Meeting Agenda

**BOARD OF DIRECTORS**

Lakeshore Regional Entity

February 17, 2022 – 1:00 PM

GVSU Muskegon Innovation Hub

200 Viridian Dr, Muskegon, MI 49440

Phone: 646-558-8656 Conference ID: 889 2121 9503

1. Welcome and Introductions – Mr. DeYoung
2. Roll Call/Conflict of Interest Question – Mr. DeYoung
3. Public Comment (Limited to agenda items only)
4. Consent Items:

   ***Suggested Motion:*** To approve by consent the following items.
   - February 17, 2022, Board of Directors meeting agenda *(Attachment 1)*
   - January 20, 2021, Board of Directors meeting minutes *(Attachment 2)*

5. Reports –
   a. LRE Leadership *(Attachment 3, 4, 5, 6, 7)*
      i. Quality Annual Effectiveness Review *(Attachment 8, 9)*

6. Chairperson's Report – Mr. DeYoung
   a. February 9, 2022, Executive Committee *(Attachment 10)*
      i. CEO Evaluation

7. Action Items –
   i. LRE Travel Policy 2.11 *(Attachment 11)*

      ***Suggested Motion:*** To approve the LRE Policy 2.11, Travel

8. Financial Report and Funding Distribution – Ms. Chick *(Attachment 12)*
   a. FY2022, January Funds Distribution *(Attachment 13)*

      ***Suggested Motion:*** To approve the FY2022, January Funds Distribution as presented

   b. Statement of Activities as of 12/31/2021 and Variance Report *(Attachment 14)*
   c. Bucket Report (*Attachment 15)*

9. CEO Report – Ms. Marlatt-Dumas
10. Board Member Comments
11. Public Comment
12. Upcoming LRE Meetings
    - March 9, 2022 – LRE Executive Committee, 3:00 PM
    - March 10, 2022 – Consumer Advisory Panel, 1:00 PM

- March 17, 2022 – LRE Executive Board Meeting, 1:00 PM

13. Adjourn

Meeting Minutes
**BOARD OF DIRECTORS**
Lakeshore Regional Entity
GVSU Muskegon Innovation Hub
200 Viridian Dr, Muskegon, MI 49440
January 20, 2020 – 1:00 PM

WELCOME AND INTRODUCTIONS – Mr. DeYoung
Mr. DeYoung called the January 20, 2022, LRE Board meeting to order at 1:0 PM.

ROLL CALL/CONFLICT OF INTEREST QUESTION – Mr. DeYoung
**In Attendance:** Mark DeYoung, Peg Driesenga, Steven Gilbert, Jack Greenfield, Linda Garzelloni, Shaun Raleigh, , Ron Sanders, John Snider, Stan Stek, Jane Verduin

**Virtual Non-Exempt:** Jay Roberts-Eveland, Matt Fenske, Patricia Gardner, Jacquie Johnson

PUBLIC COMMENT
None.

CONSENT ITEMS:
LRE 22-01 Motion: To approve by consent the following items.

- January 22, 2022, Board of Directors meeting agenda as amended with items 7iv, 7v, 7vii, 8b removed.
- December 16, 2021, Board of Directors meeting minutes

Moved: Steven Gilbert Support: John Snider
MOTION CARRIED

LEADERSHIP BOARD REPORTS
LRE Leadership reports are included in packet for information.

- Mr. Greenfield would like to thank LRE staff for the effort to disseminate information to the Board.
- Mr. Stek asks if the Veteran Navigator position is a perpetual funding position?
    - This position is funded until 2025 as of now. LRE submits an application for funding annually, but this will go through 2025.

CHAIRPERSON'S REPORT
Minutes from the January 12, 2022, Executive Committee meeting are included in the packet for information.

- A link to a Survey Monkey will be sent to the Board Directors for the CEO evaluation.

ACTION ITEMS
LRE 22-02 Motion: To ratify the contract with Rubix from 5/31/21 – 11/30/21

Moved: Stan Stek Support: Jane Verduin
ROLL CALL VOTE - UNANIMOUS
MOTION CARRIED

LRE 22-03 Motion: To approve the LRE CEO to execute a contract extension with Rubix

Moved: Stan Stek Support: Peg Driesenga

ROLL CALL VOTE - UNANIMOUS
MOTION CARRIED

LRE 22-04 Motion: To approve the LRE FY22 Risk Management Strategy Plan

Moved: Ron Sanders Support: John Snider

The Risk Management Plan is approved by Jeff Wieferich at MDHHS.
ROLL CALL VOTE - UNANIMOUS
MOTION CARRIED

LRE 22-05 Motion: To approve the LRE CEO to fully execute the LRE/MDHHS Contract Sanctions Proposal

Moved: Jane Verduin Support: Linda Garzelloni

ROLL CALL VOTE - UNANIMOUS
MOTION CARRIED

FINANCIAL REPORT AND FUNDING DISTRIBUTION

**Revised FY2022 November Funds Distribution and FY 2022 December Funds Distribution**
LRE 22-06 Motion: To approve the Revised FY2022 November Funds Distribution and the FY2022 December Funds Distribution as presented

Moved: Jack Greenfield Support: John Snider
ROLL CALL VOTE - UNANIMOUS
MOTION CARRIED

**Statement of Activities as of 11/31/2021 and Variance Report-**
Included in the Board packet for information.

- LRE will include Budget adjustments for CCBHC and will complete a quarterly reconciliation with the CCBHC sites.

