients not automatically CCBHC enrolled.
- Continue efforts to improve access to SUD service data for enhanced coordination of care.
- Finish development of dashboard to monitor whether individuals who have been admitted to an Emergency Department for drug/alcohol issue have initiated or engaged in SUD treatment.
- Develop and provide training on WSA enrollment to help ensure clients are assigned accurately.
- Conduct reconciliation to ensure amounts paid during FY22 were appropriate once MDHHS provides the necessary templates.
- Ensure that the required grievance, appeal, and fair hearing information for each site is being monitored and reported to MDHHS.

Regional Support

To support local CCBHCs, the LRE should consider the following (as detailed in the Regional Support section):

- Sustainability: Advocacy to ensure that ongoing funding support is available in a timely manner that is able to effectively support CCBHCs in the region.
- Regional Forum: Provide ongoing opportunities for every CMHSP to discuss CCBHC development to learn from each other, support Member CMHSPs that are not currently a Demonstration site to increase readiness to transition to CCBHC funding through the LRE, and coordinate regional advocacy efforts. Promote the availability of the National Council for Mental Wellbeing Mentoring program for Expansion grantees planning to move into the Demonstration Project.
- Promotion and advocacy regarding the value and benefits of the CCBHC model based on local CCBHC successes.

Local Successes & Lessons Learned

Local CMHSPs report excitement about expanding services and report that their transformations to CCBHCs have resulted in:

- Improved data tracking for client outcomes.
- The ability to offer all types of services, not just those covered by Medicaid.
- Holistic care allows for better meeting consumer needs and increased coordination of care.
- The ability to invest in evidence-based practices.
- Increased partnerships and referral sources throughout the community.
- Reduced paperwork is less stigmatizing and allows treatment to start sooner.
- The ability to align operations to address the needs of our consumers.

Each CMHSP reported many lessons learned, including the following common themes:

- Change is hard. To successfully create change, leadership teams must change how they operate to bring staff and consumers along.
- Reach out to other CCBHCs. Seek out peers and learn. Don't recreate the wheel. Explore what others have done to inform your initiatives. There is too much work to do to not share.
- Communication is key. Communication with staff, community members and your board. Make sure that people understand what the shift is, why that shift, and how it will result in better services for the community.
- Expanding services may result in decreased stigma associated with receiving services from a CMHSP and allow them to move toward being considered just like other healthcare providers.

Sustainability

As discussed in the Funding Sustainability section, if MDHHS does not make CCBHCs a permanent component of Michigan's behavioral health system, sustainability of the region's CCBHCs is in danger.

MDHHS had indicated that at the end of the Demonstration grant they will evaluate the program's impact and the potential to continue or expand the initiative under the CMS State Plan option. As the only prospective mechanism to ensure long-term viability it is imperative that the structures developed to support CCBHCs under this grant become a permanent component of the MI behavioral health system.

While the Community Mental Health Association of Michigan (CMHAM), indicates that there is some level of certainty that CCBHCS will become a central and permanent part of the MI behavioral health system, it is not guaranteed. If the state has not taken action prior to the Demonstration grant ending, LRE will need to work closely with Member CMHSPs to mitigate the impact on service access if CCBHC funding is discontinued. This will also need to occur if MDHHS has not begun funding the current Member CMHSPs that are not a Demonstration site (through the Demonstration grant or the CMS State Plan option) prior to their CCBHC Expansion grants ending.

Attachment A

CCBHC PIHP Responsibilities, LRE Status Detail

Details around PIHP requirements for the oversight and support of CCBHCs within their region.

Green checkmark to demonstrate PIHP is meeting the requirement

Work is still in progress to meet the requirement

N/A Requirement cannot be completed at this time

Oversight and Support		
Contract or develop a MOU with all CCBHCs in the region and ensure access to CCBHC services for enrollees; must permit subcontracting with DCOs and reflect CCBHC Scope of services with compensation that reflects clinic specific PPS-1 rates.	LRE has established MOUs and contracts with both HW and WMCMHS that meet these requirements.	
Capacity to identify providers and DCOs who meet CCBHC standards.	LRE monitors compliance with service requirements. HW and WMCHS identify providers and DCOs who meet standards.	
Establish infrastructure to support CCBHCs in care coordination and providing required services, including but not limited to crisis services, SUD services, and primary care services.	The LRE meets regularly with HW and WMCMHS to ensure services meet these requirements and to provide support when necessary. Per member request, the LRE is working to improve access to SUD service data to allow for enhanced coordination of care. LRE is working with MI Health Information Network to determine how this can be done via LRE software.	
Collecting and sharing member-level information regarding healthcare utilization and medications with CCBHCs.	The LRE provides access to Zenith ICDP system for all CCBHCs which displays integrated healthcare information.	
Providing implementation and outcome protocols to assess CCBHC effectiveness.	Data dashboards have been developed for each CCBHC. Feedback from CCBHC will drive continuous improvement. An audit process was developed.	
Develop training and technical assistance activities that will support CCBHC in effective delivery of CCBHC services.	Technical assistance provided during FY22 included: • Development of a transfer policy for transferring an individual to a CCBHC in a different county • Regular support related to WSA • Finance meetings twice a month • Discussions about root cause for encounter errors	

Oversight and Support, continued		
Must utilize Michigan claims and encounter data for the CCBHC population	Data dashboards were developed that provide: • Enrollment breakdowns by gender • Medicaid status • # 1st time enrollees per month • WSA enrollments over time • Medicaid payments by sources • PPS-1 calculations • Utilization by CPT codes • Quality/audit page which identifies potential CCBHC services missing a required element to qualify	
PIHPs must use CareConnect 360 to analyze health data spanning different settings of care for care coordination purposes among CCBHC Medicaid beneficiaries.	Currently in development of a data dashboard to monitor Initiation & Engagement in SUD treatment following an Emergency Dept. admission with drug/alcohol involved using CC360.	
PIHPs must provide support to CCBHCs related to Health Information Technology including WSA, CareConnect360, EHR, and HIEs.	LRE provides training and assistance for WSA. In FY23 the LRE intends to create a training on WSA enrollment to help ensure clients are assigned accurately.	
Monitor CCBHC performance and lead quality improvement efforts. PIHPs are not responsible for overseeing and monitoring any certification corrective action plan. However, MDHHS will share the plans with the PIHP and the PIHP may be asked to assist the CCBHC in meeting goals where appropriate.	LRE Maintains oversight of Demonstration sites through regular meetings, both with the sites and internally to ensure compliance with the model standards. LRE has created dashboards to measure CCBHC performance against established metrics. LRE provides guidance on prospective action to improve CCBHC performance.	
Establish a continuous quality improvement program and collect/report on data that permits an evaluation of increased coordination of care and chronic disease management on clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.	LRE has created dashboards to measure CCBHC performance against established metrics. CCBHCs have access to the dashboards for real-time performance monitoring.	

Oversight and Support, continued		
Design and develop prevention and wellness initiatives and referral tracking.	CCBHCs have established referral agreements with agencies in their service areas. LRE to create tracking for referrals and wellness initiatives.	
Network monitoring and performance.	CCBHCs have begun to onboard DCOs in support of CCBHC objectives. LRE will monitor the process and ensure DCO requirements are met.	
Cost and quality report audit and compliance review.	LRE hosts a bi-monthly CCBHC Finance meeting to monitor and discuss financial aspects of CCBHC Demonstration, including encounters, PPS payments and FSR completion.	
Compliance with other State and/or Federal reporting requirements.	LRE monitors CCBHC reporting requirements and works with CCBHCs to ensure compliance.	
Enrollment and Assignment		
WSA should be utilized for CCBHC assignment activities for Medicaid and non-Medicaid patients served by CCBHCs.	WSA reports are distributed monthly to CMHs for new consumers. LRE is evaluating the need for a policy and procedure for WSA information on non-Medicaid recipients served by CCBHC.	
Verify diagnostic criteria for CCBHC recipients who aren't automatically identified and enrolled (ie: walk-ins and non-Medicaid recipients).	PIHP will evaluate the need for a policy and procedure in FY23.	
Monitor consistent collection of MDHHS-5515 consent forms for participants.	LRE conducted an audit that included consent documentation in September 2022.	

Coordination and Outreach		
Maintain a network of providers that support the CCBHC to service all Michiganders with a mental illness or substance use disorder.	Both HW and WMCMHS provide directly each of the required services and ensure service availability. To expand capacity, HW and WMCMHS may contract with DCOs. In FY22, HW had 1 DCO to provide outpatient mental health and SUD services. Statewide staffing shortages have caused challenges because many providers do not have staff capacity to expand programming.	
Develop and maintain working relationships with primary and specialty care providers such as Federally Qualified Health Centers, Rural Health Clinics, inpatient hospitals, crisis services providers, and SUD providers.	Each Demonstration site has established working relationships with primary and specialty providers and maintains their own provider network. The LRE offers technical assistance to the Members as requested. Note: Members note that staffing shortages have made it difficult to establish and maintain these working relationships.	
Assist CCBHC with outreach of eligible CCBHC recipients, if requested by CCBHC.	The LRE will provide assistance as necessary. To date no requests have been made.	
Coordinate crisis and other referral services with the Michigan Crisis and Access Line (MiCAL), when available in PIHP region.	The MiCAL system was not available in FY22. When it is, each site will ensure they coordinate as necessary.	
Coordinate services when eligible individuals utilize the PIHP's centralized access system, including assigning them to a CCBHC of their choice.	Not applicable. The LRE has a decentralized access system.	

Payments		
PIHPs are responsible for reimbursing CCBHCs at the site-specific PPS-1 rate for each valid CCBHC service encounter. The full PPS-1 payment amount (less any applicable cost offsets) must be received by the CCBHC within 60 days following the month service was rendered.	CCBHCs are being paid monthly for the PMPM for each Medicaid enrollee and the Supplemental portion of the Medicaid PPS-1 rate, up to the amount paid by MDHHS to the PIHP. CCBHCs will report final FY22 data in Feb 2023 and the LRE will determine at that time if the appropriate amount has been paid during FY22.	
Develop a process to collect CCBHC "encounters" for the non-Medicaid population for cost reporting and monitoring purposes.	Twice a month, LRE tracks encounters and daily visits utilizing PowerBI reports.	
PIHPs submit encounters to MDHHS.	Completed monthly per normal encounter submission schedule.	
Reporting		
Metrics: • Review, audit and submit quality metrics to MDHHS • Collect and report access data quarterly inc. the # of individuals requesting services and the # receiving their 1st service.	CCBHC handbook requires the PIHP to have quarterly reconciliation between the PIHP and CCBHC utilizing a template provided by MDHHS. The template has not been provided.	
PIHPs must monitor, collect, and report grievance, appeal, and fair hearing information, with details, by CCBHC, to MDHHS Note: MDHHS will specifically monitor this activity as it relates to CCBHC services related to certification criteria requiring CCBHCs to serve all populations regardless of severity, ability to pay, or county of origin). PIHPs are not responsible for recipient rights reporting.		
PIHPs must submit other MDHHS-required reports such as FSRs pursuant to MDHHS-defined instructions and timelines.	Non-Medicaid reports are due in Egrams and are submitted on time FSR's are submitted as required.	

MDHHS
Michigan Department of Health & Human Services

ATTACHMENT 7

OPIOIDS SETTLEMENT: FY2023 SPEND PLAN

PROPOSED EFFORTS

MDHHS has developed a proposed Opioid Settlement Spend Plan for the State of Michigan's Fiscal Year (FY) 2023 funding that has been driven by data, including the Opioid Settlement Prioritization Survey 2021–22, as well as ongoing programming needs and gaps due to federal funding restrictions. Proposed FY23 Spend Plan efforts relate to MDHHS' overarching goal to reduce harm associated with the opioid crisis. A brief overview of key efforts and investments are summarized below.

TREATMENT

- Invest in initiatives aimed to increase substance use disorder (SUD) treatment capacity, such as workforce training and loan repayment incentives, and infrastructure grants.
- Invest in capacity building for evidence-based practices for stimulant and polysubstance use.

PREVENTION

- Increase awareness and education around adverse child experiences (ACEs) by exploring ways to impact or reduce ACEs by bringing awareness to the relationship between ACEs and SUDs and implementing evidence-based primary prevention programming with a goal to foster positive experiences and health outcomes at the individual, family and community levels.
- Expand Quick Response Teams, a collaborative and community-led initiative that focuses on promoting pathways to treatment and recovery and preventing fatal drug overdoses. The expansion of this initiative aims to increase presence in rural counties, homeless populations and parents exiting criminal justice systems.

RECOVERY

- Expand recovery housing sites to offer stable, safe and sober housing options that are critical to those in recovery.
- Provide grant opportunities to Recovery Community Organizations that help ensure community supports are available for those in recovery.

HARM REDUCTION

- Invest in resources that reduce harm associated with substance use, such as overdose and infectious disease. Continue to fund the MDHHS Naloxone portal, which supplies an overdose reversal medication to community organizations, as well as syringe service programs, which provide access to supplies including, but not limited to, fentanyl test strips, naloxone and sterile syringes.

SPECIFIC POPULATIONS AND FOUNDATIONAL PRINCIPLES

CRIMINAL-LEGAL

- Support the provision of Medications to treat Opioid Use Disorder in jails and prisons, which are medications that have been proven to reduce the risk of overdose.

PREGNANT & PARENTING

- Expand capacity in hospitals to support "Rooming In," where mothers with infants experiencing Neonatal Abstinence Syndrome can stay together promoting recovery and family preservation.
- Expand the implementation of evidenced-based screening tools designed to identify SUDs in pregnant women; to be used in prenatal clinics across the state.
- Invest in supports for families vulnerable to child removal due to involvement with substance use, with the goal of reducing the rate of children removed from family homes and supporting family recovery and family reunification.

DATA

- Allow state-level data infrastructure investments with settlement funds for critical data capturing and monitoring.

EQUITY

- Fund recommendations of the Opioid Task Force's Racial Equity Workgroup to reduce disparities in substance use.

LOCAL GOVERNMENT TECHNICAL ASSISTANCE & RESOURCES

- Funds will allow experts from Michigan State University, University of Michigan and Wayne State University to provide technical assistance to interested communities regarding best practices for addressing opioid use disorders. The universities will also be able to provide technical assistance in tailoring programs to vulnerable populations, such as the justice-involved and pregnant and parenting populations.
- Create an Opioid Settlement website that will serve as a resource hub for local governments to utilize as they determine how to invest their settlement allocations.

ADMINISTRATION

- Invest approximately 5% of all settlement dollars to fund the necessary staff to successfully implement projects related to the settlement dollars. This follows requirements of Substance Abuse and Mental Health Services Administration grants that has historically been sufficient to administer funds while maximizing service dollars.

1/12/23

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MDOT Michigan Department of Transportation, A COMMUNITY PARTNER

1/12/23

¿QUÉ HAS ESTADO ESCUCHANDO ACERCA DEL VAPEO?

¡PROCURE QUE LA CHARLA VALGA!

CONVERSACIONES DIFÍCILES HECHAS MÁS FÁCILES

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TRAÍDO A USTED POR LAKESHORE REGIONAL ENTITY

MDOT Michigan Department of Transportation, UN COMPAÑERO COMUNITARIO

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

Responsible Tobacco Retailing Campaign of Allegan, Kent, Lake, Mason, Muskegon, Oceana, and Ottawa Counties.

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.

HOW DO I JOIN **CAP?**

If you are interested in joining the LRE CAP, you can do one of the following:

- Call LRE Customer Services at **1-800-897-3301** and tell them you are interested
- Visit the LRE website at www.lsre.org and fill out an application under the Customer Services tab
- Let staff at your CMH know that you are interested in being part of the LRE CAP either in person, or at the customer service numbers below:
- Members are recommended and approved by the CMH Directors

HealthWest	231.720.3201
Network 180	866.411.0690
OnPoint	877.608.3568
Community Mental Health Ottawa County	616.393.5648
West Michigan CMH	800.992.2061

MISSION

Our mission is to advocate for others by sitting on committees and providing input and information based on our experiences. We work to improve communications, legislation, opportunities, services, education, and supports for all people who receive behavioral health services.

COMMUNITY ADVISORY PANEL

LAKESHORE REGIONAL ENTITY

WWW.LSRE.ORG

Customer Services Manager:
Michelle Anguiano

Customer Services Specialist:
Mari Hesselink

Lakeshore Regional Entity
5000 Hakes Dr. Ste 100
Muskegon, MI 49441
(800)897-3301
www.lsre.org

LAKESHORE REGIONAL ENTITY

GUIDELINES FOR **MEMBERSHIP**

- Members serve a 3-year term.
- Prospective members must be willing and able to attend on-line meetings, usually scheduled quarterly.
- Members will receive a small stipend for attending meetings according to LRE Policy and Procedure.
- Members must live within the LRE Region: Kent, Ottawa, Allegan, Muskegon, Lake, Oceana, or Mason counties.

WHAT IS **CAP**?

Lakeshore Regional Entity's Community Advisory Panel (CAP) is a group of people who are passionate about the behavioral health system in Western Michigan and have partnered with Lakeshore Regional Entity to improve and enhance the quality of these services.

LRE relies on our Community Partners to share their experiences with us, allowing us to view the services we provide through the eyes of the people we serve. This feedback is used to make important decisions about policies, procedures, and overall operations at the LRE.

Additionally, the Community Advisory Panel members learn about the behavioral health system, are kept up-to-date on legislative efforts at the state and federal level, and are equipped to act as ambassadors in their communities.

WHO CAN JOIN

CAP members belong to one of the following groups:

- Adults with a mental illness, developmental disability, or substance use disorder
- A parent or guardian of a person (adult or child) with a mental illness, developmental disability, or substance use disorder
- Advocates working with people from any of the above groups
- People who belong to other consumer advocacy groups, clubs, or drop-ins. Cross communication is important between groups at the various CMHs to encourage information

LAKESHORE REGIONAL ENTITY

Information Officer Report – March 2023

Summary: **3/13/2023**

1. **MCIS Software**:
   The new FY23 Critical Incidents and Risk Events module will be ready for testing in late March. FY23 data has been submitted on time by LRE thus far via manual data entry into the MDHHS CRM system. Manual data entry into the MDHHS CRM system will continue in March using data from the CMH submitted files. Those files will then also be used for fully testing the new module in the LRE test system.

2. **Data Analytics and Reporting:**
   New implementations in progress:
   - Fair Hearings Dashboard
   - BHTEDS Completeness (as per exact MDHHS measurement methodology)

   Recently update/developed:
   - CCBHC Financial Dashboard
   - LOCUS Dashboard (updated)
   - Grievance & Appeals Dashboard (new)

3. **Encounter reporting to MDHHS**:
   FY22 Encounter reporting: Most CMHs are complete with their FY22 data submissions. Some are still sending in a small number of corrections to finalize FY22 in advance of that data being used for FY24 Medicaid Rate Setting. Please see also the encounter graphs attached.
   FY23 Encounter reporting is showing good volume through January 2022, as would be expected at this point in time.

   BH-TEDS reporting to MDHHS:
   FY22 BH-TEDS: LRE's CMHs submitted significant additional data (and data corrections) over the last 2 months, bringing our completeness above the 95% standard in all measurement categories.
   FY23 BH-TEDS: MDHHS completeness measurements for FY23 BH-TEDS were received on 3/09/2023. LRE is holding above the 95% standard on all 3 measures.

   It is important to also note that the "Crisis Only" Measure *(an area where we had previously struggled)* has improved substantially and is now **above 99% for FY22. This is the outcome of significant efforts at our CMHSPs to improve and stabilize this measure. Thanks and congratulations go out to our CMH staff who have contributed to this achievement!
   See also "Additional Details" on pages 3 - 5 below for the MDHHS calculated measures across all PIHPs.

4. **E**ncounter **D**ata **V**alidation (**EDV**) - (42 CFR) §438.242: HSAG draft audit questionnaire for this new audit has been released for review/feedback. MDHHS work plan involves finalizing the audit questionnaire by mid-April and then distributing that immediately to PIHPs with completion/response due back to HSAG by May 9th. See also page 2 for an overview of this new audit methodology.

Additional Details:

HSAG Encounter Data Validation (EDV) - Overview:

HSAG HEALTH SERVICES ADVISORY GROUP

Michigan State Fiscal Year (SFY) 2023 Encounter Data Validation Methodology

Overview

Pursuant to Title 42 of the Code of Federal Regulations (42 CFR) §438.242, the Michigan Department of Health and Human Services (MDHHS), must ensure that each of its contracted Medicaid managed care entities (MCEs) maintain a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. MDHHS must also review and validate encounter data collected, maintained, and submitted by the MCEs to ensure that it is a complete and accurate representation of the services provided to its Medicaid members. Accurate and complete encounter are critical to the success of a managed care program. Therefore, MDHHS requires its contracted Medicaid MCEs to submit high-quality encounter data. MDHHS relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During state fiscal year (SFY) 2023, MDHHS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct an encounter data validation (EDV) study. In alignment with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, October 2019 (CMS EQR Protocol 5)[1], HSAG will conduct the following activities for the EDV study:

- Information systems (IS) review—assessment of MDHHS' and the MCEs' information systems and processes. The goal of this activity is to examine the extent to which MDHHS' and the MCEs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's Capability in the CMS EQR Protocol 5.
- Administrative profile—analysis of MDHHS' electronic encounter data completeness, accuracy, and timeliness. The goal of this activity is to evaluate the extent to which the encounter data in MDHHS' Encounters Processing Solution (EPS) database are complete, accurate, and submitted by the MCEs in a timely manner for encounters with dates of service from October 1, 2021, through September 30, 2022. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.

BHTEDS Completeness – FY22 – per MDHHS as of 3/08/2023:

FY22 MH Encounters w/BH-TEDS records				
Encounters: 10/01/2021 - 09/30/2022*			BH-TEDS: 07/01/2020 - 03/08/2023	
		Distinct Count of Individuals With		
Region Name	Submitter ID	Non-H0002 & Non-Crisis, Non-OBRA Assessment & Non-Transportation	Non-H0002, Non-Crisis, Non-Health Home, Non-OBRA Assessment & Non-Transportation Encounters But NO BH-TEDS Record Since 07/01/2020	Current Completion Rate
CMH Partnership of SE MI	00XT	11,700	501	95.72%
Detroit/Wayne	00XH	60,877	4,175	93.14%
Lakeshore Regional Entity	00ZI	21,161	798	96.23%
Macomb	00GX	13,588	402	97.04%
Mid-State Health Network	0107	43,477	1,297	97.02%
NorthCare Network	0101	6,485	47	99.28%
Northern MI Regional Entity	0108	13,172	286	97.83%
Oakland	0058	23,927	534	97.77%
Region 10	0109	19,940	56	99.72%
Southwest MI Behavioral Health	0102	22,834	731	96.80%
Statewide		237,161	8,827	96.28%
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				

FY22 Crisis Encounters w/BH-TEDS records				
Encounters: 10/01/2021 - 09/30/2022**			BH-TEDS: 07/01/2020 - 03/08/2023	
		Distinct Count of Individuals With		
Region Name	Submitter ID	Crisis Encounters	Crisis Encounters But NO BH-TEDS Record Since 07/01/2020	Current Completion
CMH Partnership of SE MI	00XT	2,616	93	96.44%
Detroit/Wayne	00XH	9,873	80	99.19%
Lakeshore Regional Entity	00ZI	6,774	65	99.04%
Macomb	00GX	1,877	23	98.77%
Mid-State Health Network	0107	12,016	364	96.97%
NorthCare Network	0101	2,166	3	99.86%
Northern MI Regional Entity	0108	4,764	183	96.16%
Oakland	0058	3,428	11	99.68%
Region 10	0109	2,457	6	99.76%
Southwest MI Behavioral Health	0102	4,148	31	99.25%
Statewide		50,119	859	98.29%
Key				
95.00+ = Compliant		**Encounters include H2011, S9484, T1023, 90839, 90840		
90.00-94.99				
85.00-89.99				
<85.00				

FY22 SUD Encounters w/BH-TEDS records				
SUD Encounters from 10/01/2021-09/30/2022***			Does Not Have Open Admission at Time of Encounter as of 03/08/2023	
		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	2,834	26	99.08%
Detroit/Wayne	00XH	7,906	2	99.97%
Lakeshore Regional Entity	00ZI	5,932	69	98.84%
Macomb	00GX	3,779	17	99.55%
Mid-State Health Network	0107	10,319	10	99.90%
NorthCare Network	0101	1,864	3	99.84%
Northern MI Regional Entity	0108	3,806	43	98.87%
Oakland	0058	3,417	1	99.97%
Region 10	0109	5,417	27	99.50%
Salvation Army	002Y	NO FY22 Encounters Submitted Yet at 03/08/2023		
Southwest MI Behavioral Health	0102	6,005	185	96.92%
Statewide		51,279	383	99.25%
Key				
95.00+ = Compliant		***Encounters = All SUD encounters **excluding** H2034, S0280 & T1040		
90.00-94.99				
85.00-89.99				
<85.00				

BHTEDS Completeness – FY23 – per MDHHS as of 3/09/2023:

FY23 MH Encounters w/BH-TEDS records				
Encounters: 10/01/2022 - 01/31/2023*			BH-TEDS: 07/01/2021 - 03/08/2023	
		Distinct Count of Individuals With		
Region Name	Submitter ID	Non-H0002 & Non-Crisis, Non-OBRA Assessment & Non-Transportation	Non-H0002, Non-Crisis, Non-Health Home, Non-OBRA Assessment & Non-Transportation Encounters But NO BH-TEDS Record Since 07/01/2020	Current Completion Rate
CMH Partnership of SE MI	00XT	8,926	546	93.88%
Detroit/Wayne	00XH	45,059	2,341	94.80%
Lakeshore Regional Entity	00ZI	15,133	578	96.18%
Macomb	00GX	10,354	370	96.43%
Mid-State Health Network	0107	31,344	1,456	95.35%
NorthCare Network	0101	5,002	102	97.96%
Northern MI Regional Entity	0108	9,516	258	97.29%
Oakland	0058	19,064	273	98.57%
Region 10	0109	15,816	309	98.05%
Southwest MI Behavioral Health	0102	15,172	87	99.43%
Statewide		175,386	6,320	96.40%
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 - 01/31/2023**			BH-TEDS: 07/01/2021 - 03/08/2023	
		Distinct Count of Individuals With		
Region Name	Submitter ID	Crisis Encounters	Crisis Encounters But NO BH-TEDS Record Since 07/01/2020	Current Completion
CMH Partnership of SE MI	00XT	1,104	52	95.29%
Detroit/Wayne	00XH	4,275	36	99.16%
Lakeshore Regional Entity	00ZI	2,564	92	96.41%
Macomb	00GX	802	25	96.88%
Mid-State Health Network	0107	4,914	183	96.28%
NorthCare Network	0101	737	20	97.29%
Northern MI Regional Entity	0108	1,667	44	97.36%
Oakland	0058	1,004	5	99.50%
Region 10	0109	1,261	80	93.66%
Southwest MI Behavioral Health	0102	1,293	5	99.61%
Statewide		19,621	542	97.24%

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

**Encounters include H2011, S9484, T1023, 90839, 90840

FY23 SUD Encounters w/BH-TEDS records

SUD Encounters from 10/01/2022-01/31/2023***			Does Not Have Open Admission at Time of Encounter as of 03/08/2023	
		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	1,727	5	99.71%
Detroit/Wayne	00XH	4,448	1	99.98%
Lakeshore Regional Entity	00ZI	3,363	55	98.36%
Macomb	00GX	2,293	4	99.83%
Mid-State Health Network	0107	5,838	1	99.98%
NorthCare Network	0101	1,061	1	99.91%
Northern MI Regional Entity	0108	2,158	10	99.54%
Oakland	0058	1,896	0	100.00%
Region 10	0109	3,190	15	99.53%
Salvation Army	002Y	NO FY23 Encounters Submitted Yet at 03/08/2023		
Southwest MI Behavioral Health	0102	3,182	57	98.21%
Statewide		29,156	149	99.49%

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.

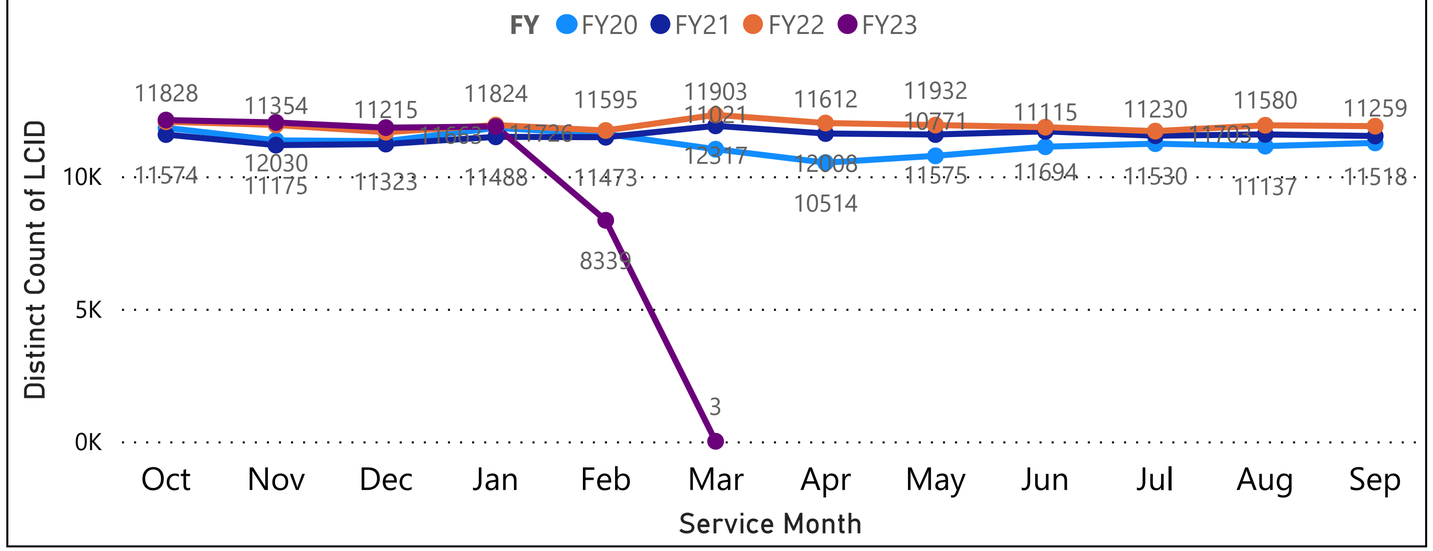
Reports in Dashboard:

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.

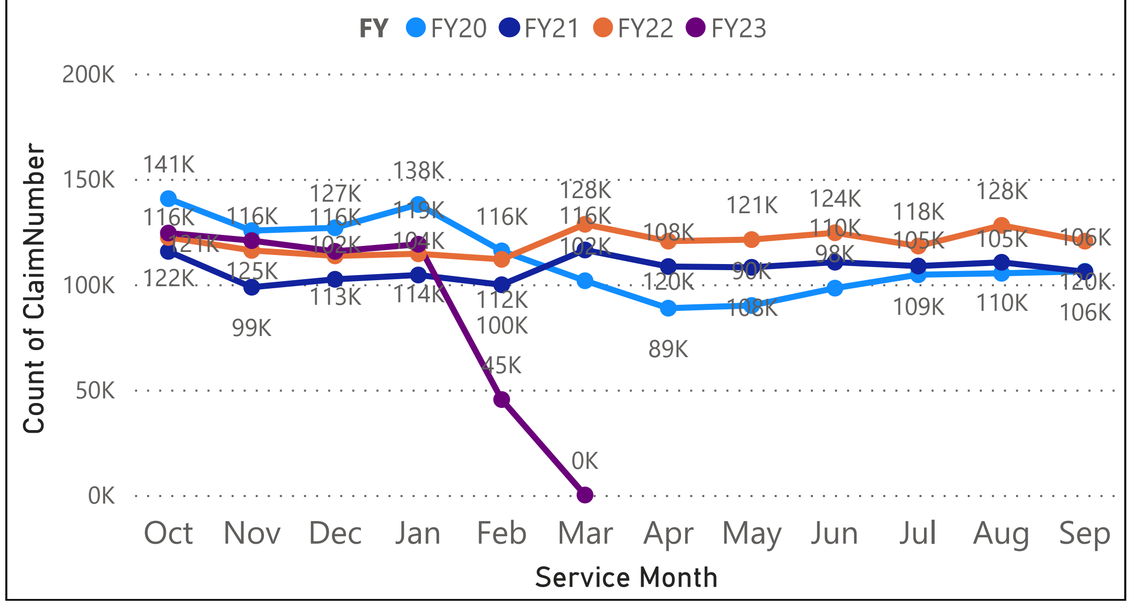
LRE
Behavioral Health

LRE Distinct Clients

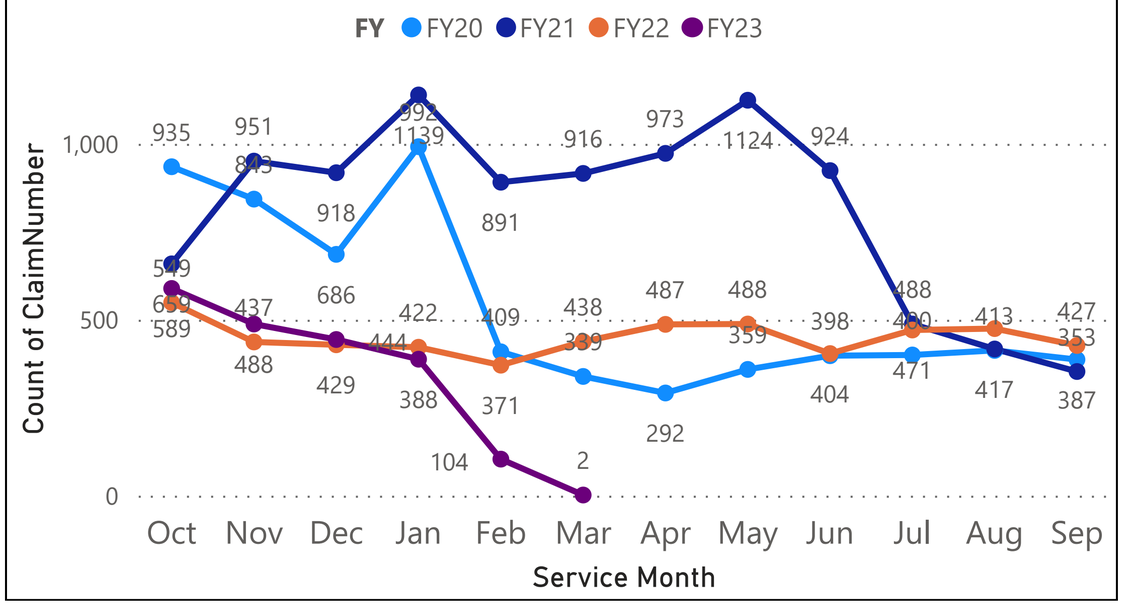


FY: All
- Select all
- FY20
- FY21
- FY22
- FY23

LRE Professional Encounter Lines



LRE Institutional Encounter Lines



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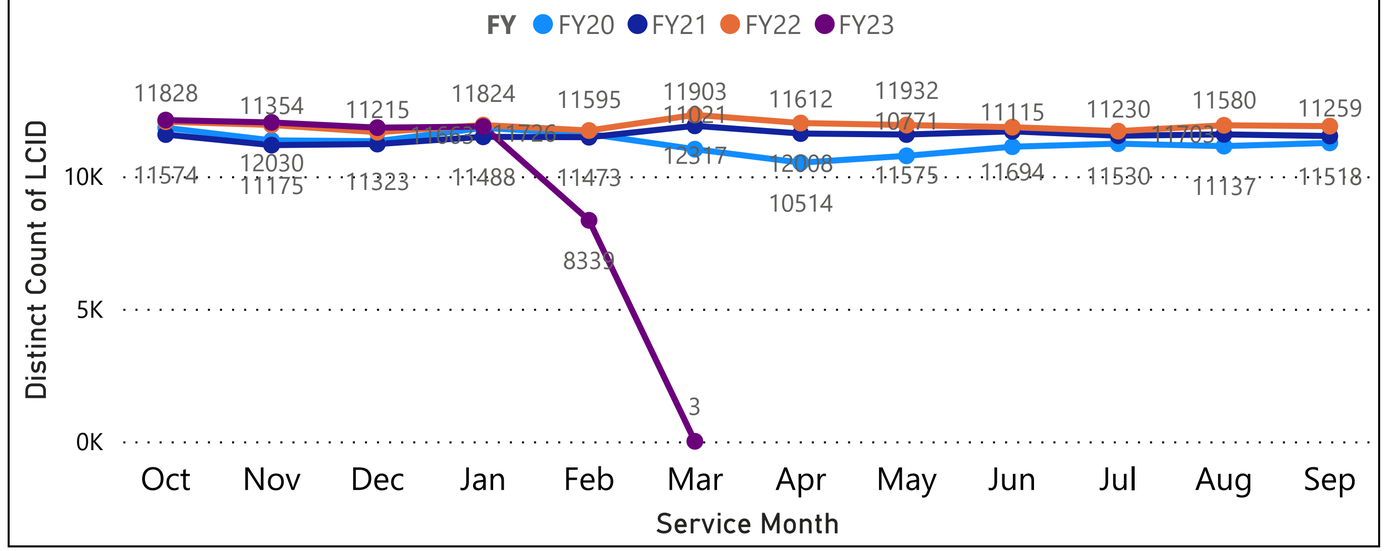
Latest ProcessDate

LRE

Behavioral Health

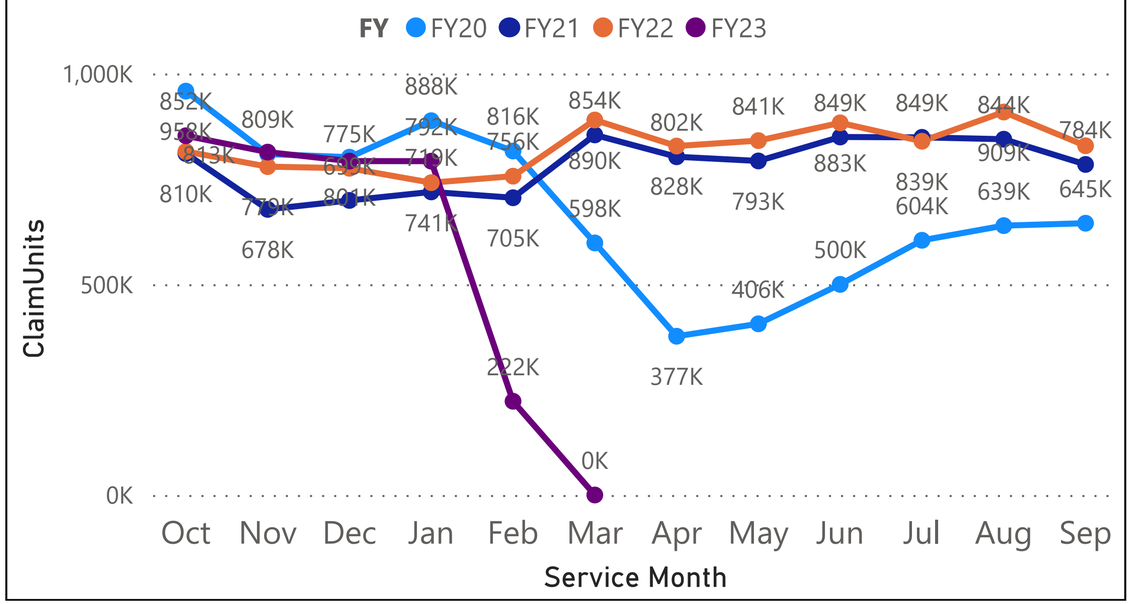
LRE Distinct Clients



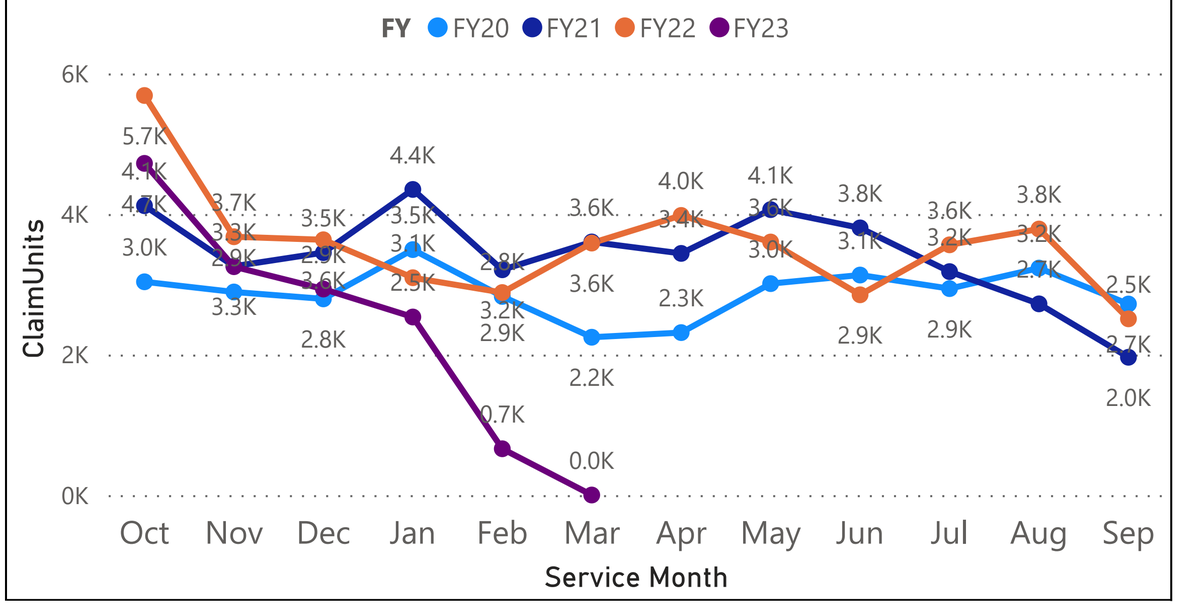
FY: All

- Select all
- FY20
- FY21
- FY22
- FY23

LRE Professional Units



LRE Institutional Units



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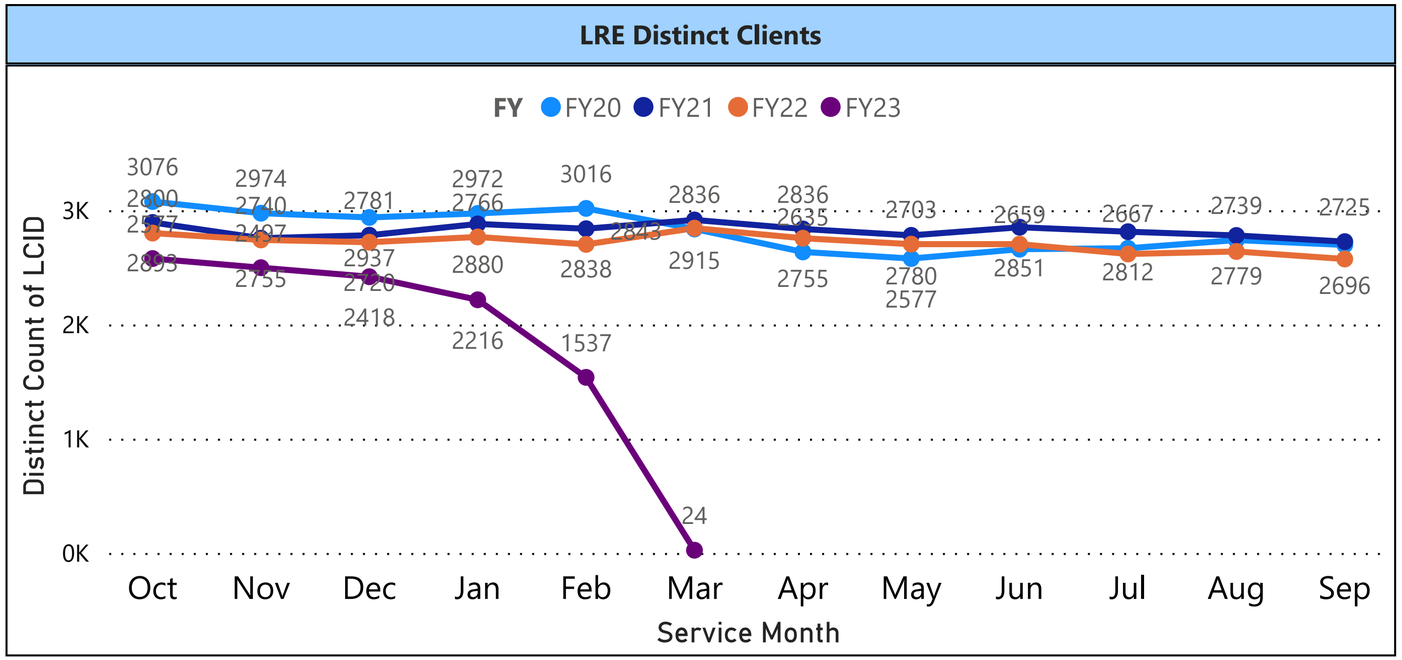
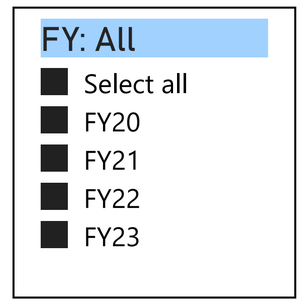
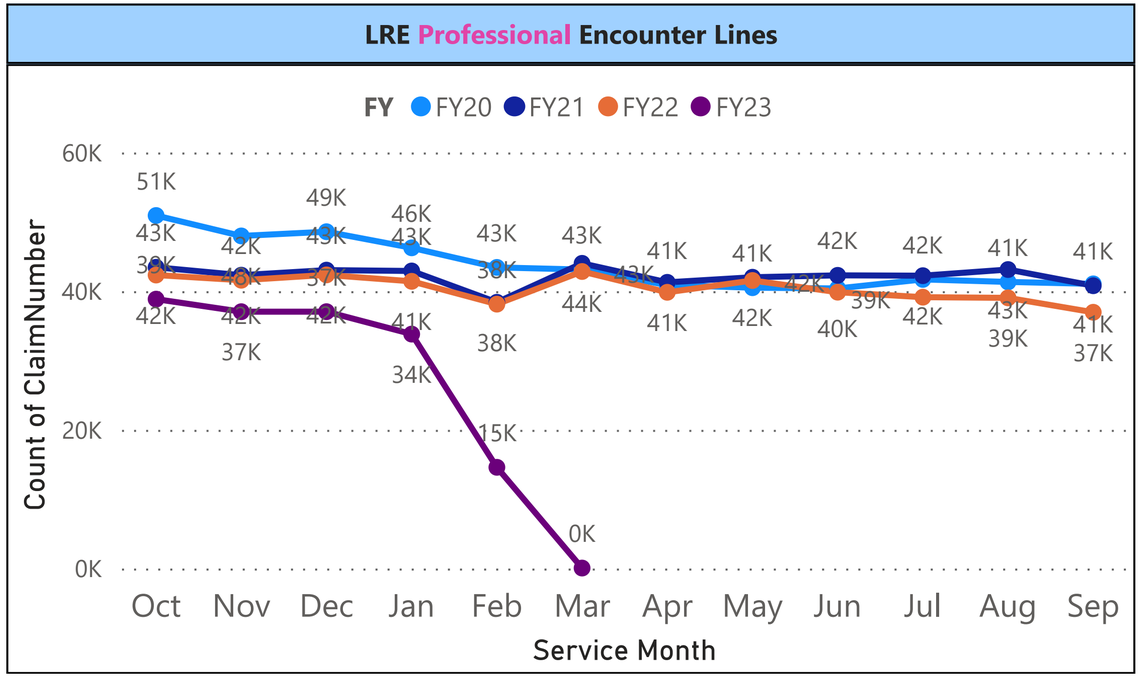
Latest ProcessDate

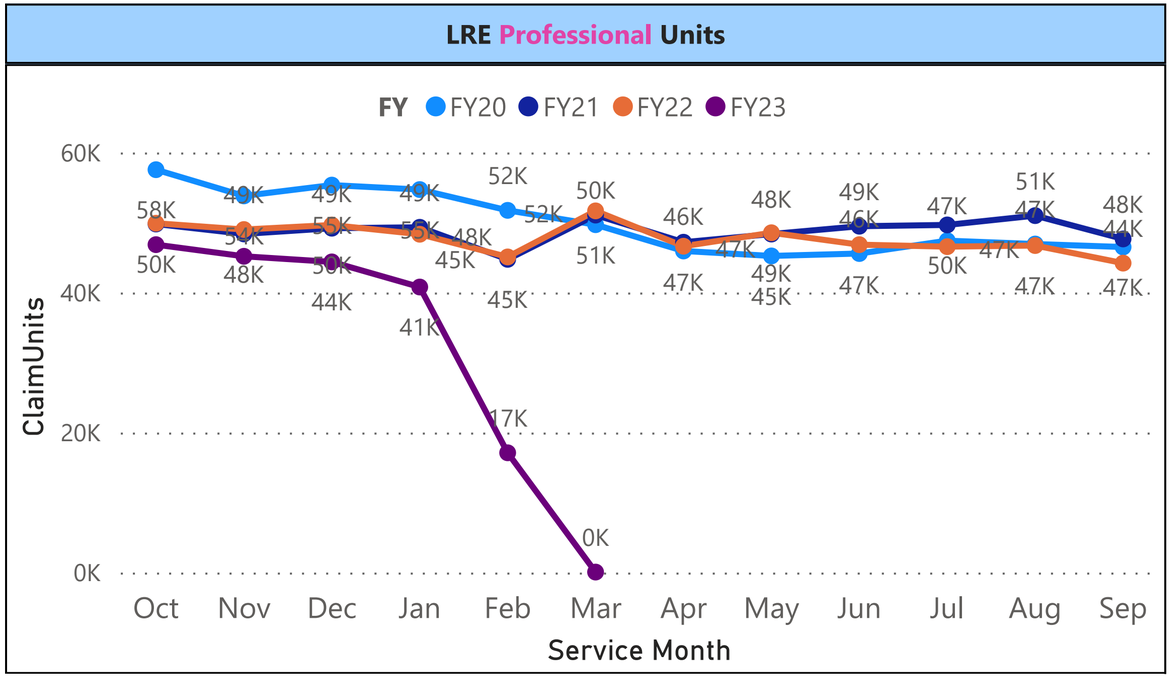
LRE

Substance Use Disorder









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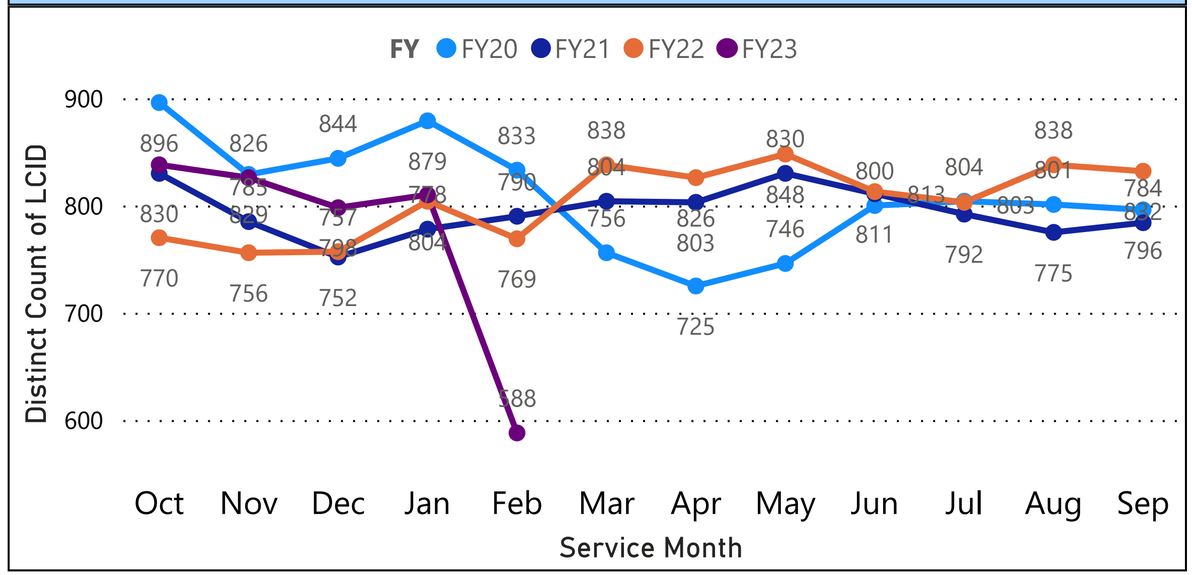
Latest ProcessDate

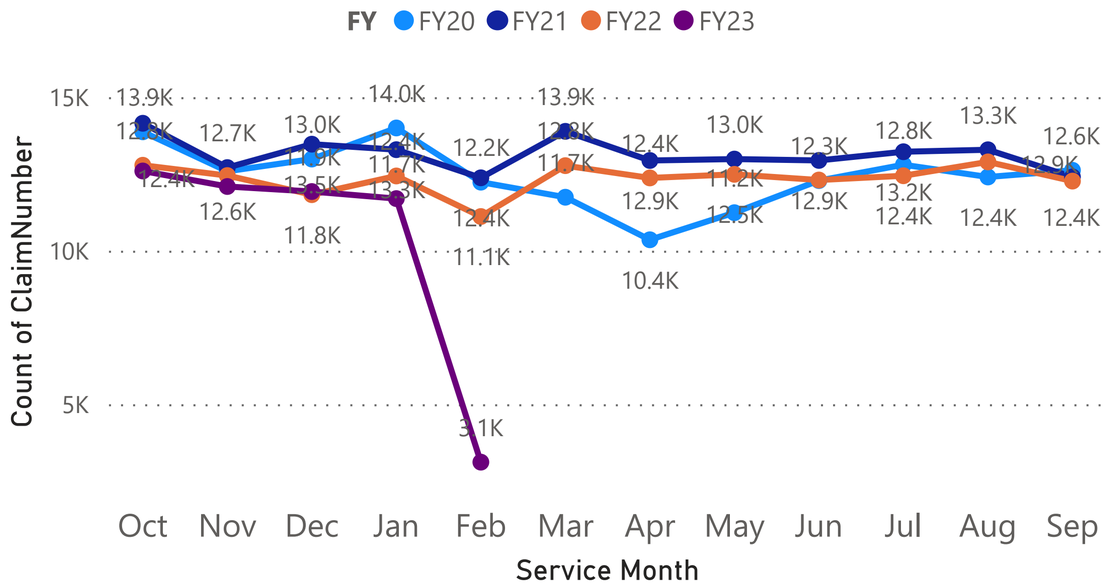
Allegan
Behavioral Health

Allegan Distinct Clients

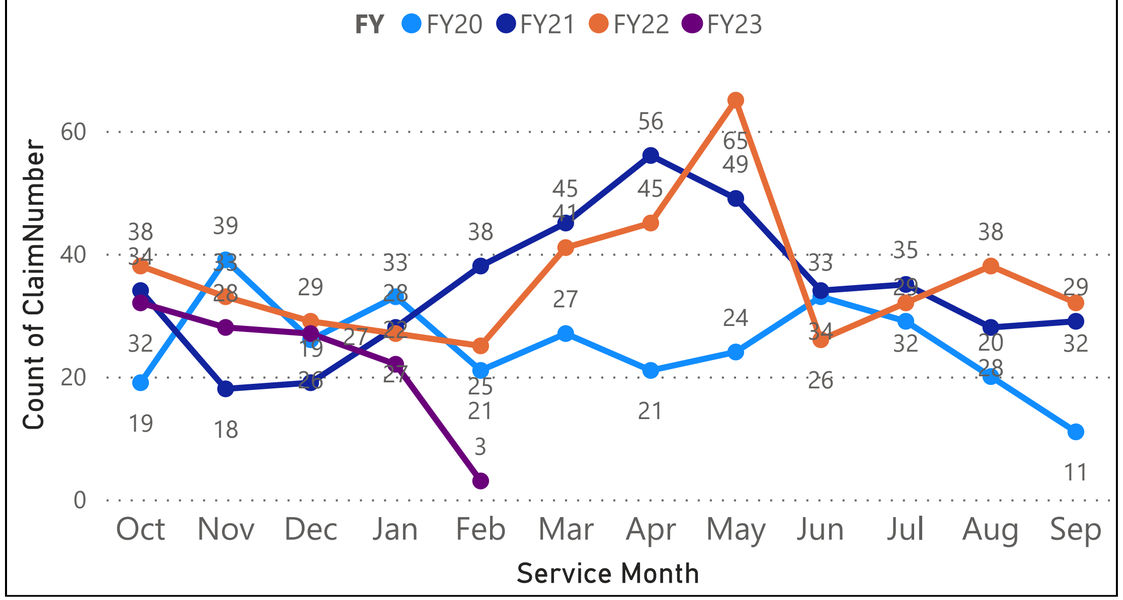


FY: All
- Select all
- FY20
- FY21
- FY22
- FY23

Allegan Professional Encounter Lines



Allegan Institutional Encounter Lines



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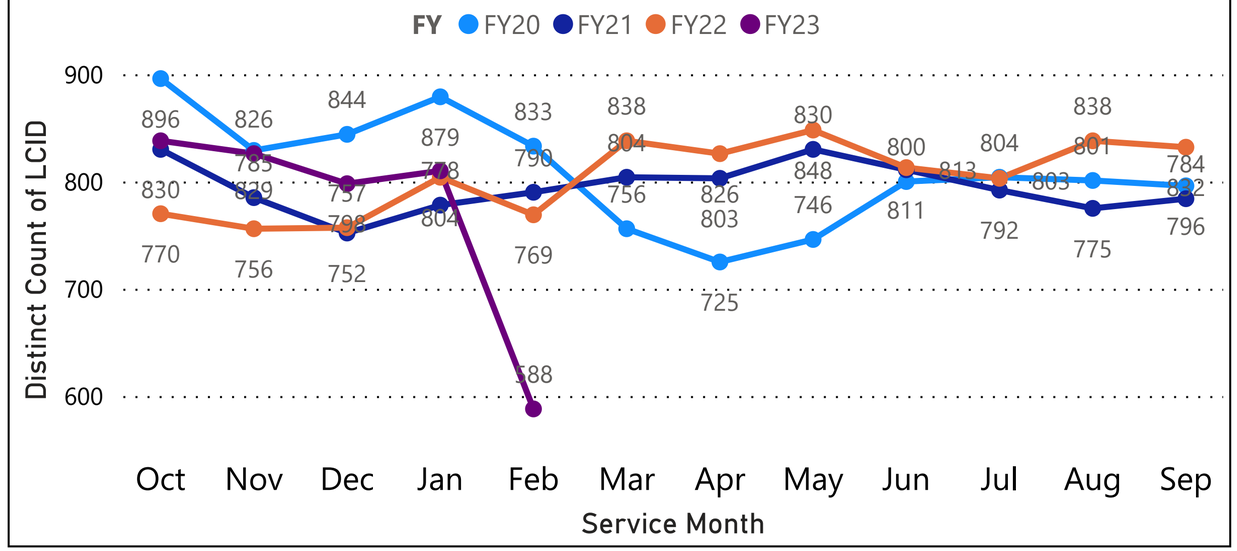
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

Allegan Behavioral Health

Allegan Distinct Clients



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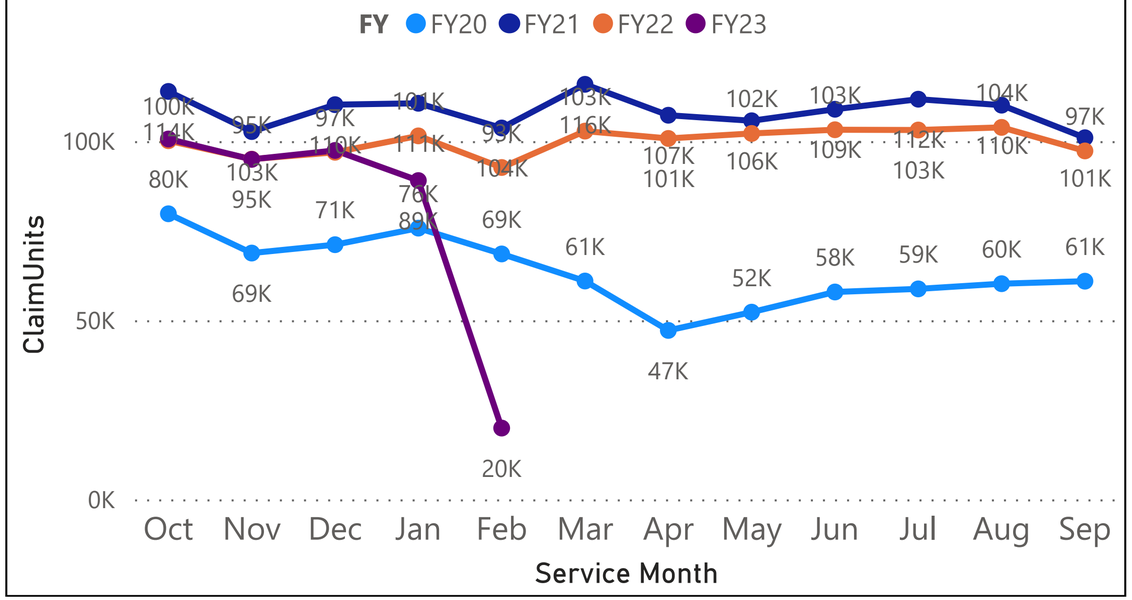
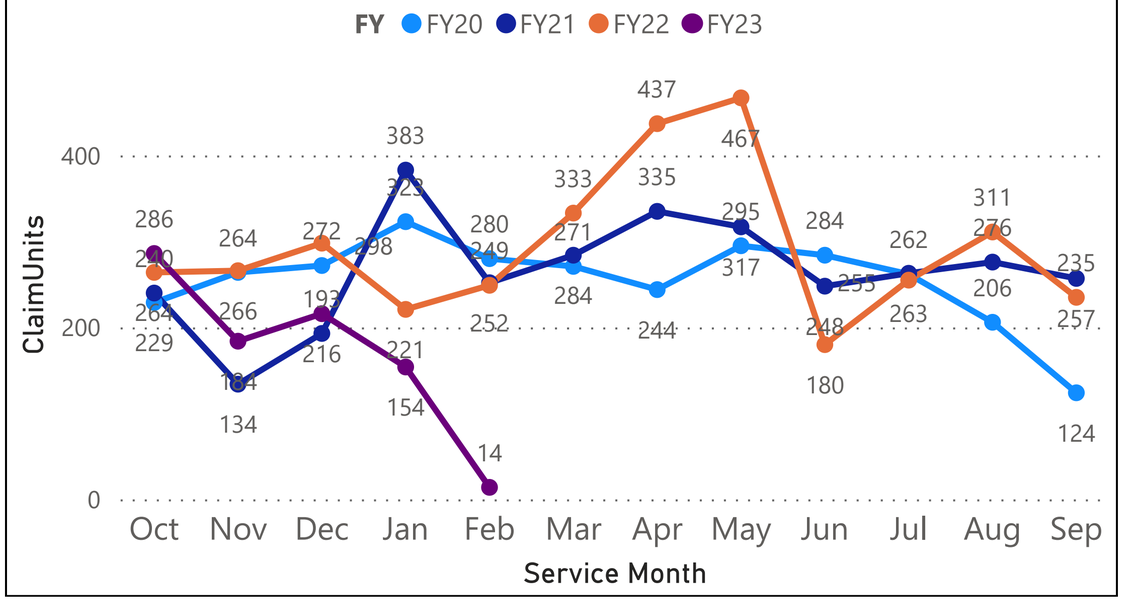
- Select all
- FY20
- FY21
- FY22
- FY23