**Member Bucket Reports-**
Not available.

CEO REPORT

- The Region received a new shipment of COVID supplies. CMHs continue to report regularly on COVID numbers.
- LRE sent Beacon the contract termination letter which will wrap up the contract by June 30, 2022.
    - Mr. Greenfield would like to know if the Board will continue to receive reports on the same level that Beacon was giving to the Board?
        - LRE is building a data warehouse that will allow us to give the Board reports.
- Ms. Marlatt-Dumas will sign the sanction proposal per the Board's approval today.
- Work shortage continues to be a consistent issue throughout Michigan.
- There continues to be opposition to the Shirkey Bills.
- LRE Operating Agreement and Bylaws was taken off action items for Board approval and will be discussed further.

BOARD MEMBER COMMENTS

- Mr. Stek would like to thank Ms. Marlatt-Dumas for the work that she has completed to have the contract sanctions lifted.
- Mr. DeYoung welcomes back Ms. Juarez (Ms. Garzelloni) to the LRE Board.
- Ms. Roberts-Eveland is resigning from the LRE Board beginning February 1, 2022.
    - Ms. Roberts-Eveland would like to thank the Board for this opportunity.
- Allegan CMH will have a groundbreaking on January 28 for the new CMH building.

UBLIC COMMENT
None.

UPCOMING LRE MEETINGS

- February 9, 2022 – LRE Executive Committee, 3:00 PM
- February 17, 2022 – LRE Executive Board Meeting, 1:00 PM

ADJOURN
Mr. DeYoung adjourned the January 20, 2022, LRE Board of Directors meeting at 1:50 PM.

_____ _____

Jane Verduin, Board Secretary

Minutes respectfully submitted by:
Marion Dyga, Executive Assistant

LAKESHORE REGIONAL ENTITY

# Chief Operating Officer (Stephanie VanDerKooi) Report

February 17, 2022

**LRE TACTICAL PLAN –**

Work continues toward implementation of functions identified in the Tactical Plan. At present, approximately 45 percent of the plan has been marked complete, and 45 percent is in process (with most of those nearing completion). The remaining 10 percent of items in the plan have not yet been started or have been removed due to shifting priorities and plans. Updates will be provided periodically throughout the year.

**BEACON –**

The LRE de-implementation with Beacon has started with a kickoff meeting that took place between LRE staff and Beacon staff on February 7. LRE staff are meeting on a regular basis with the Beacon team to ensure all functions are stood back up at the LRE on or before the June 30th contract termination. Updates on this process will be provided at future board meetings.

**AUTISM SERVICES – Justin Persoon, Autism Manager**

The Autism/Behavioral Health Treatment team at the LRE includes Justin Persoon, BCBA, LBA, LLP (Autism Manager) and Stephanie Thommen, QIDP (Autism Specialist). The Autism team has spent much of the last month reviewing ABA/BHT treatment plans, supporting CMH ABA/BHT Coordinators, reviewing and preparing BHT specific policies, reviewing and updating BHT specific forms, and developing ABA/BHT specific dashboards. While there are challenges identified with the ABA/BHT program, we are committed to refining and improving services for those who need this level of care. Some highlights of the work we have started include:

- Updated eligibility enrollment form.
- Working with CMH Autism coordinators and contract managers on a weekly basis. This Autism workgroup is currently focused on areas including, eligibility evaluations, referral processes, transition planning, and provider consistency.
- Available treatment and evaluation consultation for CMHs and external providers.
- Continued work on improved data reporting interface and Power BI dashboard reports. This work should yield improved synthetization of data for better decision making. Many reports will provide normed data across providers for more accurate comparison.

Forthcoming:

- Policy/Procedure for ongoing utilization management review of ABA/BHT service plans.
- Policy/Procedure for noticing individuals waiting for services.
- The Autism/Behavioral Health Treatment team is working on developing a training for CMH Autism coordinators and supports coordinators focused on quality of care, coordination of services, medical necessity, and transition planning.
- Development of a Q&A document for Autism/Behavior Health Treatment (BHT) to include common questions regarding, among others, Eligibility Evaluations, Behavior Assessments, Coordination of Care, Wavier Support Application (WSA), and Transition Planning.

Currently, 1565 children are open to the Autism Benefit.

| ACCMHS | HW | N180 | CMHOC | WMCMHS |
|---|---|---|---|---|
| 120 | 122 | 1,066 | 215 | 42 |

- 81 approvals in January 2022
- 16 closures in January 2022

**Children's Waiver Program (CWP) – Stephanie Thommen, Quality Management Specialist**
65 children are enrolled in the Children's Waiver Program. Four prescreens were submitted by Network180 in January. These children were invited to apply for the CWP on February 7th. There are no children on the weighing list for the CWP. The CWP has doubled its enrollees since the beginning of FY2021.

**Current Enrollments:**

- Allegan – 2
- HealthWest – 9
- Network 180 – 46
- Ottawa – 7
- West Michigan - 1

**CLINICAL/UTILIZATION MANAGEMENT (UM) – Liz Totten, Clinical UM Manager**
Clinical and UM department continue to work with Beacon to transition UM/Clinical back to the LRE. Meetings continue to occur to transition data and reporting functions as well as UM oversight functions. The approved IRR process is moving forward with all CMH's, and we look forward to using this data to identify areas of strength and need across the region and improve UM review application, consistency and reliability. Internal policy, workflow review and development of data reports in PowerBi are underway to ensure a seamless transition. From Beacon to the LRE and to provide our CMHSP's with information that can be used to make impactful changes in all UM related areas.

**CCBHC (CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC) – Michelle Anguiano, CCBHC and Customer Services Manager**
The new drafted handbook has been released and the PIHP's will be responsible for creating a policy for the verification of consents. The LRE IT team is diligently working to put together a database dashboard for our CCBHC's to begin to track key data required by the State. This data will demonstrate the effectiveness of integrating mental health and physical health to treat the whole person. We are continuing to work with KWB strategies to develop future evaluation for the CCBHC program. The entire region will meet in early March to discuss highlights of their programming and share best practice for the future.

**CUSTOMER SERVICES– Michelle Anguiano, CCBHC and Customer Services Manager**
The first Customer Services (CS) ROAT meeting was a huge success! The CS charter was reviewed together at the meeting for finalization and will be completed for approval.

THE CMH's gave input on the transition of CS from Beacon to the LRE with emphasis on having a structured workflow for the future (the workflow is in progress). The transition is continuing and will be completed sooner than expected. An LRE Appeals Board will begin meeting weekly to pull together the appeals workflow as a team. The CS group have agreed that customer satisfaction surveys will be reviewed during CS meetings.

**CREDENTIALING – Pam Bronson, Credentialing Specialist**

In January, the Credentialing Committee met, reviewed, and approved 36 providers for credentialing/re-credentialing. We continue to review and improve processes and forms with feedback from our Providers and Contract Managers. We have also been working with the Quality Team to support revisions to the member CMHSP site review process and learn how to use the PCE tools.

**Habilitation Supports Waiver (HSW) – Kim Keglovitz, Quality Management Specialist**

MDHHS will get back to normal in the next couple months regarding monitoring overdue recertifications and slot utilization. They will be sending reports to regions with recertifications that are more than 30 days overdue. Region 3 currently has 6 consumers that 30 days overdue. The CMHSP leads have been informed and are working to submit those before we receive that report.

| Recertifications overdue by CMHSP | More than 60 days overdue | More than 30 days overdue | 0-30 days overdue |
|---|---|---|---|
| Allegan | 0 | 0 | 1 |
| HealthWest | 0 | 0 | 1 |
| Network 180 | 1 | 0 | 0 |
| Ottawa | 3 | 0 | 0 |
| West Michigan | 1 | 0 | 0 |

MDHHS will also begin sending reports to the regions if they have slot utilization below 97%. Regions will be required to complete a corrective action plan if they fall below 95%. As of February 2, 2022, region 3 is at 99.7% utilization of our 629 slots.

| # of slots used in Region 3 | FY | October | November | December | January |
|---|---|---|---|---|---|
| | 2022 | 628 | 628 | 627 | 627 |

We currently have 4 open slots for February enrollment. Any new packets the CMHs would like considered for February enrollment will have to submit them to the LRE by Friday February 11. New enrollments cannot be turned into MDHHS any later than the 15th of the month. As of February 3, 2022, region 3 has 2 slots for March enrollment as well.

We have a total of 7 packets from across the region that are ready to be enrolled. We also have 10 on file that either have documents that are out of date or the IPOS goals and objectives need to reflect a habilitative need.

Recertifications are due to the LRE about 60 days ahead of their recertification date in the WSA. Recertifications for the month of February are due to the LRE by Friday February 11.
The recetifications listed overdue above are overdue by their date in the WSA.

**PROVIDER NETWORK MANAGEMENT – Don Avery, Jim McCormick, Provider Network Managers**

Provider Network Managers (PNM)continues to work with CMHSP contract staff and network staff to increase regional efficiencies with contracting and managed care functions. PNMs are beginning to develop a work plan for conducting provider focus groups to identify provider challenges and solicit input on support needs directly from providers across all service lines. This is part of the broader focus on increasing regional efficiencies with CMH contract processes and developed from discussions with CMH CEOs around ongoing provider challenges. Discussions continue with inpatient psychiatric hospitals on development of a value-based payment model. PNMs continue to work with LRE IT to develop performance dashboards specific to CMH member performance across a variety of measures.