Allegan Professional Units



Allegan Institutional Units



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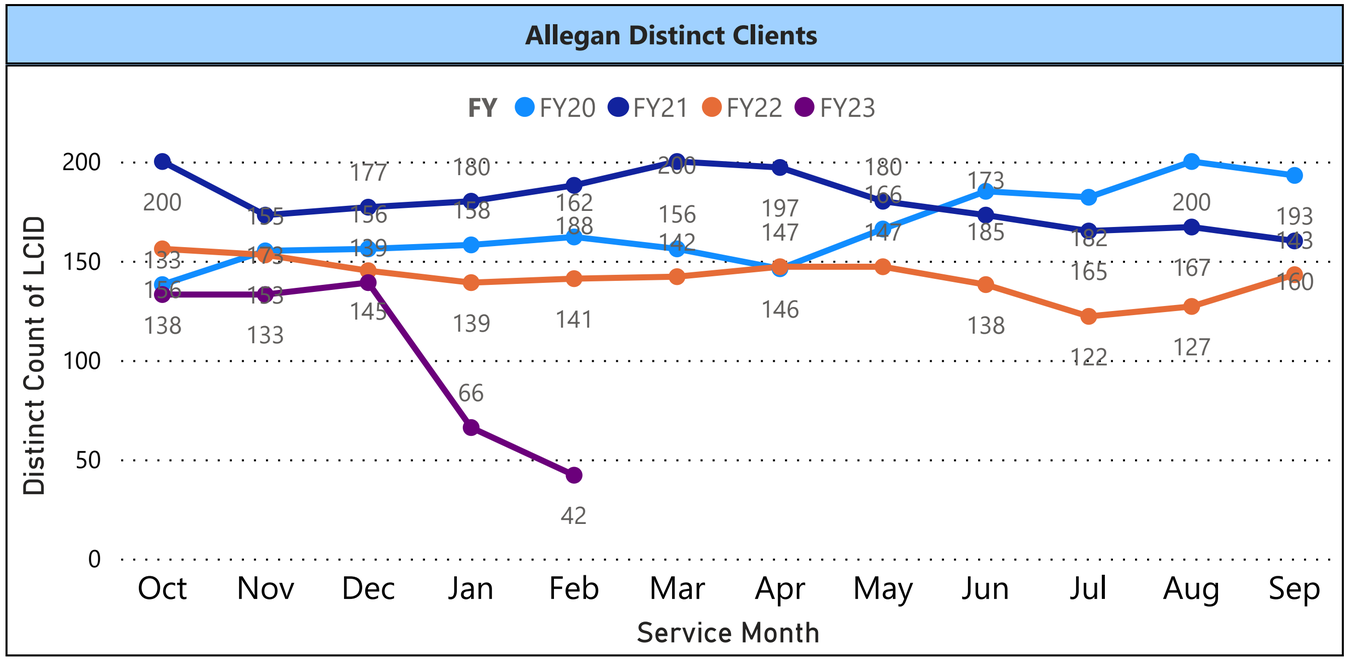
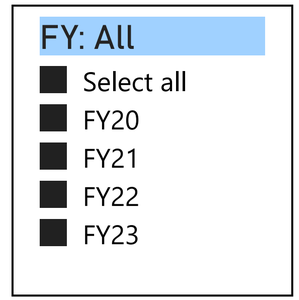
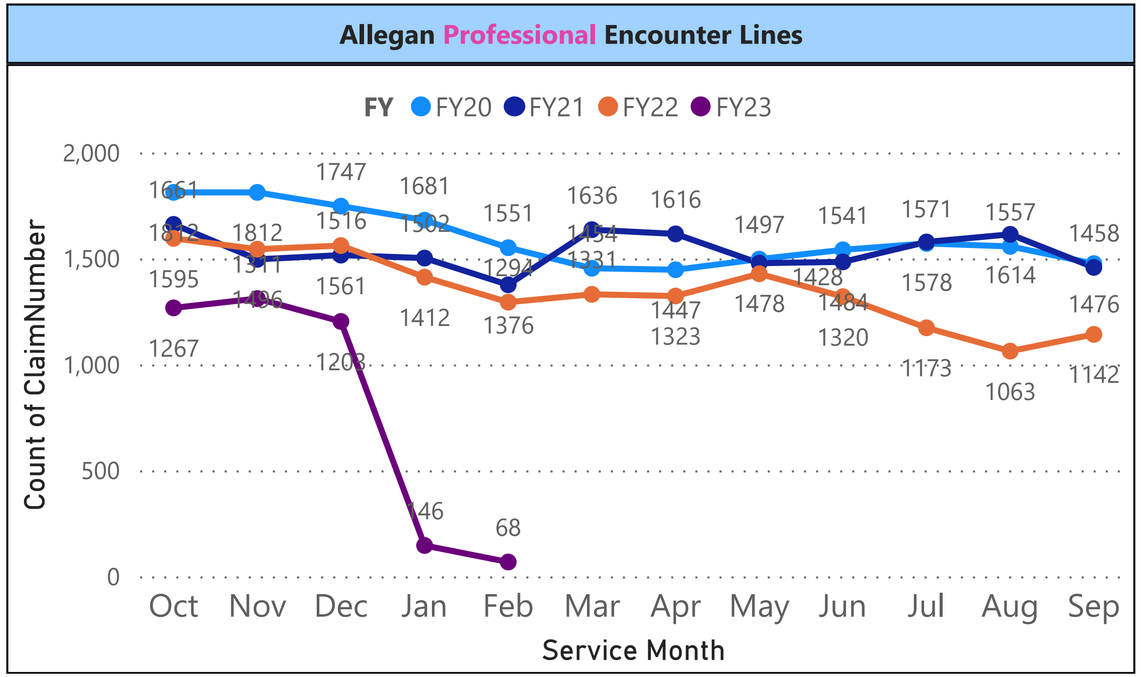
Latest ProcessDate

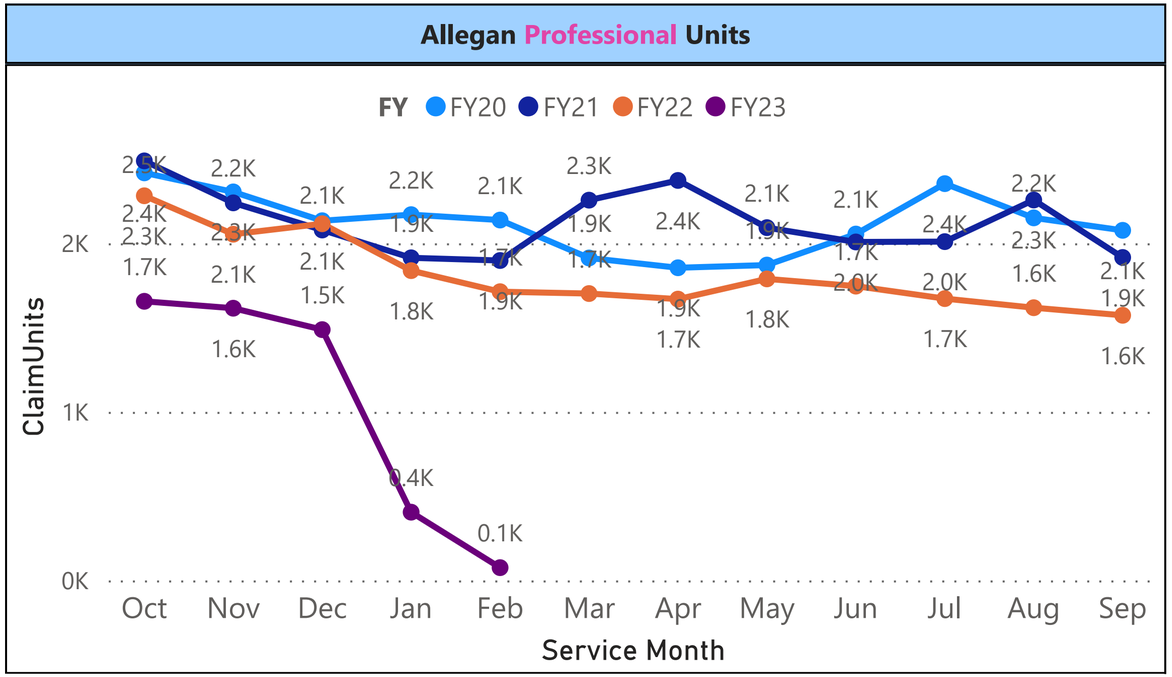
LAKESHORE REGIONAL ENTITY

Allegan
Substance Use Disorder









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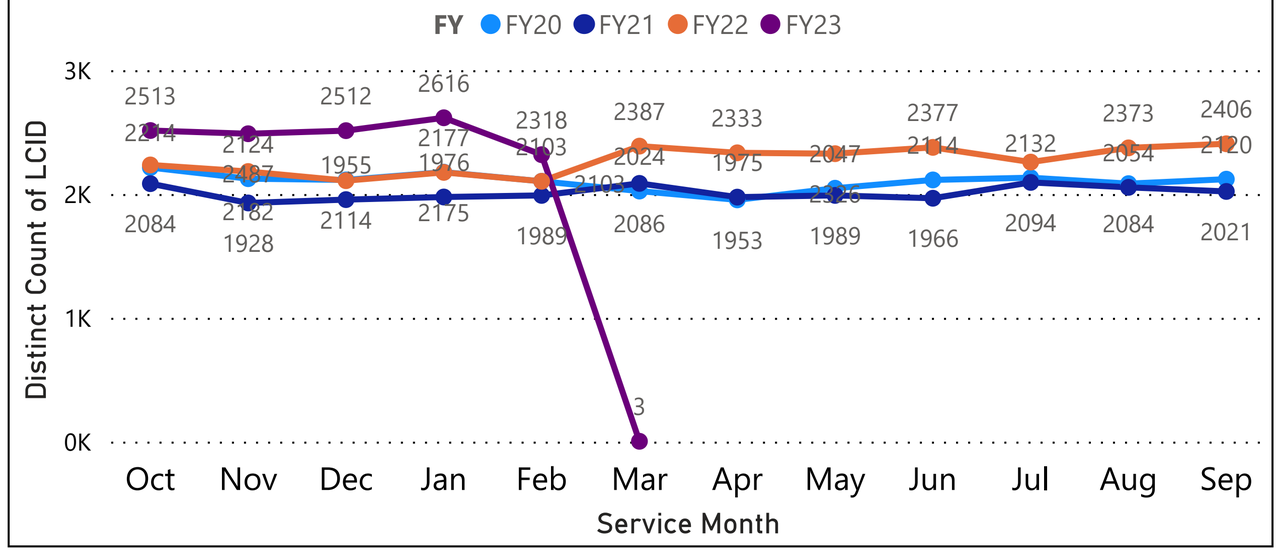
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

HealthWest
Behavioral Health

HealthWest Distinct Clients



FY: All
- Select all
- FY20
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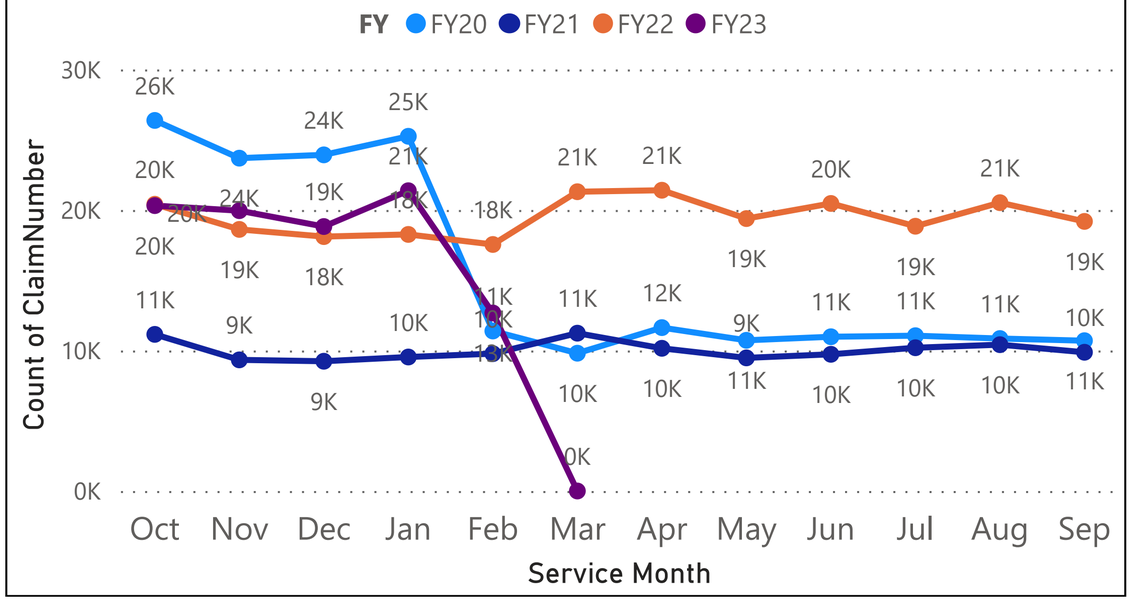
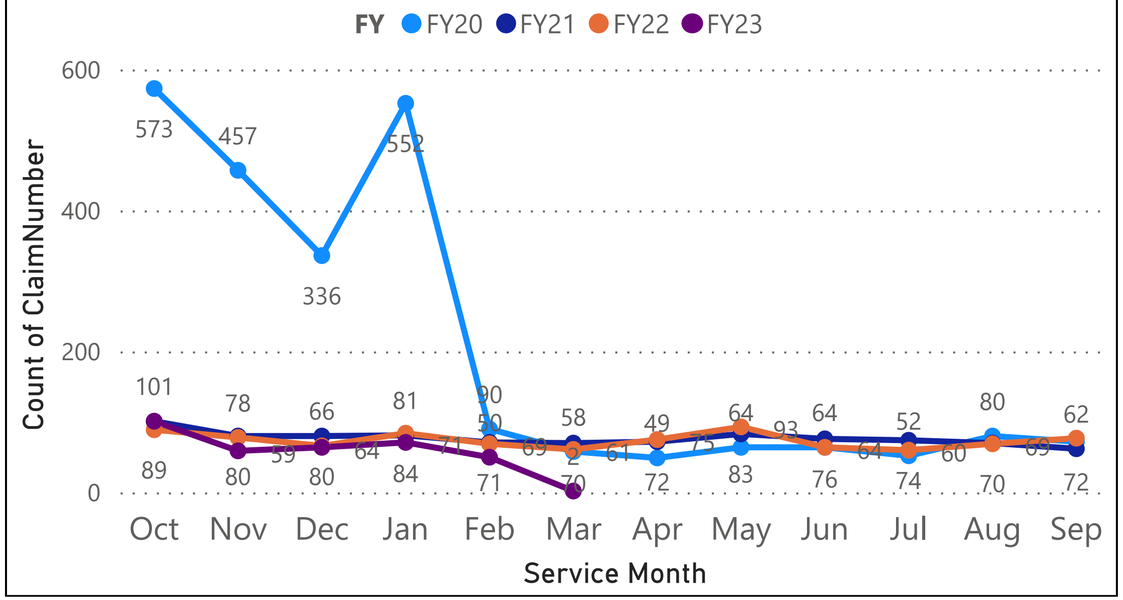
- FY23

HealthWest Professional Encounter Lines



HealthWest Institutional Encounter Lines



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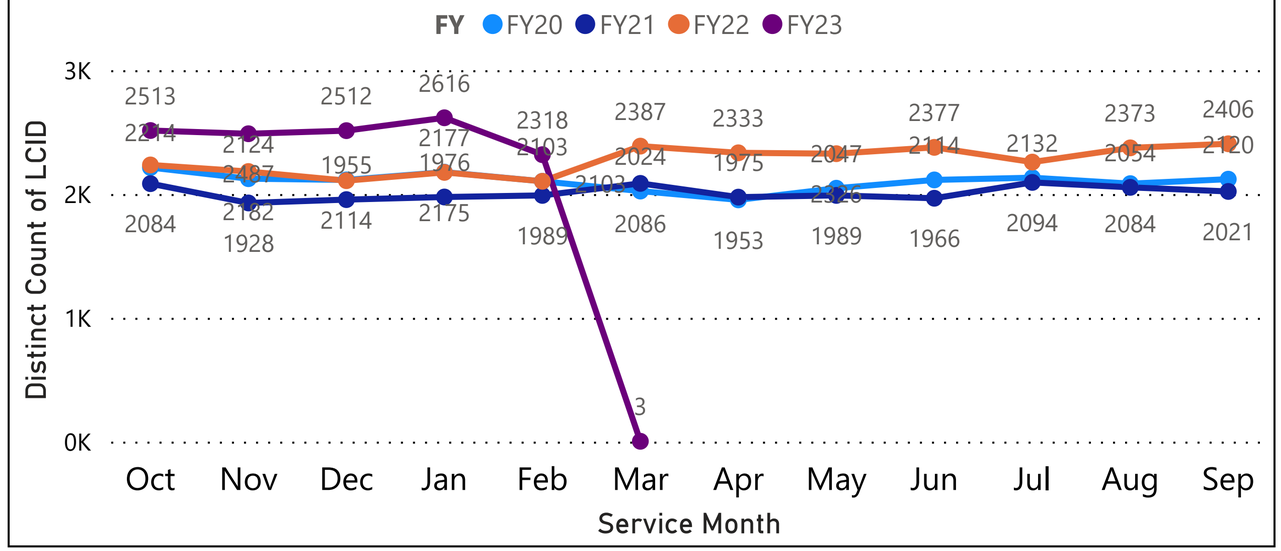
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

HealthWest Behavioral Health

HealthWest Distinct Clients



FY: All
- Select all
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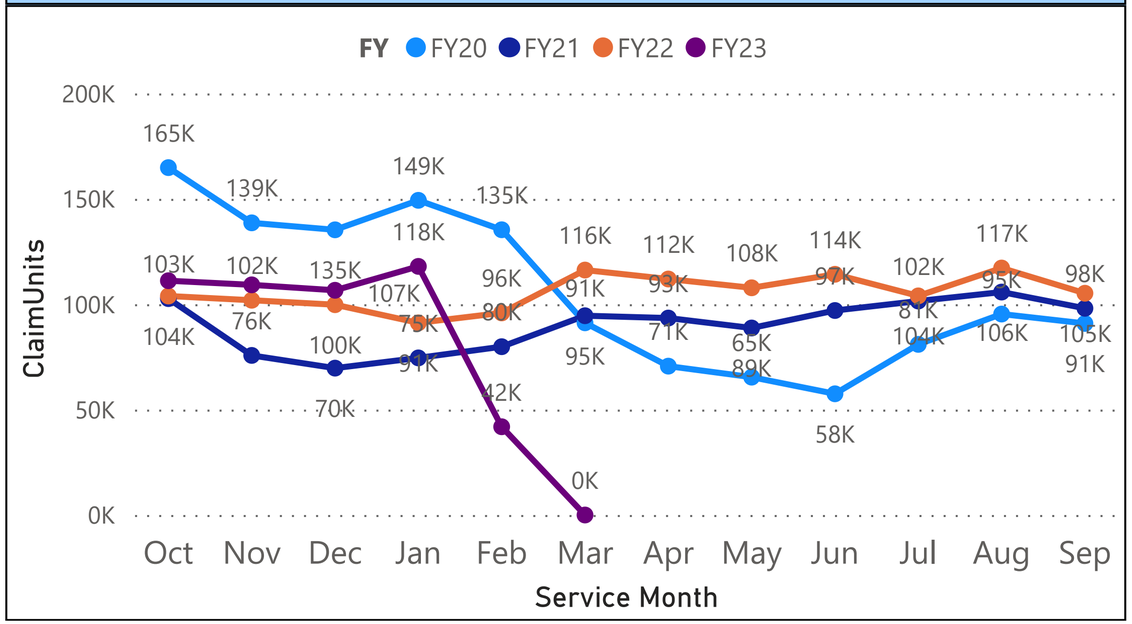
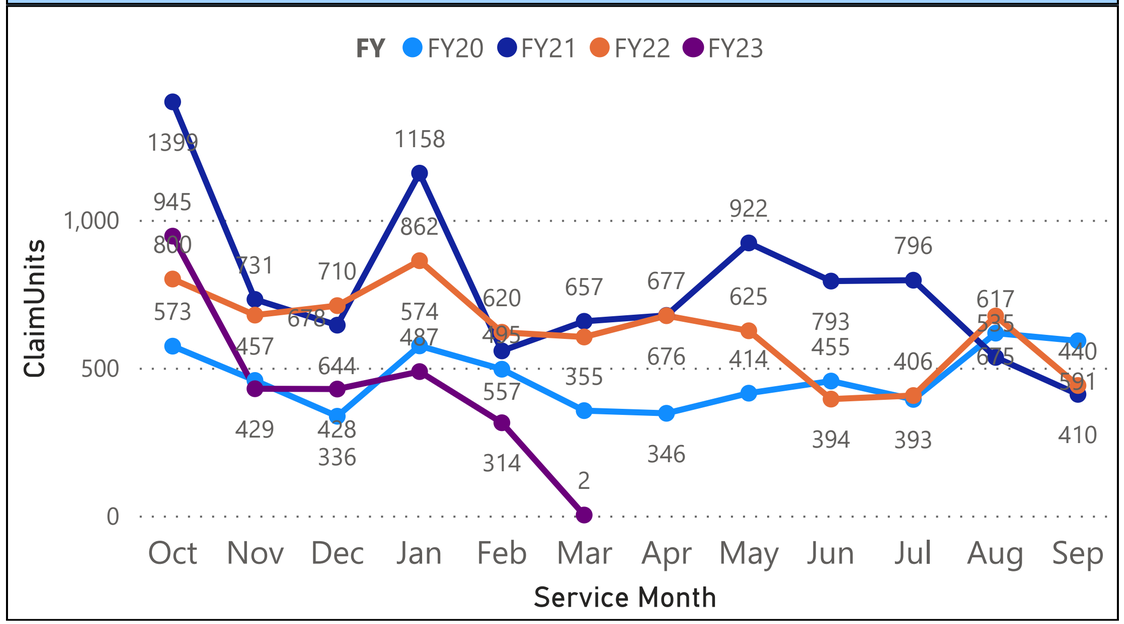
- FY22
- FY23

HealthWest Professional Units



HealthWest Institutional Units



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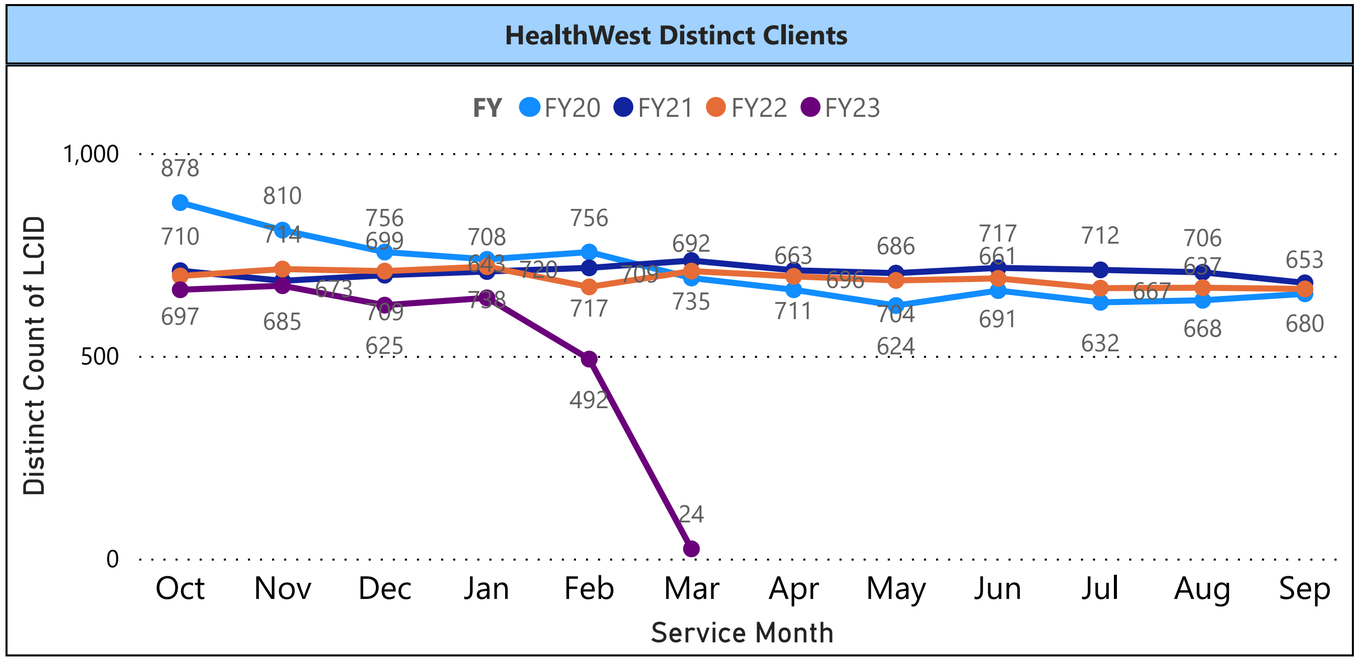
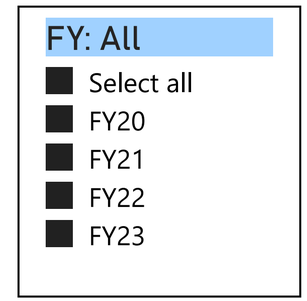
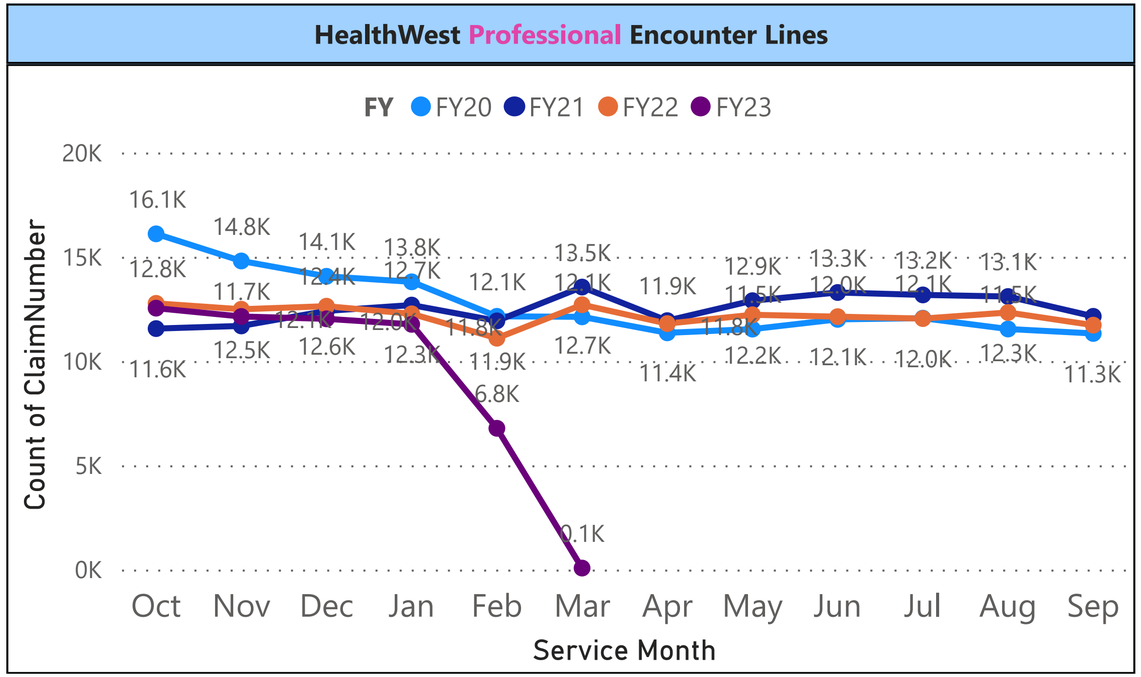
Latest ProcessDate

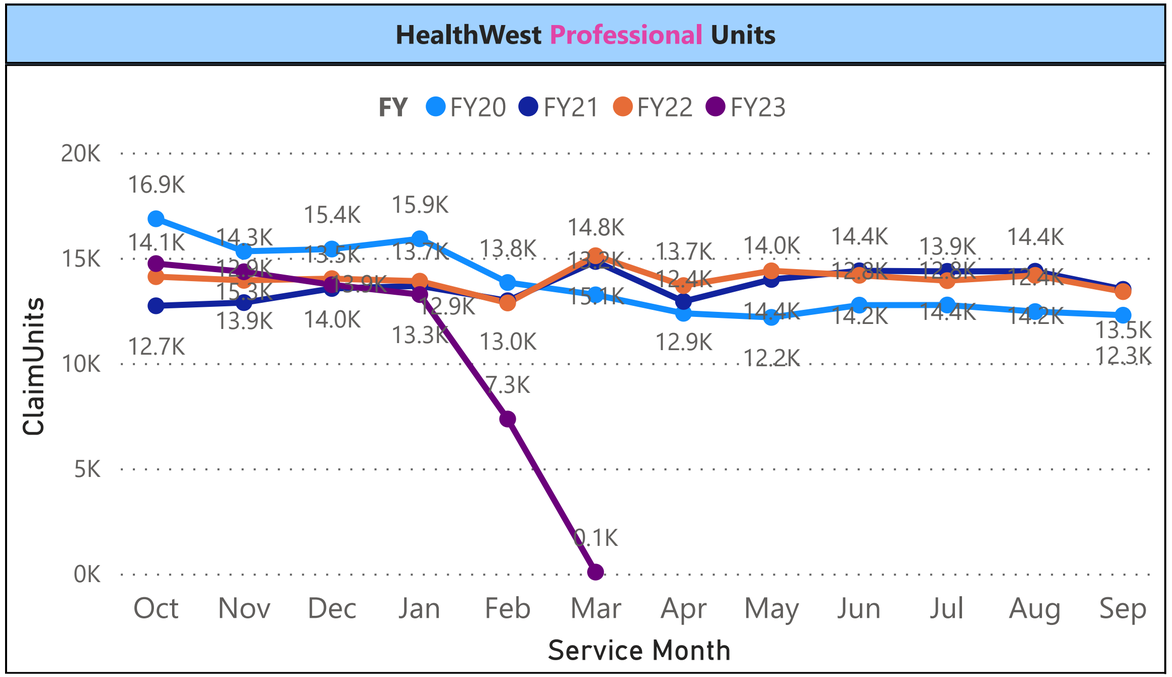
LAKESHORE REGIONAL ENTITY

HealthWest
Substance Use Disorder









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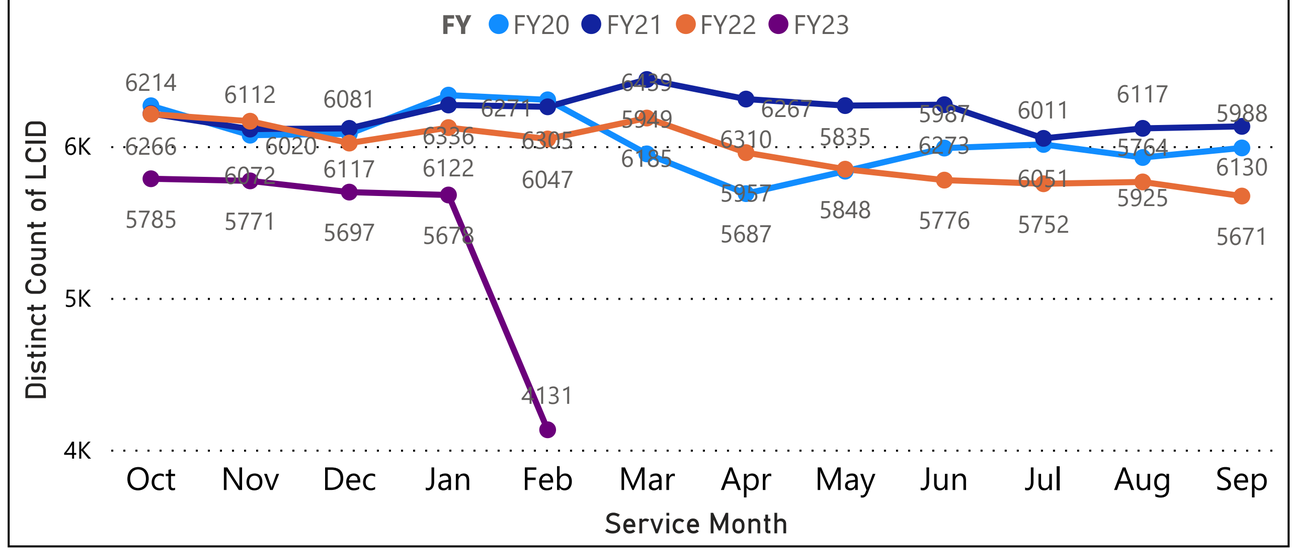
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

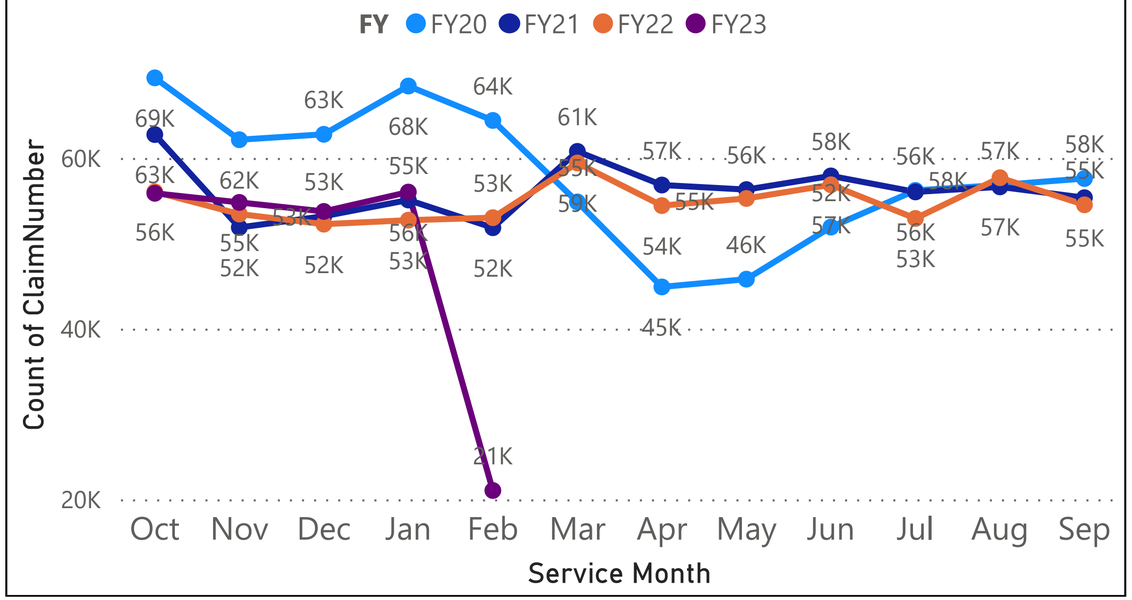
Network180 Behavioral Health

Network180 Distinct Clients

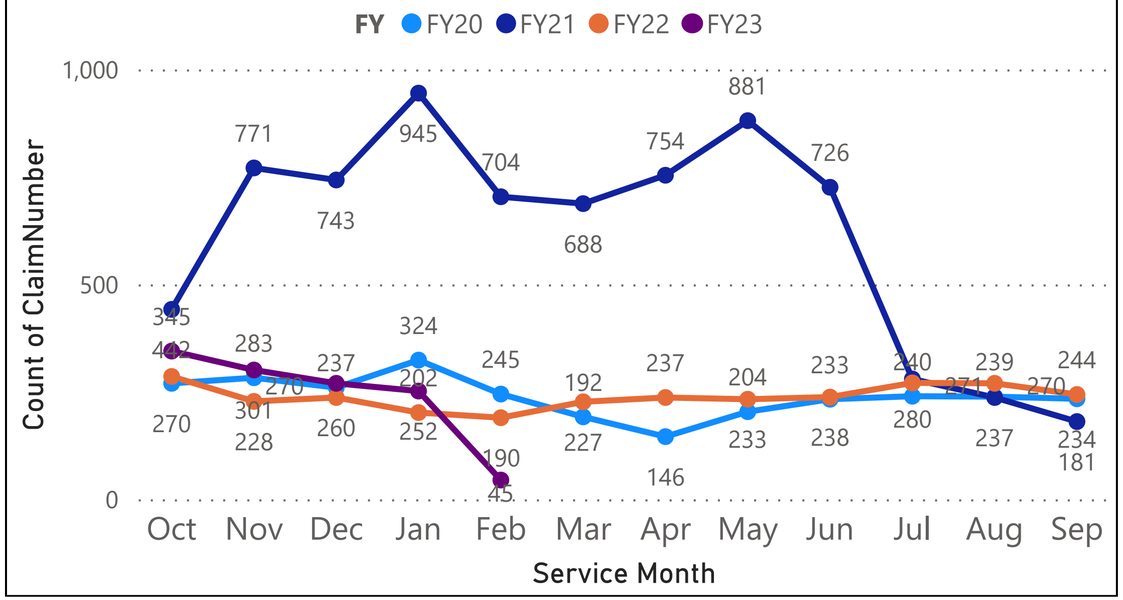


FY: All
- Select all
- FY20
- FY21
- FY22
- FY23

Network180 Professional Encounter Lines



Network180 Institutional Encounter Lines



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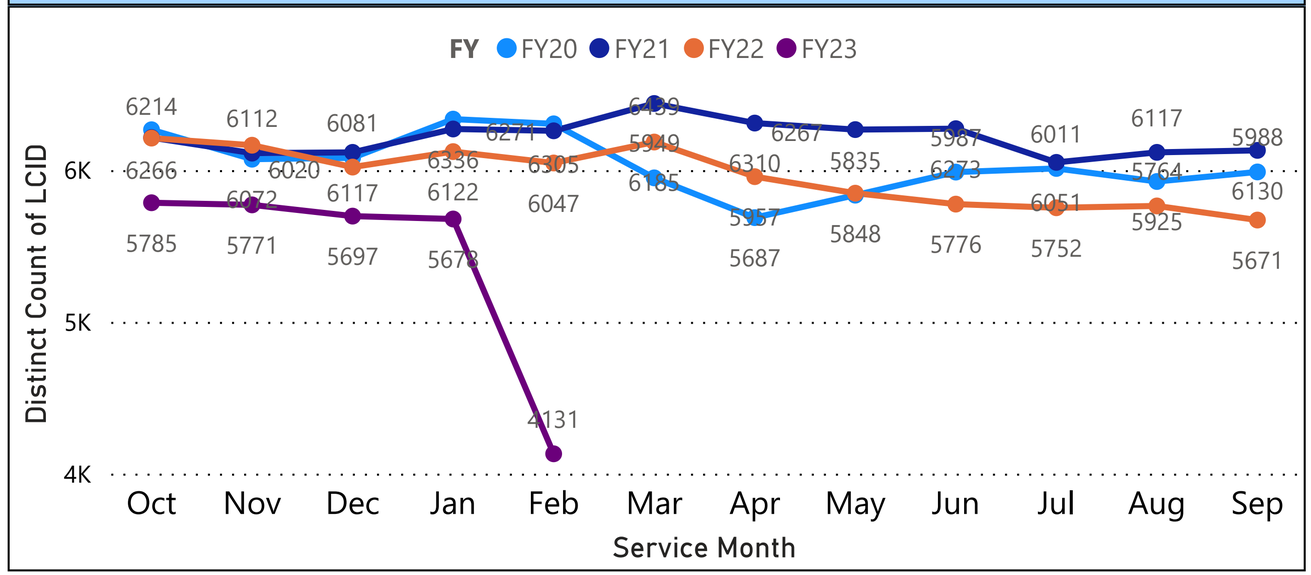
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

Network180 Behavioral Health

Network180 Distinct Clients



FY: All
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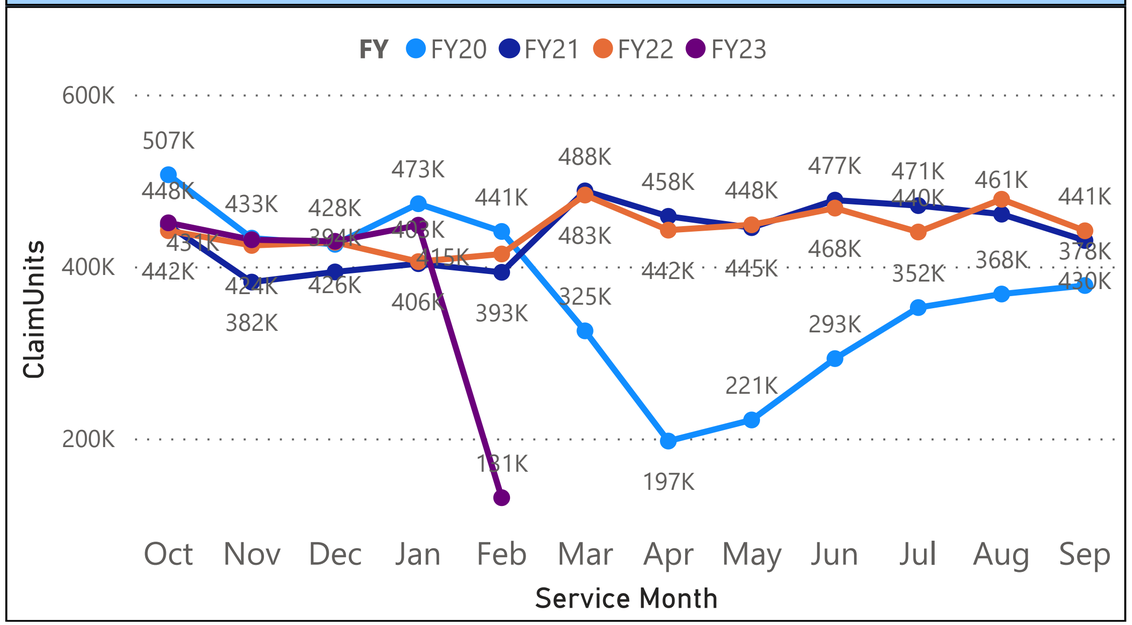
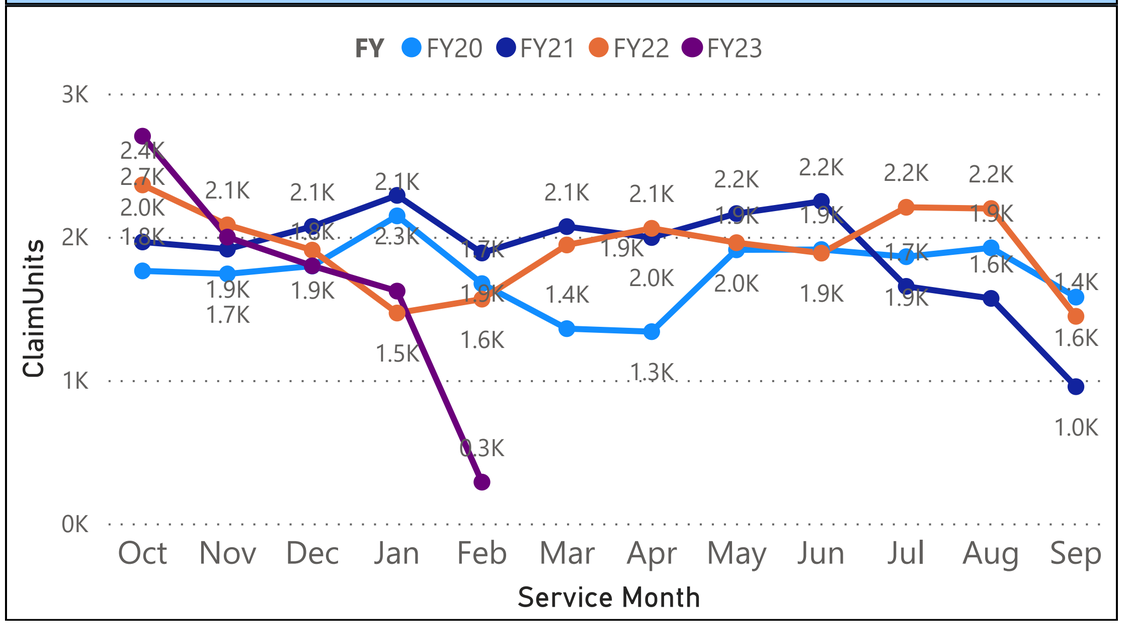
Network180 Professional Units



Network180 Institutional Units



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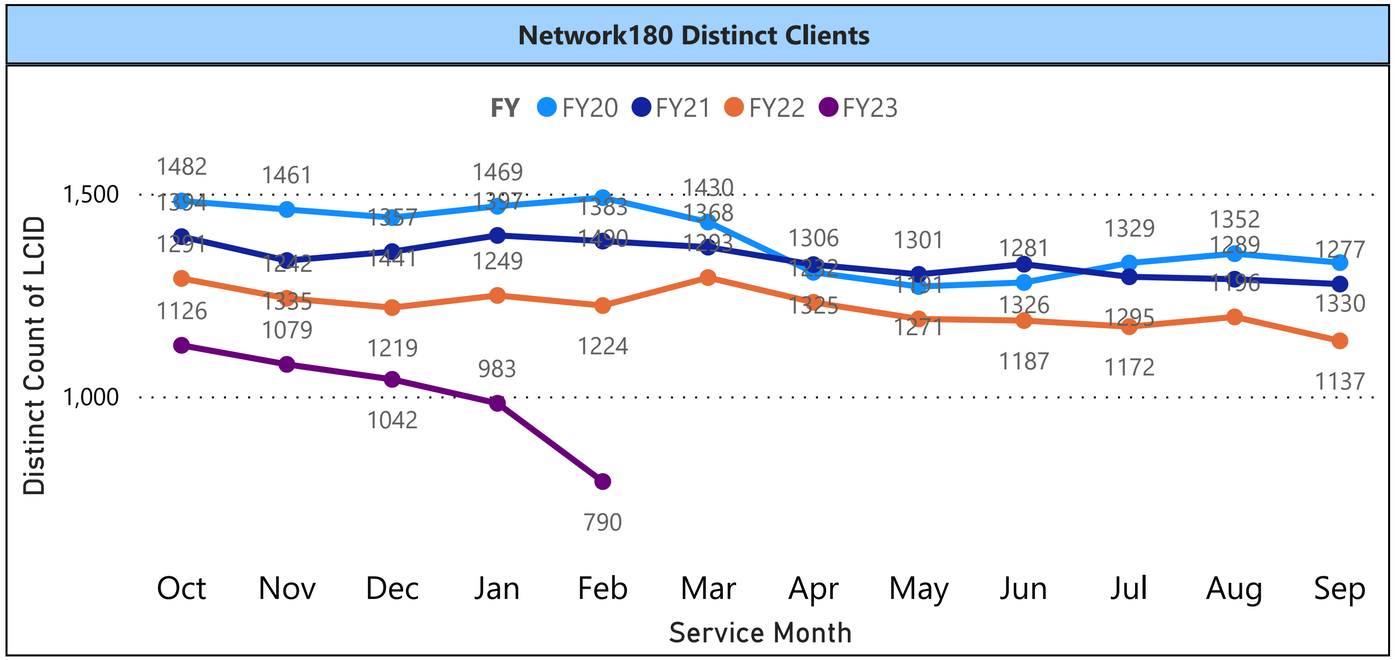
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

Network180
Substance Use Disorder



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- Select all
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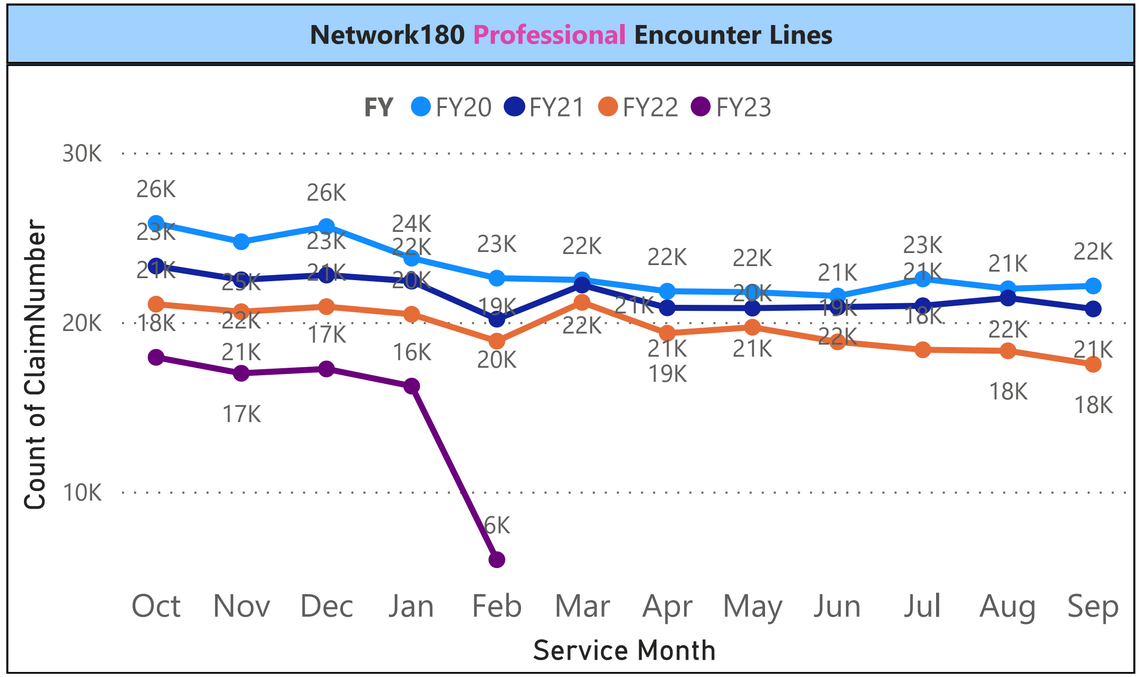
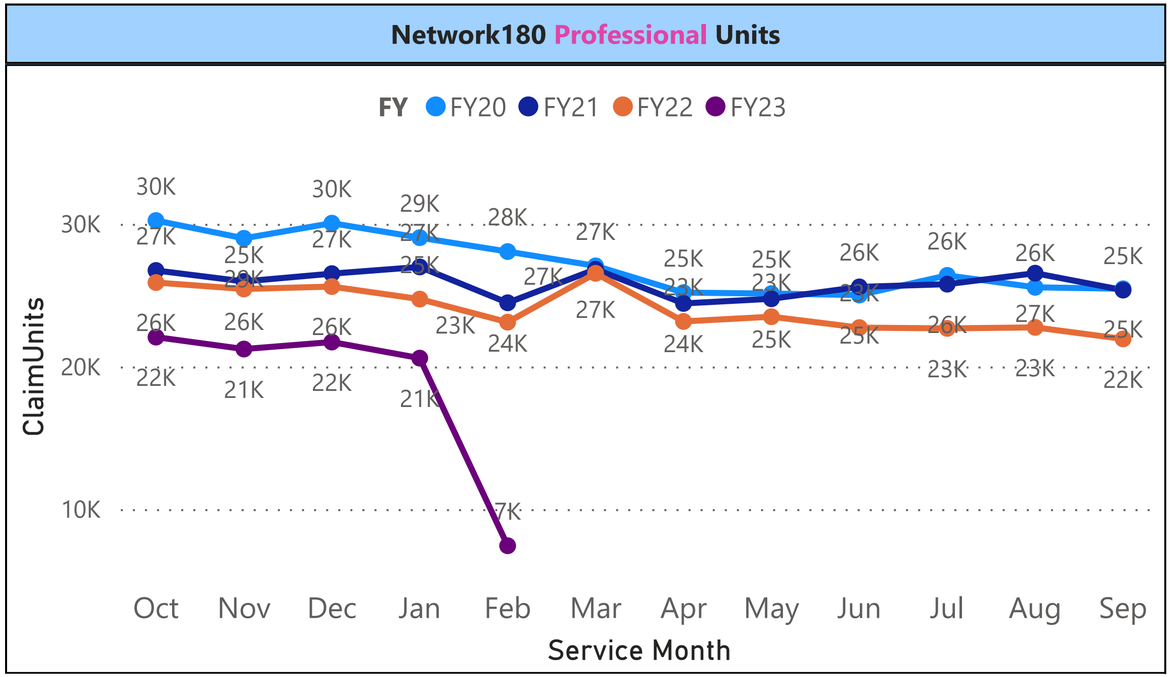
- FY23





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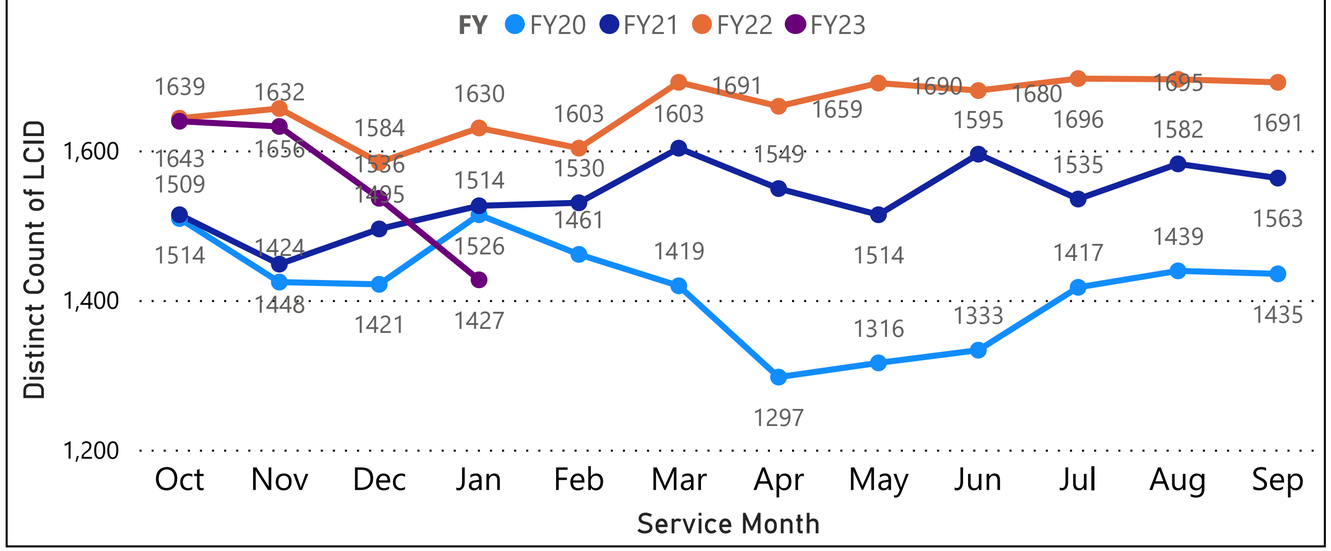
Latest ProcessDate

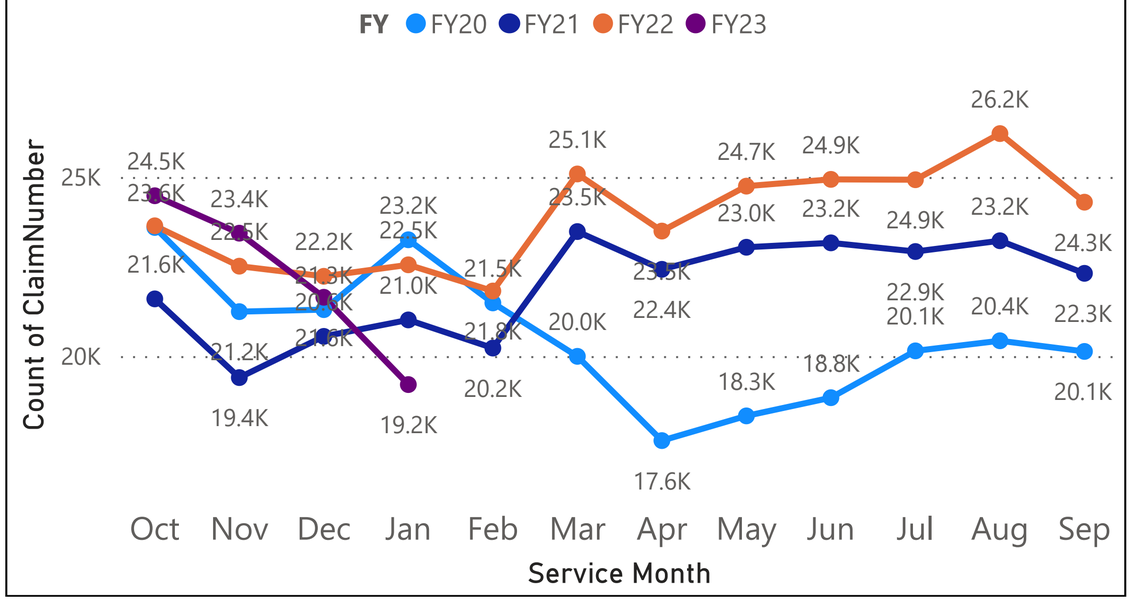
LAKESHORE REGIONAL ENTITY

Ottawa Behavioral Health

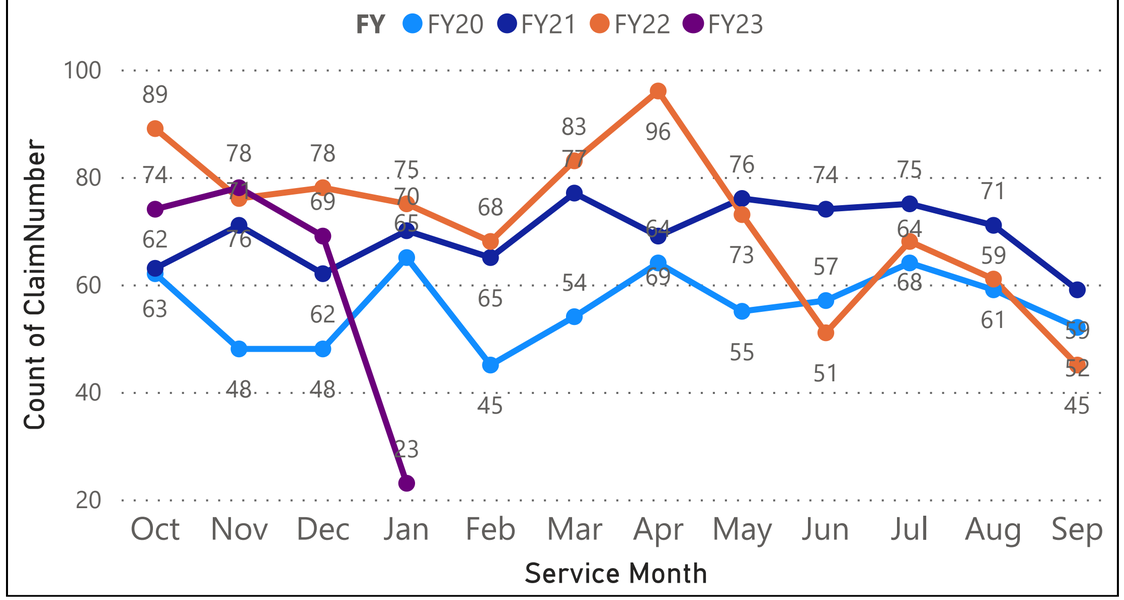
Ottawa Distinct Clients



Ottawa Professional Encounter Lines



Ottawa Institutional Encounter Lines



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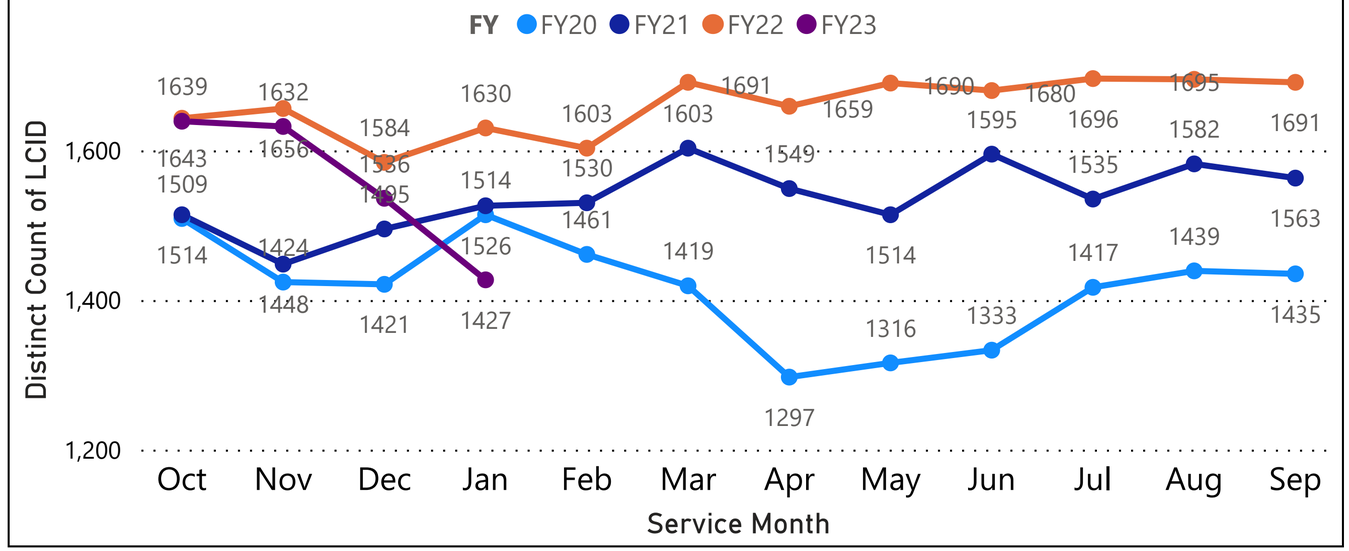
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