**SUD PREVENTION - Amy Embury, Sud Prevention Manager**

A quarterly Prevention Provider meeting will be held on February 15th. The meeting is held virtually which allows for great participation and ability for providers to share happenings and best practices in their counties. Several counties have youth summits that are in the planning process and dates set for May 2022.

Upon last notice, the American Rescue Plan funds (ARPA) are slated to be allocated to PIHPs on May 1st. These funds included specific categories of funding for Prevention, Treatment and Women's Specialty Services. The Region 3 PIHP allocated funds were smaller in some categories than were requested.

**Gambling Prevention and TalkSooner** -see the attachment from Seyferth PR.

**SUD TREATMENT - Amanda Tarantowski, SUD Treatment Manager**

- **Recovery Capital Program:** The state communicated that they will be initiating a pilot program in which Recovery Homes will use a "Recovery Capital" scale with residents to monitor progress and areas for growth.
- **American Rescue Fund Plan Funds:** The state has given a preliminary idea of the projects they are interested in supporting, but we have been informed that we will not have the allocations available until around May 1st, 2022.
- **Native American Grant:** We have re-applied for a grant through the state to serve the behavioral health needs of Native American individuals with culturally competent interventions and practices. We will hear back soon if we were selected to provide this service in conjunction with Family Outreach Center.

- **MCBAP:** MCBAP has a new Executive Director, Jennifer Mitchell. They have increased staffing, created a "chat" feature on their website and are generally trying to be more responsive and available to folks.

**VETERAN NAVIGATOR - Eric Miller**

Please see the attached report.

TalkSooner.org

seyferthpr

# BOD Feb. 2022 LRE REPORT: TalkSooner and Gambling Prevention

Powered by LAKESHORE REGIONAL ENTITY

2/11/22

TalkSooner.org

seyferthpr

# GAMBLING PREVENTION:

- Prepping for Media Campaign to coincide with National Problem Gambling Disorder Month (March, 2022):

# TalkSooner.org

seyferthpr

- Feb: Media training with LRE-scholarship recipient/Certified Gambling Disorder Treatment Counselor, LRE Subject Matter Expert:
  - Angelita Valdez, Amy Embury
- March – mid-April: Billboard campaign 2.0; Lake and Muskegon counties (highest scratch-off lotto sales)

# TalkSooner.org

seyferthpr

- April: Exploring possible interest with CPAs, accounting firms in LRE footprint; Gambling losses can now be declared on tax returns; arm CPAs, accounting firms with “stayouttathedangerzone.com” type business cards to display/make available to any/all customers.



- May- June: Geo-Fencing 2.0 campaign targeting individuals with “stayouttathedangerzone.com” ads visiting 10 top-selling lotto retailers in each county

# TalkSooner.org

seyferthpr

- Other tactics:

✓ Andy O'Riley, Positively Muskegon; interviews and stories with senior gambling responsibly focus and Kids & gambling – parent focus

✓ Exploring content/partnership opportunities with GR Kids, Kzoo Kids for awareness related to kids & gaming/gambling

# TALKSOONER:

- Huge Core Team excitement surrounding WOOD-TV/ Channel 8/Maranda-produced Teen Vaping segment

TalkSooner.org

seyferthpr

# April 12, 13, 18, 19, & 20 – coincides with "4/20 Day" – *Changing the Narrative Surrounding 4/20 Day (Unofficial Marijuana Use Day)*

## 5 Key Segments (5-6 min. long, each); multiple social media, TV airings:

1. Inside the Teen Vaping Epidemic - *Scope of Issue*
2. Truth or Consequences – *Physical Health/Mental Health Impacts of Vaping*
3. Law & Order - *Legal consequences, school policies/intervention*
4. Real talk with Our Kids About Vaping – *Talking Tips, Resources*
5. My Kid is Vaping, Now What!? – *Voices of Parents, Resources*

# TalkSooner.org

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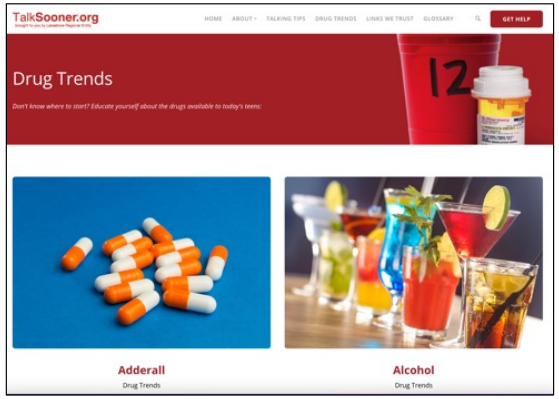
- Successfully pitched hidden drug emoji story with WGVU's Shelley Irwin


- Continued updating Drug Trend info/photography on website



# TalkSooner.org

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- Developing "Pesky Parent Q's" section for website, leverage to other social channels

- Prepping to speak at mParks March, 2022 Conference – 700 attendees

mParks℠ | Michigan Recreation & Park Association

- Continuing to build out 2022 planning matrix, continuing outreach, ideation, exploration with:
  - MyAuto Imports Automotive (Prevention Travels/Car Ride discussions)
  - Gerald R. Ford International Airport (Prevention Takes Flight)
  - Food trucks – Sober Eats - agreement to pilot collateral materials,
  - begin building base/outreach, Grand Rapids Food Truck Association
  - Outreach/exploration to Dental Offices – tie to oral health/vaping
  - Digital Benefits Toolbox – for local employers to share with employees

TalkSooner.org

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# Thank you!