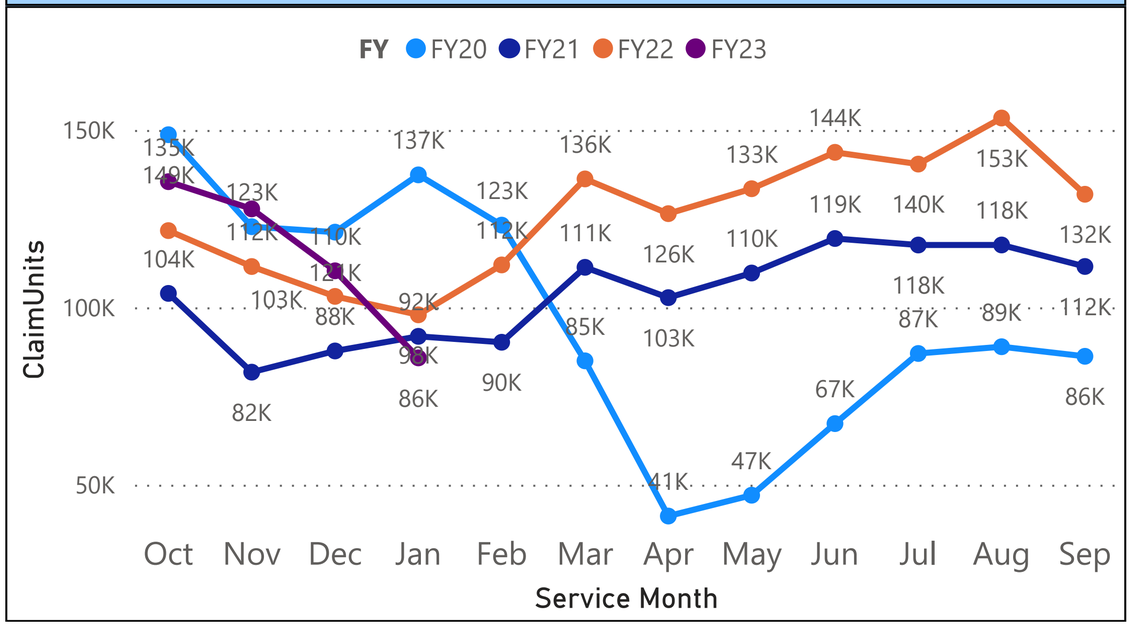
Ottawa Behavioral Health

Ottawa Distinct Clients

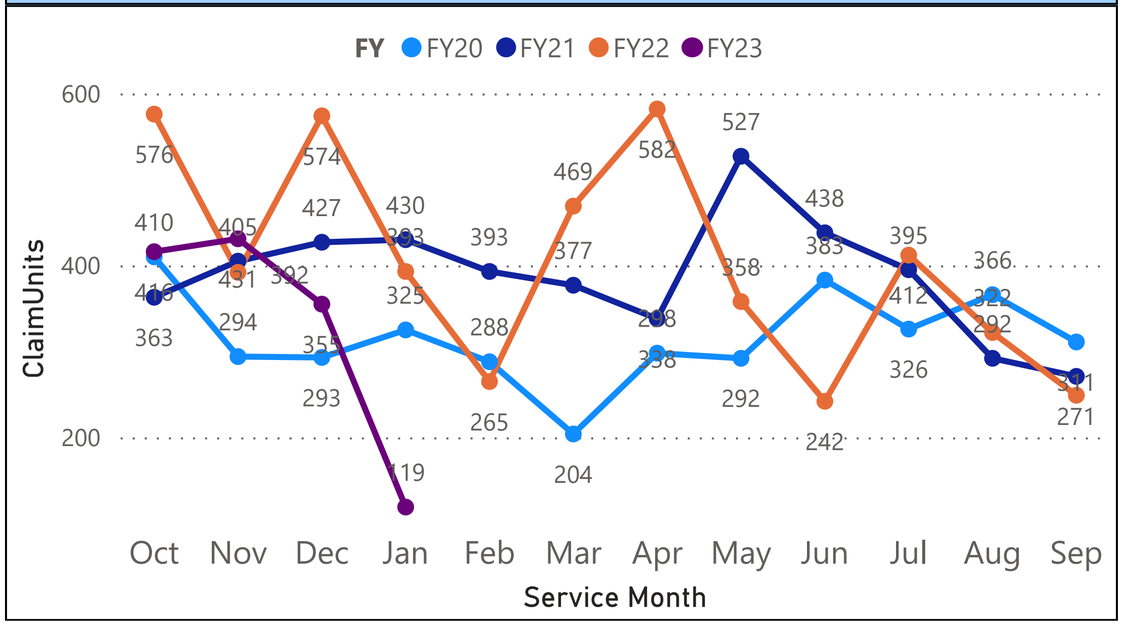


FY: All
- Select all
- FY20
- FY21
- FY22
- FY23

Ottawa Professional Units



Ottawa Institutional Units



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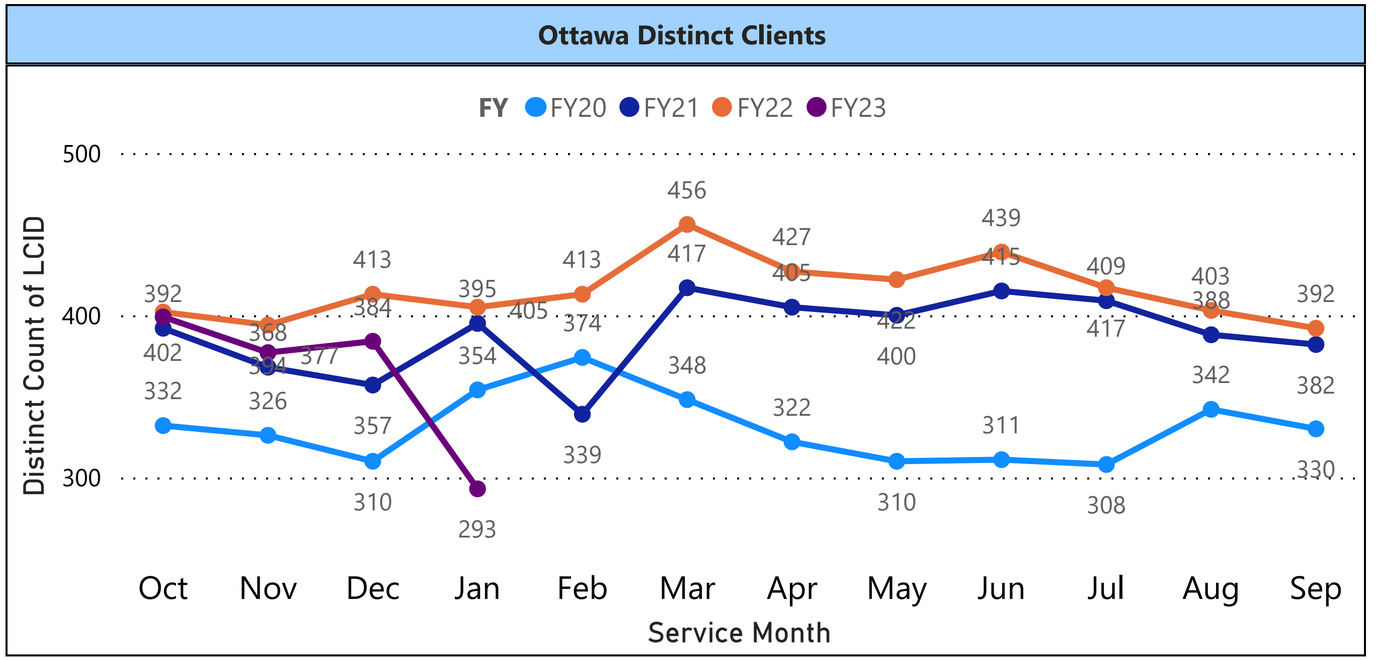
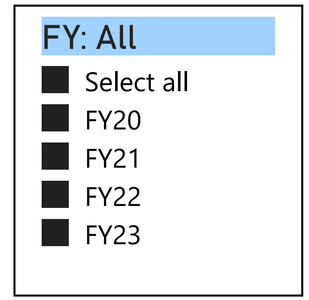
Latest ProcessDate

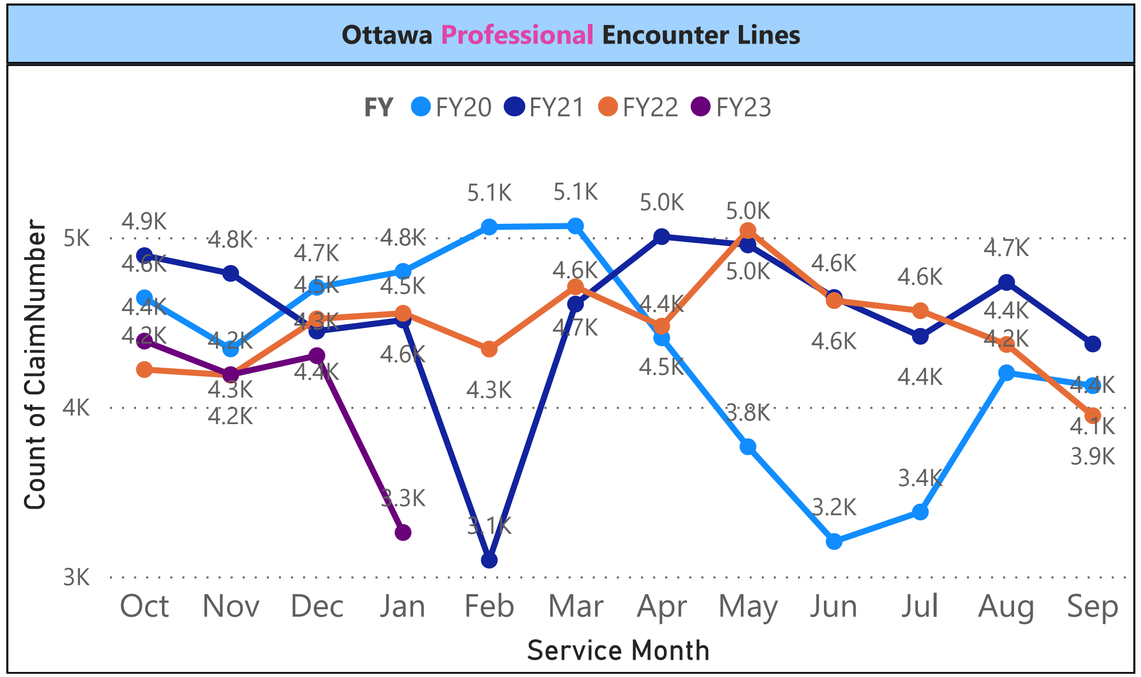
LAKESHORE REGIONAL ENTITY

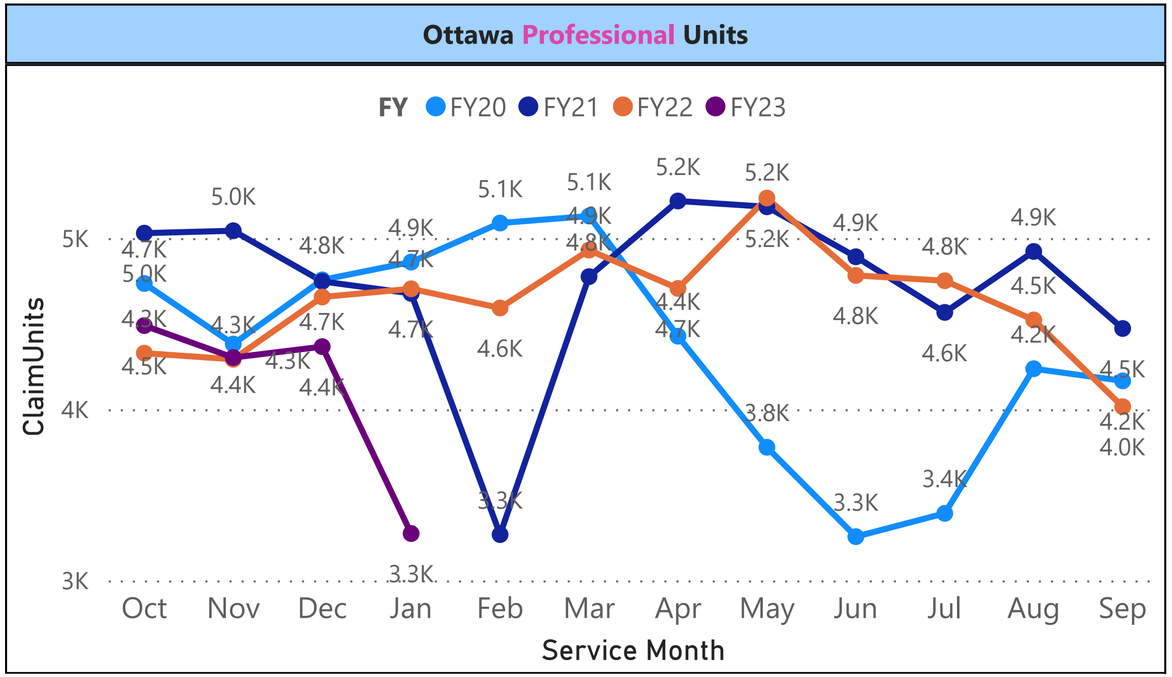
Ottawa

Substance Use Disorder









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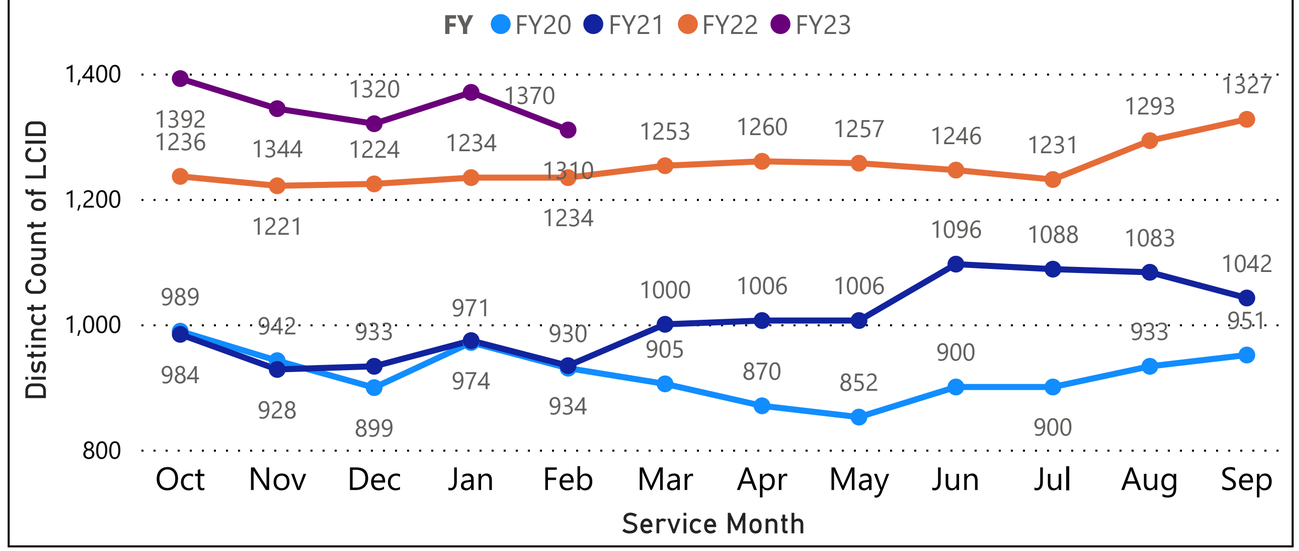
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

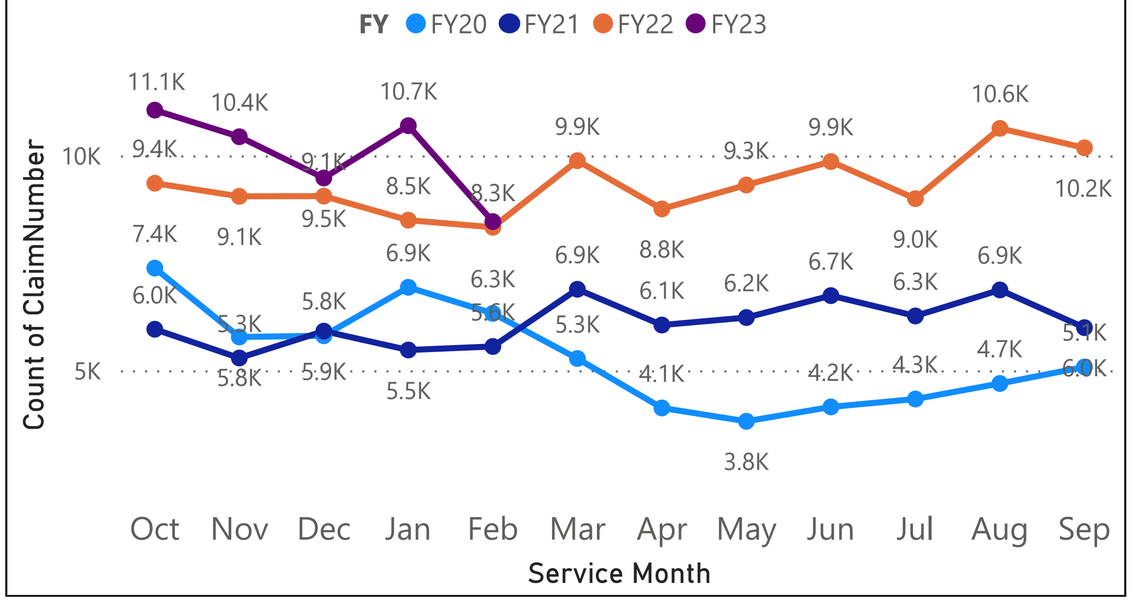
West Michigan Behavioral Health

West Michigan Distinct Clients

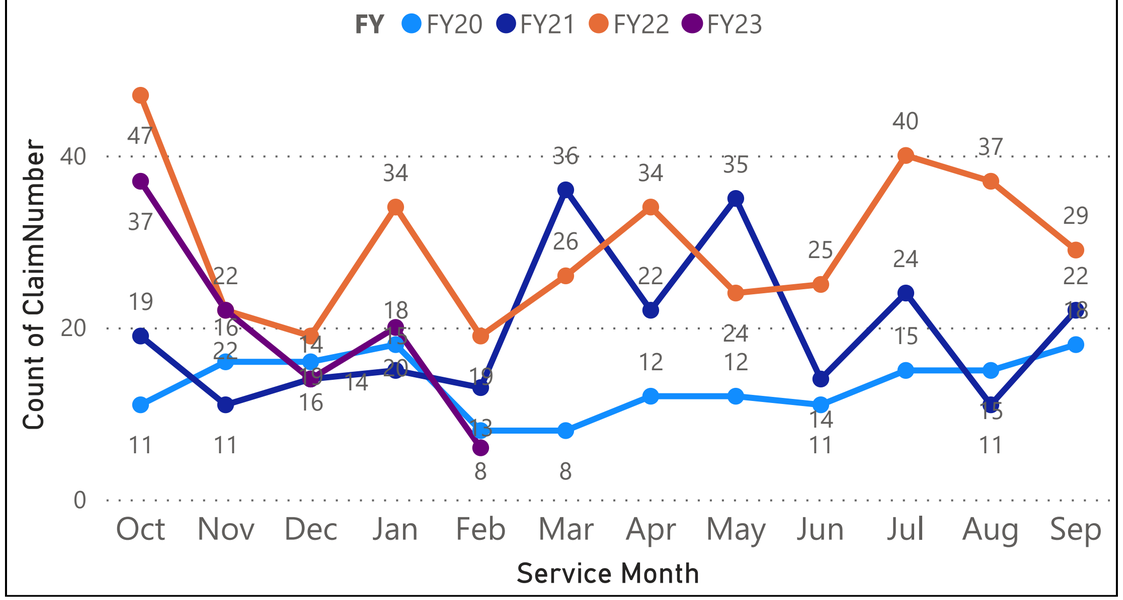


FY: All
- Select all
- FY20
- FY21
- FY22
- FY23

West Michigan Professional Encounter Lines



West Michigan Institutional Encounter Lines



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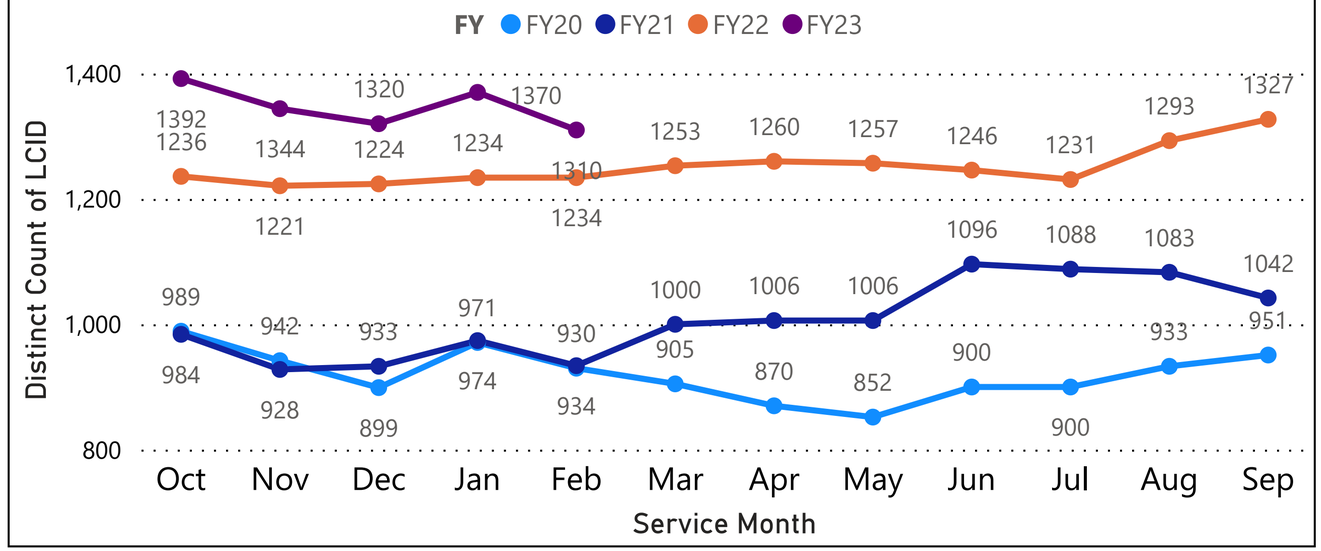
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

West Michigan Behavioral Health

West Michigan Distinct Clients



FY: All
- Select all
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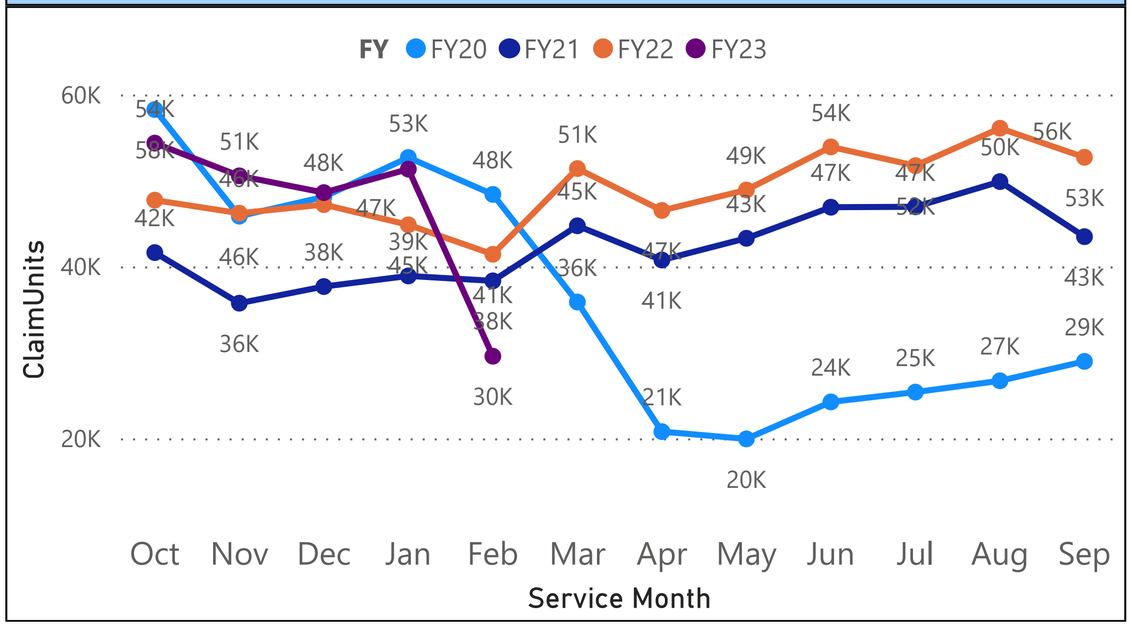
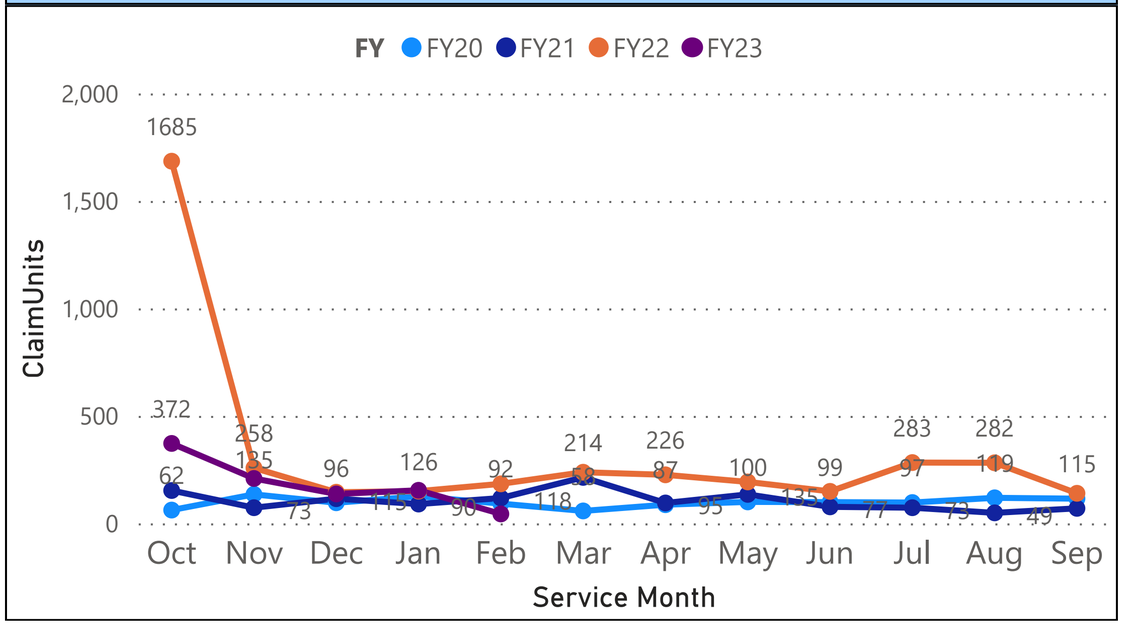
- FY22
- FY23

West Michigan Professional Units



West Michigan Institutional Units



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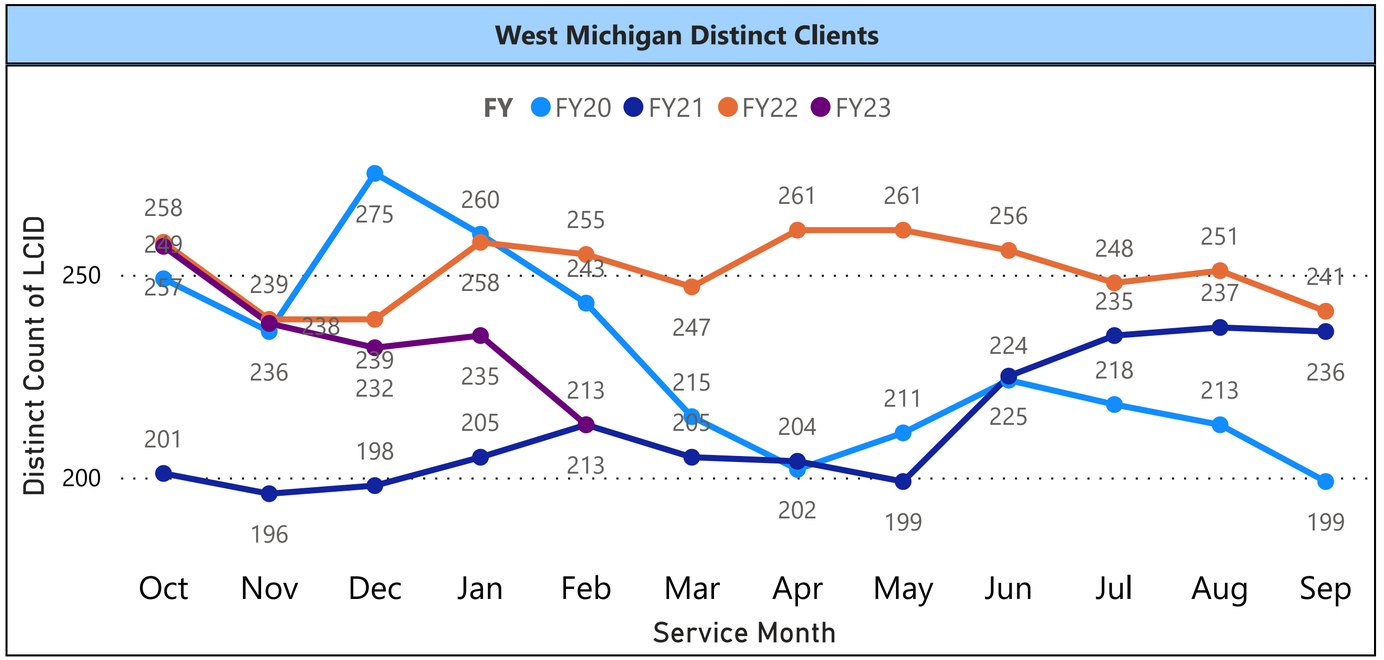
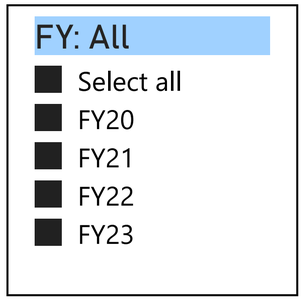
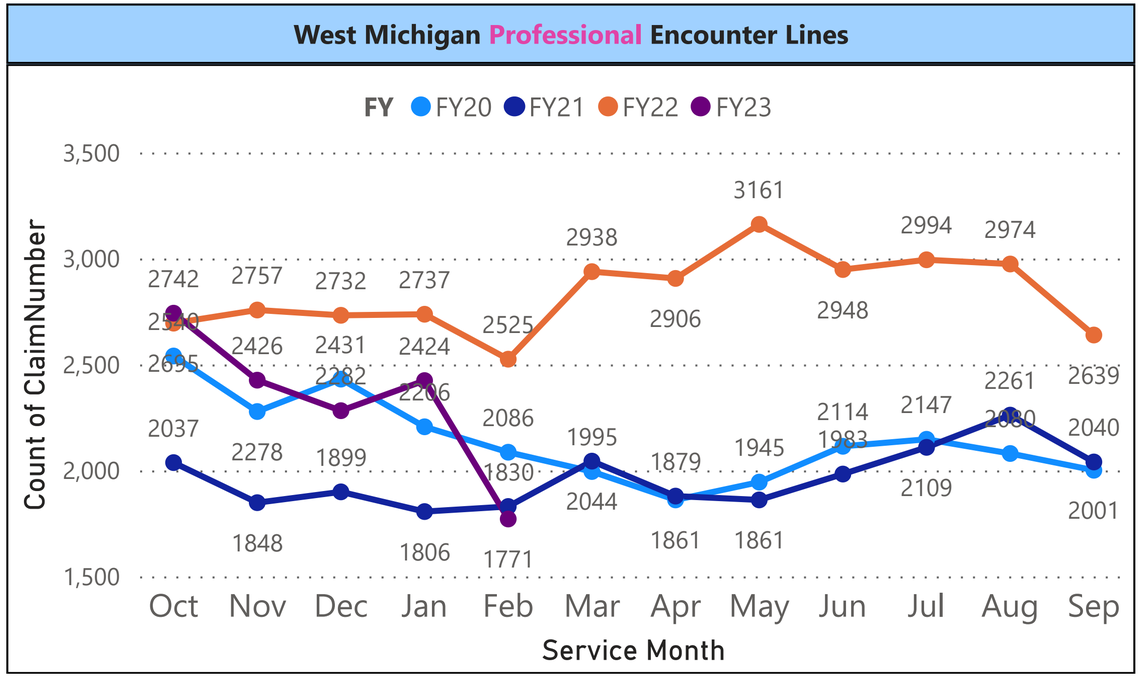
Latest ProcessDate

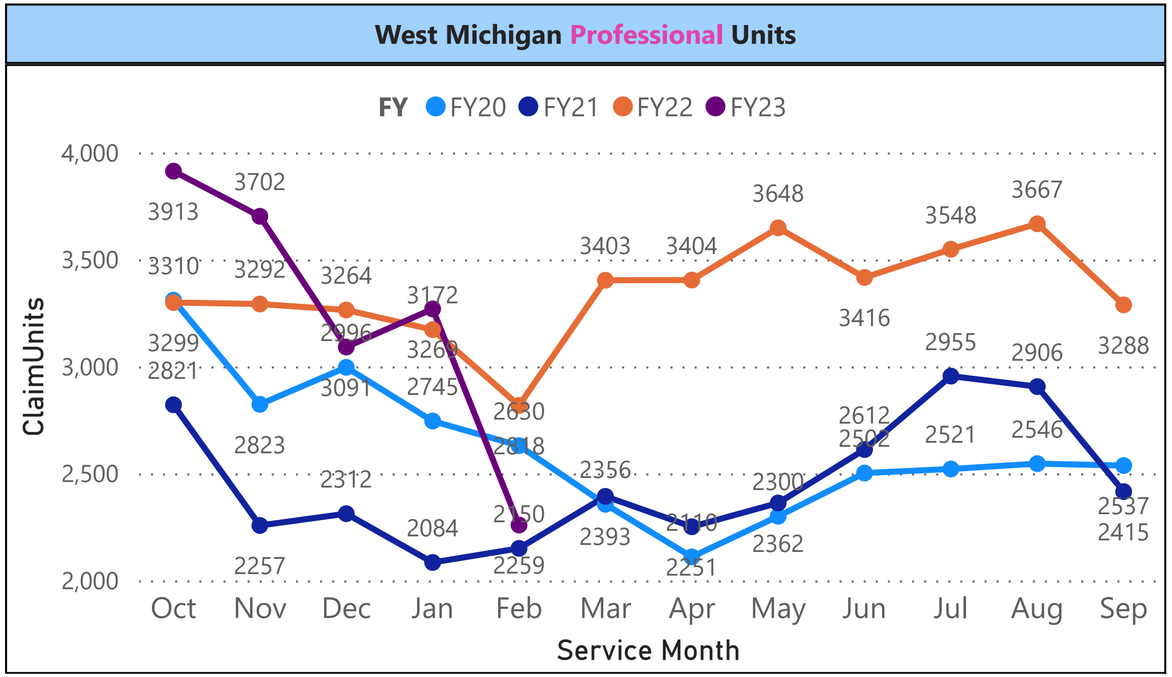
LAKESHORE REGIONAL ENTITY

West Michigan Substance Use Disorder









3/8/2023 3:23:28 PM

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

Chief Quality Officer - Report to the Board of Directors

March 22, 2023

HSAG: LRE continues to review and, where possible, implement HSAG's recommendations for all "Met" Elements, which will be audited by HSAG in July 2023 along with the FY21 & FY22 CAPs. LRE is preparing its CAP Status Report, which is due to HSAG on March 31, 2023.

CMHSP SITE REVIEWS: LRE is aggregating and reviewing FY22 Site Review data on a Regional-level in an attempt to identify any systemic issues, if they exist. LRE commences FY23 CMHSP Site Reviews beginning March 2023. A master FY23 CMHSP Site Review calendar has been created and forms/templates has been standardized for a more efficient process. Throughout this Site Review season, LRE is developing procedures and job aids to ensure proper documentation of the CMHSP Site Review process. LRE began its FY23 Site Review of CMH of Ottawa County on March 14, 2023. LRE has reserved dates and times with all other CMHSPs. LRE sent West Michigan CMHSP its Site Review notification documentation; LRE also met with N180 for Site Review planning purposes. Quality continues to interface with LRE IT to develop standardized reports for improved data analysis and report communications with CMHSPs.

NON-CMHSP SITE REVIEWS:

- **SUD FACILITIES:**
  - ✓ LRE continues to conduct SUD Treatment Site Reviews.
  - ✓ LRE has distributed Corrective Action Plans following the results of the Desk Audits and enhanced Clinical and Credentialing Audits.
- **SPECIALIZED RESIDENTIAL:**
  - ✓ Since October 1, 2022, LRE has completed almost 200 Facilities Reviews.
  - ✓ LRE's compliance rate for Specialized Residential AFCs continues to average 98%.
  - ✓ LRE continues finalizing reports and plans of correction, while working closely with each provider to educate and train in resolving any non-compliant element.
  - ✓ Since June 1, 2022, LRE has issued 131 Corrective Action Plans with 34 remaining outstanding.
  - ✓ Region 3's most out of compliance elements, which are contained within Corrective Action Plans, are related to HCBS requirements and mostly center around lack of documentation supporting practices deemed restrictive by the HCBS Final Rule and use of locks preventing access to common spaces (cabinets, refrigerators) or lack of locks on private spaces (bathrooms, bedrooms). Other shortcomings include untimely fire inspections and incomplete emergency bags.

LRE continues to develop the policy, procedure, and workflows for all Non-CMHSP Site Reviews. LRE continues to review and revise its Non-CMHSP Review tools for implementation, which has been adjourned to April 1, 2023 for a clean break at the start of a new quarter.

LRE has transitioned facilities reviews of autism providers from Operations to Quality starting March 1, 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. This is particularly concerning given that CMS has not granted MDHHS an extension beyond the mandated March 17, 2023, deadline that requires all qualifying setting to be

compliance with the HCBS rule. 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 door locks. Lock manufacturers have resolved the backorder issue and locks are arriving in the hands of providers for installation. LRE has experienced a significant number of providers receiving and installing the newly available HCBS compliant locks.

LRE has conducted HCBS training for all but one Member CMHSP. LRE is finalizing efforts to post the trainings on the LRE website.

LRE will begin the next round of HCBS surveying of consumers and providers for any setting that was on the HCBS de-escalation list as well as those providers who received an HCBS provisional survey since September 4, 2021.

QAPIP – FY23: LRE finalized its FY23 QAPIP and FY22 QAPIP Annual Effectiveness Review for the LRE Executive Team's and Board's review in February 2023. Due to inclement weather, the LRE Board did not meet. LRE timely submitted the FY23 QAPIP and the FY22 QAPIP Annual Effectiveness Review to MDHHS on February 27, 2023, which will be reviewed on March 22, 2023. (Attachment A).

LRE PERFORMANCE IMPROVEMENT PROJECTS ("PIP"): LRE's to PIPs related to the HEDIS® Follow-up After Hospitalization for Mental Illness in 30-day quality metric ("FUH"). Specifically, LRE's objective is to improve FUH across Region 3 and reduce the disparity in FUH among Blacks/African Americans versus White. This PIP intends to improve quality of care and outcomes for all consumers within the FUH population through ongoing collaboration with Medicaid Health Plans and standardized processes for the distribution, submission, and tracking of FUH data. LRE has completed its efforts in establishing standardized processes for distributing FUH data to the Medicaid Health Plans, submitting FUH data to MDHHS, and following up with consumers within the FUH population. LRE now pivots toward implementing interventions to achieve its FUH objectives, which will include Region-wide initiatives.

CRITICAL INCIDENT REBOOT: LRE continues to hand enter critical incidents into MDHHS' CRM module. LRE continues to work with its EMR Vendor to make modifications to the CIRE module to accommodate LRE's reporting needs. MDHHS continues to make enhancements to the CRM Critical Incident module. LRE has created a CIRE Workgroup to manage the CRM changes.

MASTER PROVIDER LIST: LRE Quality Department is working very closely with LRE IT Department to operationalize a Region 3 Master Provider List and subsequent modules within the PCE LIDS environment. LRE is holding meetings with all internal stakeholder and developing a Roadmap that clearly sets forth the unmet needs that currently exist as they relate to a Master Provider List.

MEDICAID VERIFICATION ("MEV"):

MEV Annual Report - SUD Services:

Last month, LRE reported that in Fiscal Year 2022, Region 3 SUD providers performed below expectations during the LRE Medicaid Services Verification audits. Overall, LRE audited a total of 159 encounters and found a total of 39 non-compliant claims/encounters with the following issues:

REASON FOR NON-COMPLIANCE	*COUNT*	*CAUSE*	*OUTCOME*
Insufficient Documentation	1		Recoupment
Missing Documentation	14	Non-Responsive Provider or Non-Retreivable Chart	Recoupment
Services not in IPOS	9		Recoupment
Invalid IPOS at Date of Service	9		Recoupment
Provider not Qualified to Render Services	6		Recoupment

During the MEV audit, LRE experienced lower than expected engagement from SUD providers and communicated this concern to the CMHSPs, which had the potential of recoupment. Each CMHSP contacted those SUD providers with non-compliant audit results in an effort to collect clinical documentation for LRE's secondary review. LRE received documentation and conducted its secondary review of any subsequent documentation submission and determine that what, if any, recoupments are necessary. Five recoupments totaling $38.50 were required due to missing documentation.

Based on this new recoupment value, LRE revised its MEV Annual Report. (Attachment B). In summary, LRE determined SUD Treatment Providers were 99.82% compliant with MEV standards.

Audit Period	*Total Medicaid Dollars*	*Amount Recouped*	*% Recoupment*
FY 22 Oct 2021 - Jun 2022	$21,990.80	$38.50	0.18%
Total	**$21,990.80**	**$38.50**	**0.18%**

REASON FOR NON-COMPLIANCE	*COUNT*	*CAUSE*	*OUTCOME*
Missing Documentation	5	No Cause Given	Recoupment
Missing Documentation	2	"Glitch" in EMR - CAP issues	Paid by GF

LRE issued one corrective action plan to a single CMHSP due to the fact that one SUD Treatment provider could not produce any documentation due to a "glitch" in its EMR.

MEV – FY23 Schedule:

Barring any unexpected delays, LRE has scheduled the following FY23 MEV audits for its Member CMHSPs:

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

Attachment A

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Plan FY2023

Prepared by LRE Chief Quality Officer: February 10, 2023
Reviewed by LRE Executive Team: February 16, 2023
Reviewed and Approved by LRE Board of Directors: March 22, 2023*
Submitted to MDHHS: February 27, 2023
Resubmitted to MDHHS: March 22, 2023

*Due to inclement weather, LRE's Board of Directors did not meet in February 2023.

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I. INTRODUCTION

Lakeshore Regional Entity ("LRE") is a regional entity under Section 1204(b) of the Michigan Mental Health Code and responsible for the financial and administrative management of Behavioral Health, Mental Health and Substance Use Disorder Services for adults and children who reside in one of our seven (7) county areas: Kent, Muskegon, Ottawa, Oceana, Lake, Mason, and Allegan.

This document outlines requirements for the annual QAPIP ("Quality Assessment and Performance Improvement Program") as set forth in the PIHP/MDHHS Medicaid Managed Specialty Supports and Services Program Contract Attachment and the MDHHS Policy - QAPIP for Specialty Prepaid Inpatient Health Plans.[1] It also describes how these functions are accomplished and the organizational structure and responsibilities relative to these functions.

II. PURPOSE

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

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

III. QUALITY IMPROVEMENT AUTHORITY AND ORGANIZATIONAL STRUCTURE

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

A. Governing Body

1. ***Membership:*** The LRE 15-member Governing Board includes three representatives from each of the five (5) Member CMHSP Boards of Directors. Currently, LRE Governing

[1] MDHHS, BH and DD Administration, Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans (michigan.gov).

Board has two (2) vacancies, one in OnPoint CMH (f/k/a Allegan CMH) and one in West Michigan CMSHP, which the CMHSP Boards of Directors are taking strides towards appointment to the LRE Governing Board.

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

    a. ***Oversight of the QAPIP:*** This includes documented evidence that the Governing Board has approved the overall QAPIP and QI Plan.

    b. ***QAPIP Progress Reports:*** The LRE Governing Board routinely receives written reports from the Chief Quality Officer describing performance improvement initiatives undertaken, the actions taken, and the results of those actions.

    c. ***Annual QAPIP Review:*** The LRE Governing Board formally reviews a written report on the operation of the QAPIP, at least annually.

    d. ***Adopting and Communicating Process and Outcome Improvement:*** The LRE Governing Board adopts the QAPIP via Board Motions and communicates the process and outcome improvement to stakeholders via Board of Directors meeting minutes, which are published on the LRE website for public consumption. LRE also publishes the QAPIP and QAPIP Annual Effectiveness Review on its website and provides electronic copies to all Member CMHSPs for distribution via its Newsletter to the provider network.

    e. ***Reporting Accountability:*** Following review and approval by the LRE Governing Body, the LRE CQO submits the QAPIP, QAPIP Annual Effectiveness Review, and MDHHS Governing Body Form to MDHHS on or before February 28th each year.

B. Organizational Structure

In Fiscal Year 2022, LRE reorganized its organization structure and added the role of Chief Quality Officer ("CQO") thereby enhancing LRE's organization structure to support the implementation, management, and oversight of the QAPIP. LRE's new organization structure allows for the clear and appropriate administration and evaluation of the QAPIP. Exhibit A.

C. Designated Senior Official

The LRE Chief Executive Officer ("CEO") has delegated to the Chief Quality Officer ("CQO") the responsibility for submitting a regional QAPIP to the LRE Board of Directors for final approval. LRE CEO also provides regular QAPIP updates to the Operations Advisory Council, which includes all Member CMHSP CEOs, where applicable. In addition, if issues or barriers to

operational effectiveness are identified, these are escalated to the Operations Advisory Council and/or the LRE Board of Directors for input, resolution and/or awareness.

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

D. Regional Operations Advisory Teams

LRE's overall structure supports the management and oversight of the QAPIP and all components necessary for its implementation. Exhibit B.

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

For Fiscal Year 2023, LRE created the LRE Quality Improvement Council ("LRE QIC"), which consists of the LRE Executive Team, with the charter being to regularly review all managed care functions, including all QAPIP activities, with internal stakeholders and, when necessary, external stakeholders such as the LRE Governing Board, Member CMHSPs, ROAT members, providers, etc.

IV. ACTIVE PARTICIPATION OF CONSUMERS AND PROVIDERS

LRE recognizes the importance of stakeholder input and its role in improving quality, customer experiences, and outcomes. Consumers and families are valued contributors into the Quality Improvement process. LRE supports an active Consumer Advisory Panel. There is a bi-directional feedback and input loop between LRE ROATs and the Consumer Advisory Panel to ensure consumer engagement on quality initiatives. There are multiple opportunities for consumers, or guardians, to respond to satisfaction surveys. Customer Services staff responds to any complaint, request for feedback, or request for assistance regardless of the means collected. LRE's website includes a link to allow interested parties to provide feedback on any areas of concern at any time.

Provider agency involvement is also important to the LRE Quality Improvement process. There are regular quarterly meetings open to all regional provider organizations, which allows an opportunity to share information and consider recommendations for quality improvement.

V. QUALITY MANAGEMENT SYSTEM

LRE's Quality Management System combines the traditional aspects of quality assurance and adds the elements of continuous quality improvement by utilizing the Plan-Do-Study-Act process (Attachment C).

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

The *Quality Management System* includes:

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

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

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

VI. PERFORMANCE INDICATORS

A. Michigan Mission Based Performance Indicator System

LRE measures its performance using standardized indicators based on the systemic, ongoing collection, and analysis of valid and reliable data. Specifically, LRE utilizes the performance measure established by MDHHS, meaning the Michigan Mission Based Performance Indicator System ("MMBPIS") in the areas of access, efficiency, and outcomes, which LRE reports to MDHHS on a quarterly basis.

LRE takes great strides to ensure its Member CMHSPs MMBPIS data is valid and reliable. For every reporting quarter, LRE reviews each Member CMHSP's MMBPIS data and, while considering each submitted consumer's arc of treatment, selects samples for a quality check. Each Member CMHSP then submits its proofs for each sample selected to demonstrate compliance with the MMBPIS Code Book. Once LRE is confident its Member CMHSPs' MMBPIS data is valid and reliable, LRE directs each Member CMHSP to finalize its MMBPIS data, and LRE then aggregates the MMBPIS data for submission to MDHHS.

LRE utilizes its QAPIP to assure that each Member CMHSP meets the minimum MMBPIS performance thresholds set forth by MDHHS. On a quarterly basis, LRE aggregates, analyzes, and reviews the MMBPIS data with the MMBPIS Workgroup and QI ROAT while paying special attention to outliers and negative trends. This collaboration also seeks to identify possible causes for any outliers or negative trends. If a Member CMHSP is out of compliance in any given quarter, LRE issues a Corrective Action Plan ("CAP") and monitors the CAP through to remediation and validation ensuring quality improvement in access, efficiency, and outcomes.

B. Key Performance Indicators

LRE utilizes PowerBI to review its HEDIS® Key Performance Indicator ("KPI") Dashboard, with data sourced from the by Zenith Technology Services – ICDP – Integrated Care Delivery Platform, on a quarterly basis. LRE distributes and discusses the KPI Dashboard via the QI ROAT. Since February 2021, LRE has added two additional "slicers" to its KPI Dashboard PowerBI, the 1) Member CMHSP and 2) race/ethnicity categories in an effort to better understand the data on a Member CMHSP and race/ethnicity basis, which is necessary for the 2022 Race/Ethnicity Disparity PIP as directed by MDHHS.

VII. PERFORMANCE IMPROVEMENT PROJECTS

LRE conducts performance improvement projects ("PIPs") that achieve, through ongoing measurement and intervention, demonstrable, and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and individual satisfaction.

LRE is required to conduct at least two PIPs each fiscal year. One of the two PIPs is mandated by MDHHS and is reviewed and evaluated by HSAG for compliance with the PIP requirements. The second PIP may be of the choosing of LRE and must be submitted to MDHHS along with the QAPIP.

LRE encourages all stakeholders to regularly submit improvement recommendations through local QI processes. During QI ROAT, LRE asks each Member CMHSP for ideas for performance improvement projects. LRE also relies upon LRE staff, ROATs, Workgroups, providers, consumers, etc. to generate ideas for potential PIPs.

LRE utilizes the Plan-Do-Study-Act process (Exhibit C) when conducting all PIPs to facilitate a statistically significant improvement that is sustainable over time.

For PIPs required by the state, LRE submits recommendations through the Operations Advisory Council. All identified PIPs will be reported through the QI ROAT, to the Operations Advisory Council and Consumer Advisory Panel.

For Fiscal Year 2023, LRE is conducting two PIPs centered on improving the HEDIS® Follow-up After Hospitalization. LRE's research suggests that an increase in the FUH metric can improve outcomes, decrease suicides, decrease recidivism, and increase satisfaction.

A. FUH Metric: Improve FUH Data Distribution, Submission, and Tracking

Upon transitioning FUH reporting from Beacon Health Options back to LRE, LRE determined it was necessary to standardize the process for distributing FUH data to the Medicaid Health Plans, submitting FUH data to MDHHS, and following up with consumers within the FUH population. This PIP intends to improve quality of care and outcomes for all consumers within the FUH population through ongoing collaboration with Medicaid Health Plans and standardized processes for the distribution, submission, and tracking of FUH data.

B. FUH Metric: Decrease in Racial Disparity between African Americans/Blacks and Whites

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

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

VIII. EVENT REPORTING AND NOTIFICATIONS

LRE requires each Member CMHSP with direct services as well as contracted, external providers to record, assess, and report critical incidents, risk events, sentinel events, unexpected deaths, and immediately reportable events (a/k/a immediate event notification) according to LRE policies and procedures. LRE reports critical incidents, risk events, sentinel events, unexpected deaths, and immediately reportable events in accordance with MDHHS contractual requirements.

Beginning October 1, 2022, MDHHS requires all critical incidents, sentinel events, and unexpected deaths be reported via the Customer Relationship Management ("CRM") platform. LRE will utilize the required field in the CRM platform to identify the provider and exact place where a critical incident occurs. LRE will analyze this data with an eye towards protecting one of its most vulnerable populations, which is the specialized residential consumers.

LRE collects, aggregates, and analyzes all critical incidents and risk events on a quarterly basis. LRE CIRE Workgroup also reviews all sentinel events and unexpected deaths, and immediately reportable events on a monthly basis. LRE's analyses of the critical incidents, risk events, sentinel events, unexpected deaths, and immediately reportable events endeavor to determine what, if any, action is needed to remediate any problem or situation, prevent the occurrence of additional events and incidents, and ensure compliance with reporting requirements.

LRE reports these findings, outliers, and trends to QI ROAT, and, when necessary, to the Operations Advisory Council, on a quarterly basis via the LRE's Critical Incidents Monitoring Report, Risk Event Monitoring Report, Sentinel Event|Unexpected Death Timeliness Report, and Mortality Report. LRE also reports Event Reporting and Notifications to its Governing Board annually.

A. Critical Incidents

LRE captures data on critical incidents for mental health and SUD consumers, which are defined as:

1. Suicide
2. Non-Suicide Death
3. Emergency Medical Treatment due to Injury or Medication Error ("EMT")
4. Hospitalization due to Injury or Medication Error ("Hospital"),

5. Arrest of Consumer,
6. Death of Unknown Cause,
7. MAT Medication Error,
8. SUD Medication Error, and
9. Seriously Challenging Behavior.

LRE requires each Member CMHSP to submit its Critical Incidents by the 15th of each month. LRE reports to MDHHS the following Critical Incidents to MDHHS within sixty (60) days after the end of the month, except for Suicides which are reportable within thirty (30) days, in which the incident occurred for individuals who, at the time of the incident, were actively receiving services:

Service	Suicide (01)	Death (02)	EMT (03)	Hospital (04)	Arrest (05)	Death of Unknown Cause (06)	MAT Med Error (07)	SUD Med Error (08)	Serious Challenging Behaviors (09)
ACT	●	●				●			
CLS	●	●				●			
Case Management	●	●				●			
Homebased	●	●				●			
Support Coordination	●	●				●			
Wraparound	●	●				●			
Any other Service	●	●				●			
SUD Services	●	●				●	●		
Hab Waiver	●	●	●	●	●	●			
SED Waiver	●	●	●	●	●	●			
Child Waiver	●	●	●	●	●	●			
Living Situation									
Specialized Residential	●	●	●	●	●	●	●		
Child Caring Institution	●	●	●	●	●	●	●		
SUD Residential	●	●	●	●	●	●	●	●	●

B. Risk Events

LRE also captures data on events that put individuals at risk of harm, which are defined as:

1. Harm to Self,
2. Harm to Others,
3. Police Calls by Staff under Certain Circumstances,
4. Emergency Use of Physical Management, and
5. Two or More Unscheduled Admissions to a Hospital within a 12-month Period.

LRE requires each Member CMHSP to submit its Risk Event by the 15th of each month. LRE requires Member CMHSPs to report the following Risk Events to LRE within sixty (60) days after the end of the month in which the event occurred for individuals who, at the time of the event,

were actively receiving services:

Service	Harm to Self	Harm to Others	Police Calls	Physical Management	Hospitalization
Supports Coordination	●	●	●	●	●
Case Management	●	●	●	●	●
ACT	●	●	●	●	●
Home-Based	●	●	●	●	●

C. Sentinel Events and Unexpected Deaths

LRE reports sentinel events and unexpected deaths consistent with MDHHS contract requirements. Member CMHSPs, per contract, must notify LRE within 24 hours of learning of an Unexpected Death or possible Sentinel Event. Member CMHSPs have three (3) business days after the occurrence of a Critical Incident to determine if it is a Sentinel Event. If the Critical Incident is classified as a Sentinel Event, the Member CMHSP then has two (2) subsequent business days to commence a Root Cause Analysis ("RCA") of the event. LRE established that RCAs must be completed within 45 days.

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

D. Immediate Event Notification

LRE reports all Immediately Reportable Events to MDHHS according to contract and as follows:

1. Any death that occurs because of suspected staff member action or inaction or any death that is the subject of a recipient rights, licensing, or police investigation is reported to MDHHS within 48 hours of either the death, the PIHPs receipt of notification of the death, or the PIHPs receipt of notification that a rights, licensing, and/or police investigation has commenced to QMPMeasures@michigan.gov and include the following information:

    a. Name of Beneficiary,
    b. Beneficiary ID Number (Medicaid, MiChild),
    c. Consumer I (CONID) if there is no Beneficiary ID Number,

d. Date, Time, and Place of Death (if a licensed foster care facility, include the license number),
e. Preliminary Cause of Death, and
f. Contact Person's Name and Email Address.

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

IX. BEHAVIOR TREATMENT REVIEW

Member CMHSPs collect and submit Behavior Treatment/HAB Waiver data to LRE quarterly. The regional Behavior Treatment Committee ("BTC"), with representation from each Member CMHSP and LRE, convenes quarterly to review and analyze the CMHSP BTR/HAB Waiver data. The committee ensures submitted data is correct and complete and reviews the data for any trends or areas of concern. Where intrusive or restrictive techniques have been approved for use and/or where physical management or 911 calls to law enforcement in an emergency have occurred, the BTC conducts quarterly analysis of the data submitted by Member CMHSPs to identify trends and subsequent actions that may need to be taken to reduce the potential for future events. The LRE Physical Management Episode Tracking Report is reviewed quarterly by both the LRE Behavior Treatment Committee and the QI ROAT. This report allows for the review of the physical management data including the number of interventions and length of time the interventions were used per individual. LRE adheres to the provisions outlined in the MDHHS Technical Requirements for Behavior Treatment Plans Policy and the current MDHHS-PIHP Contract.[2]

X. CUSTOMER SATISFACTION ASSESSMENT

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

[2] MDHHS, Behavioral Health and Developmental Disabilities Administration, Technical Requirement for Behavior Treatment Plans (michigan.gov).

case management and supports coordination as well as other services and supports being rendered.

The LRE Survey includes a section specifically designed for individuals within the LTSS population in addition to questions on telehealth experiences given the new modality of service delivery due to the Public Health Emergency.

The LRE Survey also provides space for individuals filling out the survey to provide comments. LRE requires Member CMHSP Customer Services staff to follow-up on any negative comments or less than desirable Survey score.

Member CMHSPs submit the Survey data to LRE and LRE aggregates and analyzes the data via a PowerBI Dashboard to identify strengths, areas for improvement, and make recommendations for action and follow up, as appropriate. LRE reviews and reports the Survey findings to the QI ROAT and Customer Services ROAT quarterly as well as the LRE Governing Board annually to improve services, processes, communication, and overall customer satisfaction.

XI. CLINICAL PRACTICE GUIDELINES

LRE supports the use of Clinical Practice Guidelines ("CPGs") in service provision. CPGs are available to assist practitioners and members in making decisions about appropriate health care for specific clinical circumstances. LRE endorses CPGs that have been adopted by the American Psychiatric Association. LRE adopted the American Psychiatric Association CPGs in concert with Member CMHSPs through the Clinical ROAT and Utilization Management ROAT. LRE disseminates the CPGs ia LRE and CMHSP websites, LRE newsletter, and ROAT reviews and education.

LRE along with its Member CMHSPs developed and approved an Inter-Rater Reliability Process ensuring that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. LRE reviews all Audit Summary results in the Clinical ROAT and Utilization Management ROAT.

LRE monitors the use of established guidelines as part of its Member CMHSP Site Reviews.

XII. CREDENTIALING

LRE ensures that services and supports are consistently provided by staff (contracted or directly operated) who are properly and currently credentialed, licensed, and qualified. LRE Policy # 4.4: Organizational Credentialing and Recredentialing outlines the guidelines and responsibilities for credentialing and re-credentialing provider staff and agencies.

LRE conducts Organizational Credentialing to assure each organization maintains necessary licensure and meets basic expectation for contracting. LRE requires each organization to

complete a Credentialing Application and provide proofs, such as state licensures, insurance certificates, W-9 or IRS letter, NPI enumerator documentation, accreditation certificates, fidelity bonding certificate, disclosure of ownership and controlling interest statement, etc. LRE also conducts OIG, SAM, MDHHS checks to ensure organizational providers are not excluded from doing business with LRE or its Member CMHSPs.

LRE also conducts credentialing and recredentialing for any individual or professional staff with which it directly contracts.

LRE delegates the credentialing of individual and professional staff to its Member CMHSPs. LRE oversees the Member CMHSPs' credentialing/recredentialing efforts in two ways. Quarterly, MDHHS requires LRE to submit credentialing reports for both Organizational and Individual Providers. In turn, LRE requires each Member CMHSP to submit credentialing/recredentialing data on a quarterly basis. LRE then aggregates and analyzes the credentialing/recredentialing data. LRE may, at times, collaborate with CMHSPs to ensure data integrity. Once assured the credentialing/recredentialing data is integrous, LRE submits LRE's credentialing/recredentialing data to MDHHS. Secondly, LRE also provides oversight of appropriate credentialing/ qualifications by auditing a sample of credentialed staff during its Member CMHSP Site Reviews. If LRE finds gaps in a Member CMHSP's credentialing/recredentialing efforts, LRE assigns the Member CMHSP a plan of correction. These findings are reported to LRE Executive Team, CMHSP Leadership, Provider Network ROAT, Clinical ROAT, Utilization Management ROAT, and the Quality Improvement ROAT.

LRE is attempting to incorporate quality measures into its recredentialing process by considering the extent an organization or a practitioner has been grieved, has received a less than desired Survey score, has fallen below performance indicator thresholds, which could include CMHSP Site Review results for clinical and credentialing audits, or has experienced a rise in critical incident or sentinel events. Prior to being able to implement such quality measures into the recredentialing process, LRE requires reprogramming of its EMR. Currently, LRE is developing the technical requirements for such reprogramming.

XIII. STAFF TRAINING AND DEVELOPMENT

LRE and its Member CMHSPs ensure that consumers are served by staff with adequate training, competencies, and qualifications. This function is performed across the region with materials and processes that are developed to be uniformly compliant with regulations but using procedures developed by the Member CMHSPs.

LRE requires its Member CMHSPs to identify staff training needs and provide in-service training, continuing education, and staff development activities. A regional Training Workgroup is responsible for the development of staff training and education standards to support reciprocity and efficiencies across the region.

During CMHSP Site Reviews, LRE annually audits each Member CMHSPs' adherence to LRE policies and procedures related to staff possessing the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following:

1. Educational Background,
2. Relevant Work Experience,
3. Cultural Competence,
4. Certification, Registration, and Licensure as Required by Law, and
5. Training of New Personnel Regarding their Responsibilities, Program Policy and Staff Development Activities.

LRE monitors corrective action plans to ensure that the plans are implemented, and provider and agency staff are meeting training requirements.

In addition, LRE Policy 4.2 Provider Network and Contract Management describes mechanism for monitoring and assessing compliance with contract, state, and federal requirements of service providers.

XIV. MEDICAID SERVICES VERIFICATION

MDHHS requires all PIHPs to submit an annual report, due December 31, covering the claims/encounters verification process for the prior fiscal year and must describe the PIHP's Medicaid Services Verification methodology and summarize the audit results, which must contain the following required elements:

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

LRE established a written policy and procedure for monitoring and evaluating the claims/encounters submitted by its Member CMHSPs ensuring compliance with federal and state regulations as well as the MDHHS Medicaid Verification Process technical requirements.[3]

LRE's policy and procedure consider conflicts of interest, validation of claims/encounters data, sampling methodology, audit criteria, review and reporting standards, recoupment procedures,

[3] MDHHS, Behavioral Health and Developmental Disabilities Administration, Medicaid Services Verification (michigan.gov).

corrective action plan procedures, and documentation standards, as required by the MDHHS Medicaid Verification Process policy.

In January 2022, LRE increased the frequency of its Medicaid Services Verification audits from semi-annually to quarterly and increased the sampling size across all service types. Additionally, LRE revised its report template for the Medicaid Claims/Encounters Verification Process Annual Report.

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

XV. UTILIZATION MANAGEMENT

At the LRE, Utilization Management ("UM") is guided by LRE policy and procedure and an annual UM Plan. UM activities are conducted across the region to assure the appropriate delivery of services. Utilization mechanisms identify and correct under-utilization as well as over-utilization. LRE leverages PowerBI Dashboards to the review and analysis under and over utilization. LRE also conducts Utilization Reviews that include the review and monitoring of individual consumer records, specific provider practices, and system trends. UM data is aggregated and reviewed by the UM ROAT to identify trends and make service improvement recommendations. Findings are reported to the LRE CEO and Operations Advisory Council.

XVI. OVERSIGHT OF PROVIDER NETWORK

A. CMHSP Site Reviews

LRE maintains oversight of its Provider Network by conducting annual CMHSP Site Reviews that ensure compliance with federal, state, and regional regulations and requirements. The LRE CMSHP Site Review process is a systematic and comprehensive approach to monitor, benchmark, and improve the quality of care and delivery of mental health and substance use disorder services.

During the CMHSP Site Review Process, LRE evaluates the Member CMHSPs' and external providers' compliance is the areas of

1. Federal Regulations, State Requirements, and Regional Policies.
2. Contractual Obligations.
3. Delegated Managed Care Functions.
4. Clinical Documentation Standards.

As a result of the CMHSP Site Reviews, LRE is able to

1. Establish prioritized clinical and non-clinical priority areas for improvement.
2. Analyze the delivery of services and quality of care using a variety of audit tools.
3. Develop performance goals and compare findings with past performance.
4. Provide performance feedback through exit conferences and written reports.
5. Conduct targeted monitoring of consumers defined to be vulnerable by MDHHS.
6. Require improvements from providers via CAPs for areas that do not meet predetermined thresholds or are not compliant with defined standards.
7. Ensure CAP remediation by providers.
8. Identify systemic, regional issues and develop improvement plans to improve quality of care and delivery of services.

If LRE requires a CAP, the Member CMHSP or provider has 30 days to respond. LRE either approves the CAP as written or denies it and requests more information and/or recommends additional changes. LRE has a process to review the CAP during the following year's CMHSP Site Review.

B. MDHHS Site Reviews

LRE participates in site reviews conducted by MDHHS to monitor CMHSP member performance. Upon completion of the MDHHS Site Review a CAP report, MDHHS provides LRE with its findings. When LRE receives the CAP report, it distributes to all applicable stakeholders for CAP development.

To best address local concerns, each Member CMHSP drafts CAPs for all citations for which the Member CMHSP has been identified as being out of compliance. LRE ensures that CAPs and remedial actions are implemented. LRE may rely upon Workgroups and consult with ROATS to address systemic issues that are identified by the MDHHS reviewers.

C. External Quality Reviews

LRE participates in External Quality Reviews ("EQRs"), which are conducted by Health Services Advisory Group ("HSAG") and required under The Balanced Budget Act of 1997 ("BBA"). Generally, HSAG evaluates the quality and timeliness of, and access to, health care services provided to consumers. HSAG's stated objective for the EQR is to provide meaningful information that MDHHS and the LRE can use for

1. Evaluating the quality, timeliness, and access to mental health and substance abuse care furnished by the LRE.
2. Identifying, implementing, and monitoring system interventions to improve quality.
3. Evaluating one of the two performance improvement projects of the LRE.
4. Planning and initiating activities to sustain and enhance current performance processes.

D. Facilities Reviews

LRE conducts annual Facilities Reviews for all contracted, external providers to ensure compliance with the following requirements:

1. General Health and Safety Standards,
2. Emergency Procedures,
3. Medication Reviews,
4. Resident Funds Reviews,
5. Policies and Procedures, and
6. HCBS Final Rule.

LRE works hand-in-hand with providers to develop CAPs for non-compliant findings and assists providers in remediating these findings as efficiently as possible. LRE utilizes the aggregate data from these Facilities Reviews to determine what trainings and tools are needed at the provider level to improve the quality of care of and delivery of services to consumers.

XVII. LONG TERM SERVICES AND SUPPORTS

During the CMHSP Site Reviews, LRE ensures its sampling methodology used to select consumers for clinical chart audits is a representative cross-section of the overall distribution of service types provided in Region 3 by distinct consumer. For example, for FY22, LRE served almost 70% of its distinct consumer count with services defined by 1115 Pathway to Integration Waiver as Long-Term Services and Supports ("LTSS").[4] Hence, when LRE selects its random sample for its clinical chart audits, most of the samples selected tether to individuals receiving LTSS. LRE's sampling methodology is the first step ensuring that LRE is able to assess the quality and appropriateness of care furnished to individuals receiving LTSS.

Secondly, LRE's Clinical Chart Audit Tool, which is used during CMSHP Site Reviews, is the mechanism used to assess the quality and appropriateness of care furnished to individuals receiving LTSS. Specifically, LRE's Clinical Chart Audit Tool contains sections on Person-Centered Planning ("PCP"), which allows LRE to assess member care between care settings, and Service Delivery, which allows LRE to compare the services received by the individual compared to the services identified in the individuals treatment/service plan. LRE's Clinical Chart Audit Tool is compliant with MDHHS' PCP Guidelines Policy and the Medicaid Provider Manual ensuing LRE assesses the quality and appropriateness of care furnished to individuals receiving

[4] 1115 Pathway to Integration defines Long-Term Services and Supports as Community Living Supports, Enhanced Medical Equipment and Supplies, Enhanced Pharmacy, Environmental Modification, Family and Support Training, Fiscal Intermediary, Goods and Services, Non-Family Training, Out-of-Home Non-Vocational Habilitation, Personal Emergency Response System, Prevocational Services, Skill Building Assistance, Specialty Services/Therapies (Music Therapy, Recreation Therapy, Art Therapy, and Massage Therapy), Supports and Service Coordination, Respite, Private Duty Nursing, Supported/Integrated Employment Services, Child Therapeutic Foster Care, Therapeutic Overnight Camping, Transitional Services.

LTSS.[5]

LRE also ensures all individuals, including those receiving LTSS, receive a LOCUS/CAFAS upon admission, annually, and when there has been a significant change in consumer's presentation. In an effort to improve visibility of LOCUS utilization, LRE has developed PowerBI Dashboards. Additionally, LRE has contracted with an agency to conduct SIS training for all interested parties in Region 3, which will only strengthen LRE's commitment to ensuring individuals receiving LTSS receive quality, appropriate care over the long-term.

Finally, LRE has created a Personal Emergency Response System Workgroup encouraging independence among all consumers, including those receiving LTSS.[6]

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[5] Person-Centered Planning section comports with the MDHHS Person-Centered Planning Guidelines Policy. MDHHS, Behavioral Health and Developmental Disabilities Administration, Person-Centered Planning Practice Guideline (michigan.gov). Service Delivery section comports with the Medicaid Provider Manual.

[6] LRE co-leads a Regional Emergency Response System Workgroup initiated by Lynne Doyle Ottawa CMH, CEO.

XVIII. FISCAL YEAR 2023 QAPIP WORKPLAN

FY 2023 LRE QAPIP Goals and Work Plan: October 1, 2022 - September 30, 2023

QAPIP Component	Goal / Opportunity	Objectives (Specific Actions to be taken)	Responsible Party	Deadline
Performance Measures	LRE will meet and maintain the performance standards as set by the MDHHS / PIHP Contract.	1. CMHSPs will consistently meet all MDHHS MMPBIS 95% Standards for Indicator 1, 4a, & 4b, and the less than 15% Standard for Indicator 10. 2. LRE will require Plans of Correction from each CMHSP for each Indicators not meeting MDHHS Standards.	CQO Monitored By: 1. MMBPIS Workgroup 2. QI ROAT	Ongoing
Performance Measures	LRE will show improvement in the percentage of new individuals receiving a psychosocial assessment within 14 days of a non-emergent request and of new individuals starting on-going treatment following the psychosocial assessment	1. LRE QI Staff will closely monitor data CMHSPS submit for Indicators 2 and 3 analyzing out of compliance codes looking for trends. and improvement opportunities. 2. LRE MMBPIS training is scheduled for January 2023. Data codes will be reviewed and discussed for the purpose of a regionwide understanding of code definitions. This will improve the ability of LRE QI Staff to monitor and accurately trend the MMBPIS data. 3. Add CAP provision for any downward trend for more than 2 quarters in a row. 4. Integrate MDHHS Performance Indicator Thresholds, once established.	CQO Monitored By: 1. MMBPIS Workgroup 2. QI ROAT	9/30/2023
Performance Improvement Projects	LRE will implement two PIP projects that meet MDHHS Standards. Formal PIP: FUH Metric: Decrease in Racial Disparity between Whites and African American/ Blacks Baseline Data for FY2022: submitted to HSAG July 2022 FUH_ Adults and Children who identify as African American/Black: 60.2% FUH_Adults and Children who identify as While: 70.9%	1. The objective for the PIP is that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African-Americans/ Blacks) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (Whites). 2. LRE will develop improvement strategies and interventions to impact this performance indicator outcomes and achieve significant improvememt. 3. LRE will work with the five CMHSPs within Region 3 to implement agreed upon interventions	CQO Monitored By: 1. QI ROAT	9/30/2023
Performance Improvement Projects	LRE will implement two PIP projects that meet MDHHS Standards. 2nd PIP: FUH HEDIS Measure: The percentage of discharges for patients 6 years of age or older who were hospitalized for treatment of selected mental illness or intentional self harm diagnoses and who had follow-up visit with a mental health provider within 30 days of discharge. Baseline FUH Data: TBD	1. LRE will develop workflows for ADT data dissemination, follow-up after discharge, and CMHSP weekly data submission requirements. LRE will also develop an FUH error report for dissemination to and remediation by its CMHSPs at least bi-monthly. 2. The objective for the PIP is to demonstrate a significant increase over the baseline rate for all consumers to which FUH applies. 3. LRE will develop improvement strategies and interventions to impact this performance indicator outcomes and achieve significant improvememt. 4. LRE will work with the five CMHSPs within Region 3 to implement agreed upon interventions.	Provider Network Staff (#1) CQO (#2-#4) Monitored By: 1. FUH Workgroup (#1) 2. UM/Clinical ROAT (#1) 3. QI ROAT (#2-#4)	9/30/2023
Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Management	Ensure contractual requirements are being met in Sentinel Events, Critical Incidents, and Risk Events.	LRE will 1. Analyze and monitor CIRE data to ensure data completeness, accuracy, and timeliness. 2. Determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. 3. Monitor CMHSPs for follow-up of remediations efforts with providers, as needed.	CQO Monitored By: 1. CIRE Workgroup 2. QI ROAT	Ongoing

Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Management	LRE delegates the process of review and follow-up of sentinel events to the CMHSP. LRE will continually monitor the five regional CMHSP's sentinel event and unexpected death processes ensuring timeliness of reporting, completion of RCAs and follow up as required per contract.	LRE will monitor the following: 1. CMHSPs will notify the LRE of a possible sentinel event / unexpected death within 24 hours of their knowledge of event. 2. CMHSPs have 3 business days to determine if the event is a sentinel event. 3. CMHSPs have 2 business days to commence an RCA if the event was determined to be a possible sentinel event / unexpected death. 4. CMHSPs have 48 ours to submit the completed unexpected death/ SE form to the LRE following completion of the RCA. 5. LRE will follow-up to ensure remediation of issues found through the RCA within 90 days following receipt of the RCA.	CQO (#1-#4) Provider Network Staff (#5) Monitored By: 1. CIRE Workgroup 2. QI ROAT	Ongoing
Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Management	LRE will review and monitor CIRE events by type of incident and facility incident occurred.	MDHHS is implementing a new CIRE process using MiCAL/CRM for FY23. 1. LRE will develop a new process for submitted the CIRE data to MDHHS by 3/31/2023. 2. CMHSPs will consistently submit their CIRE data to LRE by the 15th of reporting month. 3. LRE IT will develop a Power BI report for CIRE data by 8/30/2023. 4. LRE will monitor CIRE data using the Power BI report looking for trends with incident types and /or facilities by 8/30/2023. Previous to the development of the Power BI, LRE will continue to monitor through Excel processes.	IT Staff (#1) CQO (#2-#4) Monitored By: 1. CIRE Workgroup 2. QI ROAT	9/30/2023
Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Management	LRE will monitor mortality data over time.	1. LRE QI Staff will review mortality data looking for trends in the causes of natural deaths and unexpected deaths. (suicide, accidental, homicide) 2. Mortality data report trends and issues will be discussed quarterly at the CIRE Workgroup and semi annually at the QI ROAT.	CQO Monitored By: 1. CIRE Workgroup 2. QI ROAT	Ongoing
Behavior Treatment Review	LRE will review and analyze behavior treatment review committee physical management data by individual and length of time for each instance of physical management used in an emergency behavioral crisis.	1. CMHSPs will submit physical management data for every instance of physical management used in an emergency behavioral health crisis to the LRE at least quarterly. This data will be reported by: • individual (separately for each instance), • include demographics of population, • Hab Waiver: Yes/No, • Behavior Plan: Yes/No, and • Time per instance will be reported in minutes and seconds. 2. LRE QI Staff will aggregate physical managment data quarterly. • quarterly data will be reviewed for trends, issues, and performance improvement opportunities. • quarterly reports and analysis will be reviewed and discussed by Behavior Treatment Workgroup and QI ROAT. 3. LRE QI Staff will work with IT staff to have the Phyical managment data in Power Bi by 9/30/2023	CQO (#1-#2) IT Staff (#3) Monitored By: 1. LRE Behavior Treatment Workgroup 2. QI ROAT	9/30/2023

Member Experience with Services	LRE will complete quantitative and qualitative assessments of member experiences with its services.	1. Implementation of the LRE Satisfaction Survey process has been delegated to the CMHSPs within Region 3. CMHSPs will collect satisfaction survey data using the LRE Satisfaction Survey. CMHSPs will submit satisfaction survey data vai FastLane. 2. Customer Services Staff will run quarterly satisfaction survey reports using Power BI. 3. Customer Services Staff will review the quarterly satisfaction survey data, analyzing for trends/ issues. Customer Services Staff will present quarterly reports to CS ROAT and QI ROAT. 4. Customer Services Staff will review all survey comments and follow up with the individual who completed the survey. Follow up will be documented and reviewed for trends / issues. 5. Annually, LRE will collect information from CMHSPs on any focus groups held during the year and the results/ findings from the group.	Customer Services Staff Monitored By: 1. CQO 2. QIC 3. Customer Services Workgroup 4. QI ROAT	9/30/2023
Grievance and Appeals	Provider grievances, appeals and NABD's will be compliant with MDHHS Standards and Policy.	1. Establish policy and procedure to conduct quarterly grievance, appeals, and NABDs audit at the CMHSP level to ensure compliance with Federal regulations and State reqirements.	Customer Services Staff Monitored By: 1. CQO 2. QIC 3. Customer Services Workgroup 4. QI ROAT	9/30/2023
Practice Guidelines	Ensure continued education and monitoring of Clinical Practice Guidelines while improving dissemination and education to the LRE Provider network. Adopt new/alternate practice guidelines as necessary.	1. CPGs will be reviewed and updated two times a year by the LRE Medical Director and the Clinical / UM Department staff. 2. CPG information will be disseminated to the provider network through various educational opportunities as well as links to the LRE CPGs via CMHSP and LRE Websites. 3. Disseminate the Clinical Practice Guidelines to its Regional Provider Network via LRE newsletter at least annually.	UM Staff Monitored By: 1. CQO 2. QIC 3. Clinical ROAT 4. QI ROAT	9/30/2023
Credentialing and Re-Credentialing	Enhance the credentialing/recredentialing process through successful implementation of the MDHHS CRM Universal Credentialing Module.	QAPIP Standards require that credentialing data be regularly reviewed 1. A credentialing data report will be developed by January 2023. 2. QI with LRE Credentialing Staff will review and monitor the credentialing data report monthly to identify trends and areas of concern. 3. Credentialing data report will be presented to the QI ROAT quarterly to discuss trends and areas of concerns. 4. Identified trends and areas of concern will be discussed with Provider Network Managers and a improvement plan to address and work on these with the Providers and CMHSPs will be developed as needed.	Credentialing Staff Monitored By: 1. QIC 2. QI ROAT	4/1/2023
Credentialing and Re-Credentialing	Develop specifications for developing a credentialing/recredentialing module within LIDS and reports with the assistance of PCE Systems that complies with MDHHS Provider Credentialing Policy.	1. Work with Stakeholder to identify unmet needs related to Master Provider Database. 2. Interface with PCE to ensure tranfer of technical requirements to functional module.	IT Staff CQO Monitored By: 1. Credentialing Staff 2. QI ROAT	9/30/2023
Credentialing and Re-Credentialing	Develop a process for integrating grievances, appeals, performance indicators, critical incidents, etc. into the recredentialing process.	1. Establish procedures to integrating grievances, appeals, performance indicators, critical incidents, etc. into the recredentialing process.	CQO Monitored By: 1. QIC 2. Credenialing Staff 3. QI ROAT	9/30/2023

Credentialing and Re-Credentialing	Develop a process for tracking, reporting, and monitoring Credentialing & Recredentialing Efforts. Organizational: # applications, # approvals, # denials/basis for denials, # revoke/basis for revocation, # closed/basis for closure, # of consumer affected by revocation/closures, timeliness of approvals/denials. Individual: Site Review data analysis - trainings, credentialing, first aid, etc. - trends/outliners - what did LRE do to support the CMHSPs/Provider Network when negative trends/outliers were found, timeliness of approvals/denials.	QAPIP Standards require that credentialing data be regularly reviewed 1. A credentialing data report will be developed by January 2023. 2. QI with LRE Credentialing Staff will review and monitor the credentialing data report monthly to identify trends and areas of concern. 3. Credentialing data report will be presented to the QI ROAT quarterly to discuss trends and areas of concerns. 4. Identified trends and areas of concern will be discussed with Provider Network Managers and a improvement plan to address and work on these with the Providers and CMHSPs will be developed as needed.	CQO Monitored By: 1. QIC 2. Credenialing Staff 3. QI ROAT	9/30/2023
Credentialing and Re-Credentialing	LRE will monitor the CMHSPs credentialing/recredentialing through the annual site review process. LRE will monitor its Organizational credentialing/recredentialing via internal audits. <u>Background:</u> LRE received recommendation from HSAG that the PIHP use the information it obtains through its ongoing monitoring of quality data and member concerns Ii.e. grievances, appeals, etc.) as part of the re-credentialing decision -making process.	1. FY23 Credentialing Site Review Tools will be updated in order to better reflect measurement and tracking of member CMHSP's re-credentialing of individual practitioners. a. <u>For Individual Provider Re-credentialing:</u> LRE will modify its FY23 Credentialing Site Review Tools to require CMHSP to utilize FY22 and FY23 quarter-to-date grievance reports during the re-credentialing of individual providers. 2. <u>For Organization Re-credentialing:</u> LRE will utilize FY22 and FY23 quarter-to-date grievance reports during re-credentialing of providers. 3. Update all relevant policies, procedures, forms, checklists, etc.	Credentialing Staff QI Staff Monitored By: 1. QIC 2. QI ROAT	Ongoing
Verification of Services	The LRE will complete Medicaid Verification of services reimbursed by Medicaid as required by MDHHS Contract.	LRE will: 1. Complete quarterly Medicaid Verification Reviews based on a sample of Medicaid paid claims from each of the five regional CMHSPs and their larger providers. 2. Complete quarterly Medicaid Verifications reports with analysis of findings. (reviewed by the QI ROAT). 3. Prepare and submit an annual Medicaid Verification report to MDHHS that includes claim verification methodology, findings, and actions taken in response to findings.	CQO Monitored by 1. MEV Staff 2. QI ROAT	Ongoing
Utilization Management	LRE will continue to establish and develop mechanisms to detect over/under utilization of services across its provider network by leveraging Information Technology to develop Power Bi Dashboards which will provide real-time highly quantitative date and service utilization reports by 10/1/2023.	1. Reports will be developed to review the lower 15% and the upper 15% using claims and authorization data for HLOC and SIS/Community Living Supports. 2. LOCUS dashboards will be developed to identify outliers for scores of 14 and below as well as scores of 20 and higher.	UM Staff Monitored by: 1. UM/Clinical ROAT 2. CQO	9/30/2023
Oversight of Provider Network	LRE will ensure CMHSP Site Review Tools comply with Federal regulations and State requirement.	1. Review 42 CFR 438 monthly to ensure Federal reglations have not changed and if they do, document such changes so as to incorporate in the CMHSP Site Review Tools for the following audit year.	CQO	Ongoing

Long Term Services and Supports (LTSS)	LRE will monitor services and supports for individuals receiving Long Term Services and Supports (LTSS)	1. A section of the LRE Satisfaction Survey has questions specifically for individuals receiving LTSS. Surveys questions will be aggregated and monitored quarterly using the Power BI platform. Survey data will be analized for trends and issues. Any issues found will be addressed. 2. LRE QI staff complete an annual CMHSP Site Review of each of the five CMHSPS in Region. 3. Clinical chart reviews are completed as part of this process.-, including specific Waiver Review Questions. Waiver questions will be aggregated by question and reviewed/analyzed for trends and issues. These trends /issues will be addressed with the responsible CMH with a required CAP with individualized remediation required. 4. QI I Staff complete annual facility reviews of specialized residential facilities. Specialized Residential facilities will be reviewed and monitored for HCBS required Standards. 5. Incorporate LTSS into UM Plan.	CQO UM Staff Monitored By: 1. UM ROAT 2. Clinical ROAT 3. QI ROAT	Ongoing

XIX. MDHHS GOVERNING BODY FORM

Governing Body Form

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

Name of PIHP		
Lakeshore Regional Entity		
List of members of the Governing Body (add additional rows as needed)		
Name	**Credentials**	**Organization** (if applicable)
1. Mark DeYoung	LRE Board Chair, Allegan County Commissioner, Allegan CMH Board Chair	OnPoint CMH (f/k/a Allegan CMH)
2. Linda Garzelloni	LRE Board Co-Chair, Retired CEO Hackley Community Care,	HealthWest
3. Jane Verduin	LRE Board Secretary, Physical Health Provider	West Michigan CMH
4. Alice Kelsey	LRE Board Member	OnPoint CMH (f/k/a Allegan CMH)
5. Janet Thomas	LRE Board Member, Lawyer, HW Board Chai	HealthWest
6. Patricia Gardner	LRE Board member, Kent County Judge	Network180
7. Stan Stek	LRE Board Member, Kent County Commissioner, N180 Board Member	Network180
8. Jack Greenfield	LRE Board member, Retired Provider Network (MOKA	Network180
9. Sara Hogan	LRE Board Member, Director of Administration (Benjamin's Hope) Provider Network,	Ottawa CMH
10. Richard Kanten	LRE Board Member, LRE OPB	Ottawa CMH
11. Susan Meston	LRE Board Member, Teacher/Principal	Ottawa CMH
12. Ron Bacon	LRE Board Member, WM CMH Board Member	West Michigan CMH

13. Ron Sanders	LRE Board Member	West Michigan CMH
Changes to membership during the past year: **Directors no longer on LRE Board:** Peg Driesenga, John Snider, Matt Fenske, Shaun Raleigh, Jacquie Johnson, Steven Gilbert, Dawn Rodgers-DeFouw		
Date the Governing Body approved the annual QAPIP (prior SFY QAPIP evaluation, current SFY QAPIP description, and current SFY QAPIP work plan)*		
Date:		
Dates the Governing Body received routine written reports from the QAPIP (during the prior SFY; add additional rows as needed)*		
Date:		
Date:		
Date:		
Date:		
MDHHS Feedback		

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

XX. ACRONYMS

BBA – Balanced Budget Act

BTC – Behavior Treatment Committee

BTP – Behavior Treatment Plan

CAP – Corrective Action Plan

CAFAS – Child and Adolescent Functional Assessment Scale

CEO – Chief Executive Officer

CIRE – Critical Incidents & Risk Events

CQO – Chief Quality Officer

CMHSP – Community Mental Health Service Provider

CMS – Centers for Medicare and Medicaid Services

COO – Chief Operations Officer

CPG – Clinical Practice Guideline

CRM – Customer Relationship Management

CS – Customer Satisfaction

EQR– External Quality Review / External Quality Review Organization

HSAG – Health Services Advisory Group (External Quality Review Organization contracted by MDHHS to conduct annual reviews of each PIHP)

HCBS – Home and Community-Based Services

HIPAA – Health Insurance Portability and Accountability Act

HMP – Healthy Michigan Plan

ICO – Integrated Care Organization

I/DD – Intellectual/Developmental Disability

IPOS – Individual Plan of Service

KPI – Key Performance Indicator

LOCUS – Level of Care Utilization System

LTSS – Long-Term Services and Supports

LRE – Lakeshore Regional Entity

MDHHS – Michigan Department of Health and Human Services

MHL – MI Health Link Demonstration Program

MHP – Medicaid Health Plan

MI – Mental Illness

MMBPIS – Michigan Mission Based Performance Indicator System

PCP – Person-Centered Planning

PIHP – Prepaid Inpatient Health Plan

PIP – Performance Improvement Project

QAPIP – Quality Assessment and Performance Improvement Plan

QIC – Quality Improvement Council

QI – Quality Improvement

ROAT – Regional Operations Advisory Team

Survey – Customer Satisfaction Survey

UM – Utilization Management

LAKESHORE REGIONAL ENTITY

Exhibit A
ORGANIZATIONAL CHART

CEO
Mary Marlatt Dumas

Medical Director
Richard Tooker, MD

Executive Assistant
Marion Dyga

Chief Financial Officer
Stacia Chick

Chief Operations Officer
Stephanie VanDerKooi

Chief Compliance / Privacy Officer
George Motakis

Chief Information / HIPAA Security Officer
Ione Myers

Chief Quality Officer
Wendi Price

Finance Manager
Maxine Coleman

SUD Treatment Manager
Amanda Tarantowski

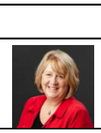
Executive Assistant - Operations
Patricia Genesky

Customer Services Manager
Michelle Anguiano

Senior Analyst/ DBA
Brian DeYoung

Quality Improvement & Performance Specialist
Jeff Rozema

Medicaid Events Verification Specialist
Jill Osterhout



Finance Assistant
Susan Dennison

SUD Prevention Manager
Amy Embury

Administrative Assistant
Greg Opsommer

UM/Clinical Manager
Elizabeth Totten

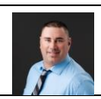
Data Analytics Developer
James Morse

Quality Improvement & Performance Specialist
Kathy Curtiss Newell

Transitioning Quality Manager
Deb Fiedler

Finance Analyst
Kenyetta Brewer

Provider Network Manager
Jim McCormick



Veteran Navigator
Eric Miller

Utilization Management Coordinator
Tom Rocheleau

Data Analytics Developer
Jordan Siemon

Quality Improvement & Performance Specialist
Melissa Westerhof

HCBS Manager
Lorna Dawson

Finance Analyst
Wesley Woods

Provider Network Manager
Don Avery

Credentialing Specialist
Pam Bronson

Waiver Quality Analyst
Melanie Misiuk

Data Submissions Coordinator
Kris Jefferies

Quality Improvement & Performance Specialist
Jackie Schut

Behavioral Health Facilities Reviewer
Jodi Wiate

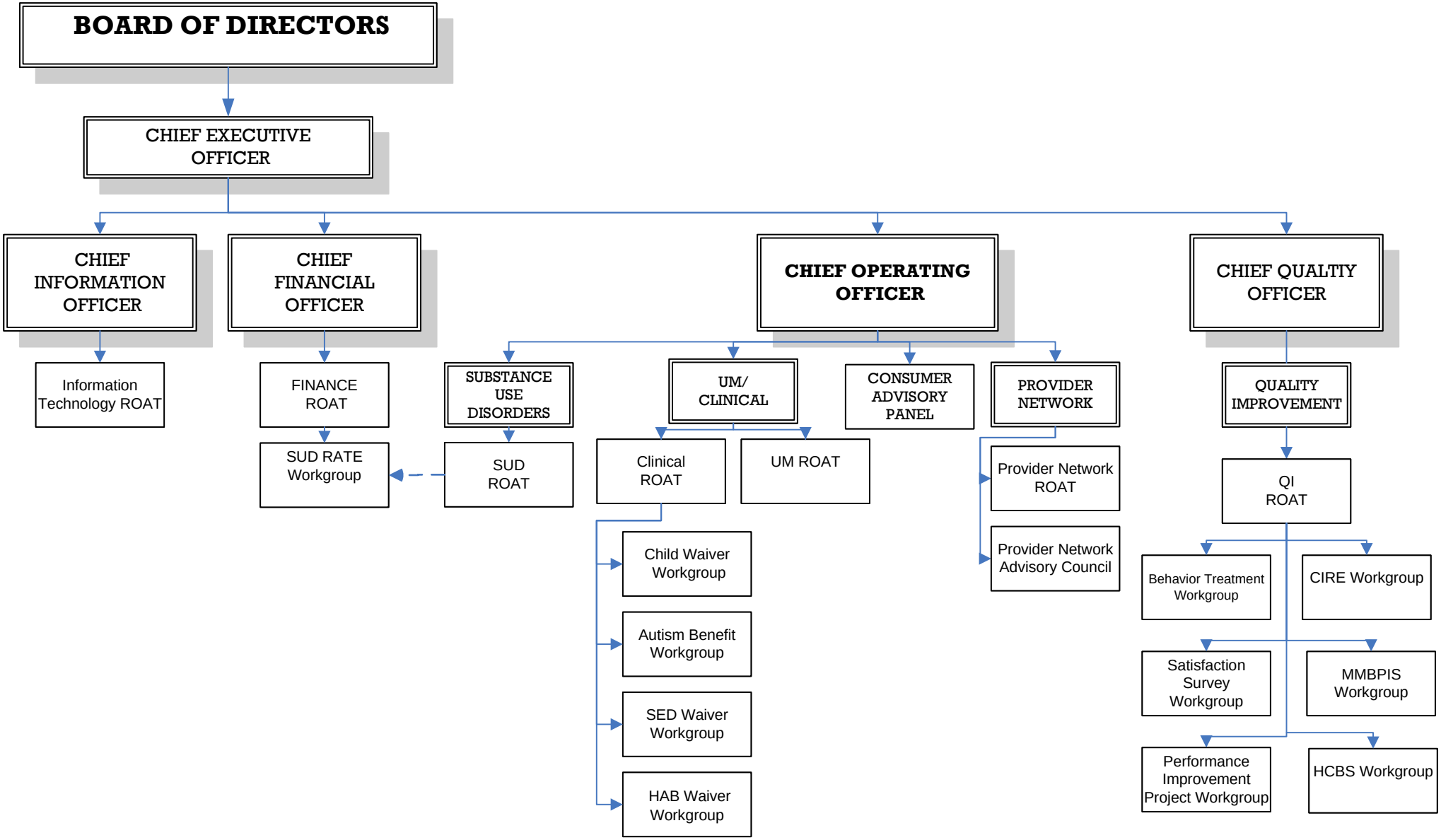
Autism Manager
Justin Persoon

HSW/WSA Specialist
Kim Keglovitz

Customer Services Specialist
Mari Hesselink

Autism and Waiver Specialist
Stewart Mills

ROAT STRUCTURE



The Plan-Do-Study-Act (PDSA) process is a problem-solving approach commonly used in quality control efforts. It is oftentimes referred to as the Deming Cycle. There are four steps to the process and the process can be repeated indefinitely until the desired outcome is achieved:

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

2. ***Do:*** implement the plan and measure its performance

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

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

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

FY22 QAPIP Annual Effectiveness Review

Prepared by LRE Chief Quality Officer: February 10, 2023
Reviewed by LRE Executive Team: February 16, 2023
Reviewed by LRE Board of Directors: March 22, 2023*
Submitted to MDHHS: February 27, 2023

*Due to inclement weather, LRE's Board of Directors did not meet in February 2023.

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I. INTRODUCTION

Lakeshore Regional Entity ("LRE") is a regional entity under Section 1204(b) of the Michigan Mental Health Code and responsible for the financial and administrative management of Behavioral Health, Mental Health and Substance Use Disorder Services for adults and children who reside in one of our seven (7) county areas: Kent, Muskegon, Ottawa, Oceana, Lake, Mason, and Allegan.

This document fulfills the evaluation requirement for the annual QAPIP ("Quality Assessment and Performance Improvement Program") as set forth in the PIHP/MDHHS Medicaid Managed Specialty Supports and Services Program Contract Attachment and the MDHHS Policy - QAPIP for Specialty Prepaid Inpatient Health Plans.[1]

II. PURPOSE

In addition to meeting contractual requirements, the Fiscal Year 2022 Annual QAPIP Review evaluates LRE's performance on each QAPIP component ensuring that LRE is monitoring all QAPIP components as well as deploying Quality Improvement ("QI") Processes when performance improvement is required.

Specifically, LRE monitors and evaluates each the following QAPIP components, at a minimum:

1. Michigan Mission Based Performance Indicator System ("MMBPIS")
2. Performance Improvement Projects ("PIPs")
3. Critical Incidents ("CI")
4. Risk Events ("RE")
5. Sentinel Events ("SE")
6. Unexpected Deaths ("UD")
7. Immediate Event Notifications
8. Behavior Treatment Reviews
9. Consumer Experience Assessment
10. Clinical Practice Guidelines ("CPGs")
11. Credentialing
12. Staff Training and Development
13. Medicaid Services Verification ("MEV")
14. Utilization Management ("UM")
15. Oversight of Provider Network
16. Long Term Services and Supports ("LTSS")

LRE's Annual FY22 QAPIP Review will discuss each component one at a time.

[1] MDHHS, BH and DD Administration, Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans (michigan.gov).

III. PERFORMANCE INDICATORS

A. Michigan Mission Based Performance Indicator System

Michigan Department of Health and Human Services ("MDHHS") mandates compliance with established measures related to access, efficiency, and outcomes. MDHHS' established measures are known as the Michigan Mission Based Performance Indicator System ("MMBPIS").

LRE MMBPIS data to MDHHS quarterly, which consist of the following 20 metrics, also known as indicators:

	MMBPIS INDICATORS		
Indicator #	***Description***	***Threshold***	***Populations***
Indicator 1	Percentage Who Received a Prescreen within 3 Hours of Request	≥ 95%	Child/Adult
Indicator 2a	Percentage of New Persons during the Quarter Receiving a Completed Biopsychosocial Assessment within 14 Calendar Days of a Non-emergency Request for Service	None	MI Child/Adult DD Child/Adult Total
Indicator 2e	Percentage of New Persons during the Quarter Receiving a Face-to-Face Service for Treatment or Supports within 14 Calendar Days of a Non-emergency Request for Service for Persons with Substance Use Disorders	None	SUD
Indicator 3	Percentage of New Persons During the Quarter Starting any Medically Necessary On-going Covered Service within 14 days of Completing a Non-emergent Biopsychosocial Assessment	None	MI Child/Adult DD Child/Adult Total
Indicator 4a	Follow-Up within 7 Days of Discharge from a Psychiatric Unit	≥ 95%	Child/Adult
Indicator 4b	Follow-Up within 7 Days of Discharge from a from a SUD Detox Unit	≥ 95%	SUD
Indicator 5	% of Area Medicaid Having Received PIHP Managed Services	None	All
Indicator 6	% of HSW Enrollees in Quarter who Received at Least 1 HSW Service Each Month other than Support Coordination	None	All
Indicator 10	Re-admission to Psychiatric Unit within 30 Days	≤ 15%	Child/Adult

LRE's FY22 MMBPIS Goal is to meet or exceed all MMBPIS Indicators for which MDHHS has established a threshold. On April 1, 2020, MDHHS eliminated thresholds for Indicators #2 and #3. For Indicators #2 and #3, LRE trends the data ensuring that any decline in performance is analyzed and discussed during QI ROAT to understand the root cause for any decline in performance and determine improvement opportunities.

In aggregate for FY22, LRE met or exceeded its goal for all MMBPIS Indicators with established thresholds, except for Indicator 4a for children, which returned a compliance rate of 93.2%, 1.8% below the established threshold (Attachment A).

Indicator #	Indicator Description	Population Group	# Quarters MDHHS Standards Met	% of Quarters MDHHS Standards Met	LRE Annual Average Score Per Indicator
1	**Pre-admission Screening Disposition 3 hours or less**	Child	4 out of 4	100%	99.0%
		Adult	4 out of 4	100%	98.4%
2	**Request to Assessment within 14 days** *Note: In April 2020, MDHHS revised this indicator and no longer allows exceptions. 95% Standard removed.*	MI Child			66.2%
		MI Adult			64.1%
		DD Child			71.2%
		DD Adult			53.2%
		LRE Total			64.7%
3	**Assessment to Start of Ongoing Services within 14 days** *Note: In April 2020, MDHHS revised this indicator and no longer allows exceptions. 95% Standard removed.*	MI Child			63.2%
		MI Adult			63.6%
		DD Child			69.4%
		DD Adult			69.9%
		LRE Total			64.5%
4a	**Follow-up Within 7 Days of Inpatient Discharge**	Children	1 out of 4	25%	93.2%
		Adults	4 out of 4	100%	95.9%
4b	**Follow-up Within 7 Days of SUD Discharge**	SUD	3 out of 4	75%	97.3%
10	**Inpatient Recidivism**	Children	3 out of 4	75%	10.8%
		Adults	4 out of 4	100%	9.6%

Table 1. LRE FY22 MMBPIS Performance

On a quarterly basis, LRE met or exceeded the established thresholds 82.1% of the time, which is down from FY21 and on par with FY19 and FY20.

LRE FY22 MMBPIS Performance Indicators 1, 4a, 4b, 10				
	FY19	**FY20**	**FY21**	**FY22**
# of Indicators Met	56/76	46/52	28/28	23/28
% of Indicators Met	**73.6%**	**88.5%**	**100%**	**82.1%**

Table 2. LRE Longitudinal Trend – Indicators 1, 4a, 4b, & 10

1. Indicators 1, 4a, 4b, and 10

LRE analyzed the data for the three Indicators that fell below the established thresholds for any given quarter in FY22 and determined the following:

1. *Indicator 4a for Children.* LRE fell below the 95% threshold for three out of four quarters (Q2 92.1%, Q3 89.1%, Q4 93.3%) with 14 out of 162 cases being out of compliance for these quarters. LRE determined that the out of compliance cases were due to Staff Canceling (1), Lack of Staff/Wait List (9), Failure to Schedule Timely (4). Staffing concerns continue to plague Region 3. For those cases where staff cancelled or staff failed to timely schedule the follow-up appointment, Member CMHSPs, as part of the corrective action plans, have trained and re-educated staff of the 7-day follow-up appointment requirement.

2. *Indicator 4b.* LRE fell below the 95% threshold for in FY22 Q2, 94.8%, with 5 out of 96 cases being out of compliance during this quarter. LRE determined that the out of compliance cases were due to Failure to Schedule Timely (5). For these cases, Member CMHSPs, as part of the corrective action plans, have trained and re-educated staff of the 14-day follow-up appointment requirement.

3. *Indicator 10 for Children.* LRE rose above the 15% threshold for FY22 Q2, 18.3%, with 11 out of 60 cases being out of compliance count during this quarter. After reviewing each out of compliance case through an arc of treatment lens, LRE determined that for four of these readmissions, parents/guardians either chose not to utilize Member CMHSP services post-discharge (2) or the consumer did not keep the follow-up appointment (2), which was scheduled within the 7-day standard. For the remaining seven cases, LRE assessed that in each case, Member CMHSPs scheduled timely follow-up appointments post-discharge, consumers attended the follow-up appointments, consumers engaged in services, but these consumers did readmit for medical necessity.

2. Indicators 2a and 3

LRE analyzed the data for Indicators 2a and 3, which do not have established thresholds, on an aggregate, annual basis to determine if performance declined over time. *Graph 1.*

LRE determined that over the past four quarters, Indicators 2a and 3 have declined over time and then analyzed the FY22 data for reasons for the decline. *Table 3.*

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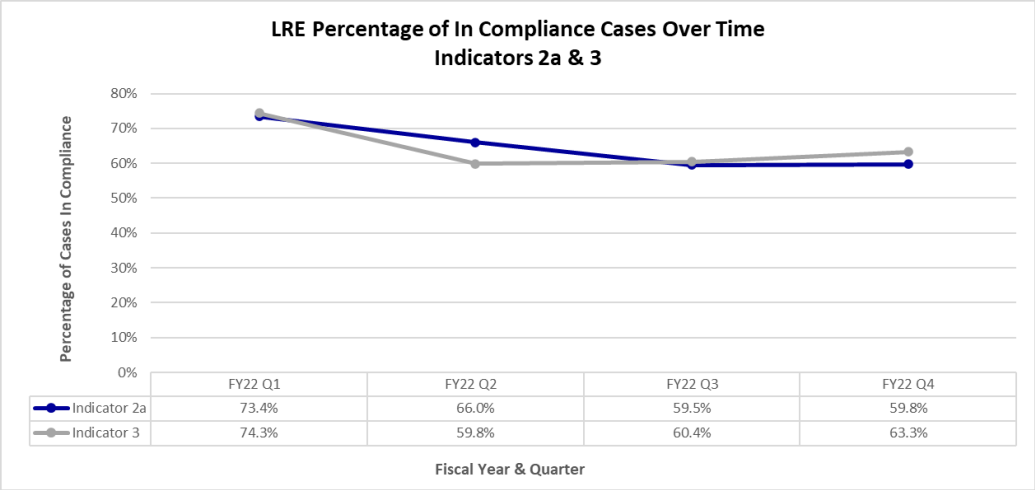


Graph 1. LRE FY22 Trend – Indicators 2a & 3

2a Exception Code	2a Exception Code Description	Count	%
NS	No Show	429	24%
SI	Staff issues or resource shortage	409	23%
CD	Client Choice of Date	166	9%
SY	System Issue	154	9%
RC	Rescheduled by client	150	8%
DI	Documentation Issue - no explanation or missing	127	7%
CC	Client Canceled	100	6%
UR	Unable to reach client to schedule within timeframe	77	4%
OT	Other	50	3%
CX	Cleint Choice not to use CMHSP/PIHP Services	36	2%
RS	Rescheduled by staff	24	1%
CP	Client Choice - agency or therapist	21	1%
NR	Client Not Reachable to schedule ever	17	1%
SC	Staff canceled	17	1%

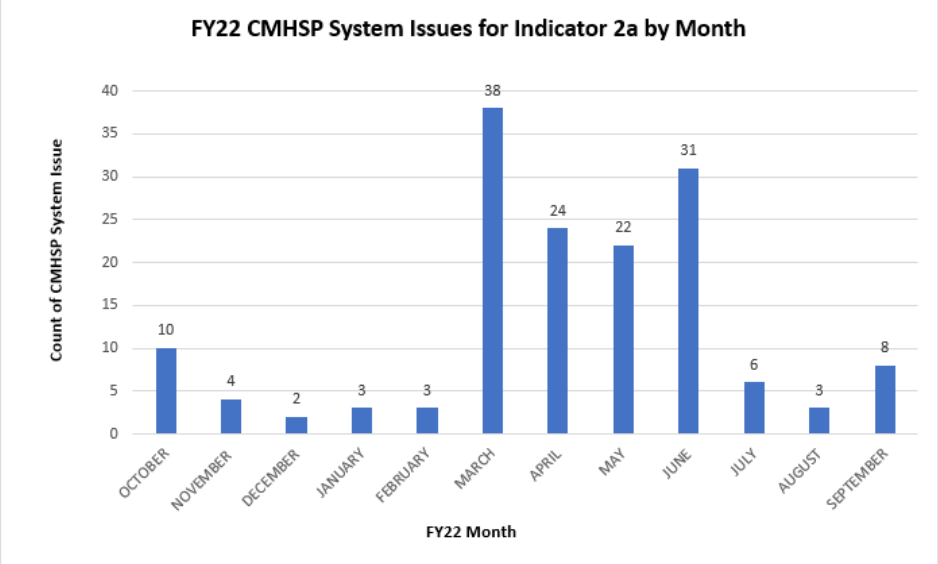
Table 3. Exception Codes for Non-Compliant Cases – Indicator 2a

i. Indicator 2a

LRE attributes the decline in Indicator 2a to two primary codes Consumer Did Not Show Up for Appointment (24%) and Staff Shortages (23%), which contributed greatly, almost 50%, to the overall reason for out of compliance cases for Indicator 2a. LRE's analysis also found that Client's Choice of Appointment Date (9%), CMHSP System Issue (9%), and Appointment Rescheduled by Consumer (8%) contributed another 26% to the out of compliance cases.

The LRE QI ROAT discusses the trending of Indicator 2a data and the out of compliance codes contributing to the decline in the Indicator 2a compliance rate. The LRE QI ROAT bifurcates the out of compliance codes into those that the Member CMHSPs have the ability to influence and those that cannot be included by Member CMHSP intervention.

Based on its review, the QI ROAT agrees that the single out of compliance code that can be influenced by Member CMHSP intervention is the CMHSP System Issue. Further investigation into this code found that a single Member CMHSP's contributed primarily to the out of compliance cases for Indicator 2a due to the fact that the Member CMHSP's implemented a new electronic medical record ("EMR"). LRE can confirm that over time, as the Member CMHSP finalized its implementation of its new EMR, the impact of the CMHSP System Issue code on out of compliance cases for Indicator 2a have lessened. *Graph 2.*



Graph 2. Impact of CMHSP System Issue - Indicator 2a

ii. Indicator 3

LRE attributes the decline in Indicator 3 to three primary codes Staff Shortages (27%), Consumer Did Not Show Up for Appointment (20%), and Documentation Issues – no explanation or missing (10%), which contributed greatly, almost 60%, to the overall reason for out of compliance cases for Indicator 3. Table 4. LRE's analysis also found that Client's Choice of Appointment Date (9%) also contributed to the out of compliance cases.

As with Indicator 2a, the LRE QI ROAT discusses the trending of Indicator 3 data and the out of compliance codes contributing to the decline in the Indicator 3 compliance rate.

Based on its review, the QI ROAT agrees that the single out of compliance code that can be influenced by Member CMHSP intervention is the Documentation Issue. LRE found that the majority of documentation issues are generated by three Member CMHSPs. LRE monitors quarterly MMBPIS submissions for improvement in Documentation Issues.

3 Exception Code	3 Exception Code Description	Count	%
SI	Staff issues or resource shortage	381	27%
NS	No Show	274	20%
DI	Documentation Issue - no explanation or missing	143	10%
CD	Client Choice of Date	125	9%
SY	System Issue	83	6%
RC	Rescheduled by client	82	6%
UR	Unable to reach client to schedule within timeframe	80	6%
CC	Client Canceled	78	6%
CX	Client Choice not to use CMHSP/PIHP Services	36	3%
NR	Client Not Reachable to schedule ever.	34	2%
OT	Other	32	2%
RS	Rescheduled by staff	18	1%
SC	Staff canceled	18	1%
CP	Client Choice - agency or therapist	10	1%
CT	Client Canceled - due to Transportation	1	0%

Table 4. Exception Codes for Non-Compliant Cases – Indicator 3

LRE. in collaboration with its Member CMHSPs. work diligently to find solutions to staff shortages and will continue to do so in Fiscal Year 2023.

LRE partially achieved its FY22 MMBPIS Goal.

IV. PERFORMANCE IMPROVEMENT PROJECTS

LRE conducts performance improvement projects ("PIPs") that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and individual satisfaction.

LRE is required to conduct at least two PIPs each fiscal year. One of the two PIPs is mandated by MDHHS and is reviewed and evaluated by HSAG for compliance with the PIP requirements. The second PIP may be of LRE's choosing and must be submitted to MDHHS along with the QAPIP.

LRE's FY22 Performance Improvement Projects Goal to identify two PIPs that meet MDHHS' expectation for the next 3 years. For Fiscal Year 2023, LRE is conducting two PIPs centered on improving the HEDIS® Follow-up After Hospitalization. (Attachments B & C). LRE's research suggests that an increase in the FUH metric can improve outcomes, decrease suicides, decrease recidivism, and increase satisfaction.

A. FUH Metric: Improve FUH Data Distribution, Submission, and Tracking

After transitioning Managed Care Functions from Beacon Health Options back to LRE in June 2022, LRE determined it was necessary to standardize the process for distributing FUH data to the Medicaid Health Plans, submitting FUH data to MDHHS, and following up with consumers

within the FUH population.

LRE created a cross-functional FUH Workgroup that includes Provider Network Management, Information Technology, Utilization Management, and all Member CMHSPs to develop the technical requirements for reporting tools and processes/procedures to improve timeliness for FUH. Currently, LRE's FUH reporting process is highly manual.

To date, the FUH Workgroup has developed an error report that LRE runs and reviews weekly with feedback distributed to Member CMHSPs, if applicable. The FUH Workgroup is also standardizing procedures for complex FUH reporting issues such as when Member CMHSPs do not receive discharge paperwork in a timely manner from the in-patient facility, which can be 2-3 days.

The FUH Workgroup meets weekly and has developed an FUH Roadmap that guides activities and produces intentional planning by all FUH Workgroup members.

B. FUH Metric: Decrease in Racial Disparity between African Americans/Blacks and Whites

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

LRE created a PowerBI Dashboard that utilizes Region 3's FUH data and applies filters that allow LRE to monitor FUH with and without a race/ethnicity lens by Member CMHSP. LRE continues to monitor FUH metrics while the FUH Workgroup solidifies a standardized process for Member CMHSP reporting to the LRE and the distribution of data to MHPs.

LRE continues developing interventions for deployment across Region 3 during the first measurement period, which runs from January 1, 2023 to December 31, 2023.

LRE has achieved its FY22 PIP Goal.

V. EVENT REPORTING AND NOTIFICATIONS

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

policies and procedures. LRE reports critical incidents, risk events, sentinel events, unexpected deaths, and immediately reportable events in accordance with MDHHS contractual requirements.

LRE's FY22 Event Reporting and Notifications Goal is to report all critical incidents, sentinel events, and unexpected deaths to MDHHS in a timely and accurate manner, meaning meeting contractual requirements. LRE has achieved its FY22 goal through timely and accurate reporting of its critical incidents to MDHHS for the entirety of Fiscal Year 2022. LRE developed a tool used to monitor Member CMHSP timeliness of reporting sentinel events and unexpected deaths to LRE. This tool, along with training, has improved timeliness and review standards as LRE entered FY23.

Midway through FY22, as a result of MDHHS' implementation of its Customer Relationship Management ("CRM") platform, LRE established a secondary goal to develop a comprehensive Critical Incident and Risk Event reporting module in collaboration with PCE Systems, LRE's EMR vendor, that interfaces with MDHHS' CRM. It should be noted that LRE has utilized MDHHS' CRM when reporting FY23 Q1 critical incidents, sentinel events, and unexpected deaths, albeit through manual entry.

Beginning October 1, 2022, MDHHS requires all critical incidents, sentinel events, and unexpected deaths be reported via MDHHS' CRM, which interfaces with PCE Systems for data transfer. LRE does not utilize PCE Systems for its Critical Incident reporting because the PCE Systems is not programmed to manage Risk Event data along side the Critical Incident data. LRE has commissioned PCE Systems to enhance its Critical Incident module to include the ability to handle Risk Event data seamlessly. When PCE Systems completes the necessary programming, LRE will test it to ensure it meets LRE's technical requirements. Since LRE does not currently utilize PCE Systems for Critical Incident reporting, LRE hand-entered the FY23 Q1 critical incidents, sentinel events, and unexpected deaths into MDHHS' CRM. While a laborious process, LRE identified opportunities for enhancements to MDHHS' CRM and shared these enhancements with MDHHS during a collaboration meeting. LRE is well on its way of reaching its goal of developing a comprehensive Critical Incident and Risk Event reporting module.

A. Critical Incidents

For FY22, LRE experienced a total of 365 critical incidents, which is a decrease of 26 compared to FY21. (Attachment D). During FY22, LRE reviewed and discussed Critical Incidents with QI ROAT quarterly.

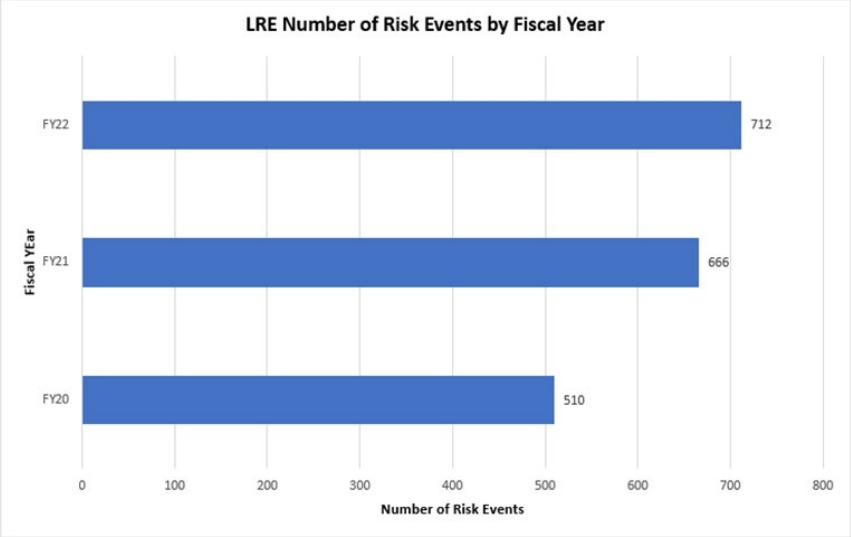
LRE analyzed the critical incident data and determined the following when comparing FY22 to FY21:

1. Suicides increased by 5 to a total of 13.
    a. Member CMHSPs experienced the following suicide counts:
        i. HealthWest: 2
        ii. OnPoint: 1
        iii. Ottawa: 1
        iv. Network 180: 4
        v. West Michigan: 4
2. Accidental Deaths decreased from 22 to 18.
3. Homicides increased to 1.
4. Injuries Requiring Emergency Medical Treatment increased by 3 to 183.
5. Medication Errors Requiring Emergency Medical Treatment decreased from 5 to 3.
6. Injuries Requiring Hospitalization decreased from 12 to 8.
7. Medication Errors Requiring Hospitalization remained unchanged at 1.
8. Arrests increased by 6 to 23.

In considering residential treatment providers in its Critical Incident analysis, LRE determined that for those incidents for which it has provider specific data no provider trends could be derived from the data.

B. Risk Events

For FY22, LRE experienced a total of 712 risk events, which is an increase of 46 compared to FY21. (Attachment E). LRE has experienced an increase in risk events for three years in a row. Graph 3.



Graph 3. LRE Longitudinal Trend – Risk Events

LRE analyzed the risk event data and determined the following when comparing FY22 to FY21:

1. Self Harm decreased by 4 to a total of 79.
2. Harm to Others decreased from 14 to 10.
3. Emergency Use of Physical Management increased by 54 to 394.
4. Police Calls by Staff Under Certain Circumstances decreased from 188 to 164.
5. Two or More Unscheduled Admissions to a Hospital within a 12-month Period increased by 30 to 68.

During FY22, LRE reviewed Risk Events with QI ROAT quarterly and specifically discussed the rationale for the increase in risk events for three straight fiscal years. Based on LRE's analysis and the QI ROAT's review and discussion, LRE determine that a single Member CMHSP primarily contributed to the increase in Risk Events for FY22 and the Member CMHSP acknowledged that the increase in the Emergency Use of Physical Management and Police Calls by Staff Under Certain Circumstances were related to one consumer. That specific Member CMHSP has developed protocols to reduce these two Risk Events for the one consumer.

C. Sentinel Events and Unexpected Deaths

In FY22, LRE experienced 40 Sentinel Events and Unexpected Deaths. Upon analysis, LRE determined that the three categories dominating the Region's Unexpected Deaths relate to 1) Overdose resulting in Accidental Death (28%), 2) Accidental (20%), and 3) Suicide (20%). Table 5. LRE also determined that the most vulnerable population serviced as it relates to Sentinel Events and Unexpected Deaths is the Mentally Ill Adult population (50%). Table 6.

LRE FY22 Sentinel Event & Unexpected Death by Category

Category	Count	%
Overdose Resulting in Accidental Death	11	28%
Accidental	8	20%
Suicide	8	20%
Potential Sentinel Event	3	8%
Other Sentinel Event	3	8%
Medication Error	2	5%
Choking	1	3%
Fall	1	3%
Vehicle Accident	1	3%
Homicide	1	3%
Fall	1	3%
Grand Total	**40**	

Table 5. LRE FY22 SE|UD by Category

LRE FY22 Sentinel Event & Unexpected Death by Population

Population	Count of	%
MIA	20	50%
SUD	5	13%
IDD	4	10%
MIA/SUD	4	10%
DDA	2	5%
DDA/Hab	2	5%
IDD/DDA	2	5%
None	1	3%
Grand Total	**40**	

Table 6. LRE FY22 SE|UD by Population

In FY22, LRE also reviewed the Sentinel Events|Unexpected Deaths timeliness and reporting standards and evaluated its Member CMHSP performance related to these standards. LRE developed a Sentinel Events|Unexpected Deaths timeliness reporting tool, revised its Sentinel Events|Unexpected Deaths reporting template, and created a Regional training on Critical Incidents, Risk Events, Sentinel Events, and Unexpected Deaths. (Attachment F). LRE also

revised its Mortality Report. One weakness of the Mortality Report is the lag time in requesting and receiving a death determination. LRE anticipates MDHHS' CRM platform will assist Region 3 in having better visibility to Sentinel Events and Unexpected Deaths in FY23.

LRE has achieved its FY22 Event Reporting and Notifications Goal.

VI. BEHAVIOR TREATMENT REVIEW

LRE's FY22 Behavior Treatment Review Goal is to monitor and analyze Behavior Treatment Review ("BTR") data to ensure consumers with behavior treatment plans ("BTPs") are provided effective BTPs that gives each consumer the opportunity to maximum outcomes while minimizing barriers.

In FY22, LRE determined that its Member CMHSPs conducted 781 BTRs for an average of 150 consumers with the vast majority of these reviews relating to 1) Harm to Self (36%), 2) Harm to Others (35%), and 3) Property Damage (19%).

LRE conducts quarterly reviews with the Behavior Treatment Workgroup. Member CMHSPs are reporting Progressing or Stable status for 54% of consumers with BTPs and Regression or No Change for 22% for the same population. Table 7.

Effectiveness of Behavior Treatment Plan	Count	%
Stable	268	34%
Progress	152	20%
New Request	145	19%
Regression	83	11%
No Change	83	11%
Improperly Implemented	29	4%
Not Implemented	19	2%

Table 7. FY22 LRE – Effectiveness of Behavior Treatment Plans

Member CMHSPs are also reporting that each Member CMHSP's Behavior Treatment Review Committee is recommending continuation of existing BTPs almost 90% of the time with only 4% of BTPs being recommended for updates. Table 8.