LAKESHORE REGIONAL ENTITY

# Veteran Navigator Program
## Quarterly Board Report

Submitted by: Eric Miller
231-260-0721
ericm@lsre.org

Year: *2022*
Quarter: *January/February*

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

## *Outreach:*

Identify and engage veterans and their families.

West Michigan CMH hired in a Navigator to help Veterans connect to resources in Mason, Oceana, and Lake counties. The regional Navigator met with her and helped get her started in the right direction to build the network of resources available to Veteran in this area.

In the process of setting up a Day at Canonsburg for Veterans and their families to come and be with other Veterans and have a day out on the slopes or tubing.

# Community Members Reached:

*3*

## *Support:*

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

- Assisted 4 Veterans with starting or increasing their Veteran Benefits with the VA, they are still in process as this takes time.
- Helped one veteran get an Oxygen machine for portable use as well as a gas card to help her be able to get groceries and am currently working on housing issues as they are trying to raise her rent
- Assisted 1 Korean War Veteran with applying for the VA as well as aid and attendance for in home care. Working with adult protective services on a fiduciary as well.
- Worked with the Ottawa county crisis intervention team to help a veteran with PTSD. Another veteran who needs Champ VA for taking care of his wife who needs to be placed in a care facility as he is unable to care for her.
- Assisted a Veteran with employment issues as they are trying to find different opportunities for work.
- Helping 2 Veterans who are being told they have to move out due to rent being increased

# New veterans Served:

*11*

# Total Service Contacts:

*27*

## *Referrals:*

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

Worked directly with the Ottawa county Crisis intervention team to improve the lives and to save the life of Veterans in need.

Working with the VA to set up a townhall meeting to improve their community authorization process for Veteran who need to be seen outside of the VA.

| # Stakeholder Collaborations this Quarter: |
|---|
| *7* |

## *Expertise:*

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

Working to set up training with Ottawa CMH to do a military cultural competency training for their staff.

Helping to guide the new Navigator for West Michigan on how to best help Veterans and improve her network of resources in her area.

| # of trainings/ consults provided this quarter: |
|---|
| *1* |

LAKESHORE REGIONAL ENTITY

# Information Officer Report – February 2022

**Summary:**

1. **MCIS Software**:
   No new updates this period.

2. **Data Analytics and Reporting:**
   Over the past month, the initial production "soft launch" of LRE's Power BI system has fully vetted for security and accuracy, and a small number of CMH and LRE users have been onboarded for connectivity testing and training. The LRE Data Analytics production platform is now fully 'live' and ready for use. Additional LRE and CMH users will be onboarded beginning 2/14/2022. Role based security at both the organization level and role (job function) level will be employed for each user login to ensure that only information (dashboards/reports) appropriate for that role are exposed to the user.

   Dashboards currently in the User Acceptance Testing phase (*will be fully implemented soon*) include:
   - LRE Key Performance Indicators
   - Autism Dashboard

   Dashboards currently in active development phase include:
   - CCBHC Services and Revenue
   - 1915(i) SPA Services and Enrollments
   - BHTEDS Data Integrity
   - Served Demographics

   It is certainly worth noting at this time that each Interactive Power BI Dashboard typically delivers multiple "Tabs" within the dashboard (*similar to how an Excel file can have multiple worksheets*), and that each "Tab" can also present multiple visualizations. As an illustrative example of this, please see the list of (22) individual visualizations contained within the Autism Dashboard (shown below under "Details" on page 2).

3. **FY21 data reporting to MDHHS**:
   **FY21 Encounters**: FY21 encounters remain with good volume for all CMHSPs across both mental health and SUD service categories. Please see also the attached encounter graphs showing year to year comparisons.
   **FY21 BH-TEDS:** BH-TEDS reporting volumes remain strong for our region for FY21 related records.

   CMHs are very attentive to FY21 data completeness at this time due to the FY21 year-end financial reports which are due to MDHHS at the end of February. LRE summary and detail listings of "FY21 Encounters→EQI format" (*over FY21 encounters submitted through 1/28/2022*) were distributed to each CMH on 2/9/2022 to assist them in their identification of any material discrepancies vs their own EQI report.

4. **FY22 data reporting to MDHHS**:
   **FY22 Encounter reporting**, overall, is showing good volumes through December 2021, which would be expected at this point in time (a substantial volume of December services should typically be reported by the end of January).
   SUD encounters from Ottawa appear to be experiencing a significant reporting lag. No Ottawa SUD services were submitted during January 2022, and there have been no SUD dates of service reported for December 2021. SUD units of service for October and November 2021 are also under-reported (with lines of service down 43% from normal).
   SUD encounters from HealthWest are still under-reported for November 2021 (with lines of service down 39% from normal).