LRE interprets the BTP data such that the Member CMHSPs are developing effective BTPs that reduce barriers and place consumers in positions to realize positive outcomes.

Recommendations for Behavior Treatment Plans	Count	%
Continued	689	88%
New Plan Approved	39	5%
Update Approved	30	4%
Discontinued	11	1%
Interim Plan Approved	6	1%
Continued with Recommendations	4	1%
New Plan with Recommendations	2	0%
No Plan	2	0%
Interim Plan Approved with Recommendations	0	0%
New Plan Not Approved	0	0%

Table 8. FY22 LRE – Recommendations for Behavior Treatment Plans

LRE has achieved its FY22 Behavior Treatment Reviews Goal.

VII. CUSTOMER SATISFACTION ASSESSMENT

LRE's FY22 Customer Satisfaction Assessment Goal was to deploy the Regional Customer Satisfaction Survey ("Survey"), which was revised in FY21 according to recommendations received from Health Services Advisory Group ("HSAG"), and create in PowerBI Dashboard to maximize data analysis and transparency. Attachment G.

In FY22, LRE's Member CMHSPs received 1,917 complete Surveys for all services types, populations, and races/ethnicities. Of the 1,917 completed Surveys, 1,495 Surveys were for 30 identified providers and 422 completed Surveys did not identify the provider by name.

The results for LRE's FY22 Survey, which is based on a scale of 1 to 6 with 6 being "Strongly Agree," are as follows:

Member CMHSP	FY22 Overall Survey Score
HealthWest	n/a
OnPoint	5.1
Ottawa	5.2
Network 180	5.3
West Michigan	5.0
LRE	***5.3***

Table 9. FY22 LRE – Survey Results

Based on the Survey results, LRE determined the following related to consumers' satisfaction levels for:

a. *Access and Availability.* Consumers agree that service locations and hours promote access and availability of services (5.3). Consumers mildly agree that the services being offered are what they need/want (3.9).

2. *Quality of Services.* Consumers agree that they feel included in the Person Centered

Planning ("PCP") process as well as supported and accepted by staff (5.2 ➔ 5.4)

3. *Long Term Services.* Consumers agree that they are satisfied with case management services (4.8). Consumer mildly agree that they are satisfied with their current housing situation (4.4).
4. *Experience with Telehealth.* Consumers mildly disagree that their telehealth experiences were satisfactory (3.4).
5. *Outcomes.* Consumers agree that their services helped them and that they are satisfied with their services (5.3).

Generally, consumers appear satisfied with the access to services, quality of services, and service outcomes. LRE admits that consumers appear less than satisfied with their telehealth experiences, current housing situations, and choices of services. LRE will continue to gather, monitor, and analyze Survey measures in FY23 to see if these less than satisfied Survey measures repeat for FY23.

LRE has achieved its FY22 Customer Satisfaction Assessment Goal.

VIII. CLINICAL PRACTICE GUIDELINES

LRE supports the use of Clinical Practice Guidelines ("CPGs") in service provision. CPGs are available to assist practitioners and members in making decisions about appropriate health care for specific clinical circumstances. LRE endorses CPGs that have been adopted by the American Psychiatric Association. LRE adopted the American Psychiatric Association CPGs in concert with Member CMHSPs through the Clinical ROAT and Utilization Management ROAT. LRE disseminates the CPGs via LRE and CMHSP websites, LRE newsletter, and ROAT reviews and education.

LRE's FY22 Clinical Practice Guidelines Goal was to develop an Inter-Rater Reliability process between LRE and its Member CMHSPs to ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. LRE in collaboration with its Member CMHSPs approved an Inter-Rater Reliability Process.

LRE monitors the use of established guidelines as part of its Member CMHSP Site Reviews.

LRE has achieved its FY22 Clinical Practice Guidelines Goal.

IX. CREDENTIALING

LRE ensures that services and supports are consistently provided by staff (contracted or directly operated) who are properly and currently credentialed, licensed, and qualified.

LRE's FY22 Credentialing Goal was to develop a process for tracking and reporting Credentialing findings. Due to MDHHS' implementation of a Universal Credentialing System, LRE revised

its original FY22 Credentialing Goal to successfully implement the Universal Credentialing System in Region 3.

LRE has worked diligently as part of the MDHHS Universal Credentialing Workgroup by attending all meetings, contributing during meetings, and disseminating information from the meetings to LRE and Member CMHSP staff in an effort to support a seamless transition starting in FY23.

Through the FY22 Audit, HSAG identified two improvements necessary to ensure the highest quality of care and services for consumers. HSAG recommended that LRE 1) integrate quality measures into its recredentialing process and 2) ensure credentialing/recredentialing proofs were primary source verified.

LRE has embarked on developing a Master Provider Database for Region 3 providers which will support incorporating quality measures into its recredentialing process. Quality measures may include the extent an organization or a practitioner has been grieved, has received a less than desired Survey score, has fallen below performance indicator thresholds, which could include CMHSP Site Review results for clinical and credentialing audits, or has experienced a rise in critical incident or sentinel events. Prior to being able to implement such quality measures into the recredentialing process, LRE requires reprogramming of its EMR. Currently, LRE is developing the technical requirements for such reprogramming.

LRE has changed its process for verifying credentialing/recredentialing proofs and now only accepts primary source verified documents.

In FY22, LRE and its Member CMHSPs credentialed 337 providers and recredentialed 201 providers.

Provider Type	Initial Credentialing	Recredentialing
Organization	104	72
Individual	233	138

Table 10. FY22 LRE – Credentialing Efforts

LRE has achieved its FY22 Credentialing Goal.

X. MEDICAID SERVICES VERIFICATION

LRE's FY22 Medicaid Services Verification Goal was to develop and implement a revised Medicaid Verification Process that comports with MDHHS Medicaid Services Verification technical requirements.[2]

[2] MDHHS Medicaid Verification Process Policy, Behavioral Health and Developmental Disabilities Administration, Medicaid Services Verification (michigan.gov), Section V. Reporting, p. 3, revised July 29, 2020.

LRE established and published a written policy for monitoring and evaluating the claims/encounters submitted by its Provider Network for Medicaid and Healthy Michigan Plan recipients ensuring compliance with federal and state regulations as well as the MDHHS Medicaid Services Verification technical requirements.

A. Non-SUD Services

During Fiscal Year 2022, LRE performed Medicaid Services Verification audits on 7,186 non-SUD claims/encounters totaling $1,474,378.90 Medicaid dollars. LRE determined that $6,301.78, or 0.43%, was subject to recoupment.

Audit Period	*Total Medicaid Dollars*	*Amount Recouped*	*% Recoupment*
FY 22 Quarter 1	$670,348.10	$318.07	0.05%
FY 22 Quarter 2	$460,237.88	$4,748.68	1.03%
FY 22 Quarter 3	$273,021.00	$1,062.59	0.39%
FY 22 Quarter 4	$343,519.90	$172.44	0.05%
Total	**$1,474,378.90**	**$6,301.78**	**0.43%**

For Fiscal Year 2022, LRE's Medicaid Services Verification audit efforts encompassed 7,186 claims/encounters across 30 different service types, 1,565 consumers, and five distinct population groups for 80 unique providers.

In Fiscal Year 2022, LRE's Medicaid Services Verification audits found all CMHSPs/providers to be in substantial compliance with federal and state regulations. Therefore, LRE did not put any CMHSP/providers on corrective action plans. Because LRE does not currently have any CMHSPs/providers on Medicaid Services Verification corrective action plans, LRE did not take any providers off corrective action plans nor did LRE cite any provider for repeat/continuing issues.

In Fiscal Year 2022, Region 3 providers performed well during the LRE Medicaid Services Verification audits. Overall, LRE audited a total of 7,186 claims/encounters and found a total of 39 non-compliant claims/encounter. Of these 39 claims/encounters, the following issues were found:

REASON FOR NON-COMPLIANCE	*COUNT*	*CAUSE*	*OUTCOME*
Claim/Encounter was Double Billed	16	CMHSP Implemented New EMR/Billing Process	Recoupment
Insufficient Documentation	7		Recoupment
Missing Documentation	12	Documentation found in 8 of 12 cases	Recoupment of 4
Services not in IPOS	4	Crisis Services	Recoupment

One CMHSP mistakenly double billed 15 claims/encounters, which were immediately recouped. The CMHSP stated that the double billing was attributed to the implementation of a new EMR and billing process that has since been resolved with the EMR vendor.

LRE recouped all funds related to the seven (7) claims/encounters where documentation was insufficient to support the claim/encounter. For the 12 claims/encounters where no documentation could be located, CMHSPs/Providers were able to locate missing documentation that supported the service in eight (8) of the 12 claims/encounters; LRE recouped funds for four (4) remaining claims/encounters. Finally, LRE recouped funds for the four (4) claims/encounters where the services provided were not included in the IPOSs.

B. SUD Services

During Fiscal Year 2022, LRE performed Medicaid Services Verification audits on 159 SUD claims/encounters totaling $21,990.80 Medicaid dollars. LRE determined that $38.50, or 0.18%, was subject to recoupment.

Audit Period	*Total Medicaid Dollars*	*Amount Recouped*	*% Recoupment*
FY 22 Oct 2021 - Jun 2022	$21,990.80	$38.50	0.18%
Total	**$21,990.80**	**$38.50**	**0.18%**

For Fiscal Year 2022, LRE's Medicaid Services Verification audit efforts for SUD Services encompassed 159 claims/encounters across 15 different service types, 69 consumers, and two distinct population groups for 23 unique providers.

LRE issued one CAP due to the fact that one SUD Treatment provider stated it could not retrieve clinical documentation due to a "glitch" in its EMR. Prior to FY22, LRE did not have any CMHSPs/providers on Medicaid Services Verification corrective action plans, LRE did not take any providers off corrective action plans nor did LRE cite any provider for repeat/continuing issues.

For FY22, Region 3 SUD providers performed above expectations during the LRE Medicaid Services Verification audits. Overall, LRE audited a total of 159 encounters and found a total of 7 non-compliant claims/encounters. Of these 7 claims/encounters, the following issues were found:

REASON FOR NON-COMPLIANCE	*COUNT*	*CAUSE*	*OUTCOME*
Missing Documentation	5	No Cause Given	Recoupment
Missing Documentation	2	"Glitch" in EMR - CAP issues	Paid by GF

LRE has achieved its FY22 Medicaid Services Verification Goal.

XI. UTILIZATION MANAGEMENT

At the LRE, Utilization Management ("UM") is guided by LRE policy and procedure and an annual UM Plan. UM activities are conducted across the region to assure the appropriate delivery of services. Utilization mechanisms identify and correct under-utilization as well as over-utilization.

LRE's FY22 Utilization Management Goal was to develop PowerBI Dashboards and reports for reviewing and analyzing under and over utilization.

LRE, in collaboration with its Member CMHSP and the FUH Workgroup has developed four Utilization Management PowerBI Dashboards to identify under and over utilization quickly and efficiently: Higher Level of Care ("HLOC"), Level of Care Utilization System ("LOCUS"), Supports Intensity Scale/Community Living Supports ("SIS/CLS"), and Follow-up After Hospitalization for Mental Illness ("FUH"). LRE reviews the reports with the UM and Clinical ROATs monthly ensuring consumers are matched with services and supports that meet their level of care needs thereby providing each consumer the opportunity to overcome barriers and maximize outcomes.

LRE has achieved its FY22 Utilization Management Goal.

XII. OVERSIGHT OF PROVIDER NETWORK

A. CMHSP Site Reviews

LRE maintains oversight of its Provider Network by conducting annual CMHSP Site Reviews that ensure compliance with federal, state, and regional regulations and requirements.

LRE's FY22 CMHSP Site Review Goals were to 1) develop Site Review tools that comport with federal, state, and regional regulations and requirements within LRE's EMR and 2) deploy the new CMHSP Site Review tools and process.

LRE created entirely new Site Review tools in the following categories and deployed them in LRE's EMR:

1. Desk Audits for Administration of Managed Care Functions
2. Program Specific Audits.
3. Clinical Chart Audits.
4. Credentialing Audits.
5. Training Audits.

LRE also continued to conduct validation audits for the following:

1. MMBPIS
2. Critical Incidents
3. Risk Events
4. Medicaid Services Verification
5. Behavior Treatment Plans

During the CMHSP Site Review Process, LRE evaluates the Member CMHSPs' and external providers' compliance in the areas of

1. Federal Regulations, State Requirements, and Regional Policies.
2. Contractual Obligations.
3. Delegated Managed Care Functions.
4. Clinical Documentation Standards.

LRE conducted CMSHP Site Reviews for all five of its Member CMHSPs with the following results:

LRE FY22 CMHSP Site Review: Scores by Member CMHSP					
CMHSP Site Review Audit Type	**HealthWest**	**On Point**	**Ottawa**	**Network 180**	**West Michigan**
Desk Audit. Administration of Managed Care Functions	93.40%	91.90%	97.30%	98.40%	99.00%
Program Specific Standards	96.40%	96.30%	95.90%	98.60%	96.90%
Non-Waiver/Autism Clinical Charts	92.70%	95.10%	95.00%	98.20%	96.60%
Non-Waiver/Non-Autism Staff Training	89.60%	95.10%	99.70%	98.10%	97.10%
Non-Waiver/Non-Autism Staff Credentialing	95.20%	96.40%	95.80%	92.60%	97.70%
Autism Clinical Charts	95.90%	95.10%	90.10%	91.90%	88.40%
Autism Training/HR	91.60%	91.60%	95.50%	96.10%	98.30%
SEDW Clinical Charts	97.40%	89.30%	62.90%	91.00%	90.00%
SEDW Training/HR	79.30%	96.00%	94.60%	96.40%	82.70%
HSW Clinical Charts	88.80%	96.50%	93.90%	95.90%	78.50%
HSW Training/HR	89.20%	78.10%	88.30%	92.00%	88.60%
CWP Clinical Charts	93.80%	92.60%	90.30%	95.60%	81.40%
CWP Training/HR	90.80%	91.20%	86.20%	89.50%	70.70%
MEV Validation	99.50%	100%	99.90%	100%	100%
MMBPIS Validation	99.00%	100%	100%	100%	100%
CIRE Validation	95.50%	100%	95.50%	100%	93.50%
Comprehensive Score	**93.00%**	**93.70%**	**93.90%**	**95.90%**	**94.80%**

Member CMHSPs performed well given the breath and depth of changes to the Site Review tools. Due to the changes of its CMHSP Site Review tools, LRE could not complete a longitudinal trend for CMHSP Site Review performance.

LRE requires CAPs for each element found out of compliance, meaning "Not Met" or "Partially Met." LRE also requires individual and systemic remediation for any Autism and Waiver Clinical Chart and Credentialing Audit elements that required CAPs.

By way of its CMHSP Site Reviews, LRE maintains oversight of its Provider Network by utilizing the Site Review scores to

1. Establish prioritized clinical and non-clinical priority areas for improvement.
2. Analyze the delivery of services and quality of care using a variety of audit tools.
3. Develop performance goals and compare findings with past performance.
4. Provide performance feedback through exit conferences and written reports.
5. Conduct targeted monitoring of consumers defined to be vulnerable by MDHHS.
6. Require improvements from providers via CAPs for areas that do not meet predetermined thresholds or are not compliant with defined standards.

LRE's CMHSP Site Review CAP process ensures improvements to quality of care and reduction of barriers through the CAP process and subsequent remediation validation.

LRE has achieved its FY22 CMHSP Site Review Goal.

B. MDHHS Site Reviews

LRE's FY22 MDHHS Site Review Goal was to actively participate in the Site Review and oversee CAP development and remediation validation. LRE participated in the Site Review and monitored CAP development at the Member CMHSP level. LRE is now working to validate CAP remediation efforts at the Member CMHSP level.

LRE has achieved its FY22 MDHHS Site Review Goal.

C. External Quality Reviews

LRE participates in External Quality Reviews ("EQRs"), which are conducted by Health Services Advisory Group ("HSAG") and required under The Balanced Budget Act of 1997 ("BBA"). Generally, HSAG evaluates the quality and timeliness of, and access to, health care services provided to consumers.

LRE's FY22 HSAG Audit Goals were to 1) integrate Subject Matter Experts ("SMEs") into the preparation of HSAG Compliance Review tools and proofs and 2) perform at least as well as years past.

HSAG conducts its Audit in three parts:

1. Performance Measurements Validation
2. Performance Improvement Projects Validation
3. Compliance Review

1. Performance Measurement Validation

For FY22, HSAG validated LRE's Performance Measurements and found:

1. No concerns with LRE's receipt and processing of eligibility data.
2. No major concerns with how LRE received and processed claim/encounter data for submission to MDHHS.
3. Lakeshore had sufficient oversight of its five affiliated CMHSPs.

HSAG commended LRE on the following strengths:

1. Lakeshore demonstrated appropriate oversight, implementation, and monitoring of CAPs that had been implemented with its CMHSPs throughout the measurement period.
2. Lakeshore deployed significant data quality improvement mechanisms throughout the prior year, investing in a data warehouse and more real-time monitoring of its data through Power BI technology. The PIHP demonstrated strength in its efforts to maintain closer oversight of its data, including CMHSP-reported data, through the use of the new Power BI dashboards, ensuring ongoing monitoring of data completeness and accuracy.

HSAG also noted two opportunities for LRE to improve:

1. While Lakeshore has strong CMHSP oversight processes in place, HSAG observed some individual user error in documentation of system data, which could potentially result in errors in reporting.
2. After reviewing the final BH-TEDS data submitted by MDHHS, HSAG noted 13 Lakeshore member records with discrepant employment and minimum wage BH-TEDS data.

2. Performance Improvement Projects Validation

FY22 is a baseline development year for both of LRE's PIPs.

HSAG approved LRE's race/ethnicity PIP titled FUH Metric: Decrease in Racial Disparity between African Americans/Blacks and Whites. LRE will determine whether targeted interventions result in significant improvement (over time) in the number of members who identify as African American/Black that receive follow-up within 30 days after an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm when compared to those similarly situated members who identify as White, meaning a decrease in the racial disparity between the two measurement groups, during the measurement period, without a decline in performance for the White members.

3. Compliance Review

In July 2022, HSAG conducted it Compliance Review of LRE. LRE's SMEs prepared HSAG tools and proofs.

LRE scored as follows:

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	13	3	0	**81%**
Standard VIII—Confidentiality	11	11	9	2	0	**82%**
Standard IX—Grievance and Appeal Systems	38	38	33	5	0	**87%**
Standard X—Subcontractual Relationships and Delegation	5	5	3	2	0	**60%**
Standard XI—Practice Guidelines	7	7	6	1	0	**86%**
Standard XII—Health Information Systems	12	11	9	2	1	**82%**
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	26	4	0	**87%**
Total	**119**	**118**	**99**	**19**	**1**	**84%**

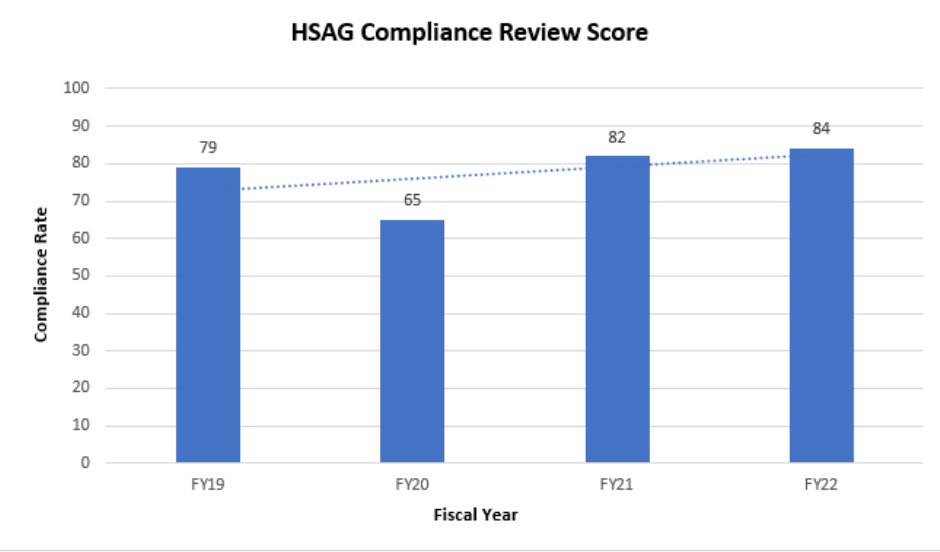
M* = *Met*; *NM* = *Not Met*; *NA* = *Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

While LRE failed to score above an 87% on any given Compliance Review Standard, LRE's FY22 performance surpassed that of the last three years as shown below:



Graph 6: LRE Longitudinal Trend – HSAG Compliance Review Scores

LRE has achieved its FY22 HSAG Goals.

D. Facilities Reviews

LRE also maintains oversight of its Provider Network by conducting annual Facilities Reviews for all contracted, external providers to ensure compliance with the following requirements:

1. General Health and Safety Standards,
2. Emergency Procedures,
3. Medication Reviews,
4. Resident Funds Reviews,
5. Policies and Procedures, and
6. HCBS Final Rule.

LRE's FY22 Facilities Review Goals were to 1) incorporate audit questions regarding the Home and Community Based Services ("HCBS") Final Rule into the Facilities Review tool and 2) and launch Facilities Review tools within LRE's EMR.

LRE revised its Facilities Review tool by incorporating audit questions pertaining to the HCBS Final Rule to mitigate risk to the Provider Network as it relates to Heightened Scrutiny settings. LRE has completed Facilities Reviews for all settings on the HCBS Heightened Scrutiny list as dictated by MDHHS.

In FY22, LRE conducted approximately 225 Facilities Reviews and determined that providers required education and training regarding the HCBS Final Rule. Table

Audit Section	Audit Question	Percent
HCBS	13b. If restrictions affect other members of the home, each resident in the home has documentation of the restriction in the IPOS documenting how they can overcome the restriction	50%
Facility Review	11. Odor-Free	67%
HCBS	6. All bedrooms have appropriate keyed locks (individually keyed, non-locking against egress)	88%
HCBS	12b. If restrictions exist, the individual(s) in the home requiring a restriction has documentation of health/safety rationale in the IPOS.	89%
HCBS	13a. If there are residents with a Behavior Management Plan are the restriction(s) documented in the Behavior Management Plan and are all staff trained?	91%
Health and Safety Review	1. Freezer temperature < 0 degrees	94%
HCBS	3. Home is free from locked gates outside the home.	94%
Health and Safety Review	2. Refrigerator temperature < 40 degrees	95%
HCBS	2. Home is free of Lock/Alarms on exterior doors	95%
Health and Safety Review	11p. Is there a Checklist to monitor bag routinely reviewed (at least quarterly), initialed/dated))	95%

Table 11. LRE FY22 Facilities Reviews

The most common out of compliance element is the lack of documentation in IPOSs for restrictions contrary to the HCBS Final Rule. LRE issued CAPS for all elements found to be out of

compliance. LRE has also developed HCBS trainings and conducted many Region-wide training sessions with Member CMHSP, providers, and clinical staff.

LRE's efforts related to Facilities Reviews ensures consumers are placed in settings that are healthy and safe with minimal barriers, unless a restriction is deemed medically necessary or appropriate.

Where applicable, LRE collaborates with its Member CMHSP and LARA Licensing.

LRE has achieved its FY22 Facilities Review Goal.

XIII. LONG TERM SERVICES AND SUPPORTS

LRE's FY22 Long Term Services and Supports Goal was to elucidate the avenues LRE explores to ensure consumers receiving Long Term Services and Supports are well represented in LRE's QAPIP efforts ensuring improved quality of care and maximum outcomes for consumers.

During the CMHSP Site Reviews, LRE ensures its sampling methodology used to select consumers for clinical chart audits is a representative cross-section of the overall distribution of service types provided in Region 3 by distinct consumer. For example, for FY22, LRE served almost 70% of its distinct consumer count with services defined by 1115 Pathway to Integration Waiver as Long-Term Services and Supports ("LTSS").[3] Hence, when LRE selects its random sample for its clinical chart audits, most of the samples selected tether to individuals receiving LTSS. LRE's sampling methodology is the first step ensuring that LRE is able to assess the quality and appropriateness of care furnished to individuals receiving LTSS.

Secondly, LRE's Clinical Chart Audit Tool, which is used during CMSHP Site Reviews, is the mechanism used to assess the quality and appropriateness of care furnished to individuals receiving LTSS. Specifically, LRE's Clinical Chart Audit Tool contains sections on Person-Centered Planning ("PCP"), which allows LRE to assess member care between care settings, and Service Delivery, which allows LRE to compare the services received by the individual compared to the services identified in the individuals treatment/service plan. LRE's Clinical Chart Audit Tool is compliant with MDHHS' PCP Guidelines Policy and the Medicaid Provider Manual ensuing LRE assesses the quality and appropriateness of care furnished to individuals receiving LTSS.[4]

LRE also ensures all individuals, including those receiving LTSS, receive a LOCUS/CAFAS upon

[3] 1115 Pathway to Integration defines Long-Term Services and Supports as Community Living Supports, Enhanced Medical Equipment and Supplies, Enhanced Pharmacy, Environmental Modification, Family and Support Training, Fiscal Intermediary, Goods and Services, Non-Family Training, Out-of-Home Non-Vocational Habilitation, Personal Emergency Response System, Prevocational Services, Skill Building Assistance, Specialty Services/Therapies (Music Therapy, Recreation Therapy, Art Therapy, and Massage Therapy), Supports and Service Coordination, Respite, Private Duty Nursing, Supported/Integrated Employment Services, Child Therapeutic Foster Care, Therapeutic Overnight Camping, Transitional Services.

[4] Person-Centered Planning section comports with the MDHHS Person-Centered Planning Guidelines Policy. MDHHS, Behavioral Health and Developmental Disabilities Administration, Person-Centered Planning Practice Guideline (michigan.gov). Service Delivery section comports with the Medicaid Provider Manual.

admission, annually, and when there has been a significant change in consumer's presentation. In an effort to improve visibility of LOCUS utilization, LRE has developed PowerBI Dashboards. Additionally, LRE has contracted with an agency to conduct SIS training for all interested parties in Region 3, which will only strengthen LRE's commitment to ensuring individuals receiving LTSS receive quality, appropriate care over the long-term.

Finally, LRE has created a Personal Emergency Response System Workgroup encouraging independence among all consumers, including those receiving LTSS.[5]

LRE has achieved its FY22 Long Term Services and Supports Goal.

[5] LRE co-leads a Regional Emergency Response System Workgroup initiated by Lynne Doyle Ottawa CMH, CEO.

XIV. ACRONYMS

BBA – Balanced Budget Act

BTC – Behavior Treatment Committee

BTP – Behavior Treatment Plan

BTR – Behavior Treatment Review

CAP – Corrective Action Plan

CAFAS – Child and Adolescent Functional Assessment Scale

CEO – Chief Executive Officer

CI – Critical Incidents

CQO – Chief Quality Officer

CMHSP – Community Mental Health Service Provider

CMS – Centers for Medicare and Medicaid Services

COO – Chief Operations Officer

CPG – Clinical Practice Guideline

CRM – Customer Relationship Management

CS – Customer Satisfaction

EQR– External Quality Review / External Quality Review Organization

EMR – Electronic Medical Record

FUH – Follow-up After Hospitalization for Mental Illness

HSAG – Health Services Advisory Group (External Quality Review Organization contracted by MDHHS to conduct annual reviews of each PIHP)

HCBS – Home and Community Based Services

HIPAA – Health Insurance Portability and Accountability Act

HLOC – Higher Level of Care

HMP – Healthy Michigan Plan

ICO – Integrated Care Organization

I/DD – Intellectual/Developmental Disability

IPOS – Individual Plan of Service

KPI – Key Performance Indicator

LOCUS – Level of Care Utilization System

LTSS – Long Term Services and Supports

LRE – Lakeshore Regional Entity

MDHHS – Michigan Department of Health and Human Services

MHP – Medicaid Health Plan

MI – Mental Illness

MMBPIS – Michigan Mission Based Performance Indicator System

PCP – Person Centered Planning

PIHP – Prepaid Inpatient Health Plan

PIP – Performance Improvement Project

QAPIP – Quality Assessment and Performance Improvement Plan

QIC – Quality Improvement Council

QI – Quality Improvement

RE – Risk Event

ROAT – Regional Operations Advisory Team

SE – Sentinel Event

SIS/CLS – Supports Intensity Scale/Community Living Supports

SME – Subject Matter Expert

Survey – Customer Satisfaction Survey

UD – Unexpected Death

UM – Utilization Management

LAKESHORE REGIONAL ENTITY

MMBPIS Performance Indicator Dashboard
FY 2022

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

Indicator #	PIHP Quarterly Measures	Target	Oct-Dec21	Q1 State Avg	Jan-Mar22	Q2 State Avg	Apr-Jun22	Q3 State Avg	July-Sept22	Q4 State Avg
Indicator #1	% of Pre-Admission Screening Dispositions 3 hrs or less - Children	95%	99.7%	98.9%	98.2%	98.8%	98.6%	98.9%	99.5%	99.2%
	% of Pre-Admission Screening Dispositions 3 hrs or less - Adults	95%	98.8%	98.4%	98.5%	98.6%	98.5%	98.4%	97.6%	98.5%
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%
Indicator #4b	% Seen Within 7 Days of SA Detox Unit Discharge -SUD	95%	97.7%	97.7%	94.8%	96.3%	99.0%	97.9%	97.9%	96.4%
Indicator #10	Inpatient Recidivism Rate - Children	15% or less	6.0%	7.4%	18.3%	7.1%	4.7%	5.9%	14.3%	8.9%
	Inpatient Recidivism Rate - Adults	15% or less	9.8%	11.4%	7.4%	11.4%	11.2%	11.7%	10.2%	12.7%
MDHHS collects and reports the following indicators										
Indicator #2e	F/F Service for Treatment Support within 14 days --SUD	MDHHS INFO	68.48%	71.8%	67.65%	70.9%	68.60%	70.4%	67.95%	70.70%
Indicator #5	% of Area Medicaid Having Received PIHP Managed Services	MDHHS INFO	5.33%	6.3%	5.36%	6.51%	5.32%	6.53%	5.17%	6.41%
Indicator #6	% of HSW Enrollees in Quarter who Received at Least 1 HSW Service each Month other than Support Coordination	MDHHS INFO	77.2%	88.5%	90.6%	92.2%	93.8%	94.0%	95.3%	94.9%

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	

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 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.

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

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.

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.

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.

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.

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).

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	

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).

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	477	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					

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:

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

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

				Click to select status	Click to select status
				Click to select status	Click to select status

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

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

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.

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**

State of Michigan 2021-22 PIP Submission Form
LRE PIP#2: FUH Metric: Follow-Up after Hospitalization for Mental Illness

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#2 Title: **FUH Metric: Follow-Up after Hospitalization for Mental Illness**	
Submission Date: n/a	
Resubmission Date (if applicable):	

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: Increase the number of individuals age 6 years and older that receive a follow-up care with a mental health provider within 30 days of discharge from an Psychiatric Inpatient facility is the LRE's second PIP. Data and monitoring will be broke out by Adults and Children.**

Plan-Specific Data:

Data for Adults age 18 and older

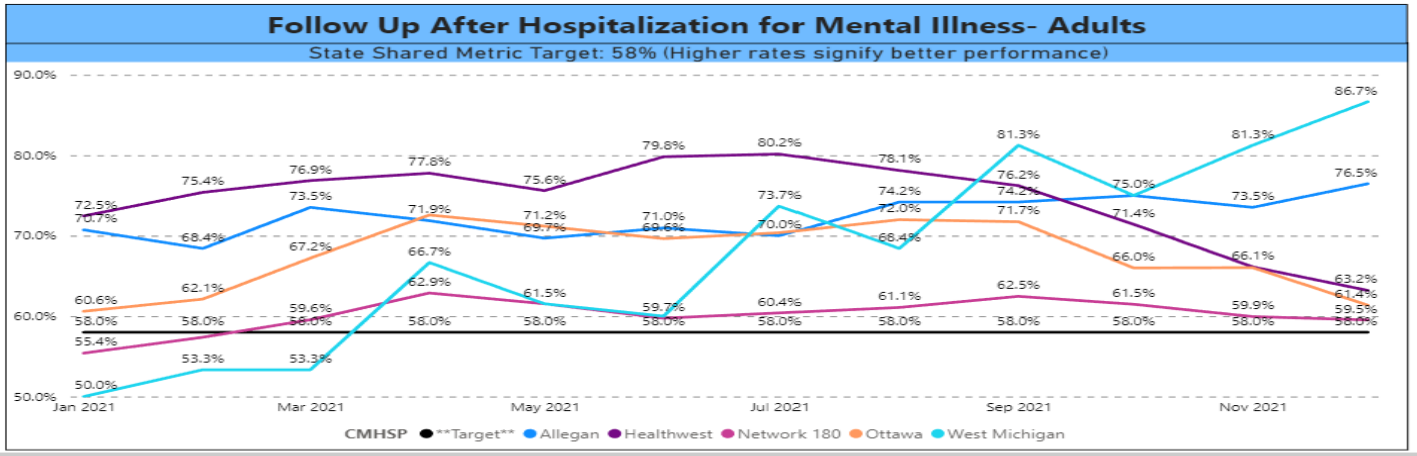
LAKESHORE REGIONAL ENTITY

by CMHSP

The percentage of discharges for patients 18 years of age or older who were hospitalized for treatment of selected mental illness or intentional self harm diagnoses and who had follow-up visit with a mental health provider within 30 days of discharge.

Numerator: A follow-up visit with a mental health provider within 30 days after discharge. Does not include visits that occur on the date of discharge.
Denominator: Discharges from an acute inpatient care setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (ex: Jan1 to Dec 1) for patients 18 years or older.
Exclusions: Excludes 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. Excludes discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health.

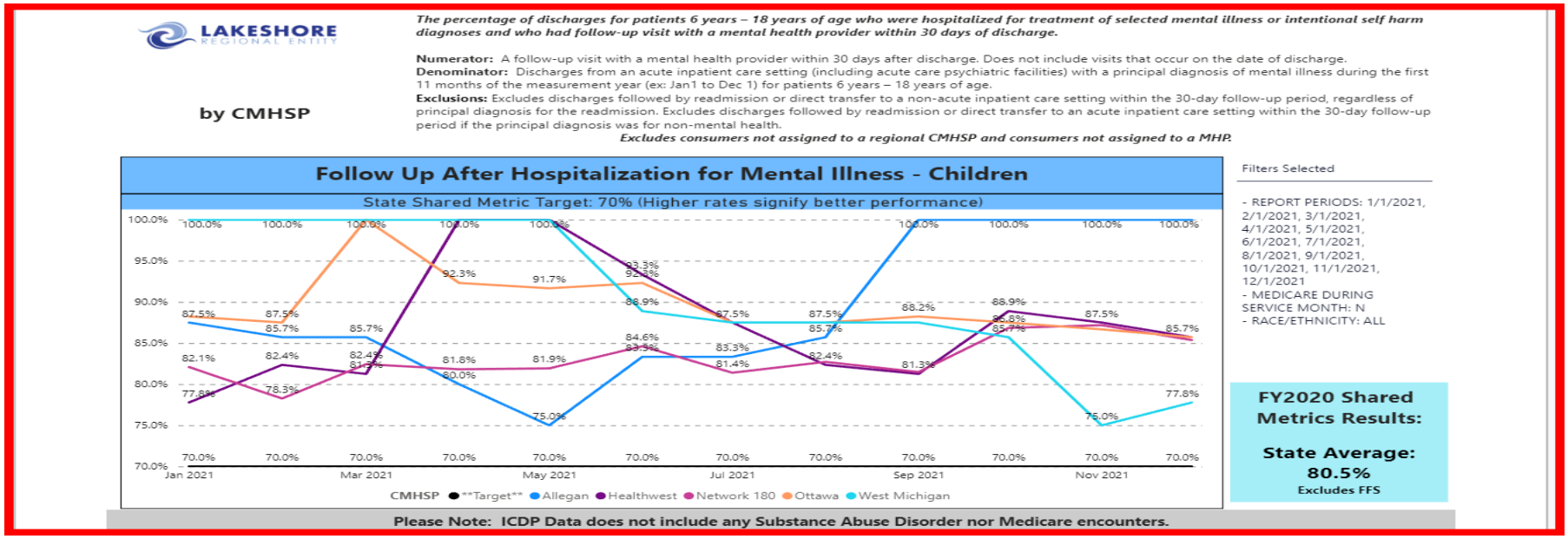
Excludes consumers not assigned to a regional CMHSP and consumers not assigned to a MHP.



Please Note: ICDP Data does not include any Substance Abuse Disorder nor Medicare encounters.

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.

Data for Children age 6 to 18



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.

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

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.

1) **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.
2) **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.
3) **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. LRE's research indicates that interventions exist that will improve R3's FUH performance.[1] 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] LRE's research strongly suggests that an increase in the FUH metric can improve outcomes, decrease suicide, decrease recidivism, and increase satisfaction.

[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 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.

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 with a mental illness age 6 and above 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 Baseline data (Jan 1, 2021 – 12/31/2021).

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.

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.

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.

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.

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), 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), and HEDIS® FUH Procedure, Diagnosis, and Place of Service codes.

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: The percentage of discharges for individuals age 18 years or older who were hospitalized for treatment of a selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days of discharge.**
	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), 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).
Numerator Description:	Individuals age 18 and over who had follow-up visit with a mental health provider within 30 days after discharge from an inpatient hospitalizations for specified mental illness. Note: Does not include visits that occur on the date of discharge
Denominator Description:	Individuals age 18 and over who had a discharges from an acute inpatient care setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the measurement period.

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."

Exclusions:	1. Excludes 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. Excludes discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health. 3. Excludes consumers not assigned to a regional CMHSP and consumers not assigned to an MHP
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
Mandated Goal/Target, if applicable	Not applicable
Indicator 2	**FUH Metric for Children: The percentage of discharges for individuals age 6 years to age 18, who were hospitalized for treatment of a selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days of discharge.**

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."

	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), 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).
Numerator Description:	Individuals aged 6 to age 18 who had follow-up visit with a mental health provider within 30 days after discharge from an inpatient hospitalizations for specified mental illness. Note: Does not include visits that occur on the date of discharge
Denominator Description:	Individuals aged 6 to age 18 who had a discharges from an acute inpatient care setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the measurement period.
Exclusions:	1. Excludes 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. Excludes discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health.

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."

	3. Excludes consumers not assigned to a regional CMHSP and consumers not assigned to an MHP
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
Mandated Goal/Target, if applicable	
Use this area to provide additional information.	

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; HEDIS® FUH Data via ZTS, 834 Eligibility, MDHHS Fix File. Other Requirements [X] Codes used to identify data elements (e.g., ICD-10, CPT codes)- [ ] 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 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.

Data Collection Process Summary

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

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			60.6%	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 1 Title: FUH Metric for Children

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			70.1%	N/A for baseline	N/A for baseline
01/01/2023-12/31/2023	Remeasurement 1					
01/01/2024-12/31/2024	Remeasurement 2					

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. 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,.

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.

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:

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

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

				Click to select status	Click to select status
				Click to select status	Click to select status

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

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

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.

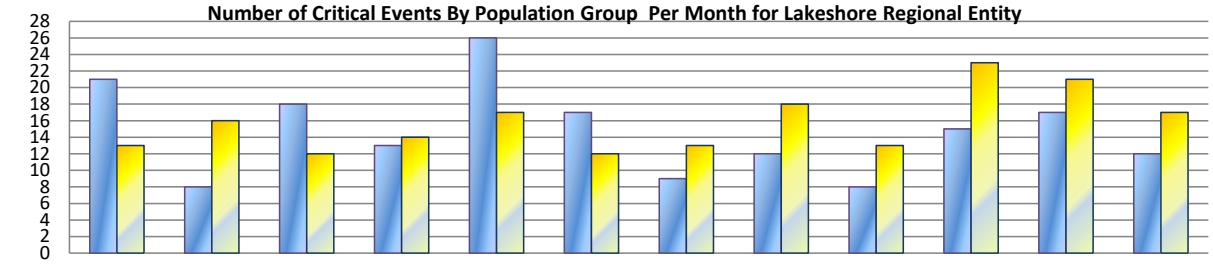
Clinical Improvement		
Remeasurement Period	**Narrative Summary of Clinical Improvement**	**Supporting Quantitative or Qualitative Data**
Programmatic Improvement		
Remeasurement Period	**Narrative Summary of Programmatic Improvement**	**Supporting Quantitative or Qualitative Data**

LAKESHORE REGIONAL ENTITY

Attachment D

Lakeshore Regional Entity
Critical Event Monitoring For Oct 2021- Sept 2022
Report Date 1/18/2023

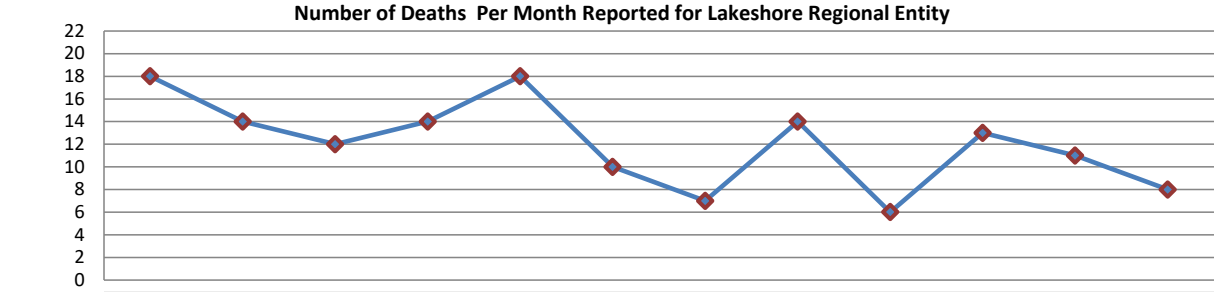
		IDD	MI	FY 2022 Annual Report
Unduplicated Count of individuals With a Reported Critical Incident Year to Date	HealthWest	27	23	*There were a total of 365 critical incidents reported for FY22, which is a decrease of 26 compared to the FY21 Report. A total of 13 suicides were reported compared to 7 reported in FY21. West Michigan reported 4 suicides, N1804; HealthWest 2; and OnPoint and Ottawa 1 each. There were 18 accidental deaths reported in FY22, compared to 22 last year. One homicide was reported in FY22. There were 180 injuries requiring medical care reported forFY22, which is an increase of 3 compared to last year. Twelve reported injuries required hospitalization in FY22 which is a decrease of 8 compared to last year. decrease of 2 noted in the number of med errors requiring medical treatment in FY22, with 3 reported. Med errors requiring hospitalization remained the same as last year with 1 reported. Number of arrests increased from 17 to 23.*
	Ottawa	10	19	
	Allegan	24	11	
	Network 180	57	57	
	West Michigan	27	41	
	LRE	145	151	



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
#DD	21	8	18	13	26	17	9	12	8	15	17	12
#MI	13	16	12	14	17	12	13	18	13	23	21	17

Total Number of Critical Events by Population Year to Date	
	176
	189

Deaths Reported: **Note:** Suicide - Reported for any person actively receiving services at time of death
Non-Suicide - Reported for individuals who live in a Specialized Residential / Child-Caring Institution; receiving CLS, Supports Coordination, ACT, HBS, WrapAround, Hab Support Waiver, SED Waiver or Children's Waiver Services

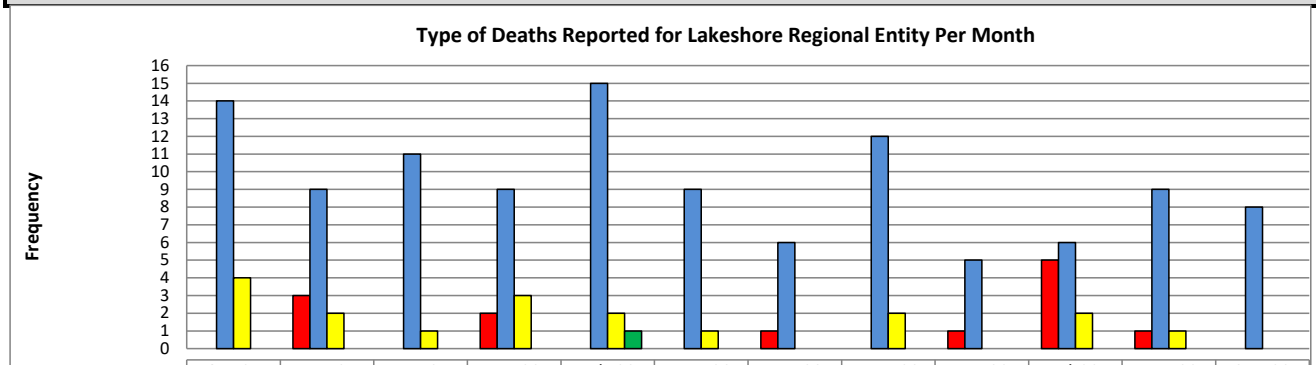


	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Total Reported Deaths	18	14	12	14	18	10	7	14	6	13	11	8

Total Deaths Reported YTD
145

2. Type of Deaths Reported to MDHHS Per Month

Note: Suicide - Reported for any person actively receiving services at time of death
Non-Suicide - Reported for individuals who live in a Specialized Residential / Child-Caring Institution; receiving CLS, Supports Coordination, ACT, HBS, WrapAround, Hab Support Waiver, SED Waiver or Children's Waiver Services



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Suicide	0	3	0	2	0	0	1	0	1	5	1	0
Natural Causes	14	9	11	9	15	9	6	12	5	6	9	8
Accidental	4	2	1	3	2	1	0	2	0	2	1	0
Homicide	0	0	0	0	1	0	0	0	0	0	0	0

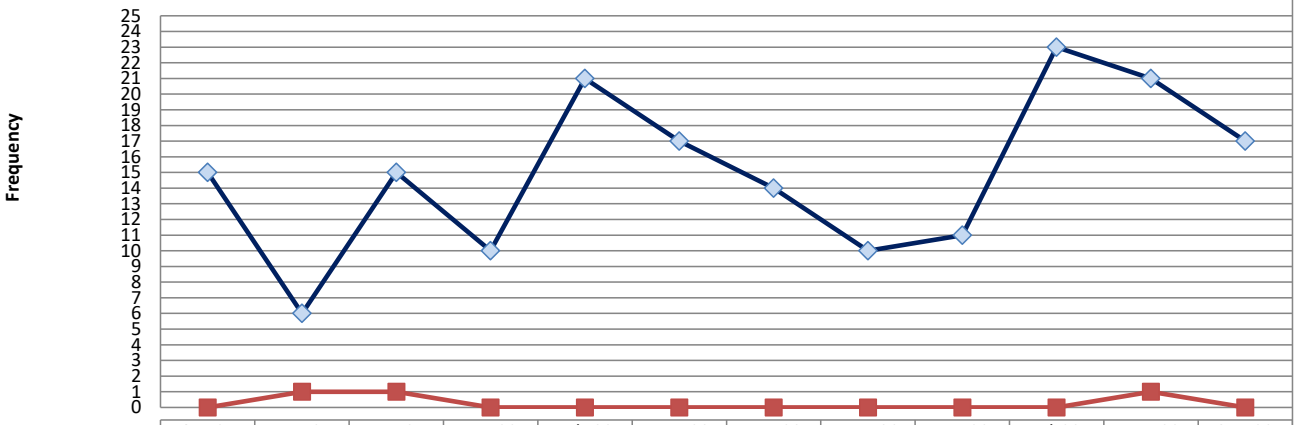
Reported YTD by Type of Death
Suicide 13
Natural Causes 113
Accidental 18
Homicide

1

3. Emergency Medical Treatment Due to Injury or Med Error Reported to MDHHS

Note: Reported for individuals living in a Specialized Residential Facility / Child Caring Institution or receiving Hab Waiver Services, SED Waiver Services or Children's Waiver Services

# of Individuals Who Required Emergency Medical Treatment Reported for Lakeshore Regional Entity



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Injury	15	6	15	10	21	17	14	10	11	23	21	17
Med Error	0	1	1	0	0	0	0	0	0	0	1	0

Total Emergency Treatments Reported YTD

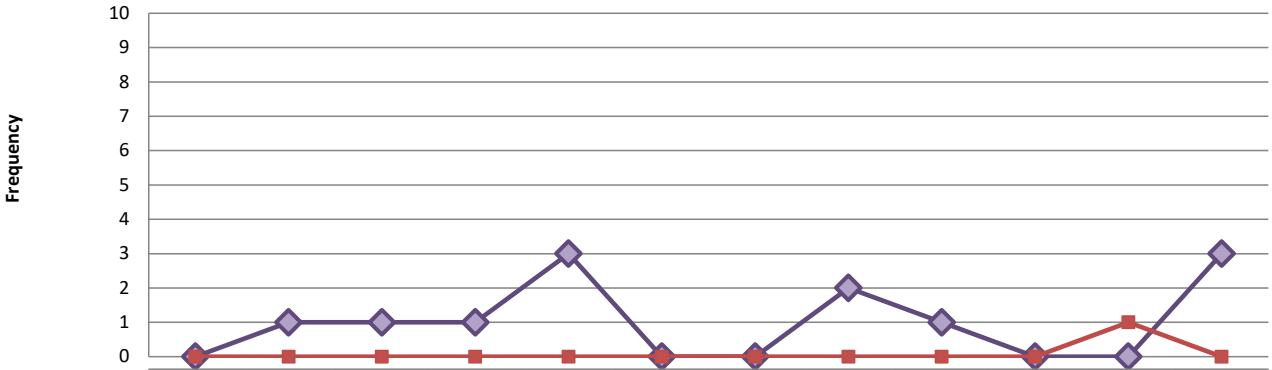
 # Due to Injuries
180

 # Due to Med Error
3

4: Hospitalizations Due to Injury / Med Errors Reported to MDHHS

Note: Reported for individuals living in a Specialized Residential Facility / Child Caring Institution or receiving Hab Waiver Services, SED Waiver Services or Children's Waiver Services

# of Hospitalizations due to Injury / Med Error Reported for Lakeshore Regional Entity Per Month



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Injury	0	1	1	1	3	0	0	2	1	0	0	3
Med Error	0	0	0	0	0	0	0	0	0	0	1	0

Total Hospital-izations for injury / Med Errors Reported YTD

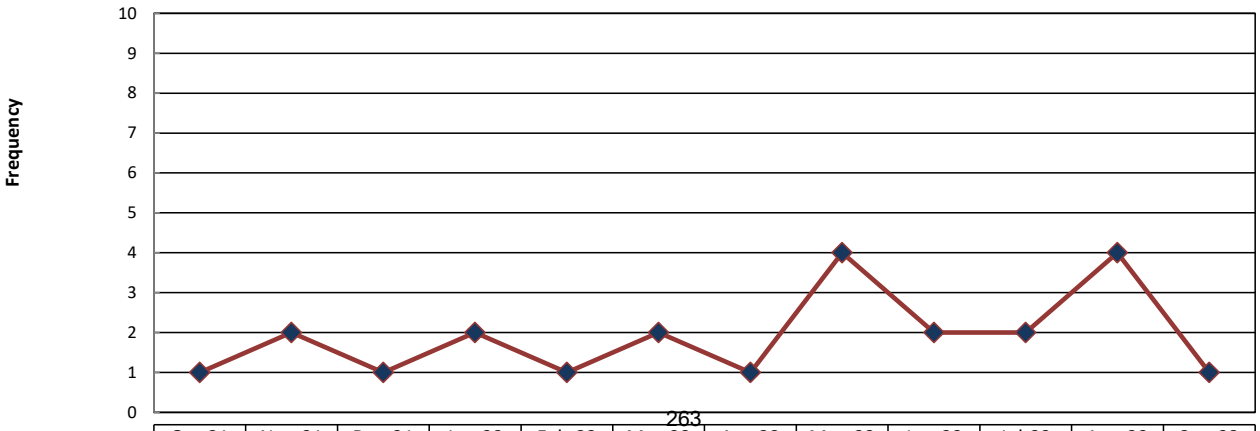
 # Due to Injuries
12

 # Due to Med Error
1

5: Arrests Reported

Note: Reported for individuals living in a Specialized Residential Facility / Child Caring Institution or receiving Hab Waiver Services, SED Waiver Services or Children's Waiver Services

Number of Arrests Reported for Lakeshore Regional Entity Per Month



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Arrest	1	2	1	2	1	2	1	4	2	2	4	1

Total Arrests Reported YTD

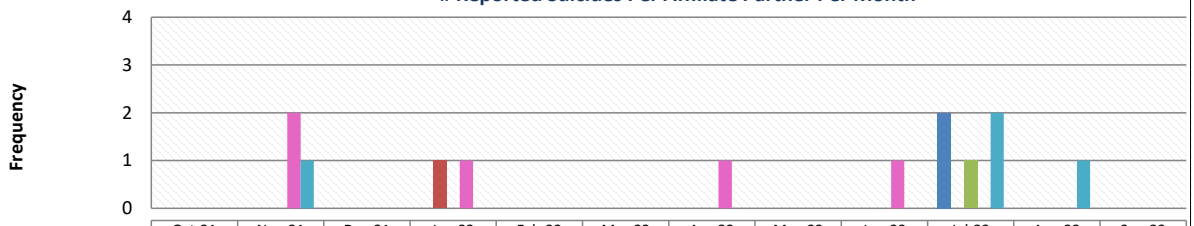
23

LAKESHORE REGIONAL ENTITY

Lakeshore Regional Entity -- Critical Incident -Type of Death Reports

Report Date 01/18/2023

Reported Suicides Per Affiliate Partner Per Month



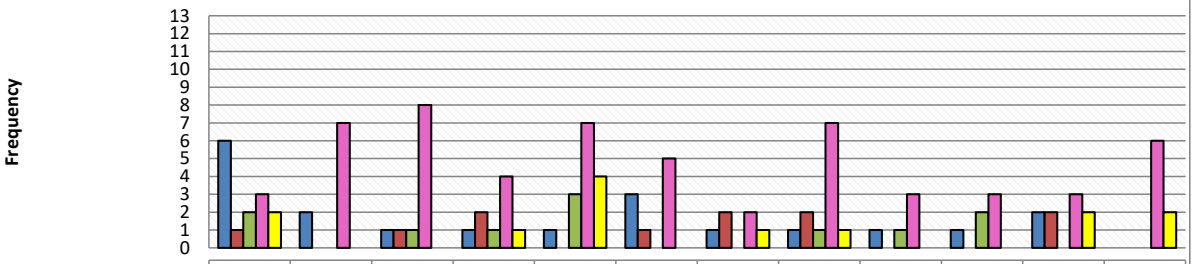
	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
HW_Suicide	0	0	0	0	0	0	0	0	0	2	0	0
Ott_Suicide	0	0	0	1	0	0	0	0	0	0	0	0
Alg_Suicide	0	0	0	0	0	0	0	0	0	1	0	0
N180 Suicide	0	2	0	1	0	0	1	0	1	0	0	0
WM Suicide	0	1	0	0	0	0	0	0	0	2	1	0

Total # of Suicides per Affiliate Year to Date	
HealthWest	2
Ottawa	1
On Point	1
N180	5
W. Michigan	4

LRE TOTALS YEAR TO DATE

13

Death by Natural Causes Per CMHSP Per Month



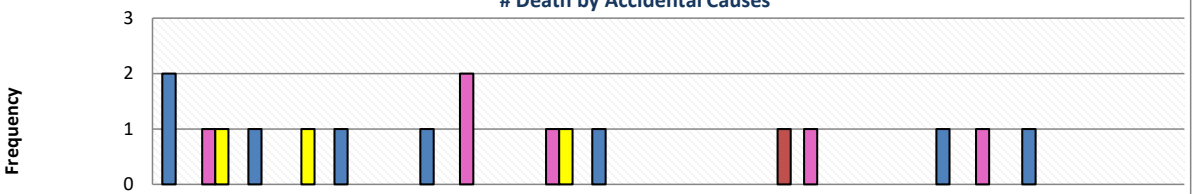
	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
HW_Natural Causes	6	2	1	1	1	3	1	1	1	1	2	0
Ott_Natural Causes	1	0	1	2	0	1	2	2	0	0	2	0
Alg Natural Causes	2	0	1	1	3	0	0	1	1	2	0	0
N180 Natural Causes	3	7	8	4	7	5	2	7	3	3	3	6
W. Mich Natural Causes	2	0	0	1	4	0	1	1	0	0	2	2

Total Deaths due to Natural Causes per Affiliate Year to Date	
HealthWest	20
Ottawa	11
On Point	11
N180	58
W. Michigan	13

LRE TOTALS YEAR TO DATE

113

Death by Accidental Causes



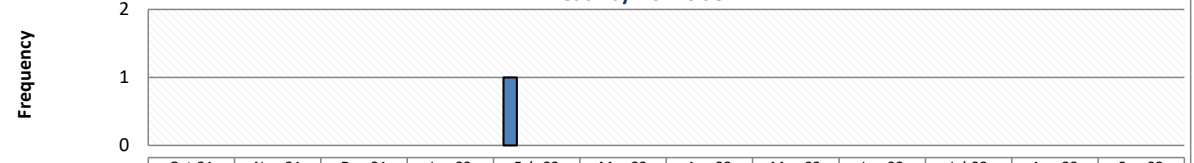
	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
HW_Accidental	2	1	1	1	0	1	0	0	0	1	1	0
Ott_Accidental	0	0	0	0	0	0	0	1	0	0	0	0
Alg Accidental	0	0	0	0	0	0	0	0	0	0	0	0
N180 Accidental	1	0	0	2	1	0	0	1	0	1	0	0
WM Accidental	1	1	0	0	1	0	0	0	0	0	0	0

Total Deaths due to Accidents per Affiliate Year to Date	
HealthWest	8
Ottawa	1
On Point	0
N180	6
W. Michigan	3

LRE TOTALS YEAR TO DATE

18

Death by Homicide



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
HW_Homicide	0	0	0	0	1	0	0	0	0	0	0	0
Ott_Homicide	0	0	0	0	0	0	0	0	0	0	0	0
Alg Homicide	0	0	0	0	0	0	0	0	0	0	0	0
N180 Homicide	0	0	0	0	0	0	0	0	0	0	0	0
Alg HOmicide	0	0	0	0	0	0	0	0	0	0	0	0

Total Deaths due to Homicide per Affiliate Year to Date	
HealthWest	1
Ottawa	0
On Point	0
N180	0
W. Michigan	0

LRE TOTALS YEAR TO DATE

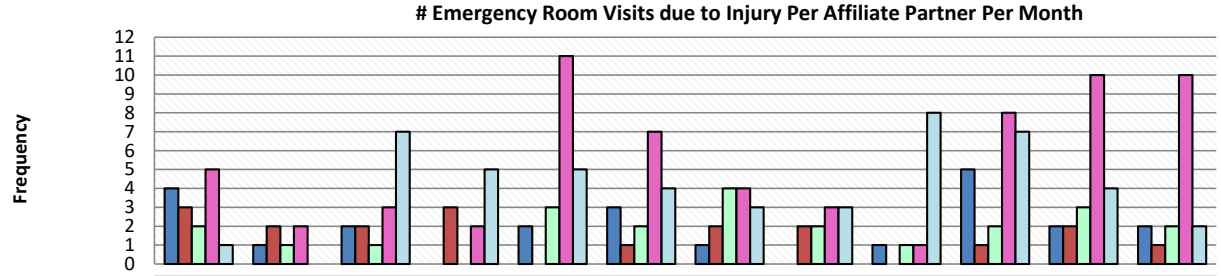
1

LAKESHORE REGIONAL ENTITY

Lakeshore Regional Entity -- Critical Incident -ER Visits & Hospitalization Due to Injury or Med Error Report

Report Date 01/18/2023

Emergency Room Visits due to Injury Per Affiliate Partner Per Month



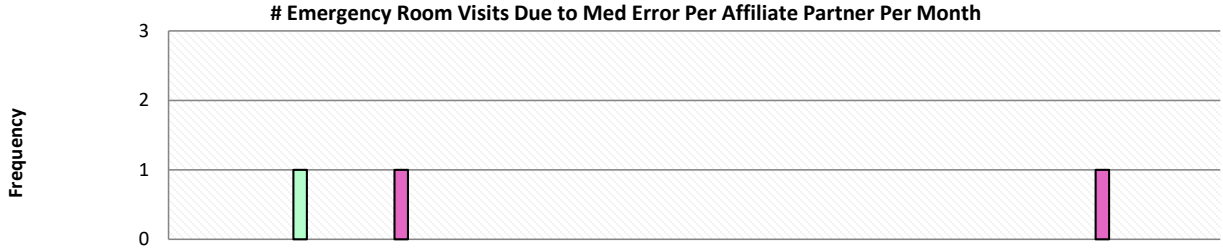
	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
HW_Injury	4	1	2	0	2	3	1	0	1	5	2	2
Ott_Injury	3	2	2	3	0	1	2	2	0	1	2	1
Alg Injury	2	1	1	0	3	2	4	2	1	2	3	2
N180 Injury	5	2	3	2	11	7	4	3	1	8	10	10
WM Injury	1	0	7	5	5	4	3	3	8	7	4	2

Total # of ER Visits due to Injury per Affiliate Year to Date	
HealthWest	23
Ottawa	19
On Point	23
N180	66
W. Michigan	49

LRE TOTALS YEAR TO DATE

180

Emergency Room Visits Due to Med Error Per Affiliate Partner Per Month



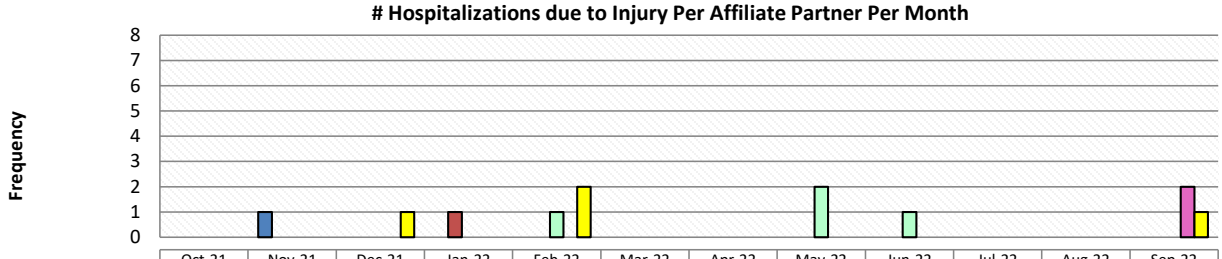
	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
HW_Med Error	0	0	0	0	0	0	0	0	0	0	0	0
Ott_Med Error	0	0	0	0	0	0	0	0	0	0	0	0
Alg Med Error	0	1	0	0	0	0	0	0	0	0	0	0
N180 Med Error	0	0	1	0	0	0	0	0	0	0	1	0
WM Med Error	0	0	0	0	0	0	0	0	0	0	0	0

Total # ER Visits due to Med Errors per Affiliate Year to Date	
HealthWest	0
Ottawa	0
On Point	1
N180	2
W. Michigan	0

LRE TOTALS YEAR TO DATE

3

Hospitalizations due to Injury Per Affiliate Partner Per Month



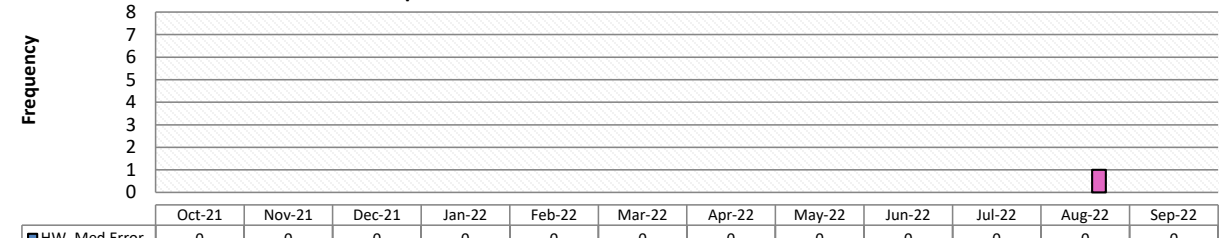
	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
HW_Injury	0	1	0	0	0	0	0	0	0	0	0	0
Ott_Injury	0	0	0	1	0	0	0	0	0	0	0	0
Alg Injury	0	0	0	0	1	0	0	2	1	0	0	0
N180 Injury	0	0	0	0	0	0	0	0	0	0	0	2
WM Injury	0	0	1	0	2	0	0	0	0	0	0	1

Total # Hospitalizations due to Injury per Affiliate Year to Date	
HealthWest	1
Ottawa	1
On Point	4
N180	2
W. Michigan	4

LRE TOTALS YEAR TO DATE

12

Hospitalizations due to Med Error Per Affiliate Partner Per Month



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
HW_Med Error	0	0	0	0	0	0	0	0	0	0	0	0
Ott_Med Error	0	0	0	0	0	0	0	0	0	0	0	0
Alg Med Error	0	0	0	0	0	0	0	0	0	0	0	0
N180 Med Error	0	0	0	0	0	0	0	0	0	0	1	0
WM Med Error	0	0	0	0	0	0	0	0	0	0	0	0

Total #Hospitalization due to Med Error per Affiliate Year to Date	
HealthWest	0
Ottawa	0
On Point	0
N180	1
W. Michigan	0

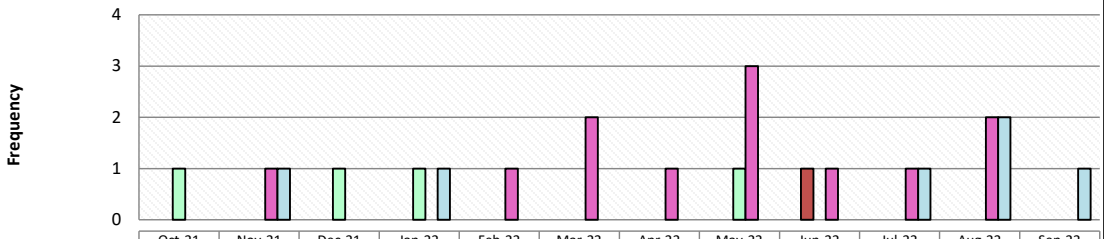
LRE TOTALS YEAR TO DATE

1

LAKESHORE REGIONAL ENTITY

Lakeshore Regional Entity -- Arrest Report

Report Date 01/18/2023



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
HW_Arrests	0	0	0	0	0	0	0	0	0	0	0	0
Ott_Arrests	0	0	0	0	0	0	0	0	1	0	0	0
Alg Arrests	1	0	1	1	0	0	0	1	0	0	0	0
N180 Arrests	0	1	0	0	1	2	1	3	1	1	2	0
WM Arrests	0	1	0	1	0	0	0	0	0	1	2	1

Total # of Arrests per Affiliate Year to Date	
HealthWest	0
Ottawa	1
On Point	4
N180	12
W. Michigan	6

LRE TOTALS YEAR TO DATE

23

LAKESHORE REGIONAL ENTITY

Attachment E

Lakeshore Regional Entity
Risk Event Monitoring For Oct 2021- Sept 2022
Report Date 1/19/2023

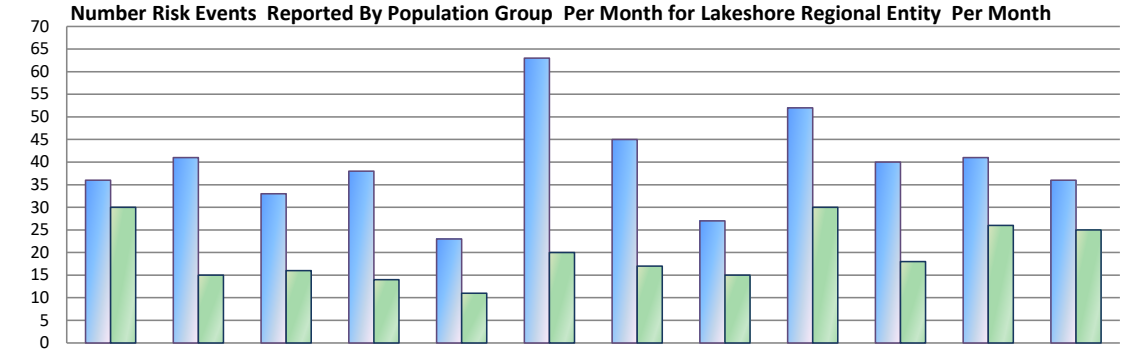
Risk Events data is collected on all individuals receiving services at the time of the Event, who received either Supports Coordination, HBS or ACT Services.

Unduplicated Count of Individuals who Had a Risk Event Per Affiliate Partner Year to Date (YTD)

	DD	MI
HealthWest	8	4
Ottawa	13	15
Allegan	14	8
Network 180	53	37
West Michigan	19	31
LRP Unduplicated Count	107	95

The Risk Event Data is not reported to MDCH, however PIHP is required to have a process for collecting, aggregating, monitoring trending, and follow-up of the events. This process will be reviewed by MDHHS at annual site review.

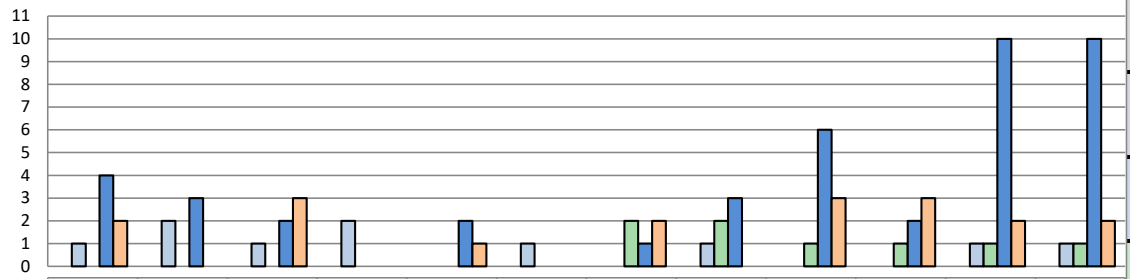
Risk Events FY22 Annual Report: Increase noted in the number of reported risk events for FY22, with 712 reported compared to 666 reported in FY21. This is the third year in a row there has been an increase in the number of reported risk events for the region. FY20, 510; FY21, 666 and FY22, 712 were reported. Self-harm reported events decreased this year from 83 last year to 79 this year. Harm to others decreased this year from 14 in FY21 to 10 in FY22. The number of Physical Management events increased by 54, as340 were reported in FY21 and 394 reported in FY22. The number of reported Police calls (164) decreased by 24 in FY22 compared to FY21. The number of individuals reported with 2 or more hospitalizations increased by thirty as 38 were reported last year and 68 reported this year.



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
#DD	36	41	33	38	23	63	45	27	52	40	41	36
#MI	30	15	16	14	11	20	17	15	30	18	26	25

Total # of Risk Events Reported by Population Group YTD
DD 475
MI 237

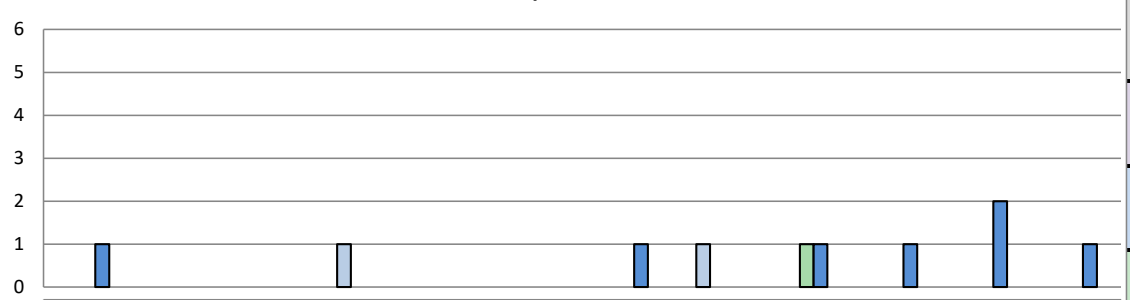
6. Number of Harm to Self Risk Events



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
HW_Harm to Self	0	0	0	0	0	0	0	0	0	0	0	0
Ott_Harm to Self	1	2	1	2	0	1	0	1	0	0	1	1
Alg_Harm to Self	0	0	0	0	0	0	2	2	1	1	1	1
N180_Harm to Self	4	3	2	0	2	0	1	3	6	2	10	10
WM_Harm to Self	2	0	3	0	1	0	2	0	3	3	2	2

Total # LRE Self Harm Events YTD
79
HealthWest Totals 0
Ottawa Totals 10
On Point Totals 8
N180 Totals 43
West Michigan 18

7: Number of Harm to Others Risk Events

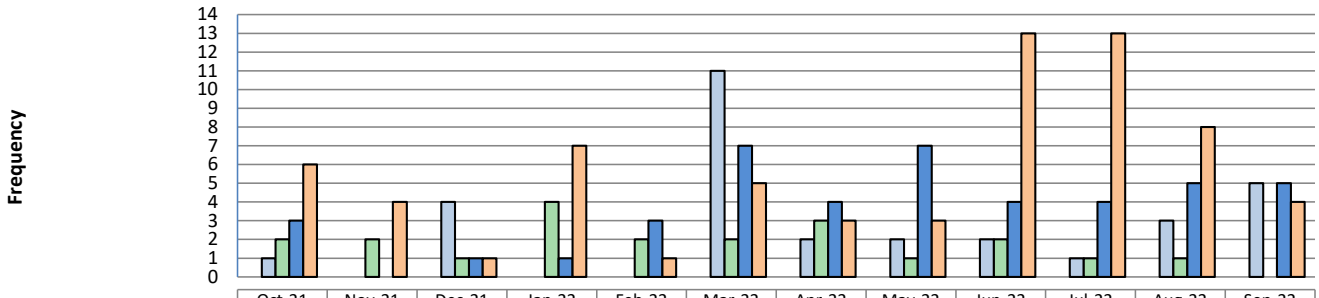


	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
HW_Harm to Others	0	0	0	0	0	0	0	0	0	0	0	0
Ott_Harm to Others	0	0	0	1	0	0	0	1	0	0	0	0
Alg_Harm to Others	0	0	0	0	0	269 0	0	0	1	0	0	0
N180_Harm to Others	1	0	0	0	0	0	1	0	1	1	2	1
WM_Harm to Others	0	0	0	0	0	0	0	0	0	0	0	0

Total # LRE Harm to Others Events YTD
10
HealthWest Totals 0
Ottawa Totals 2
On Point Totals 1
N180 Totals 7
West Michigan

0

8. Number of Police Calls Risk Events



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
HW_Police Calls	0	0	0	0	0	0	0	0	0	0	0	0
Ott_Police Calls	1	0	4	0	0	11	2	2	2	1	3	5
Alg_Police Calls	2	2	1	4	2	2	3	1	2	1	1	0
N180_Police Calls	3	0	1	1	3	7	4	7	4	4	5	5
WM_Police Calls	6	4	1	7	1	5	3	3	13	13	8	4

Total # LRE Police Calls YTD
164

HealthWest Totals
0

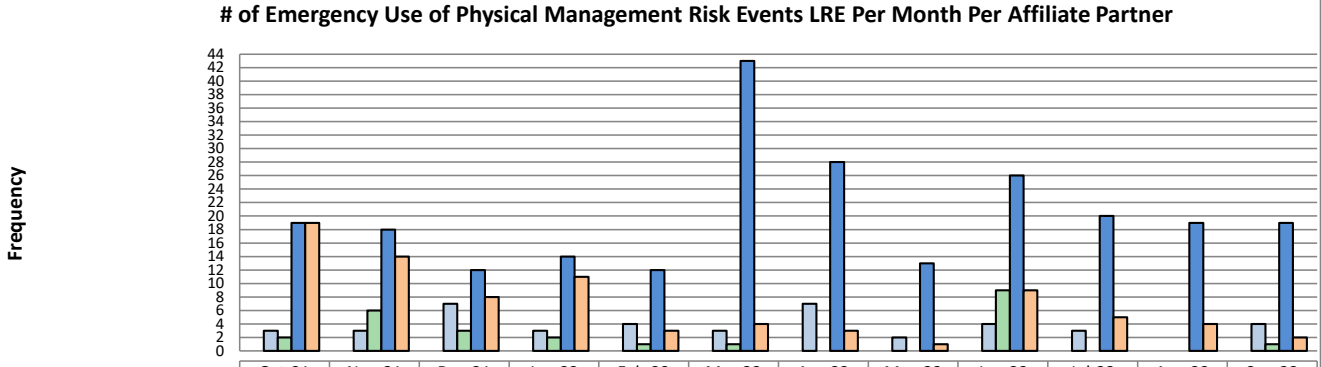
Ottawa Totals
31

On Point Totals
21

N180 Totals
44

West Michigan
68

9: Number of Emergency Use of Physical Management Risk Events.



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
HW_Emerg Use of PM	0	0	0	0	0	0	0	0	0	0	0	0
Ott_Emerg Use of PM	3	3	7	3	4	3	7	2	4	3	0	4
Alg_Emerg Use of PM	2	6	3	2	1	1	0	0	9	0	0	1
N180_Emerg Use of PM	19	18	12	14	12	43	28	13	26	20	19	19
WM_Emerg Use of PM	19	14	8	11	3	4	3	1	9	5	4	2

Total # LRE Emergency Use of Physical Management YTD
394

HealthWest Totals
0

Ottawa Totals
43

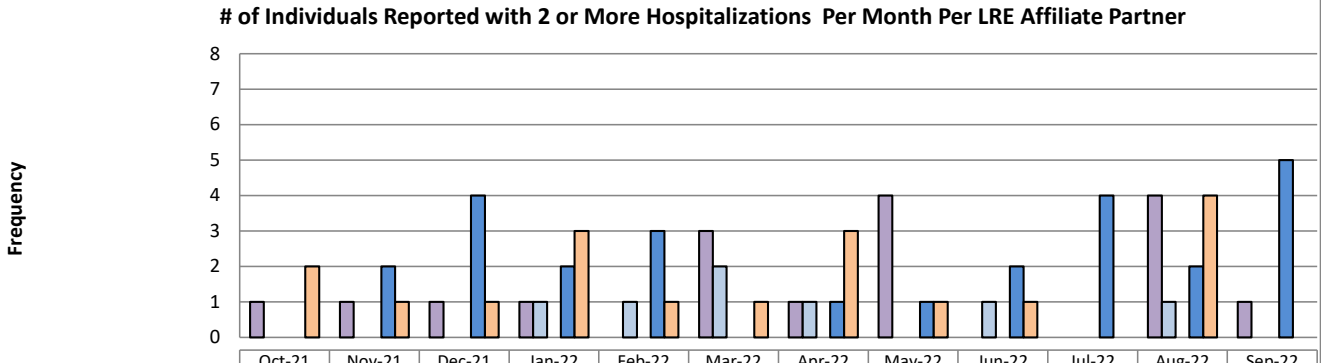
On Point Totals
25

N180 Totals
243

West Michigan
83

10: Number of Individuals who had two or more Unscheduled Hospitalizations Risk Events

NOTE: Two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period.



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
HW_Hospitalizations	1	1	1	1	0	3	1	4	0	0	4	1
Ott_Hospitalizations	0	0	0	1	1	2	1	0	1	0	1	0
Alg_Hospitalizations	0	0	0	0	0	0	0	0	0	0	0	0
N180_Hospitalizations	0	2	4	2	3	0	1	1	2	4	2	5
WM_Hospitalizations	2	1	1	3	1	1	3	1	1	0	4	0

Total # LRE Hospit-alizations YTD
68

HealthWest Totals
17

Ottawa Totals
7

On Point Totals
0

N180 Totals
26

West Michigan
18

Lakeshore Regional Entity
Sentinel Events and Critical Incidents
Monitoring Report FY22
(In Accordance with: 42 CFR §438.330(b)(5)(ii), MDHHS-PIHP Contract Schedule A-1(K)(2)(a), QAPIP Technical Guidelines, Section VIII)

Attachment F

									REVIEW STANDARDS	TIMELINESS STANDARDS				REVIEW STANDARDS						MONITORING STANDARD				
									Contract Schedule A—1(K)(2)(a)		Contract Schedule A—1(K)(2)(a)			Contract Schedule A—1(K)(2)(a)						42 CFR §438.330(b)(5)(ii)			42 CFR §438.330(b)(5)(ii)	42 CFR §438.330(b)(5)(ii)
									QAPIPs for Specialty PIHPs, Section VIII(C)	LRE Policy	QAPIPs for Specialty PIHPs, Section VIII(A)	LRE Policy	LRE Policy	QAPIPs for Specialty PIHPs, Section VIII(B)	LRE Procedure	LRE Procedure	LRE Procedure	LRE Procedure	LRE Procedure	Contract Schedule A—1(K)(2)(a)			Contract Schedule A—1(K)(2)(a)	Contract Schedule A—1(K)(2)(a)
																				QAPIPs for Specialty PIHPs, Section VIII(A-D)		LRE Procedure	QAPIPs for Specialty PIHPs, Section VIII(A-D)	QAPIPs for Specialty PIHPs, Section VIII(A-D)
# received for 2022	Date of Incident	Type of Event	Date CMH had knowledge of Incident	Email Notification - Date	RCA Start Date	RCA Completed Date	Completed Unexpected Death Form Received Date	CIRE/QOC Committee Review Date		# Days from knowledge of occurrence to LRE Notification **Standard: 24 hours**	# Days to Start RCA. **Standard: 3 days to determine if SE then 2 business days to commence RCA**	# Days to Complete RCA after started: **Standard: 45 Days**	# Days to Send LRE Completed Unexpected Death Form: **Policy states within 48 hours** Data below in DAYS	Comments/ Extensions	Health Care Professional Signature **Standard: MD/DO/RN Only**	Health Care Professional's Credentials **Standard: Credentials Present**	Health Care Professional Signature Date **Standard: Date Present**	Quality Improvement Personnel Signature **Standard: Appropriate Credentials**	Quality Improvement Personnel Credentials **Standard: Credentials Present**	Quality Improvement Professional Signature Date **Standard: Date Present**	CMHSP Self-Determined Follow-Up Task **Standard: Task Present**	Comment on signatures	CMHSP Self-Determined Follow-Up Task **Standard: 30 days following RCA completion**	LRE Validation of Remediation **Standard: At Least Annually**	Outcome of LRE Validation of Remediation **Standard: Validated**
1	11/15/2021	Suicide	11/19/2021	11/19/21	11/19/21	12/15/21	12/15/2021	1/25/2022		0	1	19	0		No	No	Yes	Yes	Yes	Yes	Yes		1/14/2022	7/13/2022	
2	10/26/2021	Accidental	11/6/2021	11/06/21	11/06/21	12/17/21	12/21/2021	1/25/2022		0	1	30	2		Yes	Yes	Yes	Yes	No	Yes	Yes		1/16/2022	7/15/2022	
3	1/11/2022	Accidental	1/13/2022	01/13/22	01/13/22	02/03/22	2/3/2022	2/28/2022		0	1	16	0		Yes	Yes	Yes	Yes	Yes	Yes	Yes		3/5/2022	9/1/2022	
4	2/18/2021	Accidental	2/18/2021	07/26/21	07/26/21	02/03/22	4/25/2022	5/23/2022		112	113	139	57		No	No	No	No	No	Yes	no	typed for QI no signature; no health professional signature Used typed date	3/5/2022	9/1/2022	
5	1/16/2022	Suicide	1/17/2022	01/18/22	01/17/22	02/08/22	2/9/2022	2/28/2022		1	1	17	1		Yes	Yes	Yes	Yes	Yes	Yes	Yes		3/10/2022	9/6/2022	
6	9/2/2021	Potential	9/7/2021	09/07/21	Not Provided	09/17/21	9/18/2021	2/28/2022		0	Not Provided	Not Provided	0		Yes	Yes	Yes	Yes	No	Yes	Yes		10/17/2021	4/15/2022	
7	7/7/2021	Accidental	9/8/2021	09/08/21	09/08/21	09/30/21	9/30/2021	2/28/2022		0	1	17	0		Yes	Yes	Yes	Yes	Yes	Yes	Yes		10/30/2021	4/28/2022	
8	9/8/2021	Potential	9/10/2021	09/13/21	09/14/21	10/08/21	10/12/2021	2/28/2022		1	3	19	2		Yes	Yes	Yes	Yes	No	Yes	Yes		11/7/2021	5/6/2022	
9	10/6/2021	Accidental	10/8/2021	10/08/21	10/08/21	10/27/21	10/27/2021	2/28/2022		0	1	14	0		Yes	Yes	Yes	Yes	Yes	Yes	Yes		11/26/2021	5/25/2022	
10	1/23/2022	Accidental	1/24/2022	01/24/22	01/24/22	02/19/22	2/21/2022	2/28/2022		0	1	20	0		Yes	Yes	Yes	Yes	Yes	Yes	Yes		3/21/2022	9/17/2022	
11	2/1/2022	Accidental	2/3/2022	02/03/22	02/03/22	2/28/2022	2/28/2022	3/28/2022		0	1	18	0		Yes	Yes	Yes	Yes	Yes	Yes	Yes		3/30/2022	9/26/2022	
12	1/16/2022	Accidental	2/8/2022	02/10/22	02/10/22	3/2/2022	3/2/2022	3/28/2022		2	3	15	0		Yes	No	Yes	Yes	Yes	Yes	Yes		4/1/2022	9/28/2022	
13	2/21/2022	Suicide	2/22/2022	02/22/22	03/22/22	3/29/2022	4/4/2022	4/25/2022		0	21	6	4	Waited for Death Certificate to start RCA	Yes	No	Yes	Yes	No	Yes	Yes	Signed no credentials.	4/28/2022	10/25/2022	
14	9/13/2021	Accidental	9/13/2021	09/13/21	Not Provided	Not Provided	2/9/2022	2/28/2022		0	Not Provided	Not Provided	Not Provided		No	No	No	No	No	No	Yes		#VALUE!	#VALUE!	
15	10/15/2021	Other	10/18/2021	10/18/21	03/01/22	5/4/2022	6/22/2022	6/27/2022		0	97	47	35		No	No	No	No	No	Yes	Yes	No Health Care signature, no credentials for QI. Used typed date forQI	6/3/2022	11/30/2022	
16	10/12/2021	Other	10/19/2021	10/19/21	10/19/21	3/22/2022	4/5/2022	4/25/2022		0	1	111	10		No	No	No	No	No	Yes	Yes	typed for QI no signature; no health professional signature Used typed date	4/21/2022	10/18/2022	
17	2/7/2022	Other --Death Certificate listed as Accidental	2/9/2022	02/10/22	03/08/22	4/6/2022	4/14/2022	4/25/2022		1	20	22	6		No	No	No	No	No	Yes	Yes	typed for QI no signature; no health professional signature: Used typed date	5/6/2022	11/2/2022	
18	9/1/2021	Potential	9/2/2021	09/09/21	09/17/21	10/8/2021	10/12/2021	4/25/2022		5	12	16	2		No	No	Yes	No	No	Yes	Yes	typed for QI no signature; no health professional signature; Used typed date	11/7/2021	5/6/2022	
19	2/8/2022	Homicide	2/9/2022	02/17/22	02/09/22	3/22/2022	4/5/2022	4/25/2022		6	1	30	10		Yes	Yes	Yes	Yes	No	Yes	no	typed for QI no signature; no health professional signature; Used typed date	4/21/2022	10/18/2022	
20	3/13/2022	SE	3/17/2022	03/17/22	03/18/22	4/26/2022	5/7/2022	5/23/2022		0	2	28	8		Yes	Yes	Yes	Yes	No	Yes	Yes	Used typed date for QI	5/26/2022	11/22/2022	
21	1/16/2022	Accidental	1/18/2022	04/11/22	04/11/22	5/10/2022	5/11/2022	5/23/2022		59	60	22	1	Waited for Death Certificate to start RCA	Yes	Yes	Yes	Yes	Yes	Yes	Yes		6/9/2022	12/6/2022	
22	4/24/2022	Accidental	5/5/2022	05/09/22	05/09/22	6/14/2022	6/16/2022	6/27/2022		2	3	27	2		Yes	Yes	Yes	Yes	Yes	Yes	Yes		7/14/2022	1/10/2023	
23	3/13/2022	Accidental	4/13/2022	05/09/22	05/09/22	6/16/2022	6/16/2022	6/27/2022		18	19	29	0		Yes	Yes	Yes	Yes	Yes	Yes	Yes		7/16/2022	1/12/2023	
24	1/21/2022	Overdose/ accidental death	2/7/2022	Did not notify LRE	02/07/22	3/4/2022	4/5/2022	4/25/2022		Not Provided	1	20	22		No	No	No	No	No	Yes	Yes	typed for QI no signature; no health professional signature; Used typed date	4/3/2022	9/30/2022	
25	5/2/2022	Suicide	6/1/2022	06/02/22	06/02/22	7/20/2022	7/20/2022	7/25/2022		1	2	35	0	Network 180 requested an extension over the 45 days, Wendi said OK	Yes	Yes	Yes	Yes	Yes	Yes	Yes		8/19/2022	2/15/2023	
26	5/16/2022	SE	6/3/2022	06/03/22	06/03/22	7/11/2022	7/15/2022	7/25/2022		0	1	27	4		Yes	Yes	Yes	Yes	No	Yes	Yes		8/10/2022	2/6/2023	
27	1/12/2022	Other	1/12/2022	01/13/22	02/08/22	4/15/2022	7/26/2022	8/22/2022		1	20	49	72		No	No	No	No	No	Yes	no	No Health Care signature, no credentials for QI. Used typed date forQI		6/28/1900	
28	6/24/2022	SE_Harm to Self requiring EMT	6/27/2022	06/27/22	06/27/22	7/27/2022	7/27/2022	8/22/2022		0	1	23	0		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Listed reccomendations for follow up		6/28/1900	
29	5/20/2022	Accidental	7/8/2022	07/08/22	07/09/22	8/12/2022	8/15/2022	8/22/2022		0	1	25	1		Yes	Yes	Yes	Yes	Yes	Yes	Yes		9/11/2022	3/10/2023	
30	6/4/2022	Suicide	7/26/2022	07/27/22	07/27/22	8/23/2022	8/23/2022	9/26/2022		1	2	20	0		Yes	Yes	Yes	Yes	Yes	Yes	Yes		9/22/2022	3/21/2023	
31	5/13/2022	Accidental	5/16/2022	05/16/22	09/04/22	9/18/2022	9/20/2022	9/26/2022		0	80	10	1	Did not have death Certificate until 9/3/2022	Yes	Yes	Yes	Yes	Yes	Yes	Yes		10/18/2022	4/16/2023	

Lakeshore Regional Entity
Sentinel Events and Critical Incidents
Monitoring Report FY22
(In Accordance with: 42 CFR §438.330(b)(5)(ii), MDHHS-PIHP Contract Schedule A-1(K)(2)(a), QAPIP Technical Guidelines, Section VIII)

32	8/18/2022	Medication Error	8/18/2022	08/19/22	08/19/22	9/30/2022	9/30/2022	10/24/2022	1	2	31	0		Yes	Yes	Yes	Yes	Yes	Yes	Yes		10/30/2022	4/28/2023	
33	7/27/2022	Accidental	7/28/2022	07/28/22	07/28/22	9/7/2022	9/30/2022	10/24/2022	0	1	30	17		Yes	Yes	Yes	Yes	no	Yes	Yes		10/7/2022	4/5/2023	
34	5/23/2022	Accidental	5/24/2022	10/07/22	none completed	None Completed	10/7/2022	10/24/2022	98	Not Provided	Not Provided	Not Provided		No	Yes	Yes	No	No	Yes	No	Typed signatures and credential for RN	#VALUE!	#VALUE!	
35	5/6/2022	Accidental	5/17/2022	10/07/22	none completed	None Completed	10/7/2022	10/24/2022	103	Not Provided	Not Provided	Not Provided		No	Yes	Yes	No	No	Yes	No	Typed signatures and credential for RN	#VALUE!	#VALUE!	
36	8/20/2000	Suicide	8/24/2022	08/24/22	none completed	None Completed	10/7/2022	10/24/2022	0	Not Provided	Not Provided	Not Provided		No	Yes	Yes	No	No	Yes	No	Typed signatures and credential for RN	#VALUE!	#VALUE!	
37	5/3/2022	Suicide	5/4/2022	10/07/22	06/01/22	7/20/2022	10/7/2022	10/24/2022	112	21	36	57		No	Yes	Yes	No	No	Yes	Yes	Typed signatures and credential for RN	8/19/2022	2/15/2023	
38	2/22/2022	Other Accidental	2/23/2022	02/23/22	08/30/22	10/12/2022	10/12/2022	10/24/2022	0	135	32	0		Yes	Yes	Yes	Yes	Yes	Yes	Yes		11/11/2022	5/10/2023	
39	11/28/2021	Suicide	11/29/2021	10/13/22	NA	NA	10/13/2022	10/24/2022	228	Not Provided	Not Provided	Not Provided		Yes	Yes	Yes	Yes	no	Yes	No		#VALUE!	#VALUE!	
40	6/10/2022	Accidental	6/10/2022	09/09/22	09/09/22	10/17/2022	10/17/2022	10/24/2022	65	Not Provided	Not Provided	0		Yes	Yes	Yes	Yes	Yes	Yes	Yes		11/16/2022	5/15/2023	

	TIMELINESS STANDARDS					REVIEW STANDARDS						MONITORING STANDARD			
		Contract Schedule A—1(K)(2)(a)				Contract Schedule A—1(K)(2)(a)						42 CFR §438.330(b)(5)(ii) Contract Schedule A—1(K)(2)(a)		42 CFR §438.330(b)(5)(ii) Contract Schedule A—1(K)(2)(a)	42 CFR §438.330(b)(5)(ii) Contract Schedule A—1(K)(2)(a)
	LRE Policy	QAPIPs for Specialty PIHPs, Section VIII(A)	LRE Policy	LRE Policy		QAPIPs for Specialty PIHPs, Section VIII(B)	LRE Procedure	LRE Procedure	LRE Procedure	LRE Procedure	LRE Procedure	QAPIPs for Specialty PIHPs, Section VIII(A-D)	LRE Procedure	QAPIPs for Specialty PIHPs, Section VIII(A-D)	QAPIPs for Specialty PIHPs, Section VIII(A-D)
	# Days from knowledge of occurrence to LRE Notification **Standard: 24 hours**	# Days to Start RCA. **Standard: 3 days to determine if SE then 2 business days to commence RCA**	# Days to Complete RCA after started: **Standard: 45 Days**	# Days to Send LRE Completed Unexpected Death Form: **Policy states within 48 hours** **Data below in DAYS**		Health Care Professional Signature **Standard: MD/DO/RN Only**	Health Care Professional's Credentials **Standard: Credentials Present**	Health Care Professional Signature Date **Standard: Date Present**	Quality Improvement Personnel Signature **Standard: Appropriate Credentials**	Quality Improvement Personnel Credentials **Standard: Credentials Present**	Quality Improvement Professional Signature Date **Standard: Date Present**	CMHSP Self-Determined Follow-Up Task **Standard: Task Present**	CMHSP Self-Determined Follow-Up Task **Standard: up to 90 days following RCA completion**	LRE Validation of Remediation **Standard: At Least Annually**	Outcome of LRE Validation of Remediation **Standard: Validated**
Target:	1	5	45	2	Target:	100%	100%	100%	100%	100%	100%				
Average:	21	15	30	9	Rate:	68%	73%	83%	70%	48%	98%				
Maximum:	228	135	139	72											
Minimum:	0	1	6	0											

LRE Customer Service Satisfaction Survey Results

Purpose: Show results of Customer Service Satisfaction Surveys

Data Source: Lakeshore Regional Entity Customer Satisfaction Survey Data

Intended Audience: LRE/PIHP/CMHSP/Providers

Following Questions were asked of Consumers:

Access and Availability Measures:

When I first asked for services, it went well.
If I did not receive the services I asked for, I was given other choices.
Staff called me back within 24 hours.
Dates and times of my services worked for me.
The place of my services worked for me.

Long Term Services Measures:

I am satisfied with my support coordinator/case manager.
I am satisfied with my current housing situation.
My treatment team works well together to provide good care for me.
My services helped me improve relationships with friends, family and community members.

Outcomes Measures:

Services helped me deal better with my illness or disability.
I am satisfied with my services.

Quality Measures:

I decided the goals for my treatment plan.
I feel included in working on my treatment plan.
I felt comfortable asking questions.
Staff helped me get information to better deal with my illness or disability.

Telehealth Services Measures:

How many of your services did you receive by telehealth?
I am able to use telehealth services without technical problems.
Staff helped me when I had problems using telehealth.
I would like to use telehealth for future appointments.
Overall, I am satisfied with using telehealth for my services.

LAKESHORE REGIONAL ENTITY

Data Update Date:

1/31/2023

All visualizations exclude:
1. Surveys without an assigned CMHSP
2. Surveys labeled as Not Approved

FY: FY22
- [ ] Select all
- [ ] FY21
- [x] FY22
- [ ] FY23

QTR: All
- [x] Select all
- [x] FY22Q1
- [x] FY22Q2
- [x] FY22Q3
- [x] FY22Q4

Service Population Group: All
- [x] Select all
- [x] (Blank)
- [x]
- [x] Intellectual and/or Developmental Disability
- [x] Intellectual and/or Developmental Disability,Mental Illness
- [x] Intellectual and/or Developmental Disability,Substance Use Disorders
- [x] Intellectual and/or Developmental Disability,Substance Use Disorders,Mental Illn...
- [x] Mental Illness
- [x] Mental Illness,Intellectual and/or Developmental Disability
- [x] Mental Illness,Intellectual and/or Developmental Disability,Substance Use Disord...
- [x] Mental Illness,Substance Use Disorders
- [x] Mental Illness,Substance Use Disorders,Intellectual and/or Developmental Disabi...

Length Of Time In Service: All
- [x] Select all
- [x] (Blank)
- [x] Less than a year
- [x] More than a year

Race/Ethnicity: All
- [x] Select all
- [x] (Blank)
- [x]
- [x] Asian
- [x] Asian,Caucasian / White
- [x] Asian,Prefer to Self-Describe:
- [x] Black / African American
- [x] Black / African American,Caucasian / White
- [x] Black / African American,Caucasian / White,Native American
- [x] Black / African American,Hispanic / Latinx
- [x] Black / African American,Hispanic / Latinx,Caucasian / White
- [x] Black / African American,Hispanic / Latinx,Prefer Not to Answer
- [x] Black / African American,Native American
- [x] Caucasian / White
- [x] Caucasian / White,Asian
- [x] Caucasian / White,Black / African American
- [x] Caucasian / White,Hispanic / Latinx
- [x] Caucasian / White,Hispanic / Latinx,Native American
- [x] Caucasian / White,Native American
- [x] Caucasian / White,Pacific Islander
- [x] Caucasian / White,Prefer Not to Answer,Native American
- [x] Hispanic / Latinx

Age: All
- [x] Select all
- [x] (Blank)
- [x] Between 18 - 60
- [x] Less than 18
- [x] Over age 60

Gender: All
- [x] Select all
- [x] (Blank)
- [x] Female
- [x] Male
- [x] Prefer not to answer
- [x] Prefer to Self-Describe:

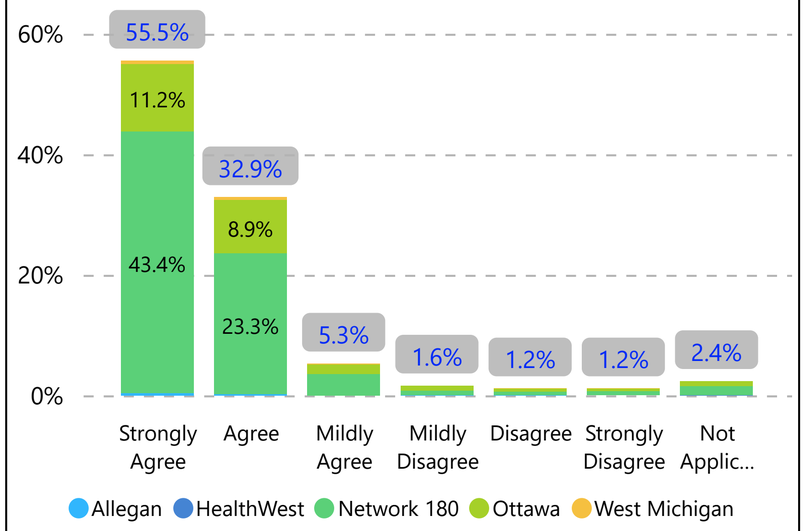
Provider: All
- [x] Select all
- [x] (Blank)
- [x] ACAC Inc
- [x] Acorn Health of Michigan
- [x] American Homestead
- [x] Arbor Circle
- [x] Benjamin's Hope
- [x] Bethany Christian Services
- [x] Braintrust Behavioral Health
- [x] Centria Healthcare
- [x] Cherry Health
- [x] Community Living Services Inc.
- [x] D.A. Blodgett - St. John's
- [x] Family Outreach Center
- [x] Goodwill Industries
- [x] Hope Network
- [x] IKUS Life Enrichment Services – Indian Trails Camp
- [x] Indian Trails Camp
- [x] InterAct of Michigan
- [x] MOKA
- [x] Ottagan Addictions Recovery
- [x] Pine Rest Christian Mental Health
- [x] Pine Rest Christian Mental Health Hospital
- [x] Preferred Employment & Living Services
- [x] Salvation Army Turning Point
- [x] Samaritas
- [x] Sparks Behavioral Services LLC

CMHSP	Number of Completed Surveys
Allegan	14
HealthWest	1
Network 180	1414
Ottawa	464
West Michigan	24
Total	**1917**

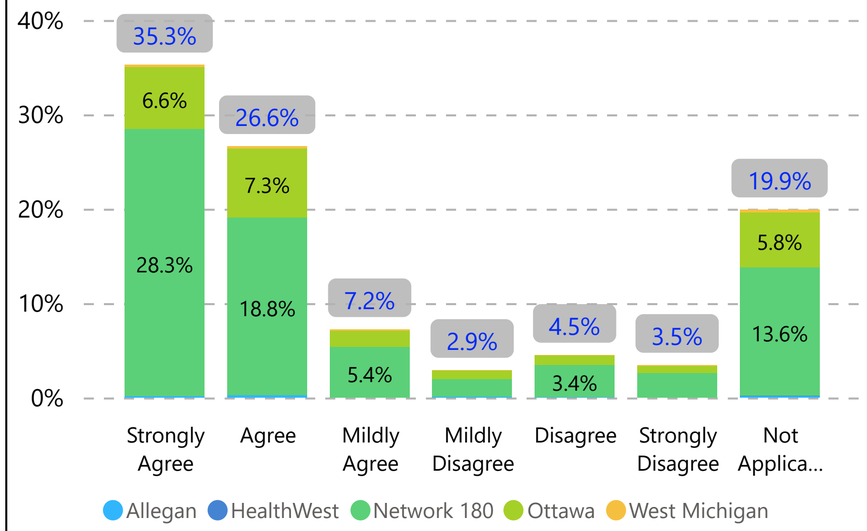
Access and Availability Measures

FY Filters Selected | QTR Filters Selected
- QTR: ALL
- FY: FY22

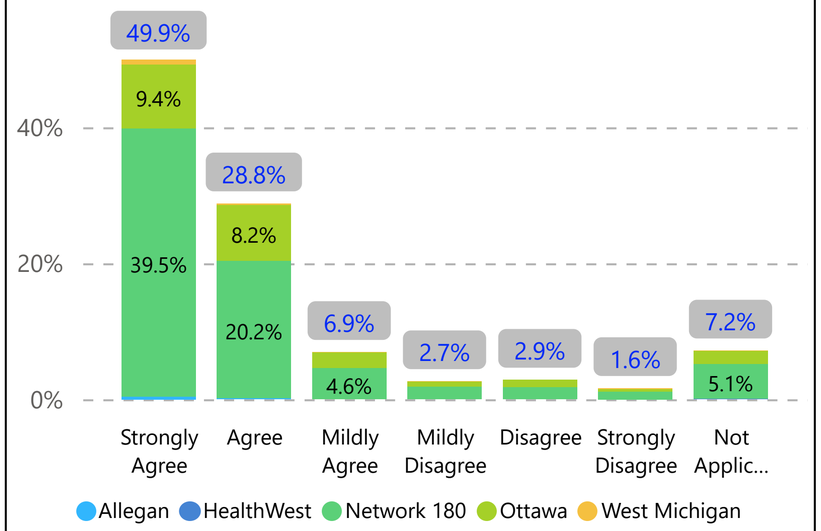
When I first asked for services, it went well.



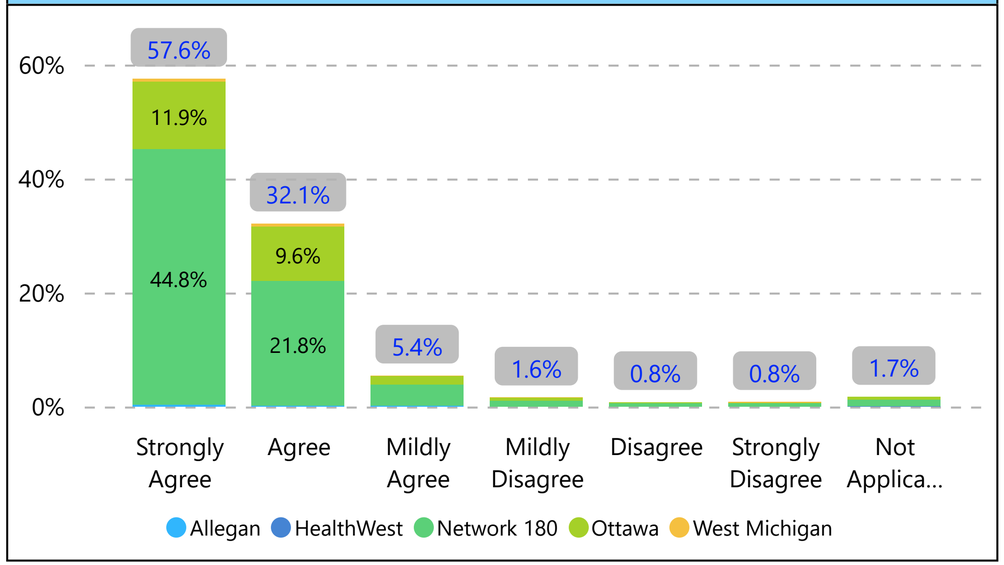
If I did not receive the services I asked for, I was given other choices.



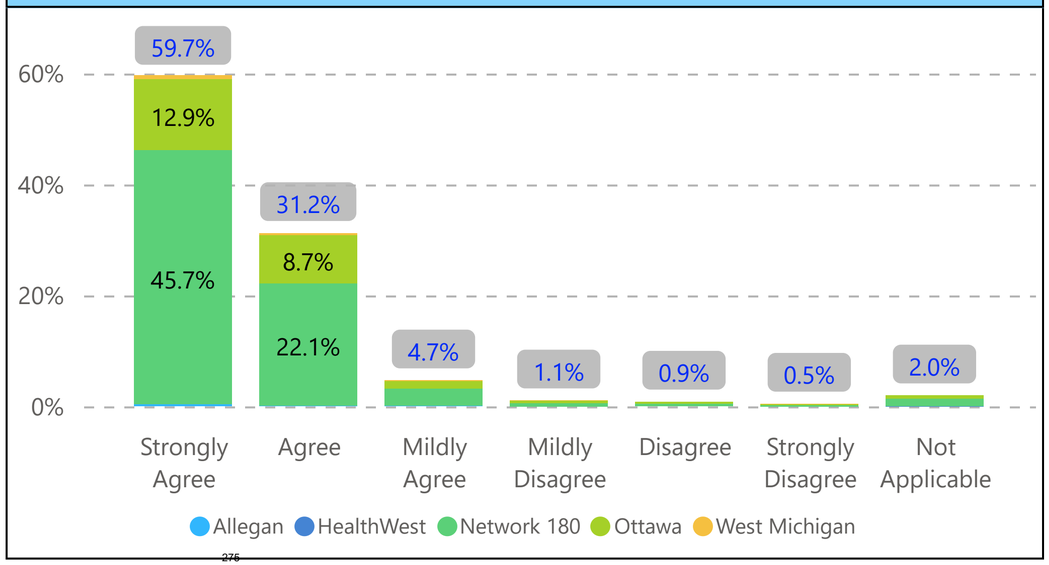
Staff called me back within 24 hours.



Dates and times of my services worked for me.



The place of my services worked for me.



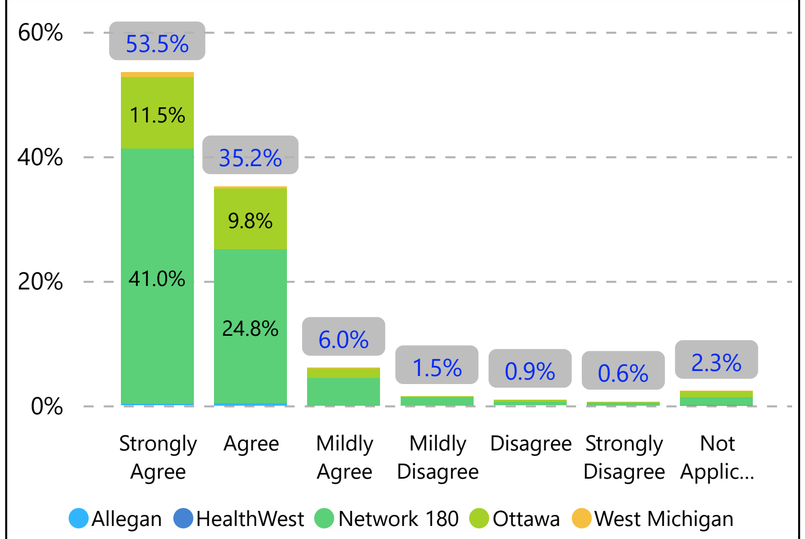
CMHSP	# of Completed Surveys
Allegan	14
HealthWest	1
Network 180	1414
Ottawa	464
West Michigan	24
Total	**1917**

Quality Measures

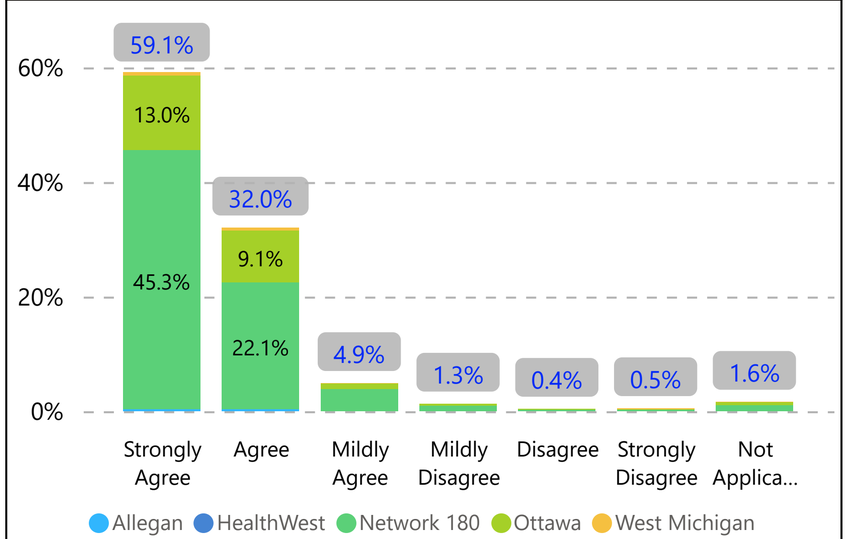
FY Filters Selected | QTR Filters Selected

- QTR: ALL
- FY: FY22

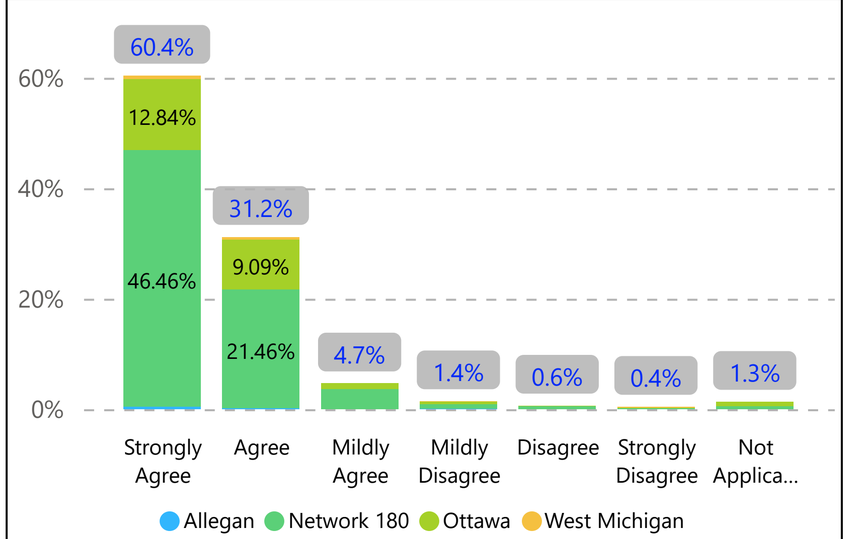
I decided the goals for my treatment plan.



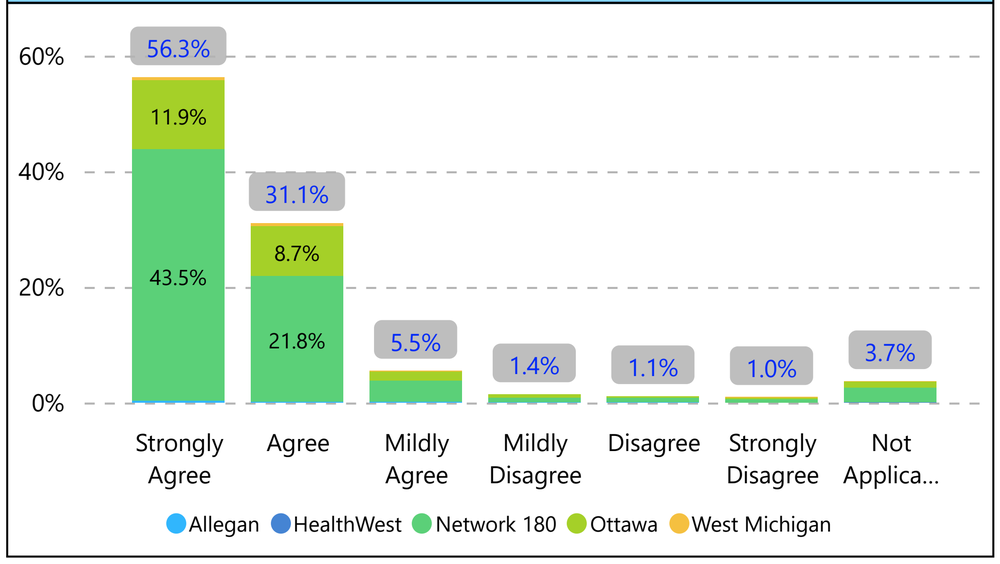
I feel included in working on my treatment plan.



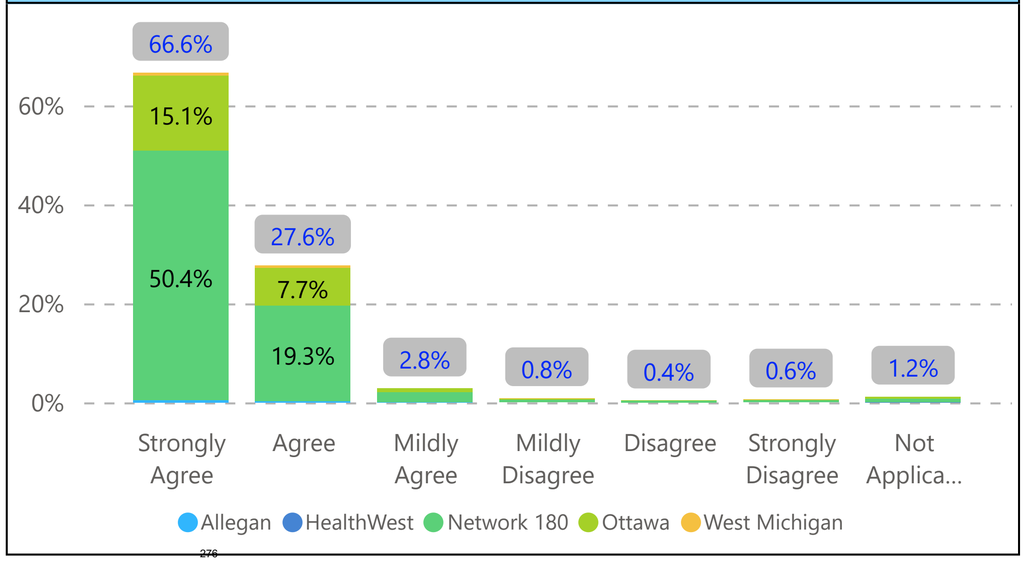
I felt comfortable asking questions.



Staff helped me get information to better deal with my illness/disability.



Staff accept me for who I am.

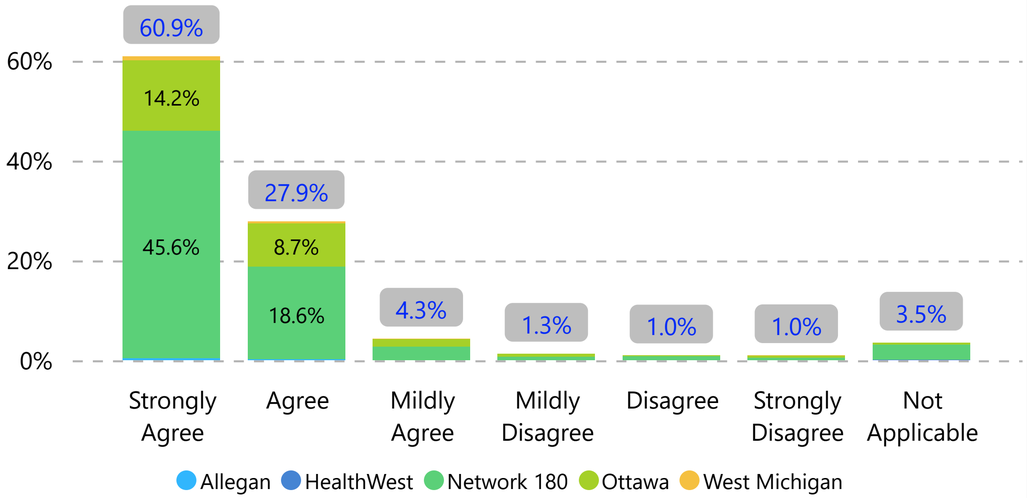


CMHSP	# of Completed Surveys
Allegan	14
HealthWest	1
Network 180	1414
Ottawa	464
West Michigan	24
Total	**1917**

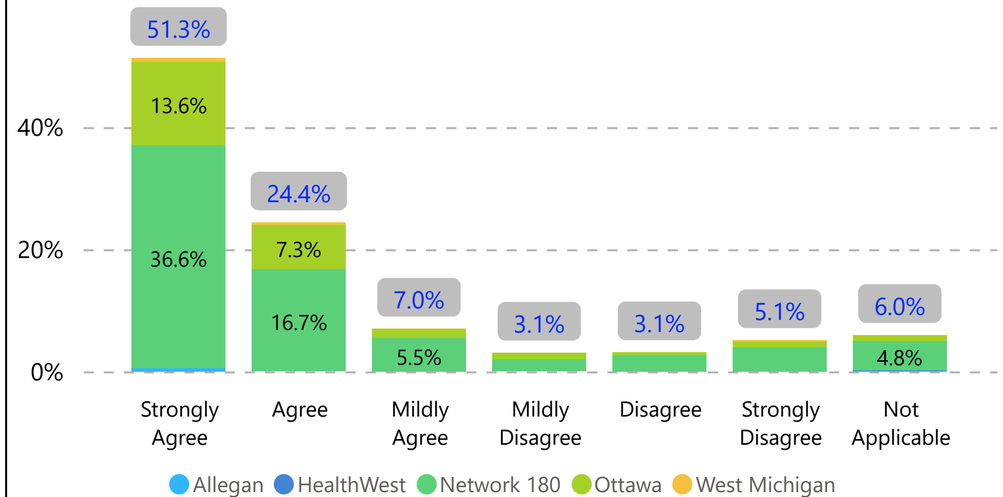
Long Term Services Measures

FY Filters Selected	QTR Filters Selected
- FY: FY22	- QTR: ALL

I am satisfied with my support coordinator/case manager.

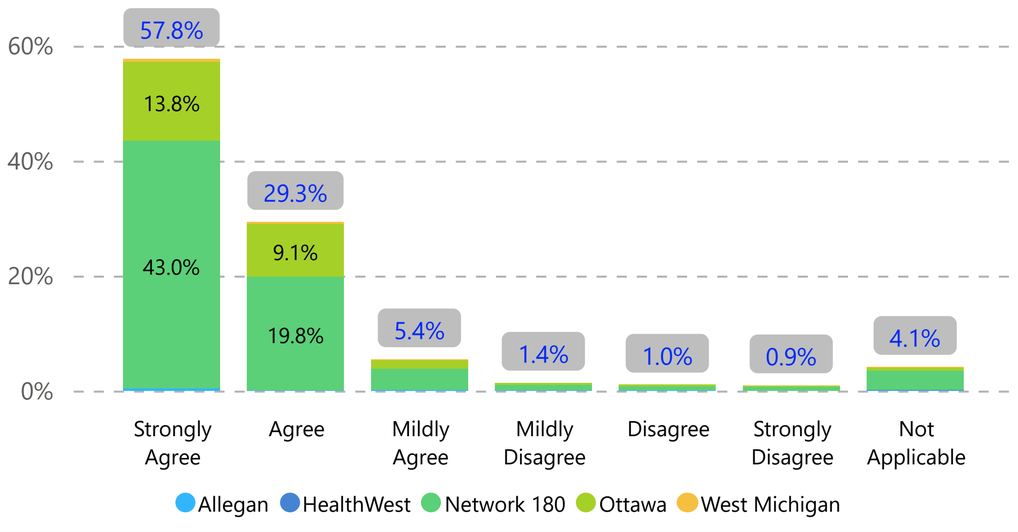


I am satisfied with my current housing situation.

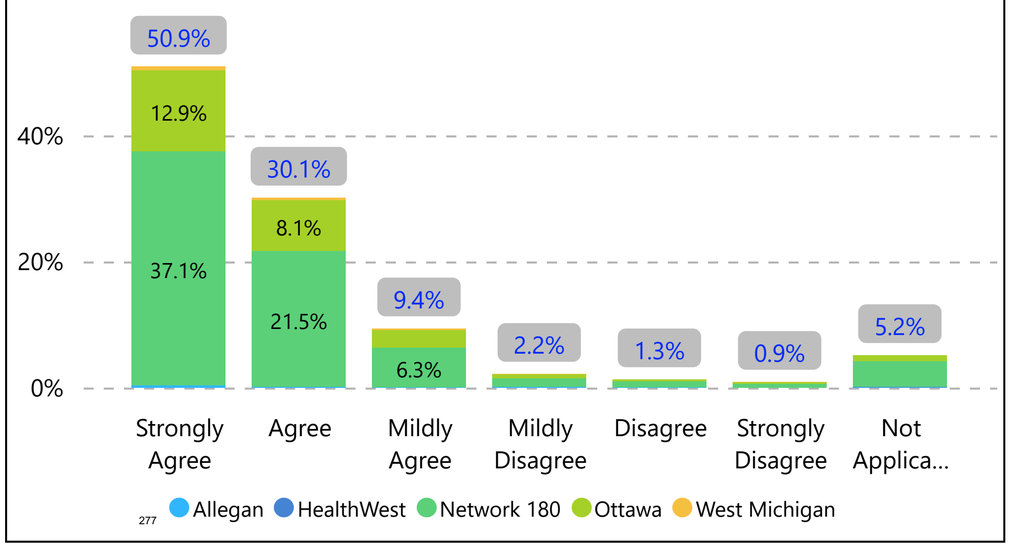


CMHSP	# of Completed Surveys
Allegan	14
HealthWest	1
Network 180	1414
Ottawa	464
West Michigan	24
Total	**1917**

My treatment team works well together to provide good care for me.