5. **Beacon Transition:**
   LRE and Beacon IT team members are working together to document and plan for all needed IT transition items. The data analytics and reporting area certainly has a natural head-start since the effort to build those inside the LRE infrastructure was already underway. There are additional needs for IT support for other transitioning business functions, including phone system changes (re-routing 800- numbers), transitioning data processing tasks that do not necessarily fall under the data analytics umbrella, and supporting the adoption of new PCE Systems modules such as the Audit module and the Grievance and Appeals module.

## Additional Details:

**Content Listing for Autism Dashboard:**

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### Autism Dashboard

### Reports in Dashboard:

- Average Units of Service per Client
- Average Units of Service per Client / by Age
- Average Cost per Client by Provider
- Average Cost per Client by CMH
- Average Cost per Age Group
- Average Cost per Client by Provider
- Average Units per Date Range Selected by CMH
- Average Units per Range Selected against Age by CMH
- Count of Consumers by Recency of Service
- Count of Consumers by Recency of Service / by Age
- ABA Identification Assessment (97151), total Claim units by CMH
- ABA Identification Assessment (97151), total units by billing Provider
- Average Units of Service per Client (97153), by CMH
- Average Units of Service per Client (97153), by billing Provider
- Average Units per Client by CMH - primary ABA/CPT Code
- Average Cost per Client by CMH
- Percent Ratio of 97155 vs 97153, by CMH
- Percent Ratio of 97155 vs 97153, by billing Provider
- Client Count total, by Age and CMH
- Average Units per Client by CMH and CPTCode
- Total Cost, Total Paid per CMH
- Total paid per billing Provider

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**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.

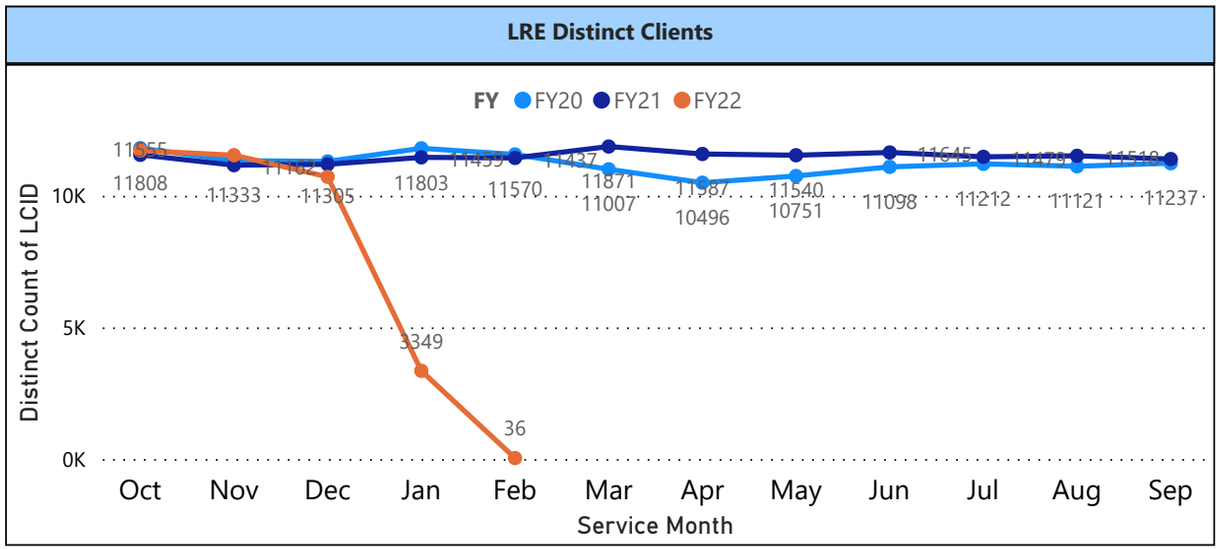
## Reports in Dashboard:

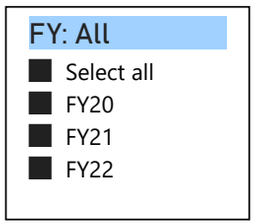
1. **LRE - MH Lines** - Shows distinct client count and mental health encounter line totals for both Professional and Institutional type transactions for the LRE as a whole.
2. **LRE - MH Units** - Shows distinct client count and mental health encounter claim unit totals for both Professional and Institutional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