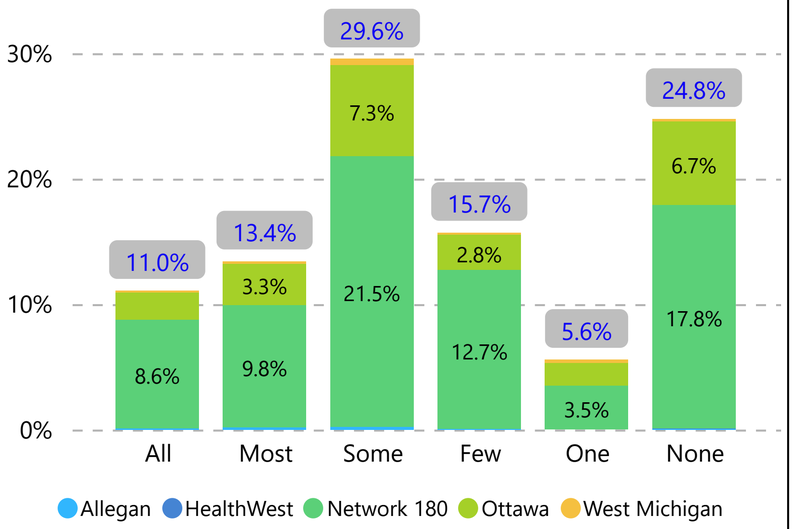
My services helped me improve relationships.



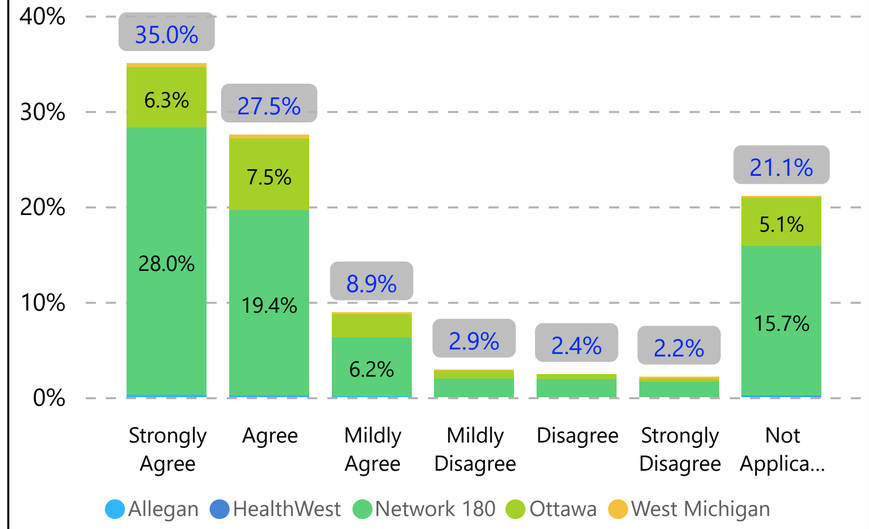
Telehealth Services Measures

FY Filters Selected	QTR Filters Selected
- FY: FY22	- QTR: ALL

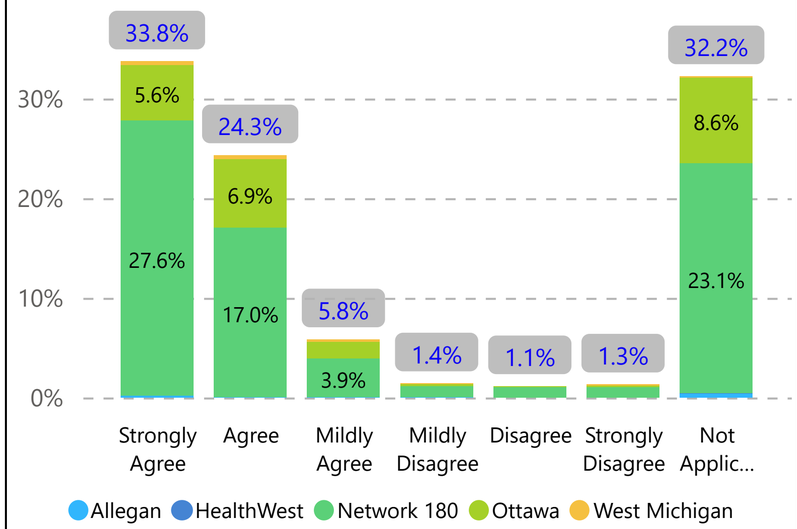
How many of your services did you receive by telehealth?



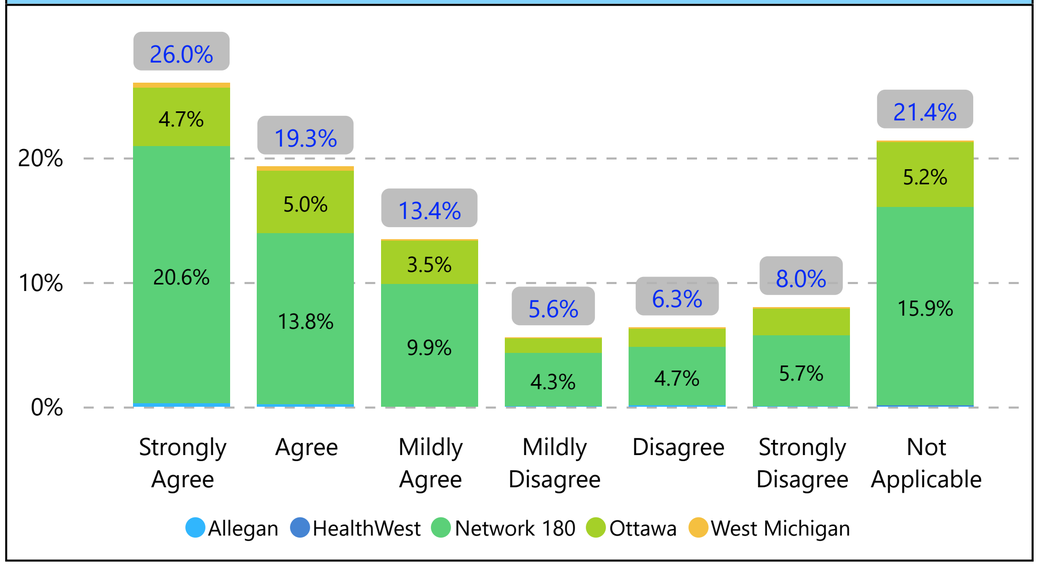
I am able to use telehealth services without technical problems.



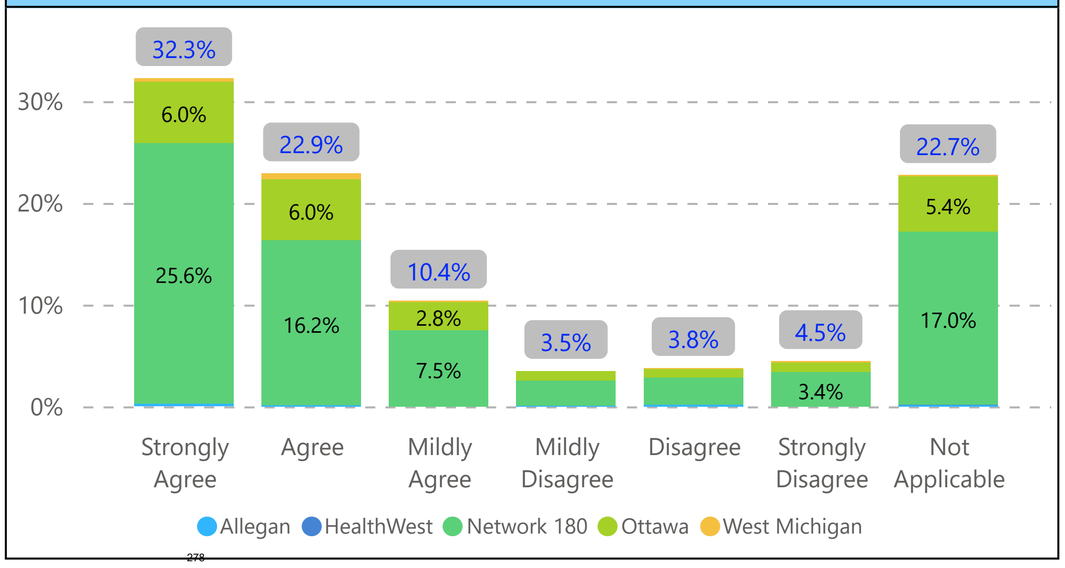
Staff helped me when I had problems using telehealth.



I would like to use telehealth for future appointments.



Overall, I am satisfied with using telehealth for my services.

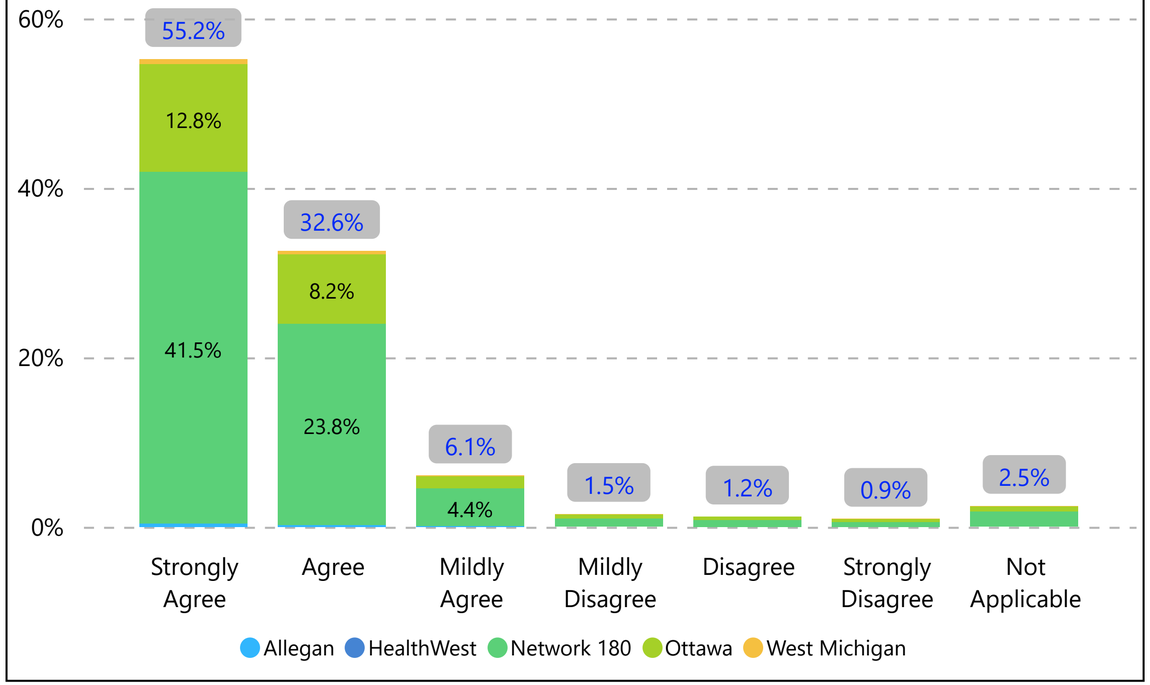


CMHSP	# of Completed Surveys
Allegan	14
HealthWest	1
Network 180	1414
Ottawa	464
West Michigan	24
Total	**1917**

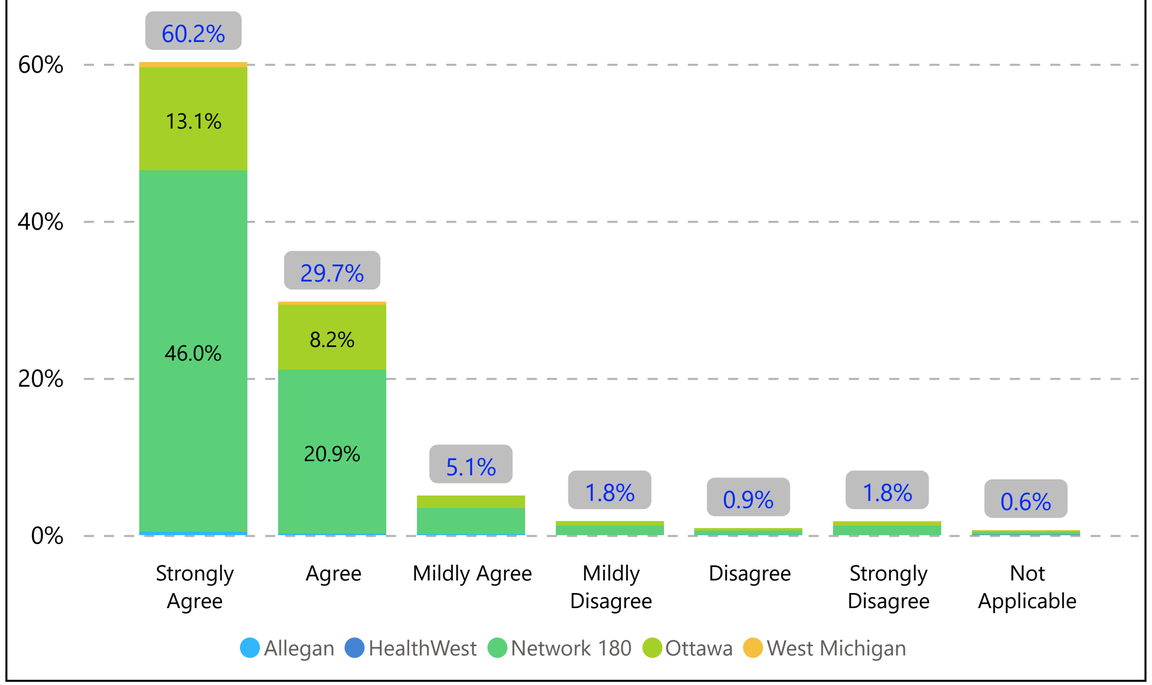
Outcomes

FY Filters Selected	QTR Filters Selected
- FY: FY22	- QTR: ALL

Services helped me deal better with my illness or disability.



I am satisfied with my services.



CMHSP	# of Completed Surveys
Allegan	14
HealthWest	1
Network 180	1414
Ottawa	464
West Michigan	24
Total	**1917**

LAKESHORE REGIONAL ENTITY

Fiscal Year Results by CMHSP

FY Filters Selected

- FY: FY22

Access and Availability - Average Scores

CMHSP	First Service	Other Svcs Choices	Staff Returned Calls	Services Times Good	Services Good Location
Allegan	5.2	3.6	4.8	5.1	5.4
HealthWest	0.0	0.0	0.0	0.0	0.0
Network 180	5.3	4.0	4.9	5.3	5.3
Ottawa	5.0	3.6	4.5	5.2	5.2
West Michigan	4.8	3.1	4.5	4.8	5.0
LRE	**5.2**	**3.9**	**4.8**	**5.3**	**5.3**

Quality - Average Scores

CMHSP	I Decided Goals	I Feel Included	Comfortable Asking Questions	Staff Helped with Questions	Staff Accepted Me
Allegan	5.4	5.4	5.2	4.9	5.5
HealthWest	0.0	0.0	0.0	0.0	0.0
Network 180	5.2	5.4	5.4	5.2	5.5
Ottawa	5.1	5.3	5.2	5.0	5.4
West Michigan	4.9	4.6	4.9	4.5	4.6
LRE	**5.2**	**5.3**	**5.4**	**5.2**	**5.4**

Long Term Services - Average Scores

CMHSP	Satisfied with CSM	Satisfied with Housing	Team Works Well	Svcs Helped Relationships
Allegan	4.5	4.4	4.3	4.1
HealthWest	0.0	0.0	0.0	0.0
Network 180	4.7	4.2	4.7	4.5
Ottawa	5.2	4.9	5.1	5.0
West Michigan	5.2	4.3	4.0	4.6
LRE	**4.8**	**4.4**	**4.8**	**4.6**

Telehealth - Average Scores

CMHSP	How Many by Telehealth	Telehealth Frequency	Able to Use Telehealth	Staff Helped with Telehealth	Like to Use Telehealth	Satisfied with Telehealth
Allegan	4.3	Some	4.1	2.1	3.8	3.5
HealthWest	1.0	None	0.0	0.0	0.0	0.0
Network 180	3.4	Few	3.8	3.4	3.2	3.5
Ottawa	3.2	Few	3.4	2.9	2.9	3.1
West Michigan	3.5	Few	4.0	4.1	3.7	4.1
LRE	**3.3**	**Few**	**3.7**	**3.3**	**3.2**	**3.4**

Outcomes - Average Scores

CMHSP	Services Helped	Satisfied with Services
Allegan	5.2	5.2
HealthWest	0.0	0.0
Network 180	5.2	5.3
Ottawa	5.1	5.2
West Michigan	4.7	4.7
LRE	**5.2**	**5.3**

Overall - Average Scores

CMHSP	Access & Availability	Quality	Long Term Services	Telehealth	Outcomes	Overall
Allegan	5.1	5.3	5.2	4.8	5.2	5.1
HealthWest	NaN	NaN	NaN	NaN	NaN	NaN
Network 180	5.4	5.5	5.3	4.9	5.4	5.3
Ottawa	5.2	5.4	5.3	4.8	5.3	5.2
West Michigan	5.0	5.1	4.6	5.1	5.0	
Total LRE	**5.3**	**5.5**	**5.3**	**4.9**	**5.4**	**5.3**

280

LRE - Results by Qtr

QTR Filters Selected

- QTR: ALL

Access and Availability - Average Scores

QTR	First Service	Other Svcs Choices	Staff Returned Calls	Services Times Good	Services Good Location
FY22Q1	5.3	3.8	5.1	5.4	5.3
FY22Q2	5.2	4.1	4.8	5.3	5.2
FY22Q3	5.2	3.6	4.7	5.3	5.3
LRE	**5.2**	**3.9**	**4.8**	**5.3**	**5.3**
# of responses *	1853	1503	1750	1861	1845

Quality - Average Scores

QTR	I Decided Goals	I Feel Included	Comfortable Asking Questions	Staff Helped with Questions	Staff Accepted Me
FY22Q1	5.4	5.4	5.5	5.3	5.4
FY22Q2	5.2	5.4	5.4	5.2	5.4
FY22Q3	5.1	5.2	5.3	5.1	5.4
LRE	**5.2**	**5.3**	**5.4**	**5.2**	**5.4**
# of responses *	1846	1863	1867	1823	1866

Long Term Services - Average Scores

QTR	Satisfied with CSM	Satisfied with Housing	Team Works Well	Svcs Helped Relationships
FY22Q1	5.3	5.0	5.2	5.2
FY22Q2	5.2	4.6	5.0	4.8
FY22Q3	4.9	4.4	4.7	4.5
LRE	**4.8**	**4.4**	**4.8**	**4.6**
# of responses *	1692	1654	1673	1656

Telehealth - Average Scores

QTR	How Many by Telehealth	Telehealth Frequency	Able to Use Telehealth	Staff Helped with Telehealth	Like to Use Telehealth	Satisfied with Telehealth
FY22Q1	3.2	Few	3.8	3.9	3.6	3.7
FY22Q2	3.5	Some	3.6	3.3	3.1	3.3
FY22Q3	3.3	Few	3.6	3.2	3.1	3.3
FY22Q4	3.3	Few	3.8	3.3	3.2	3.5
LRE	**3.3**	**Few**	**3.7**	**3.3**	**3.2**	**3.4**
# of responses *	1620		1393	1196	1387	1353

Total Completed Surveys

1917

***Note:** "Not applicable responses NOT included

Outcomes - Average Scores

QTR	Services Helped	Satisfied with Services
FY22Q1	5.4	5.5
FY22Q2	5.2	5.3
FY22Q3	5.1	5.3
LRE	**5.2**	**5.3**
# of responses *	1851	1869

Average Scores by Category

QTR	Access & Availability	Quality	Long Term Services	Telehealth	Outcomes	Overall
FY22Q1	5.3	5.5	5.4	5.1	5.5	5.4
FY22Q2	5.3	5.5	5.3	4.9	5.4	5.3
FY22Q3	5.3	5.5	5.4	4.8	5.4	5.3
Total LRE	**5.3**	**5.5**	**5.3**	**4.9**	**5.4**	**5.3**

Allegan - Results by Qtr

QTR Filters Selected

- QTR: ALL

Access and Availability - Average Scores

QTR	First Service	Other Svcs Choices	Staff Returned Calls	Services Times Good	Services Good Location
FY22Q2	5.2	3.6	4.8	5.1	5.4
Allegan	**5.2**	**3.6**	**4.8**	**5.1**	**5.4**
# of responses *	14	11	13	14	14

Quality - Average Scores

QTR	I Decided Goals	I Feel Included	Comfortable Asking Questions	Staff Helped with Questions	Staff Accepted Me
FY22Q2	5.4	5.4	5.2	4.9	5.5
Allegan	**5.4**	**5.4**	**5.2**	**4.9**	**5.5**
# of responses *	14	14	14	14	14

Long Term Services - Average Scores

QTR	Satisfied with CSM	Satisfied with Housing	Team Works Well	Svcs Helped Relationships
FY22Q2	4.5	4.4	4.3	4.1
Allegan	**4.5**	**4.4**	**4.3**	**4.1**
# of responses *	12	11	12	12

Telehealth - Average Scores

QTR	How Many by Telehealth	Telehealth Frequency	Able to Use Telehealth	Staff Helped with Telehealth	Like to Use Telehealth	Satisfied with Telehealth
FY22Q2	4.3	Some	4.1	2.1	3.8	3.5
Allegan	**4.3**	**Some**	**4.1**	**2.1**	**3.8**	**3.5**
# of responses *	11		11	6	12	11

Total Completed Surveys

14

***Note:** "Not applicable responses NOT included

Outcomes - Average Scores

QTR	Services Helped	Satisfied with Services
FY22Q2	5.2	5.2
Allegan	**5.2**	**5.2**
# of responses *	14	14

Average Scores by Category

QTR	Access & Availability	Quality	Long Term Services	Telehealth	Outcomes	Overall
FY22Q2	5.1	5.3	5.2	4.8	5.2	5.1
Total Allegan	**5.1**	**5.3**	**5.2**	**4.8**	**5.2**	**5.1**

HealthWest - Results by Qtr

QTR Filters Selected

- QTR: ALL

Access and Availability - Average Scores

QTR	First Service	Other Svcs Choices	Staff Returned Calls	Services Times Good	Services Good Location
FY22Q4	0.0	0.0	0.0	0.0	0.0
HealthWest	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
# of responses *	0	0	0	0	0

Quality - Average Scores

QTR	I Decided Goals	I Feel Included	Comfortable Asking Questions	Staff Helped with Questions	Staff Accepted Me
FY22Q4	0.0	0.0	0.0	0.0	0.0
HealthWest	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
# of responses *	0	0	0	0	0

Long Term Services - Average Scores

QTR	Satisfied with CSM	Satisfied with Housing	Team Works Well	Svcs Helped Relationships
FY22Q4	0.0	0.0	0.0	0.0
HealthWest	**0.0**	**0.0**	**0.0**	**0.0**
# of responses *	0	0	0	0

Telehealth - Average Scores

QTR	How Many by Telehealth	Telehealth Frequency	Able to Use Telehealth	Staff Helped with Telehealth	Like to Use Telehealth	Satisfied with Telehealth
FY22Q4	1.0	None	0.0	0.0	0.0	0.0
HealthWest	**1.0**	**None**	**0.0**	**0.0**	**0.0**	**0.0**
# of responses *	1		0	0	0	0

Total Completed Surveys

1

***Note:** "Not applicable responses NOT included

Outcomes - Average Scores

QTR	Services Helped	Satisfied with Services
FY22Q4	0.0	0.0
HealthWest	**0.0**	**0.0**
# of responses *	0	0

Average Scores by Category

QTR	Access & Availability	Quality	Long Term Services	Telehealth	Outcomes	Overall
FY22Q4	NaN	NaN	NaN	NaN	NaN	NaN
Total HealthWest	**NaN**	**NaN**	**NaN**	**NaN**	**NaN**	**NaN**

Network180 - Results by Qtr

QTR Filters Selected

- QTR: ALL

Access and Availability - Average Scores

QTR	First Service	Other Svcs Choices	Staff Returned Calls	Services Times Good	Services Good Location
FY22Q1	5.7	5.3	3.7	5.7	5.7
FY22Q2	5.2	4.1	4.8	5.3	5.2
FY22Q3	5.4	3.8	5.0	5.4	5.4
Network180	**5.3**	**4.0**	**4.9**	**5.3**	**5.3**
# of responses *	1374	1133	1299	1373	1359

Quality - Average Scores

QTR	I Decided Goals	I Feel Included	Comfortable Asking Questions	Staff Helped with Questions	Staff Accepted Me
FY22Q1	5.3	5.3	5.3	5.3	5.7
FY22Q2	5.2	5.4	5.4	5.2	5.4
FY22Q3	5.3	5.4	5.5	5.2	5.4
Network180	**5.2**	**5.4**	**5.4**	**5.2**	**5.5**
# of responses *	1370	1380	1384	1350	1380

Long Term Services - Average Scores

QTR	Satisfied with CSM	Satisfied with Housing	Team Works Well	Svcs Helped Relationships
FY22Q1	5.7	3.3	5.3	3.3
FY22Q2	5.2	4.6	5.1	4.8
FY22Q3	4.8	4.3	4.7	4.5
Network180	**4.7**	**4.2**	**4.7**	**4.5**
# of responses *	1211	1184	1202	1187

Telehealth - Average Scores

QTR	How Many by Telehealth	Telehealth Frequency	Able to Use Telehealth	Staff Helped with Telehealth	Like to Use Telehealth	Satisfied with Telehealth
FY22Q1	1.0	None	0.0	0.0	0.7	0.0
FY22Q2	3.5	Few	3.6	3.3	3.1	3.3
FY22Q3	3.3	Few	3.8	3.4	3.3	3.5
FY22Q4	3.3	Few	3.9	3.5	3.4	3.7
Network180	**3.4**	**Few**	**3.8**	**3.4**	**3.2**	**3.5**
# of responses *	1197		1043	913	1039	1014

Total Completed Surveys

1414

***Note:** "Not applicable responses NOT included

Outcomes - Average Scores

QTR	Services Helped	Satisfied with Services
FY22Q1	5.7	5.7
FY22Q2	5.2	5.4
FY22Q3	5.2	5.4
Network180	**5.2**	**5.3**
# of responses *	1368	1378

Average Scores by Category

QTR	Access & Availability	Quality	Long Term Services	Telehealth	Outcomes	Overall
FY22Q1	5.6	5.4	4.8	2.0	5.7	5.3
FY22Q2	5.3	5.5	5.3	4.9	5.4	5.3
FY22Q3	5.4	5.5	5.4	4.9	5.5	5.4
Total Network180	**5.4**	**5.5**	**5.3**	**4.9**	**5.4**	**5.3**

Ottawa - Results by Qtr

QTR Filters Selected

- QTR: ALL

Access and Availability - Average Scores

QTR	First Service	Other Svcs Choices	Staff Returned Calls	Services Times Good	Services Good Location
FY22Q1	5.3	3.9	5.1	5.3	5.2
FY22Q3	4.6	3.0	4.0	5.0	5.0
FY22Q4	5.1	3.8	4.7	5.3	5.3
Ottawa	**5.0**	**3.6**	**4.5**	**5.2**	**5.2**
# of responses *	442	342	417	451	449

Quality - Average Scores

QTR	I Decided Goals	I Feel Included	Comfortable Asking Questions	Staff Helped with Questions	Staff Accepted Me
FY22Q1	5.4	5.5	5.5	5.3	5.5
FY22Q3	4.6	4.9	4.8	4.6	5.3
FY22Q4	5.3	5.4	5.4	5.2	5.5
Ottawa	**5.1**	**5.3**	**5.2**	**5.0**	**5.4**
# of responses *	440	447	446	437	451

Long Term Services - Average Scores

QTR	Satisfied with CSM	Satisfied with Housing	Team Works Well	Svcs Helped Relationships
FY22Q1	5.3	5.1	5.2	5.3
FY22Q3	5.1	4.9	5.0	4.7
FY22Q4	5.2	4.8	5.2	5.0
Ottawa	**5.2**	**4.9**	**5.1**	**5.0**
# of responses *	446	437	440	435

Telehealth - Average Scores

QTR	How Many by Telehealth	Telehealth Frequency	Able to Use Telehealth	Staff Helped with Telehealth	Like to Use Telehealth	Satisfied with Telehealth
FY22Q1	3.4	Few	3.8	3.9	3.7	3.7
FY22Q3	3.3	Few	2.9	2.4	2.5	2.6
FY22Q4	3.1	Few	3.6	2.9	2.9	3.3
Ottawa	**3.2**	**Few**	**3.4**	**2.9**	**2.9**	**3.1**
# of responses *	389		318	256	316	307

Total Completed Surveys

464

***Note:** "Not applicable responses NOT included

Outcomes - Average Scores

QTR	Services Helped	Satisfied with Services
FY22Q1	5.4	5.5
FY22Q3	4.8	5.0
FY22Q4	5.3	5.3
Ottawa	**5.1**	**5.2**
# of responses *	447	455

Average Scores by Category

QTR	Access & Availability	Quality	Long Term Services	Telehealth	Outcomes	Overall
FY22Q1	5.2	5.5	5.4	5.2	5.5	5.4
FY22Q3	5.1	5.3	5.3	4.5	5.2	5.1
FY22Q4	5.2	5.5	5.3	4.8	5.4	5.3
Total Ottawa	**5.2**	**5.4**	**5.3**	**4.8**	**5.3**	**5.2**

West Michigan - Results by Qtr

QTR Filters Selected

- QTR: ALL

Access and Availability - Average Scores

QTR	First Service	Other Svcs Choices	Staff Returned Calls	Services Times Good	Services Good Location
FY22Q1	5.3	2.0	5.9	5.6	5.6
FY22Q2	4.8	4.8	5.2	5.3	5.3
FY22Q3	4.8	3.8	3.8	4.2	5.2
FY22Q4					
West Michigan	**4.8**	**3.1**	**4.5**	**4.8**	**5.0**
# of responses *	23	17	21	23	23

Quality - Average Scores

QTR	I Decided Goals	I Feel Included	Comfortable Asking Questions	Staff Helped with Questions	Staff Accepted Me
FY22Q1	4.6	4.9	5.8	5.4	4.8
FY22Q2	5.8	5.3	5.3	5.2	4.8
FY22Q3	5.7	4.7	4.5	4.8	5.2
FY22Q4					
West Michigan	**4.9**	**4.6**	**4.9**	**4.5**	**4.6**
# of responses *	22	22	23	22	21

Long Term Services - Average Scores

QTR	Satisfied with CSM	Satisfied with Housing	Team Works Well	Svcs Helped Relationships
FY22Q1	5.4	4.9	5.0	4.8
FY22Q2	5.8	4.7	5.0	5.3
FY22Q3	5.7	4.2	3.5	4.7
FY22Q4				
West Michigan	**5.2**	**4.3**	**4.0**	**4.6**
# of responses *	23	22	19	22

Telehealth - Average Scores

QTR	How Many by Telehealth	Telehealth Frequency	Able to Use Telehealth	Staff Helped with Telehealth	Like to Use Telehealth	Satisfied with Telehealth
FY22Q1	3.1	Few	4.6	4.6	3.8	4.6
FY22Q2	4.0	Some	4.8	5.2	5.0	5.2
FY22Q3	4.2	Some	3.8	4.0	3.8	4.0
FY22Q4	2.0	One	1.5	1.5	1.5	1.5
West Michigan	**3.5**	**Few**	**4.0**	**4.1**	**3.7**	**4.1**
# of responses *	22		21	21	20	21

Total Completed Surveys

24

***Note:** "Not applicable responses NOT included

Outcomes - Average Scores

QTR	Services Helped	Satisfied with Services
FY22Q1	5.5	5.6
FY22Q2	5.7	5.5
FY22Q3	4.8	3.8
FY22Q4		
West Michigan	**4.7**	**4.7**
# of responses *	22	22

Average Scores by Category

QTR	Access & Availability	Quality	Long Term Services	Telehealth	Outcomes	Overall
FY22Q1	5.6	5.5	5.5	5.2	5.6	5.5
FY22Q2	5.1	5.5	5.2	5.0	5.6	5.3
FY22Q3	4.5	5.0	4.9	3.9	4.7	4.6
FY22Q4	4.0	3.9	3.8	3.0	3.6	3.7
Total West Michigan	**5.0**	**5.1**	**5.1**	**4.6**	**5.1**	**5.0**

Data Sources and Definitions

Data Source: Lakeshore Regional Entity Customer Satisfaction Survey Data

FY and QTR: Based on the DateDue field (which is the date that the survey is entered into the LREFastlane system)

Question Values:

Strongly Agree = 6
Agree = 5
Mildly Agree = 4
Mildly Disagree = 3
Disagree = 2
Strongly Disagree = 1
Not Applicable = 0 (Excluded from data when calculating Averages)

Question Choices:

Services: Mental Illness, Intellectual and/or Developmental Disability, Substance Use Disorders
Length of Service: Less than a year or More than a Year
Gender: Male, Female, Prefer Not to Answer or Prefer to Self-Describe
Age: Less than 18, Between 18-60 or Over Age 60
Race/Ethnicity: Asian, Black/African American, Caucasian/White, Hispanic/Latinx, Native American, Pacific Islander, Prefer Not to Answer or Prefer to Self-Describe

# of Responses: Sum of responses per question, excluding blank and Not Applicable responses.

How many services received were via Telehealth (points value): All (6), Most (5), Some (4), Few (3), One (2) or None (1)

LRE Average Scores: The LRE average is calculated by averaging the all the survey results in the region. It is not an average of the CMH averages.

LAKESHORE REGIONAL ENTITY

EXECUTIVE COMMITTEE SUMMARY
Wednesday, February 15, 2023, 3:00 PM

Present: Mark DeYoung, Linda Garzelloni, Jack Greenfield
Absent: Jane Verduin
LRE: Mary Marlatt-Dumas, Stephanie VanDerKooi, Stacia Chick, Kenyetta Brewer, Wesley Woods

WELCOME

i. Review of February 15, 2023, Meeting Agenda
ii. Review of January 18, 2023, Meeting Minutes

February 15, 2023, agenda and January 18, 2023, meeting minutes are accepted as presented.

MDHHS UPDATES

i. Rate Analysis
   - Ms. Marlatt-Dumas reports that Jeff Wieferich said the state inform us when they have this same analysis complete statewide which will enable LRE to compare to the other PIHPs.
   - The rate analysis will be discussed with the Operations Council and the Board will be updated on next steps.

ii. Dec Action
   - LRE is still awaiting a judgement. The judge was very concerned about what impact this would have on the communities if the past liabilities were not paid .
   - Ms. Marlatt-Dumas would like to begin a discussion with the CMH CEOs, Executive Committee and then the full Board regarding options for whichever way the judgement lands. The discussion will include both variables: either a judgement in our favor or a judgement that will not allow us to pay the past liabilities.
   - The discussion will include a review of the CMH FSRs so the region has an understanding of where we stand regarding the amount of funds that will be available to pay the past liabilities.
   - Mr. Greenfield suggests having the Executive Committee and Operations Council meet prior to bringing to the entire Board.
   - Mr. Witte and Ms. Doyle agree that it is difficult to start scenario planning when we do not know how the judgement will land especially without legal advice. There are different degrees of impact on CMHs depending on the financial situation.
     - Ms. Doyle suggests having Ms. Marlatt-Dumas put together scenarios for CEOs to bounce ideas off. Ms. Marlatt-Dumas would like to work with the CMH CEOs on this.

- Mr. Ward comments that he would like to wait for the judgement. The counties that are owed larger amounts of money have a different view.
- Mr. DeYoung comments that there may be a need for a special Board meeting due to having so many new Board members.
- In any scenario, any action taken must be per the state and contract rules/requirements.

iii. LRE Audit Sanction

- The FY21 reconciliation has had some issues dating back to 2017 that Ms. Marlatt-Dumas will discuss with Mr. Wieferich. There is also an issue due to SUD services being delegated that will also be discussed with the state.
- LRE has asked for a hearing regarding the sanction, but it has not been scheduled yet.

WAKELY UPDATE

- LRE extended the contract with Wakely for another 60 days to gather more information.
- The EQI is showing that the non-claim cost line expenditures for FY20 is $2 million and in FY21 there was an increase in that same line to $25 million. LRE is unsure of why there is a $23 million dollar flux. Another area that is being investigated is the extremely high administrative costs in this region. This has been the case historically in this region and we are unsure how this is happening.
- Ms. Chick also reports that there was discussion at Finance ROAT regarding the impact that COVID will have.

OPERATING AGREEMENT/POLICIES

There is discussion about how the region moves forward when there is not consensus with all members on policies. There is concern that the Operating Agreement is not valid because it has not been signed by all members. Ms. Garzelloni comments that consensus is preferable but there has to be a way to manage when there is not agreement. The committee agrees that this needs further discussion.

LRE POLICIES

- Board Governance – 10.2, 10.4, 10.5, 10.12, 10.13, 10.17
    - Put back on the agenda for next month.

BOARD MEETING AGENDA ITEMS

- Take off the Board Policies
- Richard Kanten will be recommended for approval as the new Executive Committee member.

BOARD WORK SESSION AGENDA

TBD

OTHER

UPCOMING MEETINGS

- February 22, 2023 – LRE Executive Board Meeting, 1:00 PM
  GVSU, Muskegon Innovation Hub, 200 Viridian Dr, Muskegon, MI 49440
- March 15, 2023 – Executive Committee, 1:00PM
- March 22, 2023 – LRE Executive Board Meeting, 1:00 PM
  GVSU, Muskegon Innovation Hub, 200 Viridian Dr, Muskegon, MI 49440

ADJOURN

LAKESHORE REGIONAL ENTITY

EXECUTIVE COMMITTEE SUMMARY
Wednesday, March 15, 2023, 3:00 PM

Present: Mark DeYoung, Linda Garzelloni, Jack Greenfield, Jane Verduin
LRE: Mary Marlatt-Dumas

WELCOME

i. Review of March 15, 2023, Meeting Agenda
ii. Review of February 15, 2023, Meeting Minutes

March 15, 2023, agenda and February 18, 2023, meeting minutes are accepted as presented.

MDHHS UPDATES

i. Dec Action
- There has been no movement on the Dec action. Judge Shapiro knows that this is time sensitive, but it is a very involved process. LRE legal may ask the judge if there are further questions that could be answered to help move the judgement forward if 90 days pass from the last hearing and there is still no judgement.
- Muskegon County is asking the stay for their lawsuit to be lifted. LRE will ask to keep the stay in place until we have a judgement on the Dec action. Muskegon lost the suit against MDHHS.
- There is further discussion regarding how the CMH sub-capitated rate works and the process if a CMH spends above their capitation. The high enrollment due to COVID will be ending soon and the region is unsure of what that will look like, but it may have a negative impact on rates.
    - Mr. Witte explains that many enrollments are individuals that are not in the CMH system but have Medicaid (MC). These enrollees are still counted in CMH rates although they do not utilize services. Therefore, these funds are used on other individuals in service. A high percentage of the mental health MC funds are from these individuals. Because they are not in CMH services there is no way for the CMH to reach these people to make sure they are re-enrolling.
    - Ms. Marlatt-Dumas updates that this region is having a continued issue with CMHs submitting FSRs. This causes the LRE to submit to the State late and we are on a corrective action plan due to late financial reporting. This is another large concern when it comes to being able to determine where we are at financially and makes LRE unable to make projections.
    - Ms. Verduin comments that it has been known that a reduction in rates is coming due to the end of the health emergency and discussions have to start taking place to put a contingency plan into place. Ms. Marlatt-Dumas

comments that it is not a simple process to put into place and continue to meet contract requirements.
    - Mr. Greenfield suggests giving the Board a list of items that are coming down the road that we should be concerned about.
    - Mr. DeYoung suggest that LRE work with the Board Association.

ii. Jeff Wieferich Meeting
- The weekly meetings continue and are scheduled through April. Mr. Wieferich has indicated that he would like to schedule more meetings as he thinks they are very informative.

NETWORK180 UPDATES

i. Lawsuit
- LRE received Patricia Gardner's recognition due to the N180 lawsuit. Jon Campbell has been appointed to take her place.
- LRE legal suggested putting a stay in place for 60 days due to the Dec action. N180 responded with conditions to the stay that Ms. Marlatt-Dumas is discussing with legal counsel. Conditions are below but LRE is questioning how long these conditions would be in place.
    - Final cost settlement amount for N180
    - N180's amount that they believe is due to them for past deficits.
    - If LRE has to offset payments, such as DCW, because it has to go back to the state, they would like a 28-day notice.
    - LRE sends out 90% of projected revenue payment and then the next 10% is reconciled to the actual capitation received from MDHHS so that CMHs have more money up front. They would like that to stay the same.
- There must be discussion about how LRE will disburse payments for the deficit if we are successful in our case.
- Mr. Greenfield would like consideration to be able to have N180 Board representative members to attend if a closed session occurs during the LRE Board meeting.
- Ms. Verduin would like scenarios of what happens both ways if we win or lose the DEC action.

ii. Spending Plan
- N180 gave a presentation to LRE on Monday and will be presenting to Operations Committee today. This is still an informal discussion.
- The presentation showed where they need the additional funds but there was no discussion about where they could make cuts.

LRE CEO

i. Contract
- The CEO contract will be signed today.

ii. Evaluation Process
    - Bill Riley has been contracted to work on a new evaluation process and will present during the April Work Session.
    - The Executive Committee would like to meet with Bill Riley during the April meeting prior to the full Board.

LRE POLICIES

i. Board Governance
    - Take off policies and schedule a meeting with Ms. Garzelloni and Ms. Marlatt-Dumas to review the policies.

BOARD MEETING AGENDA ITEMS

i. Take the Board Governance Policies off the Board agenda.

BOARD WORK SESSION AGENDA

i. Strategic Plan
ii. QAPIP Review

OTHER

UPCOMING MEETINGS

- March 22, 2023 – LRE Executive Board Meeting, 1:00 PM
  GVSU, Muskegon Innovation Hub, 200 Viridian Dr, Muskegon, MI 49440
- April 19, 2023 – Executive Committee, 1:00PM
- April 26, 2023 – LRE Executive Board Meeting, 1:00 PM
  GVSU, Muskegon Innovation Hub, 200 Viridian Dr, Muskegon, MI 49440

ADJOURN

LAKESHORE REGIONAL ENTITY

Lakeshore Regional Entity Board
Financial Officer Report for March2023
3/22/2023

- **Disbursements Report** – A motion is requested to approve the February 2023 disbursements. A summary of those disbursements is included as an attachment.

- **Statement of Activities** – Report through January 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 January LRE Combined Monthly FSR Report is included as an attachment for March's meeting. Expense projections, as reported by each CMHSP, are noted. An actual surplus through January of $5.1 million, a projected annual surplus of $8.3 million and a budgeted surplus of $12.8 million regionally (Medicaid and HMP, excluding CCBHC) is shown in this month's report. All CMHSPs have an actual surplus except Health West with an actual deficit of $1.7 million and Network180 with an actual deficit of $218 thousand. All CMHSPs have a projected surplus, except Network180 with a projected deficit of $546 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 has been reviewed by the Finance ROAT and Operations Committee. This reporting template is still a work in progress and changes throughout the year are anticipated.

- **ISF/Medicaid Savings Estimate –**

ISF/Savings Estimates
FY2023
3/15/2023

Medicaid	Healthy Michigan	Total	
$ 23,016,692.00	$ 5,233,397.00	$ 28,250,089.00	Projected FY22 ISF Ending Balance
$ 9,024,818.00	$ 9,808,574.00	$ 18,833,392.00	Projected FY22 Savings Ending Balance
$ -	$ 1,806,499.00	$ 1,806,499.00	Projected FY23 ISF Contribution
$ (1,741,739.00)	$ 8,280,321.00	$ 6,538,582.00	Projected FY23 Savings Contribution
$ 30,299,771.00	**$ 25,128,791.00**	**$ 55,428,562.00**	**Total Projected FY23 ISF/Savings Ending Balance**
$ 23,016,692.00	$ 7,039,896.00	$ 30,056,588.00	Total Projected FY23 ISF Ending Balance
$ 25,564,781.00	$ 4,491,807.00	$ 30,056,588.00	7.5% ISF Maximum Allowable Funding
$ (2,548,089.00)	**$ 2,548,089.00**	**$ -**	**ISF Over (Under) Maximum**
		$ 25,371,974.00	Total Projected FY23 Savings Ending Balance
		$ 20,137,913.96	5% Savings Maximum Allowable Funding (Band 1)
		$ 9,918,674.04	2.5% Savings Maximum Allowable Funding (Band 2)
		$ 30,056,588.00	Total Savings Maximum Allowable Funding
		$ (4,684,614.00)	**Savings Over (Under) Maximum**
		$ 55,428,562.00	Total Projected ISF/Savings FY23 Ending Balance
		$ 60,113,176.00	Maximum Allowable Funding
		$ (4,684,614.00)	**ISF/Savings Over (Under) Maximum**

5000 Hakes Drive, Norton Shores MI 49441
Phone: 231-769-2050
Fax: 231-269-2071

- **Cash Flow Issues –** No Member CMHSP has reported any cash flow issues.

- **FY 2023 Revenue Projections** – Updated revenue and membership projections by program and CMHSP are below. The FY23 February revenue projection includes an overall increase of approximately $317,699 from the January projections. The increased revenue is primarily due to an increase in the current month payments received for DAB and TANF membership.

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 Initial to Current %Change
MCD - MH	$ 213,135,026	$ 230,503,748	$ 17,368,722	8.15%	$ 230,595,164	$ 17,460,138	8.19%	$ 91,416	0.04%
MCD - SUD	$ 8,189,247	$ 8,922,063	$ 732,815	8.95%	$ 10,007,987	$ 1,818,740	22.21%	$ 1,085,925	12.17%
HMP - MH	$ 32,718,689	$ 35,267,839	$ 2,549,150	7.79%	$ 38,841,919	$ 6,123,230	18.71%	$ 3,574,080	10.13%
HMP - SUD	$ 18,646,066	$ 20,373,667	$ 1,727,601	9.27%	$ 19,328,544	$ 682,479	3.66%	$ (1,045,122)	-5.13%
Autism	$ 41,587,466	$ 44,763,182	$ 3,175,717	7.64%	$ 43,561,807	$ 1,974,341	4.75%	$ (1,201,376)	-2.68%
Waiver	$ 41,989,313	$ 46,509,162	$ 4,519,850	10.76%	$ 44,788,877	$ 2,799,564	6.67%	$ (1,720,286)	-3.70%
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%	$ 5,003,245	$ 291,747	6.19%	$ 100,405	2.05%
Total Region	**$ 401,822,082**	**$ 399,693,525**	**$ (2,128,557)**	**-0.53%**	**$ 406,050,100**	**$ 4,228,018**	**1.05%**	**$ 6,356,575**	**1.59%**

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 Initial to Current %Change
Allegan	$ 31,638,150	$ 34,101,811	$ 2,463,661	7.79%	$ 34,342,239	$ 2,704,088	8.55%	$ 240,427	0.71%
Healthwest	$ 70,438,581	$ 80,471,573	$ 10,032,992	14.24%	$ 80,611,342	$ 10,172,761	14.44%	$ 139,769	0.17%
Network180	$ 180,590,423	$ 190,822,853	$ 10,232,430	5.67%	$ 190,782,513	$ 10,192,091	5.64%	$ (40,339)	-0.02%
Ottawa	$ 49,281,634	$ 53,873,029	$ 4,591,395	9.32%	$ 54,258,268	$ 4,976,634	10.10%	$ 385,239	0.72%
West Michigan	$ 24,317,020	$ 27,070,395	$ 2,753,376	11.32%	$ 27,129,937	$ 2,812,917	11.57%	$ 59,541	0.22%
Total CMHSPs	**$ 356,265,807**	**$ 386,339,661**	**$ 30,073,854**	**8.44%**	**$ 387,124,298**	**$ 30,858,491**	**8.66%**	**$ 784,637**	**0.20%**

	FY 22 Budget Projection	FY 23 Initial Budget Projection	FY23 Current Budget Projection	Change
Allegan	$ 97.34	$ 100.97	$ 99.05	$ (1.92)
Healthwest	$ 92.56	$ 101.53	$ 100.72	$ (0.80)
Network180	$ 89.80	$ 91.31	$ 89.58	$ (1.72)
Ottawa	$ 87.08	$ 90.89	$ 87.95	$ (2.95)
West Michigan	$ 89.29	$ 95.99	$ 95.27	$ (0.72)
Total CMHSPs	**$ 90.53**	**$ 94.34**	**$ 92.65**	**$ (1.70)**

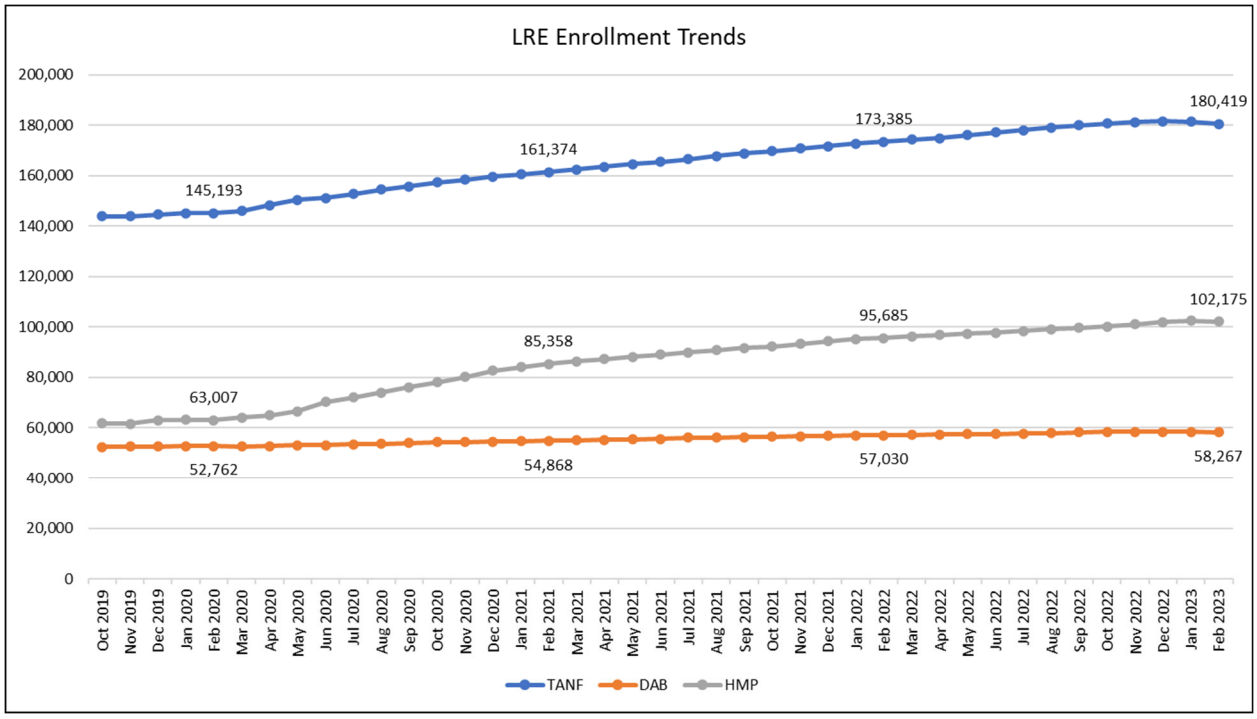
Member Month Projection

	FY 22 Budget Projection	FY 23 Initial Budget Projection	FY23 Current Budget Projection	Change
Allegan	325,041	337,728	346,703	8,975
Healthwest	761,004	792,624	800,313	7,689
Network180	2,010,987	2,089,944	2,129,699	39,755
Ottawa	565,936	592,704	616,933	24,229
West Michigan	272,333	282,012	284,766	2,754
Total Member Months	**3,935,299**	**4,095,012**	**4,178,414**	**83,402**

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	$ 19,127,493	$ 158,340
Healthwest	$ 43,665,225	$ 46,816,052	$ 46,713,814	$ (102,238)
Network180	$ 106,890,686	$ 117,079,439	$ 116,860,805	$ (218,634)
Ottawa	$ 28,593,576	$ 30,887,650	$ 31,238,135	$ 350,486
West Michigan	$ 15,525,850	$ 16,751,454	$ 16,654,917	$ (96,538)
Total MCD - MH	**$ 213,135,026**	**$ 230,503,748**	**$ 230,595,164**	**$ 91,416**
MCD - SUD				
Allegan	$ 671,848	$ 730,726	$ 815,372	$ 84,646
Healthwest	$ 1,749,475	$ 1,897,354	$ 2,134,843	$ 237,489
Network180	$ 4,108,629	$ 4,481,652	$ 5,027,075	$ 545,423
Ottawa	$ 1,038,301	$ 1,138,491	$ 1,274,970	$ 136,479
West Michigan	$ 620,994	$ 673,840	$ 755,727	$ 81,887
Total MCD - SUD	**$ 8,189,247**	**$ 8,922,063**	**$ 10,007,987**	**$ 1,085,925**
HMP - MH				
Allegan	$ 2,508,410	$ 2,697,512	$ 2,947,003	$ 249,491
Healthwest	$ 6,590,924	$ 7,106,018	$ 7,701,839	$ 595,822
Network180	$ 16,644,528	$ 17,910,233	$ 19,830,633	$ 1,920,400
Ottawa	$ 4,645,779	$ 5,066,277	$ 5,642,346	$ 576,069
West Michigan	$ 2,329,049	$ 2,487,798	$ 2,720,097	$ 232,299
Total HMP - MH	**$ 32,718,689**	**$ 35,267,839**	**$ 38,841,919**	**$ 3,574,080**
HMP - SUD				
Allegan	$ 1,412,762	$ 1,541,824	$ 1,465,210	$ (76,614)
Healthwest	$ 3,868,962	$ 4,222,890	$ 3,970,485	$ (252,404)
Network180	$ 9,498,255	$ 10,362,966	$ 9,829,732	$ (533,234)
Ottawa	$ 2,525,248	$ 2,794,857	$ 2,667,484	$ (127,373)
West Michigan	$ 1,340,839	$ 1,451,130	$ 1,395,633	$ (55,497)
Total HMP - SUD	**$ 18,646,066**	**$ 20,373,667**	**$ 19,328,544**	**$ (1,045,122)**
Autism				
Allegan	$ 3,522,099	$ 3,937,779	$ 3,892,062	$ (45,717)
Healthwest	$ 4,686,111	$ 9,028,145	$ 8,962,888	$ (65,257)
Network180	$ 25,577,745	$ 22,522,287	$ 21,777,703	$ (744,584)
Ottawa	$ 6,155,560	$ 6,591,085	$ 6,387,321	$ (203,764)
West Michigan	$ 1,645,950	$ 2,683,886	$ 2,541,832	$ (142,054)
Total Autism	**$ 41,587,466**	**$ 44,763,182**	**$ 43,561,807**	**$ (1,201,376)**
Waiver				
Allegan	$ 5,063,342	$ 6,224,816	$ 6,095,098	$ (129,718)
Healthwest	$ 9,877,884	$ 11,401,115	$ 11,127,472	$ (273,642)
Network180	$ 17,870,579	$ 18,466,274	$ 17,456,564	$ (1,009,710)
Ottawa	$ 6,323,169	$ 7,394,670	$ 7,048,012	$ (346,658)
West Michigan	$ 2,854,338	$ 3,022,287	$ 3,061,730	$ 39,443
Total Waiver	**$ 41,989,313**	**$ 46,509,162**	**$ 44,788,877**	**$ (1,720,286)**

- **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 – February 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).



- **Funding Issues –** Bruce Bridges presented the following data at the 3/16/2023 CMHAM Contract and Financial Issues (CFI) meeting:

Community Mental Health Association of Michigan - Comparison of Actuarial Projected Funding versus Actual Funding Advances FY23

As of: 3/7/23

Funding per Date Comparison *	YTD of Projected Funding in Certification	Actual Advanced on A YTD Basis	Number of Months of Advances	Year to Date Over+ & (Under -)	Percentage Advanced
DAB Capitation Behavioral Health	$ 821,083,333	$ 815,810,547	5	($5,272,787)	99.4%
DAB Capitation Substance Use Disorder	$ 17,333,333	$ 16,793,745	5	($539,588)	96.9%
TANF Capitation Behavioral Health	$ 169,416,667	$ 171,593,930	5	$2,177,263	101.3%
TANF Capitation Substance Use Disorder	$ 19,583,333	$ 20,133,229	5	$549,896	102.8%
HSW,CWP, & SED Payments	$ 235,541,667	$ 226,653,366	5	($8,888,301)	96.2%
HMP Capitation Behavioral Health	$ 179,500,000	$ 179,863,802	5	$363,802	100.2%
HMP Capitation Substance Use Disorder	$ 70,375,000	$ 71,182,970	5	$807,970	101.1%
Autism all Populations	$ 112,500,000	$ 112,100,237	5	($399,763)	99.6%
CCBHC Demonstration	$ 49,583,333	$ 42,414,808	5	($7,168,525)	85.5%
Total:	**$ 1,674,916,667**	**$ 1,656,546,634**	**5**	**($18,370,032)**	**98.9%**

Capitation Populations	*Projected Per Certification Document	Actual Paid Census	Difference	As a Percentage
DAB Average Population per month	537,992	540,750	2,758	100.5%
TANF Average Population per month	1,473,957	1,496,465	22,507	101.5%
HMP Average Population per month	987,416	993,155	5,739	100.6%
HSW Average paid per month	7,606	7,363	(244)	96.8%

** Population projection is from pages 25 & 412 of the SFY Behavioral Health Capitation Rate Certfication Document*

Public Health Emergency Comparison	DAB	HMP	TANF	All Populations
Aprox. Monthly PHE Start Count	486,718	642,395	1,182,755	2,311,868
Current Actuarial Expectation Count/Mo.	537,992	987,416	1,473,957	2,999,365
Difference	51,274	345,021	291,203	687,498
% Higher than PHE Start:	11%	54%	25%	30%

Community Mental Health Association of Michigan
Rough Projection of Capitation Populations by Month using pre-PHE Populations
Assuming Expanded Population Will Either not Re-enroll or no Longer be Qualified for Coverage

Eligibility Notification Timeline					Projection based on linear trend to ave. population counts before PHE			
Individual's Renewal Month	Awareness Letter Sent	Renewal Packet Sent*	Month Renewal Packet is Processed	Last Date of Coverage (No Longer Eligible or No Packet Returned)	Month of Capitation	DAB Population	HMP Population	TANF Population
					Feb 2023 Actual Population	544,208	1,009,914	1,508,034
					May 2023 Projected:	***547,878***	***1,028,011***	***1,533,429***
Jun-23	Mar-23	May-23	Jun-23	30-Jun-23	***June 2023 Projected:***	***542,781***	***995,876***	***1,504,206***
Jul-23	Apr-23	Jun-23	Jul-23	31-Jul-23	***July 2023 Projected:***	***537,684***	***963,741***	***1,474,983***
Aug-23	May-23	Jul-23	Aug-23	31-Aug-23	***August 2023 Projected:***	***532,587***	***931,606***	***1,445,760***
Sep-23	Jun-23	Aug-23	Sep-23	30-Sep-23	***September 2023 Projected:***	***527,490***	***899,471***	***1,416,537***
Oct-23	Jul-23	Sep-23	Oct-23	31-Oct-23	***October 2023 Projected:***	***522,393***	***867,336***	***1,387,314***
Nov-23	Aug-23	Oct-23	Nov-23	30-Nov-23	***November 2023 Projected:***	***517,296***	***835,201***	***1,358,091***
Dec-23	Sep-23	Nov-23	Dec-23	31-Dec-23	***December 2023 Projected:***	***512,199***	***803,066***	***1,328,868***
Jan-24	Oct-23	Dec-23	Jan-24	31-Jan-24	***January 2024 Projected:***	***507,102***	***770,931***	***1,299,645***
Feb-24	Nov-23	Jan-24	Feb-24	29-Feb-24	***February 2024 Projected:***	***502,005***	***738,796***	***1,270,422***
Mar-24	Dec-23	Feb-24	Mar-24	31-Mar-24	***March 2024 Projected:***	***496,908***	***706,661***	***1,241,199***
Apr-24	Jan-24	Mar-24	Apr-24	30-Apr-24	***April 2024 Projected:***	***491,811***	***674,526***	***1,211,976***
May-24	Feb-24	Apr-24	May-24	31-May-24	***May 2024 Projected:***	***486,718***	***642,395***	***1,182,755***
					Projected Population Drop per Month:	5,097	32,135	29,223

The LRE is working to develop projections for the decrease in enrollments and revenue that will begin in June 2023 due to the end of the Public Health Emergency (PHE).

- **Rate Setting Update –** During the MDHHS Joint PIHP/CCBHC Meeting on 3/16/2023, Keith White from the State Actuarial Division reported that they are planning to share the timeline for rate adjustments for PIHPs and CCBHCs for FY23 in the coming week. They are also planning to determine by the end of next week when the kickoff meeting for FY24 rate setting will occur.

- **CCBHC Expansion –** During the MDHHS Joint PIHP/CCBHC Meeting on 3/16/2023, Lindsey Naeyaert reported that Federal guidance was given that allows expansion of state demonstration sites effective February 2023. Michigan will not be expanding in FY23 due to a lack of funding in the budget. The State has developed an internal steering committee for the change from a 2-year demonstration to a 6-year demonstration, review criteria, make recommendations, develop goals, and identify gaps in the system that could be filled with CCBHCs, which will be vetted with external stakeholders. The Governor's FY24 budget included a 5% increase in funding for CCBHCs, but that is only related to current CCBHCs. Amendments to the budget or supplemental funding will be needed to expand demonstration sites in FY24 and expansion must align with the start of the demonstration year (10/1).