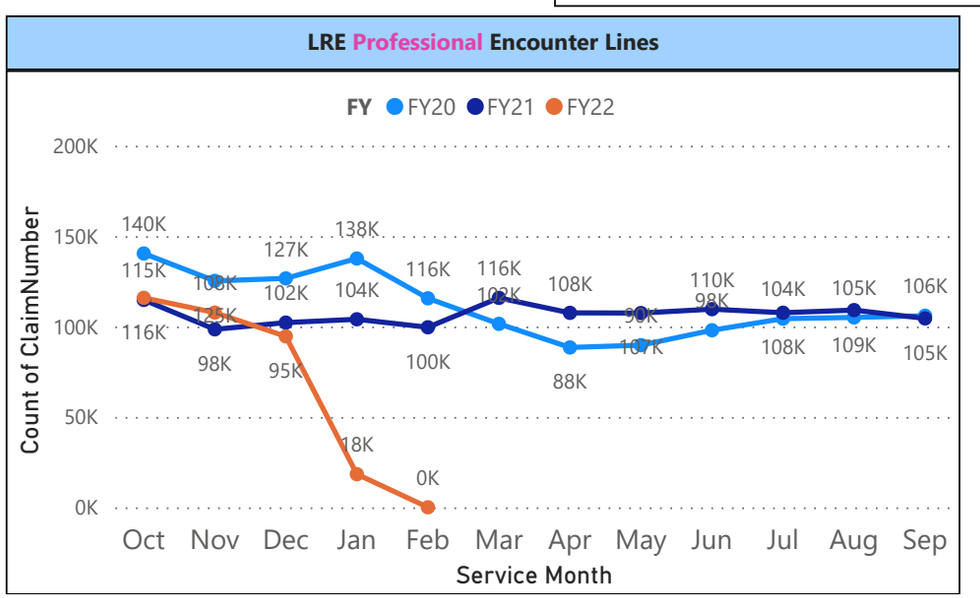
**Notes:** Items 4-6 above are repeated for each individual CMHSP.