- **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
February 28, 2023

4/30/2022	BYLAWS/OPERATING AGREEMENT	5,700.00
7/28/2022	BYLAWS/OPERATING AGREEMENT	6,500.00
	BYLAWS/OPERATING AGREEMENT TOTAL	**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	HEALTWEST LITIGATION	5,368.74
3/31/2022	HEALTWEST LITIGATION	2,016.00
4/30/2022	HEALTWEST LITIGATION	9,388.80
6/24/2022	HEALTWEST LITIGATION	13,782.40
	HEALTWEST LITIGATION TOTAL	**30,555.94**
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
	MANAGED CARE/MDHHS CONTRACT TOTAL	**283,015.56**
	GRAND TOTAL	**$ 337,159.00**

- **FY24 Key Budget Issues –** During the CMHA Contract and Financial Issues (CFI) meeting on 3/16/23, Alan Bolter provided the following on the FY24 Executive Budget and CMHA's FY24 Appropriations Key Issues:

FY24 Executive Budget Proposal

Specific Mental Health/Substance Abuse Services Line items

	FY'22 (Final)	FY'23 (Final)	FY'24 (Exec Rec)
-CMH Non-Medicaid services	$125,578,200	$125,578,200	$125,578,200
-Medicaid Mental Health Services	$3,124,618,700	$3,044,743,000	$3,145,163,500
-Medicaid Substance Abuse services	$83,067,100	$94,321,800	$93,445,100
-State disability assistance program	$2,018,800	$2,018,800	$2,018,800
-Community substance abuse (Prevention, education, and treatment programs)	$79,705,200	$79,705,200	$79,699,700
-Health Homes Program	$33,005,400	$61,337,400	$53,400,100
-Autism services	$339,141,600	$292,562,600	$283,133,200
-Healthy MI Plan (Behavioral health)	$603,614,300	$570,067,600	$590,959,600
-CCBHC	$25,597,300	$101,252,100	$106,654,900
-Total Local Dollars	$15,285,600	$10,190,500	$10,190,500

Other Highlights of the FY24 Executive Budget:

- $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%).
    - $90 million in wage support for non-direct care nursing home staff ($31.7 million general fund) extends the same level of wage support assumed for direct care workers to additional staff working in nursing facilities.

- $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.

- $5 million for services and supports to first responders (one-time, general fund) for post-traumatic stress syndrome and other mental health conditions.

Lowering Costs for Families

- Increasing the Working Families Tax Credit by delivering nearly $3,200 in refunds to 700,000 families.
- Pre-K for all saving families on average $10,000 annually.
- Expanding the Working Families Tax Credit (formerly known as the Earned Income Tax Credit, or EITC).
- Providing up to a $3,000 refundable tax credit to childcare and preschool teachers.

Education Investments

- $318 million for school safety programs, building off existing school safety grant opportunities for districts and implementing cross-sector approaches to prevent mass violence through partnerships between schools, public safety, mental health professionals, and communities.
- $300 million for student mental health to ensure students' needs can be identified and provided with the right support.
- $140 million to temporarily lower the eligibility age for Reconnect from 25 to 21, making a tuition-free associates degree or skills training available to more Michigan residents who were impacted by the pandemic.

Health Initiatives

- $210.1 million to increase wage support to direct care professionals.
- $150 million to attract and establish a Michigan-based insulin manufacturing facility to lower the cost of insulin while creating new high-skill, high-demand jobs.
- $129.7 million for additional Medicaid health access and equity to improve enrollee access to services.
- $62.1 million to fund Healthy Moms, Healthy babies, a bipartisan program that supports pregnant women, new mothers, and young children.
- $30 million increase in support to local health departments to provide essential services.
- $15 million to create a new foster care respite care program to provide temporary, occasional relief to foster parents.
- $1.9 million to implement gun violence prevention policies.

Behavioral Health Boilerplate Changes from FY 23 → FY 24

Sec. 904. (1) By May 31 of the current fiscal year, the department shall provide a report on the CMHSPs, PIHPs, and designated regional entities for substance use disorder prevention and treatment that includes the information required by this section.

Sec. 907. (1) The amount appropriated in part 1 for community substance use disorder prevention, education, and treatment shall be expended to coordinate care and services provided to individuals with severe and persistent mental illness and substance use disorder diagnoses.

REMOVED: Sec. 908. As a condition of their contracts with the department, PIHPs and CMHSPs, in consultation with the Community Mental Health Association of Michigan, shall work with the

department to implement section 206b of the mental health code, 1974 PA 258, MCL 330.1206b, to establish a uniform community mental health services credentialing program.

Sec. 909. From the funds appropriated in part 1 for health homes, the department shall use available revenue from the marihuana regulatory fund established in section 604 of the medical marihuana facilities licensing act, 2016 PA 281, MCL 333.27604, to improve physical health, expand access to substance use disorder prevention and treatment services, and strengthen the existing prevention, treatment, and recovery systems.

Sec. 910. The department shall ensure that substance use disorder treatment is provided to applicants and recipients of public assistance through the department who are required to obtain substance use disorder treatment as a condition of eligibility for public assistance.

Sec. 911. (1) The department shall ensure that each contract with a CMHSP or PIHP requires the CMHSP or PIHP to implement programs to encourage diversion of individuals with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate.

REMOVED: Sec. 912. The department shall contract directly with the Salvation Army Harbor Light program, at an amount not less than the amount provided during the fiscal year ending September 30, 2020, to provide non-Medicaid substance use disorder services if the local coordinating agency or the department confirms the Salvation Army Harbor Light program meets the standard of care. The standard of care shall include, but is not limited to, utilization of the medication assisted treatment option.

Sec. 915. From the funds appropriated in part 1 for community substance use disorder prevention, education, and treatment and opioid response activities, the department shall, to the extent possible, provide grants, pursuant to federal laws, rules, and regulations, to local public entities that provide substance use disorder services and to 1 private entity that has a statewide contract to provide community-based substance use disorder services.

Sec. 916. From the funds appropriated in part 1 for behavior health program administration, the department shall allocate $100,000.00 as a grant to a nonprofit mental health clinic located in a county with a population between 290,000 and 300,000 according to the most recent federal decennial census that provides counseling services, accepts clients regardless of their ability to pay for services through sliding scale copayments and volunteer services, and uses fundraising to support their clinic.

Sec. 917. From the funds appropriated in part 1 for opioid response activities, the department shall allocate $23,200,000.00 from the Michigan opioid healing and recovery fund created under section 3 of the Michigan trust fund act, 2000 PA 489, MCL 12.253, to create or supplement opioid-related programs and services in a manner consistent with the opioid judgement, settlement, or compromise of claims pertaining to violations, or alleged violations, of law related to the manufacture, marketing, distribution, dispensing, or sale of opioids.

Sec. 918. On a quarterly basis, providing monthly data, the department shall report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, and the state budget director on the amount of funding paid to PIHPs to support the Medicaid managed mental health care program. The information shall include the total paid to each PIHP, per capita rate paid for each eligibility group for each PIHP, and number of cases in each eligibility group for each PIHP, and year-to-date summary of eligibles and expenditures for the Medicaid managed mental health care program.

EDITED: Sec. 920. (1) As part of the Medicaid rate-setting process for behavioral health services, the department shall work with PIHP network providers and actuaries to include any state and federal wage and compensation increases that directly impact staff who provide Medicaid-funded community living supports, personal care services, respite services, skill-building services, and other similar supports and services as part of the Medicaid rate. ~~(2) It is the intent of the legislature that any increased Medicaid rate related to state minimum wage increases shall also be distributed to direct care employees.~~

EDITED: Sec. 926. (1) From the funds appropriated in part 1 for community substance use disorder prevention, education, and treatment, $500,000.00 is allocated for a specialized substance use disorder detoxification project administered by a 9-1-1 service district in conjunction with a substance use and case management provider and at a hospital within a 9-1-1 services district with at least 600,000 residents and 15 member communities within a county with a population of at least 1,500,000 according to the most recent federal decennial census.

~~(2) The substance use and case management provider receiving funds under this section shall collect and submit to the department data on the outcomes of the project throughout the duration of the project and the department shall submit a report on the project's outcomes to the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, and the state budget office.~~

REMOVED: Sec. 927. (1) The department shall, in consultation with the Community Mental Health Association of Michigan, establish, maintain, and review as necessary, a uniform community mental health services auditing process for use by CMHSPs and PIHPs.

(2) The uniform auditing process required under this section must do all of the following:

(a) Create uniformity in the collection of data and consistent measurement of the quality, efficacy, and cost effectiveness of provided services and supports.

(b) Establish a uniform audit tool that contains information necessary for the uniform community mental health services auditing process and adheres to national standards.

(c) Strive to meet the needs of community mental health service beneficiaries and meet all statewide audit requirements.

(d) Maintain audit responsibility at the local agency level.

(3) By March 1 of the current fiscal year, the department shall submit a report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, and the senate and house policy offices on the implementation status of the uniform auditing process and any barriers to implementation.

(4) A state department or agency that provides, either directly or through a contract, community mental health services and supports must comply with the uniform auditing process and utilize the audit tool maintained by the department. All forms, processes, and contracts used by the state that relate to the provision of community mental health services and supports must comply with the uniform auditing process.

(5) As used in this section, "national standards" means standards established by a national accrediting entity such as the Joint Commission, Commission on Accreditation of Rehabilitation Facilities, Council on Accreditation, National Committee for Quality Assurance, or other credible body approved by the department.

EDITED: Sec. 928. Each PIHP shall provide, from internal resources, local funds to be used as a part of the state match required under the Medicaid program in order to increase capitation rates for PIHPs. These funds shall not include either state funds received by a CMHSP for services provided to non-Medicaid recipients or the state matching portion of the Medicaid capitation payments made to a PIHP.

~~(2) It is the intent of the legislature that any funds that lapse from the funds appropriated in part 1 for Medicaid mental health services shall be redistributed to individual CMHSPs as a reimbursement of local funds on a proportional basis to those CMHSPs whose local funds were used as state Medicaid match. By April 1 of the current fiscal year, the department shall report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office on the lapse by PIHP from the previous fiscal year and the projected lapse by PIHP in the current fiscal year. (3) It is the intent of the legislature that the amount of local funds used in subsection (1) be phased out and offset with state general fund/general purpose revenue in equal amounts over a 5-year period. (4) Until the local funds are phased out as described in subsection (3), each PIHP shall not be required to provide local funds, used as part of the state match required under the Medicaid program in order to increase capitation rates for PIHPs, at an amount greater than what each PIHP received from local units of government, either directly or indirectly, during the fiscal year ending September 30, 2018 for this purpose.~~

Sec. 942. A CMHSP shall provide at least 30 days' notice before reducing, terminating, or suspending services provided by a CMHSP to CMHSP clients, with the exception of services authorized by a physician that no longer meet established criteria for medical necessity.

EDITED: Sec. 950. From the funds appropriated in part 1 for court-appointed guardian reimbursements, the department shall allocate $5,000,000.00 to reimburse court-appointed public guardians for recipients who also receive CMHSP services, at a reimbursement of $50.00 per month. The department shall make these funds available to the CMHSPs to reimburse for court-appointed public guardians for those recipients receiving CMHSP services through the CMHSP~~. It is the intent of the legislature that these funds be used in addition to any other funds currently paid to court-appointed public guardians, but a court-appointed public guardian shall not be compensated more than $83.00 per month for any CMHSP-eligible recipient regardless of funding source. By September 15 of the current fiscal year, each CMHSP that has provided reimbursement to court-appointed public guardians shall provide the department a report that shall be shared with the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office on the number of court-appointed public guardians who were reimbursed, the amount of reimbursement for each court-appointed public guardian and the number of court-appointed public guardians who received these funds, the number of court-appointed public guardians who were also reimbursed by the counties, and the per-month reimbursement rates provided by the counties.~~

REMOVED: Sec. 964. By October 1 of the current fiscal year, the department shall provide the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office with the standardized fee schedule for Medicaid behavioral health services and supports. The report shall also include the adequacy standards to be used in all contracts with PIHPs and CMHSPs. In the development of the standardized fee schedule for Medicaid behavioral health services and supports during the current fiscal year, the department must prioritize and support essential service providers and must develop a standardized fee schedule for revenue code 0204.

REMOVED: Sec. 965. From the funds appropriated in part 1, the department and the PIHPs shall increase the comparison rates and any associated reimbursement rates of the bundled rate H0020 for the administration and services of methadone to $19.00.

Sec. 972. From the funds appropriated in part 1 for behavioral health program administration, the department shall allocate not less than $3,000,000.00 general fund/general purpose revenue and any

associated federal match or federal grant funding, including, but not limited to, associated federal 988 grant funding for the mental health telephone access line known as the Michigan crisis and access line (MiCAL), to provide primary coverage in regions where a regional national suicide prevention lifeline center does not provide coverage and for statewide secondary coverage, to establish and make available to the public MiCAL in accordance with section 165 of the mental health code, 1974 PA 258, MCL 330.1165.

Sec. 977. From the funds appropriated in part 1 for community substance use disorder prevention, education, and treatment, $600,000.00 is allocated as grants to high schools specifically designated for students recovering from a substance use disorder in accordance with section 273a of the mental health code, 1974 PA 258, MCL 330.1273a.

Sec. 978. From the funds appropriated in part 1 for community substance use disorder prevention, education, and treatment, the department shall allocate $1,200,000.00 as grants for recovery community organizations to offer or expand recovery support center services or recovery community center services to individuals seeking long-term recovery from substance use disorders in accordance with section 273b of the mental health code, 1974 PA 258, MCL 330.1273b.

Sec. 995. (1) From the funds appropriated in part 1 for mental health diversion council, the department shall allocate $3,850,000.00 to continue to implement the jail diversion pilot programs intended to address the recommendations of the mental health diversion council.

NEW: Sec. 999. From the funds appropriated in part 1 for behavioral health program administration, the department shall allocate $5,000,000.00 in general fund/general purpose revenue to implement programs intended to improve recruitment and retention of behavioral health professionals.

REMOVED: Sec. 1001. By December 31 of the current fiscal year, each CMHSP shall submit a report to the department that identifies populations being served by the CMHSP broken down by program eligibility category. (EXCERPT)

Sec. 1003. The department shall notify the Community Mental Health Association of Michigan when developing policies and procedures that will impact PIHPs or CMHSPs.

REMOVED: Sec. 1004. The department shall provide the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, and the state budget office any rebased formula changes to either Medicaid behavioral health services or non-Medicaid mental health services 90 days before implementation. The notification shall include a table showing the changes in funding allocation by PIHP for Medicaid behavioral health services or by CMHSP for non-Medicaid mental health services.

EDITED: Sec. 1005. (1) From the funds appropriated in part 1 for health homes, the department shall maintain the number of behavioral health homes in ~~PIHP regions 1, 2, 6, 7, and 8 and maintain the number of substance use disorder health homes in PIHP regions 1, 2, 4, 6, 7, 9, and 10. The department may expand the number of behavioral health homes in PIHP region 5 and the number of substance use disorder health homes in PIHP regions 3, 4, 5, and 8.~~ place as of September 30 of the previous fiscal year. The department may expand the number of behavioral health homes and the number of substance use disorder health homes in at least one additional PIHP region.

Sec. 1008. PIHPs and CMHSPs shall do all of the following:

(a) Work to reduce administration costs by ensuring that PIHP and CMHSP responsible functions are efficient in allowing optimal transition of dollars to those direct services considered most effective in assisting individuals served. Any consolidation of administrative functions must demonstrate, by independent analysis,
a reduction in dollars spent on administration resulting in greater dollars spent on direct services. Savings resulting from increased efficiencies shall not be applied to PIHP and CMHSP net assets, internal service fund increases, building costs, increases in the number of PIHP and CMHSP personnel, or other areas not directly related to the delivery of improved services.
(b) Take an active role in managing mental health care by ensuring consistent and high-quality service delivery throughout its network and promote a conflict-free care management environment.
(c) Ensure that direct service rate variances are related to the level of need or other quantifiable measures to ensure that the most money possible reaches direct services.
(d) Whenever possible, promote fair and adequate direct care reimbursement, including fair wages for direct service workers.

Sec. 1010. (1) The funds appropriated in part 1 for behavioral health community supports and services must be used to reduce waiting lists at state-operated hospitals and centers through cost-effective community-based and residential services, including, but not limited to, assertive community treatment (ACT), forensic assertive community treatment (FACT), crisis stabilization units in accordance with chapter 9A of the mental health code, 1974 PA 258, MCL 330.1971 to 330.1979, and psychiatric residential treatment facilities in accordance with section 137a of the mental health code, 1974 PA 258, MCL 330.1137a.
(2) From the funds appropriated in part 1 for behavioral health community supports and services, the department shall allocate $30,450,000.00 to reimburse private providers for intensive psychiatric treatments and services outside of state-operated hospitals and centers and support efforts related to the oversight of community-based programs placement.
(3) If the private provider has an existing wait list for intensive psychiatric treatments and services, any reimbursements to private providers under this section must not be conditional on private providers giving wait-list priority to state-paid individuals.

REMOVED: Sec. 1011. To the extent permissible under section 919 of the mental health code, 1974 PA 258, MCL 330.1919, the funds appropriated in part 1 for behavioral health services may be used to reimburse out-of-state providers of crisis resolution services and outpatient services if the out-of-state provider is enrolled as a state Medicaid provider and the out-of-state provider is located closer to the client's home than an in-state provider.

REMOVED: Sec. 1012. It is the intent of the legislature that the department pursue any and all federal Medicaid waivers to maximize the use of federal Medicaid reimbursements for substance use disorder services and treatments for justice-involved individuals. By March 9 of the current fiscal year, the department shall provide a report on the types of substance use disorder waivers submitted by the department, whether those waivers have been approved by the Centers for Medicare and Medicaid Services, and the steps the department will take to request any and all federal Medicaid waivers to maximize the use of federal Medicaid reimbursements for substance use disorder services and treatments to the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office.

Sec. 1015. From the funds appropriated in part 1 for federal mental health block grant, the department shall, to the extent possible, provide grants, pursuant to federal laws, rules, and regulations, to local

public entities that provide mental health services and to 1 private entity that has a statewide contract to provide community-based mental health services.
REMOVED: Sec. 1151. (1) The department shall coordinate with the department of licensing and regulatory affairs, the department of the attorney general, all appropriate law enforcement agencies, and the Medicaid health plans to work with local substance use disorder agencies and addiction treatment providers to help inform Medicaid beneficiaries of all medically appropriate treatment options for opioid addiction when their treating physician stops prescribing prescription opioid medication for pain, and to address other appropriate recommendations of the prescription drug and opioid abuse task force outlined in its report of October 2015.
(2) By October 1 of the current fiscal year, the department shall submit a report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office on how the department is working with local substance use disorder agencies and addiction treatment providers to ensure that Medicaid beneficiaries are informed of all available and medically appropriate treatment options for opioid addiction when their treating physician stops prescribing prescription opioid medication for pain, and to address other appropriate recommendations of the task force. The report shall include any potential barriers to medication-assisted treatment, as recommended by the Michigan medication-assisted treatment guidelines, for Medicaid beneficiaries in both office-based opioid treatment and opioid treatment program facility settings.

NEW: Sec. 8-1775. (1) By March 1 of the current fiscal year, the department shall report on progress in implementing changes to the waiver to implement managed care for individuals who are eligible for both Medicare and Medicaid, known as MI Health Link. This report shall include progress updates on the transition to Dual Eligible Special Needs Plans in compliance with CMS regulations.
(2) The department shall ensure the existence of an ombudsman program that is not associated with any project service manager or provider to assist MI Health Link beneficiaries with navigating complaint and dispute resolution mechanisms and to identify problems in the demonstrations and in the complaint and dispute resolution mechanisms.

REMOVED: Sec. 1969. From the funds appropriated in part 1 for Great Lakes recovery center, the department shall allocate a grant of $250,000.00 for costs related to a women's recovery center and men's campus to a nonprofit organization accredited by CARF International with a mission to empower recovery through hope and change and that provides a variety of behavioral health services across the Upper Peninsula.

CMHA FY24 Appropriations Key Issues

Direct Care Wage Increase

- We are requesting **$286 million GF for an additional $4.00 per hour wage increase for all of the employees who were eligible for the $2.35 per hour wage increase. This figure includes both behavioral health and long-term care DCWs as well as direct supervisors.** The $286 million figure is an extrapolation of the initial appropriation for the $2.35 per hour wage increase.

- The total cost of just providing a $4/hour increase for the estimated 50,000 behavioral health direct support workers and their direct supervisors providing community living supports and other services funded through the behavioral health system is roughly $140 million GF.

    - Direct supervisors also must receive wage increases that are commensurate to the compensation of the individuals that report to them.

Continued Phase Out of Local Match draw down – Section 928

- FY24 budget to include $5 million GF/GP to offset local/county resources for Medicaid match purposes and continue the 5-year phase out of the use of local/county dollars for Medicaid match purposes.

    - FY24 should be year 4 of the 5-year phase out.

- Language from FY23 budget:

    - (3) It is the intent of the legislature that the amount of local funds used in subsection (1) be phased out and offset with state general fund/general purpose revenue in equal amounts over a 5-year period.

Medicaid rates

- Increase FY24 Medicaid rates for the public mental health system to reflect the increased wages and provider rates needed to recruit and retain clinicians from a wide variety of clinical disciplines.

- As the state unwinds the Public Health Emergency (PHE) and begins to change Medicaid eligibility for the nearly 700,000-800,000 who were added to the Medicaid program during the pandemic we are asking that MDHHS make real-time adjustments to Medicaid rates. Our PIHP/CMH system gets paid on a capitated basis (based on number

of Medicaid enrollees) and without real-time adjustments our members could see dramatic decreases in revenue over a short period of time.

Certified Community Behavioral Health Clinics (CCBHC)

On August 5, 2020 the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse & Mental Health Services Administration (SAMHSA) announced that the states of Kentucky and Michigan have been selected as additional participants in the Certified Community Behavioral Health Clinic (CCBHC) Demonstration. As part of the state implementation and roll out of the demonstration program, Michigan will be required to put up a small amount of state match dollars to draw down federal support for the program.

- **FY24 budget – expand the number of CCBHC sites that are allowed to enter the state demonstration project (once federal guidance is received). Currently only 13 out of 34 sites are in the demonstration project.**

Suggested boilerplate on Deemed Status

DHHS shall waive all reviews and audits for CMHs and provider organizations that have received full accreditation from a qualifying national accrediting entity for those program and financial reviews that were included during the national accreditation process.

- Tremendous amount of duplication and redundancy in state program/financial reviews and audits. There should be oversight of the system, but we want to eliminate the duplication and non-value added requirements.

- Ohio and Illinois both have deemed status Illinois found there was 40% redundancy between state requirements and national accreditation requirements

    - CMHA members (PIHPs/CMHs/Providers) spend thousands of staff hours and resources complying with state reviews that do not provide value, are not used in a substantive manner or are duplicative.

Better Coordination with Mental Health in school funding

FY23 budget recommended a significant amount of spending on mental health in schools, examples:

- $25 million – Universal mental health screenings
    - Collaborates with universities to develop and deploy a Michigan-survey in schools which will collect, analyze, and report on mental health data

- $120 million – School-based mental health professionals
    - Provides funding for additional mental health professionals and counselors in schools, could allow for up to 425 staff over the three years

- $50 million – Strengthen school-based mental & physical health
    - Increases existing appropriations for mental health grants from $37.8m to $87.8m

CMHA suggests taking a collaborative approach with the bulk of the $425 million. Those resources should be used by school district to purchase services from the public mental health system or resources go directly to the public mental health system to provide those services for local school districts.

- Our concern with the $120 million for school-based mental health professional will lead to an exodus of CMH/MH provider staff going to a school district.

Other Boilerplate Suggestions

1. **ELIMINATE** Sec. 1008. PIHPs and CMHSPs shall do all of the following: (a) Work to reduce administration costs by ensuring that PIHP and CMHSP responsible functions are efficient in allowing optimal transition of dollars to those direct services considered most effective in assisting individuals served. (b) Take an active role in managing mental health care by ensuring consistent and high-quality service delivery throughout its network and promote a conflict-free care management environment.

2. **ELIMINATE** Sec. 964. By October 1 of the current fiscal year, the department shall provide the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office with the standardized fee schedule for Medicaid behavioral health services and supports. The report shall also include the adequacy standards to be used in all contracts with PIHPs and CMHSPs. In the development of the standardized fee schedule for Medicaid behavioral health services and supports during the current fiscal year, the department must prioritize and support essential service providers and must develop a standardized fee schedule for revenue code 0204. **Replace it with MDHHS will only use an Actuary to certify the Medicaid rates as required by 42 CFR. All other activities must be reviewed and completed by the State Actuarial Division.**

LAKESHORE REGIONAL ENTITY

BOARD ACTION REQUEST
Subject : January 2023 Disbursements
Meeting Date February 22, 2023

RECOMMENDED MOTION:

To approve the January 2023 disbursements of $36,590,474.37 as presented.

SUMMARY OF REQUEST/INFORMATION:

Disbursements:	
Allegan County CMH	$3,190,322.92
Healthwest	$7,961,440.43
Network 180	$16,315,507.22
Ottawa County CMH	$4,779,535.66
West Michigan CMH	$3,505,760.62
SUD Prevention Expenses	$223,702.87
Local Match Payment	$0.00
Hospital Reimbursement Adjuster (HRA)	$0.00
MICHIGAN IPA TAX - QUARTERLY	$0.00
SUD Public Act 2 (PA2)	$119,753.89
Administrative Expenses	$494,450.76
Total:	**$36,590,474.37**

98.64% 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: 2/14/2022**

LAKESHORE REGIONAL ENTITY

BOARD ACTION REQUEST
Subject : February 2023 Disbursements
Meeting Date March 22, 2023

RECOMMENDED MOTION:

To approve the February 2023 disbursements of $37,374,419.49 as presented.

SUMMARY OF REQUEST/INFORMATION:

Disbursements:	
Allegan County CMH	$3,060,203.08
Healthwest	$7,727,164.94
Network 180	$17,523,118.69
Ottawa County CMH	$4,876,008.04
West Michigan CMH	$3,003,356.64
SUD Prevention Expenses	$492,499.51
SUD Public Act 2 (PA2)	$83,954.89
Administrative Expenses	$608,113.70
Total:	**$37,374,419.49**

98.37% 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: 3/22/2023**

Proposed Statement of Revenues, Expenditures & Changes in Fund Balance
Fiscal Year Ending 9/30/2023

	FY 2022/2023 Initial Budget	FY 2022/2023 Am 1 Budget	Increase / (Decrease)	Change %
Revenue				
Regional Operating Revenue				
Mental Health State Plan & 1915(i)	$ 226,531,307	$ 214,761,304	$ (11,770,003)	-5.2%
Habilitation Supports Waiver (HSW)	41,933,094	41,535,890	(397,204)	-0.9%
Children's Waiver	5,542,628	2,613,068	(2,929,560)	-52.9%
SED Waiver	-	1,023,235	1,023,235	#DIV/0!
DHS Incentive Payment	-	471,247	471,247	#DIV/0!
Autism Revenue	45,693,399	43,517,457	(2,175,942)	-4.8%
Mental Health Healthy Michigan	44,763,182	39,257,124	(5,506,059)	-12.3%
Mental Health Block Grant - Veteran Navigator	110,000	110,000	-	0.0%
Block Grants - Hisp BH, Native Am, Tob,Clubhse, ARPA CCBHC	470,800	713,560	242,760	51.6%
Substance Use Gambling, ARPA & DFC	1,009,060	1,009,060	-	0.0%
Substance Use State Plan	9,530,857	10,012,234	481,377	5.1%
Substance Use Healthy Michigan	20,373,667	19,214,908	(1,158,759)	-5.7%
Substance Use Block, State Opioid Response, COVID-19	11,447,558	11,447,558	-	0.0%
Performance Bonus Incentive Pool	2,419,516	2,819,234	399,718	16.5%
Substance Use PA2 Liquor Tax	3,249,131	3,249,131	-	0.0%
Medicaid CCBHC Base Capitation	-	15,591,288	15,591,288	#DIV/0!
Healthy Michigan CCBHC Base Capitation	-	4,260,333	4,260,333	#DIV/0!
Medicaid CCBHC Supplemental	9,345,739	9,783,024	437,285	4.7%
Healthy Michigan CCBHC Supplemental	-	3,281,229	3,281,229	#DIV/0!
CCBHC General Funds	-	693,898	693,898	#DIV/0!
Hospital Rate Adjuster (HRA)	10,523,333	9,518,432	(1,004,901)	-9.5%
Interest Earnings	81,024	299,487	218,463	269.6%
Member Local Contribution to State Medicaid	2,040,096	1,007,548	(1,032,548)	-50.6%
Miscellaneous Revenue	15,500	15,500	-	0.0%
Total Revenue	$ 435,079,891	$ 436,205,747	$ 1,125,856	
Expense				
Regional Operating Expenses				
Administration expense	$ 13,922,557	$ 13,922,557	$ -	0.0%
Block Grants - Gambl/Veterans/Hisp/Tob/NatAm	$ 989,860	$ 989,860	$ -	0.0%
SUD Prevention Direct Expenses	3,034,456	3,034,456	-	0.0%
Hospital Rate Adjustment / Taxes	14,097,418	14,496,332	398,914	2.8%
Operating Expense - Member Payments	400,995,504	402,754,995	1,759,491	0.4%
Contribution to ISF/Savings	-	-	-	#DIV/0!
Direct Care Wage Lapse	-	-	-	#DIV/0!
Local Contribution to State Medicaid	2,040,096	1,007,548	(1,032,548)	-50.6%
Total Expense	$ 435,079,891	$ 436,205,747	$ 1,125,857	
Revenue Over/(Under) Expense	(0)	(0)		

Lakeshore Regional Entity
FY 2023 SUD Budget

Prevention	Initial FY23 Allocation	Proposed FY23 Am 1	Block Grants	SOR	Amer Rescue Plan Act	COVID-19	PA2	Gambling	DFC
Allegan County									
OnPoint (Allegan Co CMH)	396,085	446,518	214,011	39,000	16,666	86,802	90,039	-	-
Total	396,085	446,518	214,011	39,000	16,666	86,802	90,039	-	-
Kent County									
Arbor Circle	151,410	202,042	45,950	-	-	91,042	65,050	-	-
Family Outreach	161,073	184,214	27,467	-	13,930	76,284	35,533	31,000	-
Kent County Health Department	403,667	486,098	54,839	65,000	16,667	82,431	267,161	-	-
Network 180	382,434	433,431	79,687	-	-	83,431	270,313	-	-
Wedgwood	182,077	199,655	63,966		16,667	57,988	61,034	-	-
Total	1,280,661	1,505,440	271,909	65,000	47,264	391,176	699,091	31,000	-
Lake County									
District Health Department #10	26,374	41,064	12,175	-	-	14,690	3,533	10,666	-
Total	26,374	41,064	12,175	-	-	14,690	3,533	10,666	-
Oceana County									
District Health Department #10	40,435	54,974	19,621	-	-	14,539	10,148	10,666	-
Total	40,435	54,974	19,621	-	-	14,539	10,148	10,666	-
Mason County									
District Health Department #10	223,097	251,698	25,463	37,200	14,766	28,601	35,000	10,668	100,000
Total	223,097	251,698	25,463	37,200	14,766	28,601	35,000	10,668	100,000
Muskegon County									
Arbor Circle (Muskegon Co)	36,596	70,387	12,500	-	-	57,887	-	-	-
Public Health Muskegon County	395,168	437,839	294,025	20,000	9,168	42,671	40,975	31,000	-
Mercy Health	92,921	107,118	35,839	-	9,168	38,293	23,818	-	-
Total	524,685	615,344	342,364	20,000	18,336	138,851	64,793	31,000	-
Ottawa County									
Arbor Circle (Ottawa Co)	442,220	482,661	116,823	25,000	31,908	63,353	218,177	27,400	-
CMH of Ottawa County	92,722	121,079	-	-	8,810	51,269	61,000	-	-
Ottawa County Department of Public Health	128,735	174,608	16,517	28,000	8,810	45,873	75,408	-	-
Total	663,677	778,348	133,340	53,000	49,528	160,495	354,585	27,400	-
LRE Regional Projects (TalkSooner, Trainings, Conference, Tech. Assistance, Family Meals Month)	188,000	275,961	82,500	-	22,500	135,961	-	35,000	-
LRE Staffing	248,589	252,429	146,899	41,090	-	24,039	-	15,401	25,000
Unallocated	104,372	-	-	-	-	-	-	-	-
Total	540,961	528,390	229,399	41,090	22,500	160,000	-	50,401	25,000
Overall Prevention Total	3,695,975	4,221,776	1,248,282	255,290	169,060	995,154	1,257,189	171,801	125,000

Treatment	Initial FY23 Allocation	Proposed FY23 Am 1	Block Grants (incl. SDA)	SOR	Amer Rescue Plan Act	COVID-19	PA2	Medicaid	Healthy Michigan
OnPoint (Allegan Co CMH)	3,325,804	3,250,724	454,395	278,375	75,000	70,629	101,887	815,936	1,454,502
Healthwest	8,736,711	8,599,155	903,290	964,454	25,000	256,015	355,144	2,134,404	3,960,848
Network 180	20,258,958	20,493,046	2,524,216	1,246,476	175,000	529,537	1,228,280	5,029,816	9,759,721
CMH of Ottawa County	5,801,737	5,998,374	858,610	257,295	200,000	548,233	210,615	1,273,175	2,650,446
West Michigan CMH (Lake, Mason Oceana)	2,846,525	2,854,849	358,839	198,900	-	52,800	96,016	758,903	1,389,391
LRE Staffing & Regional Projects	939,259	1,537,745	225,000	250,768	-	10,000	-	360,388	691,589
Overall Treatment Total	41,908,995	42,733,893	5,324,350	3,196,268	475,000	1,467,214	1,991,942	10,372,622	19,906,496
SUD Total Prevention + Treatment:	**45,604,969**	**46,955,669**	**6,572,632**	**3,451,558**	**644,060**	**2,462,368**	**3,249,131**	**10,544,423**	**20,031,496**

LAKESHORE REGIONAL ENTITY

Statement of Activities - Actual vs. Budget
Fiscal Year 2022/2023
As of Date: 12/31/22

Change in Net Assets	Year Ending 9/30/2023	12/31/2022		
	FY23 Budget	Budget to Date	Actual	Actual to Budget Variance
Operating Revenues				
Medicaid, HSW, SED, & Children's Waiver	283,537,885	70,884,471	72,758,307	1,873,836
Autism Revenue	45,693,399	11,423,350	11,368,996	(54,354)
DHS Incentive	-	-	-	-
Healthy Michigan	65,136,849	16,284,212	14,819,794	(1,464,418)
Peformance Bonus Incentive	2,419,516	604,879	-	(604,879)
Hospital Rate Adjuster (HRA)	10,523,333	2,630,833	-	(2,630,833)
Local Match Revenue (Members)	2,040,096	510,024	335,849	(174,175)
CCBHC Supplemental Revenue	9,345,739	2,336,435	2,448,182	111,747
MDHHS Grants	12,912,418	3,228,105	569,088	(2,659,016)
PA 2 Liquor Tax	3,249,131	812,283	293,759	(518,524)
Non-MDHHS Grants: DFC	125,000	31,250	34,820	3,570
Interest Revenue	81,024	20,256	74,872	54,616
Miscellaneous Revenue	15,500	3,875	-	(3,875)
Total Operating Revenues	**435,079,891**	**108,769,973**	**102,703,667**	**(6,066,305)**
Expenditures				
Salaries and Fringes	3,871,353	967,838	974,028	6,190
Office and Supplies Expense	259,630	64,908	37,821	(27,086)
Contractual and Consulting Expenses	888,445	222,111	166,644	(55,467)
Managed Care Information System (PCE)	305,200	76,300	73,800	(2,500)
Legal Expense	242,153	60,538	38,030	(22,508)
Utilities/Conferences/Mileage/Misc Exps	8,355,776	2,088,944	59,901	(2,029,043)
Grants - MDHHS & Non-MDHHS	989,860	247,465	84,869	(162,596)
Taxes, HRA, and Local Match	16,137,514	4,034,379	1,372,487	(2,661,891)
Prevention Expenses - Grant & PA2	3,034,456	758,614	620,763	(137,851)
Contribution to ISF/Savings	-	-	-	-
Member Payments - Medicaid/HMP	379,996,954	94,999,238	92,498,582	(2,500,656)
Member Payments - CCBHC	9,345,739	2,336,435	2,633,618	297,184
Member Payments - PA2 Treatment	2,001,942	500,486	176,229	(324,256)
Member Payments - Grants	9,650,869	2,412,717	1,267,105	(1,145,613)
Total Expenditures	**435,079,891**	**108,769,973**	**100,003,878**	**(8,766,095)**
Total Change in Net Assets	**(0)**	**(0)**	**2,699,789**	**2,699,789**

LAKESHORE REGIONAL ENTITY

Statement of Activities
Budget to Actual Variance Report

For the Period ending December 31, 2022

As of Date: 2/14/23

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	Budget will be included with amendment one.
Healthy Michigan	Revenue adjustments are projected and will be included in amendment one.
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. First quarter payment is expected in January.
Local Match Revenue	Local match requirement for FY23 was reduced.
CCBHC Supplemental Revenue	Supplemental Revenue is closely aligned with the current budget projections.
MDHHS Grants	Grant reimbursements on hold. SUD grant payments changed to quarterly in FY23.
PA 2 Liquor Tax	PA2 revenues are received after the Department of Treasury issues payments to the counties. Initial payments are expected in the 2nd 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.
Miscellaneous Revenue	No miscellaneous funds received as of this report. Funds are expected periodically throughout the year for trainings and Talksooner subcriptions.

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	Spending is under but billings are usually delayed. This line item will be monitored for future amendments.
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	IPA & HRA taxes are paid quarterly. Our Local Match requirement for FY23 was reduced.
Prevention Exps - Grant/PA2	SUD grant payments changed to quarterly in FY23. Some billings were delayed due to overlapping FY22 closeout and report submissions.
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 Payments	This line item will be monitored for future amendments as projections are reported by our CCBHCs.
Member PA2 Tx Payments	Billings against this line item typically occur after other grant funding is applied. Spending is based on projections and will be monitored for amendments.
Member Grant Payments	MDHHS changed SUD grant payments to quarterly in FY23. Grant payments for SUD Treatment were not received until quarter two.

LAKESHORE REGIONAL ENTITY

Statement of Activities - Actual vs. Budget
Fiscal Year 2022/2023
As of Date: 1/31/23

Change in Net Assets	Year Ending 9/30/2023 FY23 Budget	1/31/2023 Budget to Date	Actual	Actual to Budget Variance
Operating Revenues				
Medicaid, HSW, SED, & Children's Waiver	283,537,885	94,512,628	97,234,076	2,721,448
Autism Revenue	45,693,399	15,231,133	15,144,264	(86,870)
DHS Incentive	-	-	-	-
Healthy Michigan	65,136,849	21,712,283	19,866,815	(1,845,468)
Peformance Bonus Incentive	2,419,516	806,505	-	(806,505)
Hospital Rate Adjuster (HRA)	10,523,333	3,507,778	-	(3,507,778)
Local Match Revenue (Members)	2,040,096	680,032	251,887	(428,145)
CCBHC Supplemental Revenue	9,345,739	3,115,246	3,272,669	157,423
MDHHS Grants	12,912,418	4,304,139	1,845,207	(2,458,932)
PA 2 Liquor Tax	3,249,131	1,083,044	502,433	(580,611)
Non-MDHHS Grants: DFC	125,000	41,667	46,017	4,350
Interest Revenue	81,024	27,008	142,948	115,940
Miscellaneous Revenue	15,500	5,167	-	(5,167)
Total Operating Revenues	**435,079,891**	**145,026,630**	**138,306,316**	**(6,720,314)**
Expenditures				
Salaries and Fringes	3,871,353	1,290,451	1,308,438	17,987
Office and Supplies Expense	259,630	86,543	54,012	(32,531)
Contractual and Consulting Expenses	888,445	296,148	236,676	(59,472)
Managed Care Information System (PCE)	305,200	101,733	98,400	(3,333)
Legal Expense	242,153	80,718	105,208	24,490
Utilities/Conferences/Mileage/Misc Exps	8,355,776	2,785,259	85,326	(2,699,933)
Grants - MDHHS & Non-MDHHS	989,860	329,953	115,335	(214,618)
Taxes, HRA, and Local Match	16,137,514	5,379,171	3,752,095	(1,627,076)
Prevention Expenses - Grant & PA2	3,034,456	1,011,485	987,280	(24,205)
Contribution to ISF/Savings	-	-	-	-
Member Payments - Medicaid/HMP	379,996,954	126,665,651	125,090,511	(1,575,141)
Member Payments - CCBHC	9,345,739	3,115,246	3,679,964	564,718
Member Payments - PA2 Treatment	2,001,942	667,314	237,607	(429,707)
Member Payments - Grants	9,650,869	3,216,956	1,639,997	(1,576,959)
Total Expenditures	**435,079,891**	**145,026,630**	**137,390,849**	**(7,635,781)**
Total Change in Net Assets	**(0)**	**(0)**	**915,467**	**915,467**

LAKESHORE REGIONAL ENTITY

Statement of Activities
Budget to Actual Variance Report

For the Period ending January 31, 2023

As of Date: 1/31/23

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	Budget will be included with amendment one.
Healthy Michigan	Revenue adjustments are projected and will be included in amendment one.
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. First quarter payment is expected in quarter two.
Local Match Revenue	Local match requirement for FY23 was reduced.
CCBHC Supplemental Revenue	Supplemental Revenue is closely aligned with the current budget projections.
MDHHS Grants	SUD grant payments changed to quarterly in FY23.
PA 2 Liquor Tax	PA2 revenues are received after the Department of Treasury issues payments to the counties. More payments are expected for the 1st 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.
Miscellaneous Revenue	No miscellaneous funds received as of this report. Funds are expected periodically throughout the year for trainings and Talksooner subcriptions.

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	Spending is under but billings are usually delayed. This line item will be monitored for future amendments.
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	IPA & HRA taxes are paid quarterly. Our Local Match requirement for FY23 was reduced.
Prevention Exps - Grant/PA2	SUD grant payments changed to quarterly in FY23. Some billings were delayed due to overlapping FY22 closeout and report submissions.
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 Payments	This line item will be monitored for future amendments as projections are reported by our CCBHCs.
Member PA2 Tx Payments	Billings against this line item typically occur after other grant funding is applied. Spending is based on projections and will be monitored for amendments.
Member Grant Payments	MDHHS changed SUD grant payments to quarterly in FY23. Grant payments for SUD Treatment were not received until quarter two.

LAKESHORE REGIONAL ENTITY

Includes Medicaid, Autism and Healthy Michigan activity only.
Does not inlcude Grant, General Funds, Local or other funding..

Lakeshore Regional Entity Combined Monthly FSR Summary
FY 2023
December 2022 Reporting Month
Reporting Date: 2/15/2023

ACTUAL:	HealthWest	Network180	OnPoint	Ottawa	West Michigan	LRE	Total
Distributed Medicaid/HMP Revenue							
Medicaid	11,804,893	33,218,845	6,321,867	9,381,911	3,773,910	1,059,647	65,561,072
Autism	2,311,403	5,661,607	1,004,980	1,650,630	665,345	127,688	11,421,652
Healthy Michigan	1,985,765	7,279,741	1,086,968	2,026,187	619,772	162,890	13,161,323
Total Distributed Medicaid/HMP Revenue	16,102,061	46,160,193	8,413,815	13,058,728	5,059,027	1,350,225	90,144,048
Capitated Expense							
Medicaid	8,553,659	35,398,742	6,256,173	6,521,318	3,938,743	1,059,647	61,728,281
Autism	453,374	5,376,242	431,050	867,191	182,767	127,688	7,438,312
Healthy Michigan	1,487,126	5,754,275	1,058,542	666,998	359,103	162,890	9,488,934
Total Capitated Expense	10,494,159	46,529,259	7,745,765	8,055,507	4,480,613	1,350,225	78,655,528
Actual Surplus (Deficit)	5,607,901	(369,066)	668,050	5,003,221	578,414	-	11,488,520
% Variance	34.83%	-0.80%	7.94%	38.31%	11.43%	0.00%	
Information regarding Actual (Threshold: Surplus of 5% and deficit of 1%)	The 3% increase, per the spending plan, does not go into effect until January 1st. HW is anticipating some provider stability payments for the first quarter of the fiscal year.HW also has not budgeted the use of their surplus funds yet; which will occur in 60 days due to a change in	N180 calculates capitated expenses using actual claims submitted at the time of FSR prep + an estimate for IBNR based on experience. YTD, N180 expects a receivable from the LRE to cover the difference.	Actual based on known expeneses, plus IBNR for provider network claims, as of date of submission.	1st quarter claims processing focused more on FY22 payables. 3% Increase effective in January. A couple big 1/1/23 contracts.	Expenditures are under budget due to the delay in hiring for vacant positions. May need to be adjusted based on CCBHC.	Less than threshold for explanation	

PROJECTION:	HealthWest	Network180	OnPoint	Ottawa	West Michigan	LRE	Total
LRE Revenue Projections as of:							
December							
Medicaid	50,575,186	138,761,817	26,188,256	39,350,554	15,657,274	14,747,398	285,280,484
Autism	8,931,905	21,827,673	3,892,353	6,375,027	2,549,985	1,772,313	45,349,256
Healthy Michigan	9,835,879	29,165,058	4,361,894	8,147,970	2,460,938	2,353,762	56,325,500
Total Projected Medicaid/HMP Revenue	69,342,970	189,754,548	34,442,502	53,873,550	20,668,197	18,873,472	386,955,239
	(0)	-	-	-	-	-	
Expense Projections							
Medicaid	52,832,547	144,235,853	28,190,094	39,188,982	16,399,959	14,747,398	295,594,833
Autism	2,409,549	21,988,828	2,123,161	6,016,974	1,213,176	1,772,313	35,524,001
Healthy Michigan	8,177,941	24,034,986	3,763,373	7,489,239	1,359,177	2,353,762	47,178,477
Total Capitated Expense Projections	63,420,037	190,259,667	34,076,628	52,695,195	18,972,312	18,873,472	378,297,312
Projected Surplus (Deficit)	5,922,933	(505,119)	365,874	1,178,355	1,695,885	-	8,657,928
% Variance	8.54%	-0.27%	1.06%	2.19%	8.21%	0.00%	
Information regarding Projections (Threshold: Surplus of 5% and deficit of 1%)	The 3% increase, per the spending plan, does not go into effect until January 1st and is not yet included in the projected expenses. HW is anticipating some provider stability payments for the first quarter of the fiscal year but that is not yet included in the projected expenses. HW also has not budgeted the use of their surplus funds yet; which will occur in 60 days due to a change in leadershp.	Less than threshold for explanation	Expense projections have been updated based on expected utilization changes, all known rate increases (i.e. SUD rates effective 1/1/23, H0020 rate increase, Autism increases), and projected staffing and pay grade changes.	Less than threshold for explanation	Three months into the fiscal year, WM's expenditure projection is based on the spending plan. Projection information will be updated as we move futher into the fiscal year. WM has added 5 new FTEs to support operational needs currently not built into the projection. SUD Contract rate increases 1/1/23. MH provider rate increases effective 2/1/23.	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	1/13/2023	1/13/2023		
Medicaid/HMP Revenue							
Medicaid	50,592,580	138,477,148	26,226,787	39,308,314	15,685,856	14,637,966	284,928,652
Autism	8,877,222	21,807,343	3,848,342	6,357,597	2,567,623	1,962,200	45,420,327
Healthy Michigan	9,801,631	28,885,568	4,320,883	8,034,599	2,412,467	2,239,706	55,694,855
Total Budgeted Medicaid/HMP Revenue	69,271,433	189,170,059	34,396,012	53,700,511	20,665,946	18,839,873	386,043,834
Capitated Expense							
Medicaid	52,832,547	136,680,342	26,869,897	39,188,982	16,524,118	14,637,966	286,733,852
Autism	2,409,949	22,686,387	1,961,305	6,016,974	1,213,176	1,962,200	36,249,991
Healthy Michigan	8,177,941	27,916,973	3,063,222	7,489,239	1,403,241	2,239,706	50,290,323
Total Budgeted Capitated Expense	63,420,437	187,283,702	31,894,424	52,695,195	19,140,535	18,839,873	373,274,165
	-	-	-	-	-	-	
Budgeted Surplus (Deficit)	5,850,996	1,886,358	2,501,588	1,005,316	1,525,411	-	12,769,668
% Variance	8.45%	1.00%	7.27%	1.87%	7.38%	0.00%	
Information regarding Spending Plans (Threshold: Surplus of 5% and deficit of 1%)	Due to change in leadership, HealthWest has postponed an update to the spending plan for 60 days.	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	Matches OnPoint board approved budget, plus increase for H0020 to $19 per unit and 3% SUD Rate increase	Less than threshold for explanation	Typically matches WM board approved budget unless significant changes, changes due to CCBHC haven't been WM board approved yet.	Less than threshold for explanation	

Variance between Projected and Proposed Spending Plan	71,937	(2,391,477)	(2,135,714)	173,039	170,474	-	(4,111,741)
% Variance	0.10%	-1.26%	-6.21%	0.32%	0.82%	0.00%	
Explanation of variances between Projected and Proposed Spending Plan (Threshold: Surplus of 5% and deficit of 1%)	Less than threshold for explanation	Projection matches LRE revenue projection, which was finalized after the N180 Board approved budget	Spending Plan matches OnPoint Board approved budget.	Less than threshold for explanation	State change for MAT rate changes.	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
December 2022 Reporting Month
Reporting Date: 2/15/2023

CCBHC ACTIVITY

ACTUAL:	HealthWest	Network180	OnPoint	Ottawa	West Michigan	LRE	Total
Distributed Medicaid/HMP CCBHC Revenue							
Medicaid CCBHC Base Capitation	2,525,589				1,099,042		3,624,631
Medicaid CCBHC Supplemental	1,010,452				1,315,014		2,325,466
Healthy Michigan CCBHC Base Capitation	607,241				396,597		1,003,837
Healthy Michigan CCBHC Supplemental	307,411				479,420		786,831
Total Distributed Medicaid/HMP CCBHC Revenue	4,450,692	-	-	-	3,290,073	-	7,740,765
Capitated CCBHC Expense							
Medicaid CCBHC	3,536,041				2,375,536		5,911,577
Healthy Michigan CCBHC	914,652				870,796		1,785,448
Total Capitated CCBHC Expense	4,450,692	-	-	-	3,246,332	-	7,697,024
Actual CCBHC Surplus (Deficit)	-	-	-	-	43,741	-	43,741
% Variance	0.00%				1.33%		
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	9,235,815				4,802,256		14,038,070
Medicaid CCBHC Supplemental	4,547,160				5,080,846		9,628,006
Healthy Michigan CCBHC Base Capitation	1,746,766				1,610,877		3,357,643
Healthy Michigan CCBHC Supplemental	1,467,538				1,925,039		3,392,576
Total Projected Medicaid/HMP CCBHC Revenue	16,997,279				13,419,017	-	30,416,296
Capitated CCBHC Expense Projections							
Medicaid CCBHC	14,144,163				9,502,144		23,646,307
Healthy Michigan CCBHC	3,658,607				3,483,184		7,141,791
Total Capitated CCBHC Expense Projections	17,802,770	-	-	-	12,985,328	-	30,788,098
Projected CCBHC Surplus (Deficit)	(805,491)	-	-	-	433,689	-	(371,802)
% Variance	-4.74%				3.23%		
Information regarding CCBHC Projections (Threshold: Surplus of 5% and deficit of 1%)	Revenue Projections are based on the State's FY22 Rate Certification Letter. After FY22 Cost Settlement, it will be determined if updated projections are needed.				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	8/6/2022	10/18/2022	12/6/2022	12/6/2022		
Medicaid/HMP Revenue							
Medicaid CCBHC Base Capitation	9,235,815				4,802,256		14,038,070
Medicaid CCBHC Supplemental	4,547,160				5,080,846		9,628,006
Healthy Michigan CCBHC Base Capitation	1,746,766				1,610,877		3,357,643
Healthy Michigan CCBHC Supplemental	1,467,538				1,925,039		3,392,576
Total Budgeted Medicaid/HMP CCBHC Revenue	16,997,279				13,419,017	-	30,416,296
Capitated Expense							
Medicaid CCBHC	13,782,975				9,883,101		23,666,076
Healthy Michigan CCBHC	3,214,304				3,535,916		6,750,220
Total Budgeted Capitated CCBHC Expense	16,997,279				13,419,017	-	30,416,296
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	805,491				(433,689)	-	(371,802)
% Variance	4.74%				-3.23%		
Explanation of variances between CCBHC Projected and Proposed Spending Plan (Threshold: Surplus of 5% and deficit of 1%)	Revenue Projections are based on the State's FY22 Rate Certification Letter. After FY22 Cost Settlement, it will be determined if updated projections are needed.				Revenue Projections are based on the State's FY22 Rate Certification Letter. After FY22 Cost Settlement, it will be determined if updated projections are needed.		

***CCBHC Projected Revenue is based on the State's projections in the FY22 Rate Certification Letter.**

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
January 2023 Reporting Month
Reporting Date: 03/15/2023

ACTUAL:	HealthWest	Network180	OnPoint	Ottawa	West Michigan	LRE	Total
Distributed Medicaid/HMP Revenue							
Medicaid	15,367,164	44,376,764	8,378,399	12,490,333	4,994,995	1,505,227	87,112,883
Autism	3,086,386	7,548,939	1,340,039	2,203,447	886,199	162,265	15,227,276
Healthy Michigan	3,323,539	9,783,574	1,456,961	2,728,402	830,968	220,567	18,344,013
Total Distributed Medicaid/HMP Revenue	21,777,090	61,709,278	11,175,400	17,422,182	6,712,162	1,888,060	120,684,172
Capitated Expense							
Medicaid	20,291,197	46,995,420	8,464,904	9,851,884	5,010,610	1,505,227	92,119,242
Autism	724,856	6,977,905	608,242	1,206,389	250,887	162,265	9,930,543
Healthy Michigan	2,468,110	7,954,005	1,329,869	1,025,012	501,064	220,567	13,498,627
Total Capitated Expense	23,484,162	61,927,330	10,403,015	12,083,284	5,762,561	1,888,060	115,548,412
Actual Surplus (Deficit)	(1,707,073)	(218,052)	772,385	5,338,898	949,601	-	5,135,760
% Variance	-7.84%	-0.35%	6.91%	30.64%	14.15%	0.00%	
Information regarding Actual (Threshold: Surplus of 5% and deficit of 1%)	Moved to accrual based accounting per the discussion at February Finance ROAT. Not expecting a year end deficit. Expecting a y/e surplus.	Less than threshold for explanation	Recorded based on known expense, plus estimated for provider claims incurred by not yet received (IBNR). Due to provider rate increases effective January 1, OnPoint anitipates the actual suplus will reduce going forward (see projection below).	Recorded based on actual expenses only. Provider rate increases effective January 1. Final FY22 accruals were completed in this reporting month and Ottawa anticipates the actual surplus will decrease going forward.	Expenditures are under budget due to the delay in hiring for vacant positions, rate increase effective dates, and timing of some budgeted maintenace.		

PROJECTION:	HealthWest	Network180	OnPoint	Ottawa	West Michigan	LRE	Total
LRE Revenue Projections as of:							
January							
Medicaid	48,969,827	139,322,416	26,122,545	39,513,539	16,017,403	14,704,519	284,650,248
Autism	8,936,132	21,773,786	3,872,505	6,383,363	2,551,670	1,907,114	45,424,571
Healthy Michigan	8,967,561	29,427,563	4,374,730	8,246,825	2,500,457	2,288,824	55,805,961
Total Projected Medicaid/HMP Revenue	66,873,520	190,523,766	34,369,779	54,143,728	21,069,530	18,900,457	385,880,780
	(0)	-	-	-	-	-	
Expense Projections							
Medicaid	50,247,619	144,772,315	28,190,094	39,407,536	16,399,959	14,704,519	293,722,042
Autism	4,075,184	21,886,637	2,123,161	6,889,244	1,213,176	1,907,114	38,094,516
Healthy Michigan	7,885,618	24,411,053	3,763,373	6,011,096	1,359,177	2,288,824	45,719,140
Total Capitated Expense Projections	62,208,421	191,070,005	34,076,628	52,307,876	18,972,312	18,900,457	377,535,698
Projected Surplus (Deficit)	4,665,099	(546,239)	293,151	1,835,852	2,097,218	-	8,345,082
% Variance	6.98%	-0.29%	0.85%	3.39%	9.95%	0.00%	
Information regarding Projections (Threshold: Surplus of 5% and deficit of 1%)	Still reviewing the HW Spending Plan for necessary updates. Planning for April updates.	Less than threshold for explanation	Less than threshold for explanation	Less than threshold for explanation	WM's projection is based on the spending plan at this point in the fiscal year. Projection will be updated as we move further in the fiscal year. WM has added 5 new FTEs to support operational needs currently not built into the projection. SUD Contract rate increases 1/1/23. MH provider rate increases effective 2/1/23.		

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	1/13/2023	1/13/2023		
Medicaid/HMP Revenue							
Medicaid	50,592,580	138,477,148	26,226,787	39,308,314	15,685,856	14,637,966	284,928,652
Autism	8,877,222	21,807,343	3,848,342	6,357,597	2,567,623	1,962,200	45,420,327
Healthy Michigan	9,801,631	28,885,568	4,320,883	8,034,599	2,412,467	2,239,706	55,694,855
Total Budgeted Medicaid/HMP Revenue	69,271,433	189,170,059	34,396,012	53,700,511	20,665,946	18,839,873	386,043,834
Capitated Expense							
Medicaid	52,832,547	136,680,342	26,869,897	39,188,982	16,524,118	14,637,966	286,733,852
Autism	2,409,949	22,686,387	1,961,305	6,016,974	1,213,176	1,962,200	36,249,991
Healthy Michigan	8,177,941	27,916,973	3,063,222	7,489,239	1,403,241	2,239,706	50,290,323
Total Budgeted Capitated Expense	63,420,437	187,283,702	31,894,424	52,695,195	19,140,535	18,839,873	373,274,165
	-	-	-	-	-	-	
Budgeted Surplus (Deficit)	5,850,996	1,886,358	2,501,588	1,005,316	1,525,411	-	12,769,668
% Variance	8.45%	1.00%	7.27%	1.87%	7.38%	0.00%	
Information regarding Spending Plans (Threshold: Surplus of 5% and deficit of 1%)	Still reviewing the HW Spending Plan for necessary updates.	Less than threshold for explanation	Spending plan was prepared based on Board Approved budget from September 2022. Not all rate increases were known at the time the budget was prepared. See Projected expenses above for current plan.	Less than threshold for explanation	Typically matches WM board approved budget unless significant changes, changes due to CCBHC haven't been WM board approved yet. Anticipate changes in May or June.		

Variance between Projected and Proposed Spending Plan	(1,185,897)	(2,432,596)	(2,208,437)	830,537	571,807	-	(4,424,587)
% Variance	-1.71%	-1.29%	-6.42%	1.55%	2.77%	0.00%	
Explanation of variances between Projected and Proposed Spending Plan (Threshold: Surplus of 5% and deficit of 1%)	Review of the Spending Plan is necessary and in process.	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.	Proposed Spending Plan will be updated when a budget amendment is brought to OnPoint's board in April.	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
January 2023 Reporting Month
Reporting Date: 03/15/2023

CCBHC ACTIVITY

ACTUAL:	HealthWest	Network180	OnPoint	Ottawa	West Michigan	LRE	Total
Distributed Medicaid/HMP CCBHC Revenue							
Medicaid CCBHC Base Capitation	3,705,065				1,492,031		5,197,096
Medicaid CCBHC Supplemental	1,494,814				1,766,193		3,261,008
Healthy Michigan CCBHC Base Capitation	888,151				531,960		1,420,111
Healthy Michigan CCBHC Supplemental	456,249				637,494		1,093,743
Total Distributed Medicaid/HMP CCBHC Revenue	6,544,280	-	-	-	4,427,678	-	10,971,958
Capitated CCBHC Expense							
Medicaid CCBHC	5,199,880				3,258,224		8,458,104
Healthy Michigan CCBHC	1,344,400				1,169,454		2,513,854
Total Capitated CCBHC Expense	6,544,280	-	-	-	4,427,678	-	10,971,958
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	11,115,195				4,476,093		15,591,289
Medicaid CCBHC Supplemental	4,484,443				5,298,579		9,783,023
Healthy Michigan CCBHC Base Capitation	2,664,453				1,595,879		4,260,332
Healthy Michigan CCBHC Supplemental	1,368,748				1,912,482		3,281,230
Total Projected Medicaid/HMP CCBHC Revenue	19,632,839				13,283,034	-	32,915,873
Capitated CCBHC Expense Projections							
Medicaid CCBHC	15,599,639				9,774,673		25,374,311
Healthy Michigan CCBHC	4,033,201				3,508,361		7,541,562
Total Capitated CCBHC Expense Projections	19,632,839	-	-	-	13,283,034	-	32,915,873
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	8/6/2022	10/18/2022	12/6/2022	12/6/2022		
Medicaid/HMP Revenue							
Medicaid CCBHC Base Capitation	9,235,815				4,802,256		14,038,070
Medicaid CCBHC Supplemental	4,547,160				5,080,846		9,628,006
Healthy Michigan CCBHC Base Capitation	1,746,766				1,610,877		3,357,643
Healthy Michigan CCBHC Supplemental	1,467,538				1,925,039		3,392,576
Total Budgeted Medicaid/HMP CCBHC Revenue	16,997,279				13,419,017	-	30,416,296
Capitated Expense							
Medicaid CCBHC	13,782,975				9,883,101		23,666,076
Healthy Michigan CCBHC	3,214,304				3,535,916		6,750,220
Total Budgeted Capitated CCBHC Expense	16,997,279				13,419,017	-	30,416,296
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%)	Revenue Projections are based on the State's FY22 Rate Certification Letter. After FY22 Cost Settlement, it will be determined if updated projections are needed.				Revenue Projections are based on the State's FY22 Rate Certification Letter. After FY22 Cost Settlement, it will be determined if updated projections are needed.		

***CCBHC Projected Revenue is based on the State's projections in the FY22 Rate Certification Letter.**