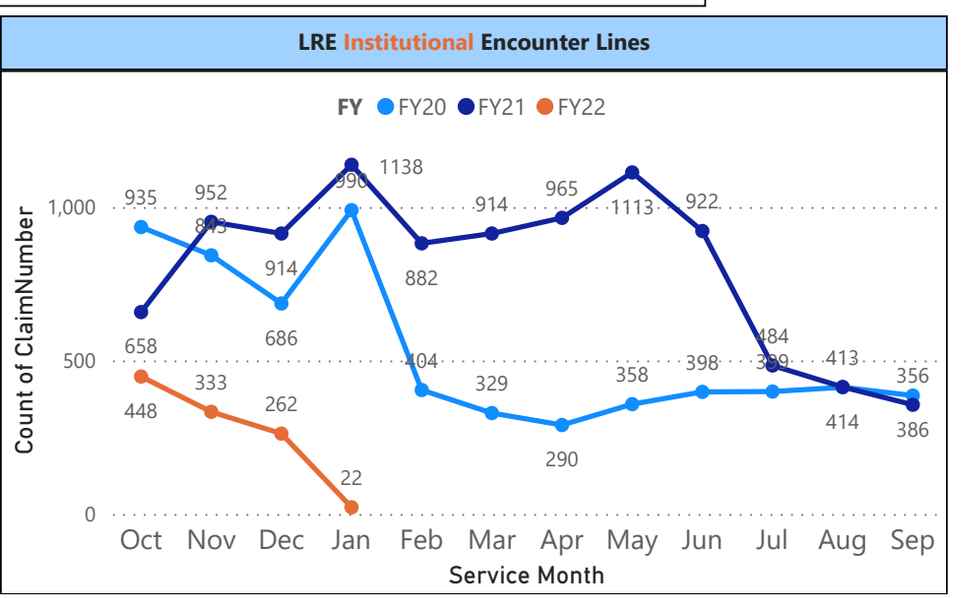
LAKESHORE REGIONAL ENTITY

# LRE
## Behavioral Health




2/9/2022 4:46:47 PM

Latest ProcessDate

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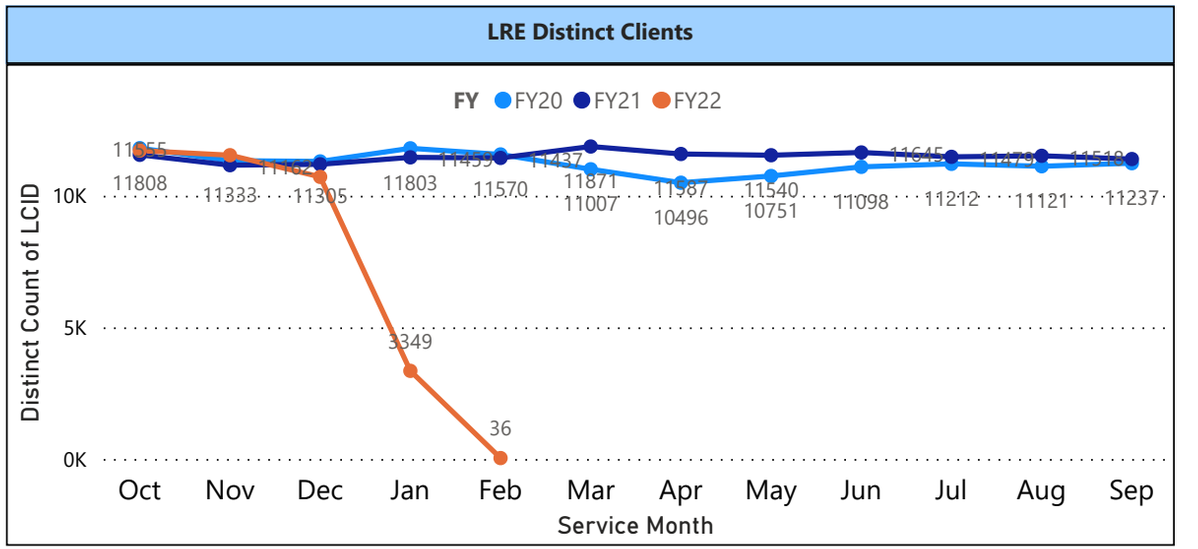
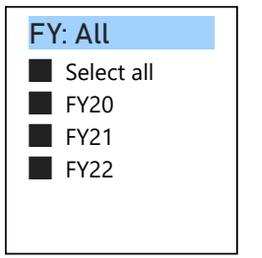
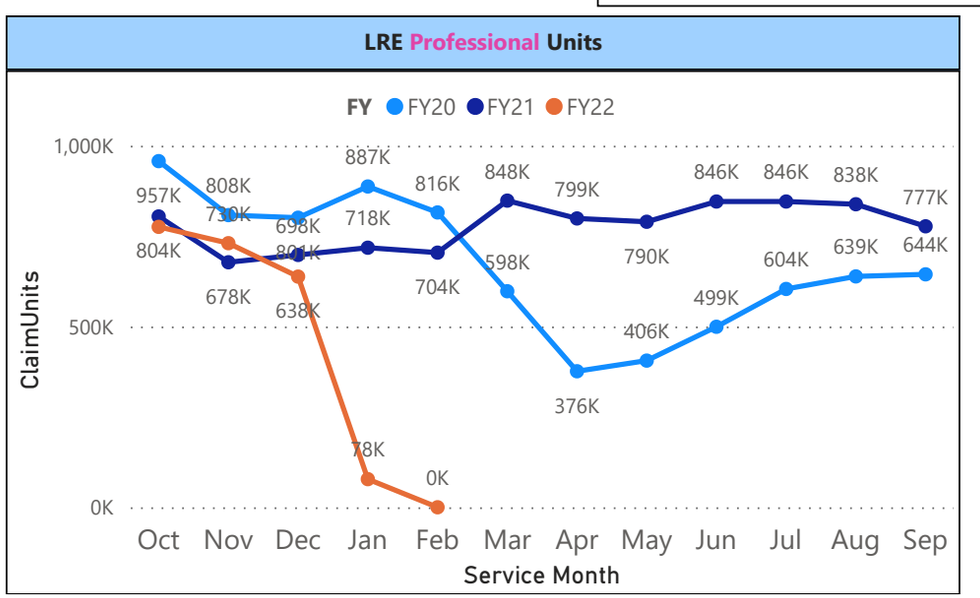
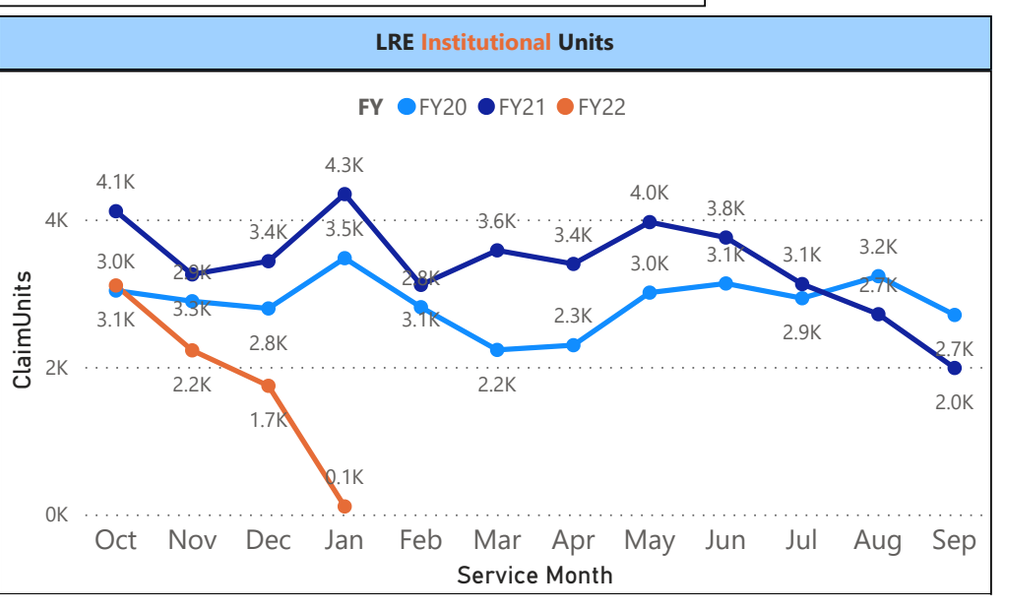
# LRE
## Behavioral Health

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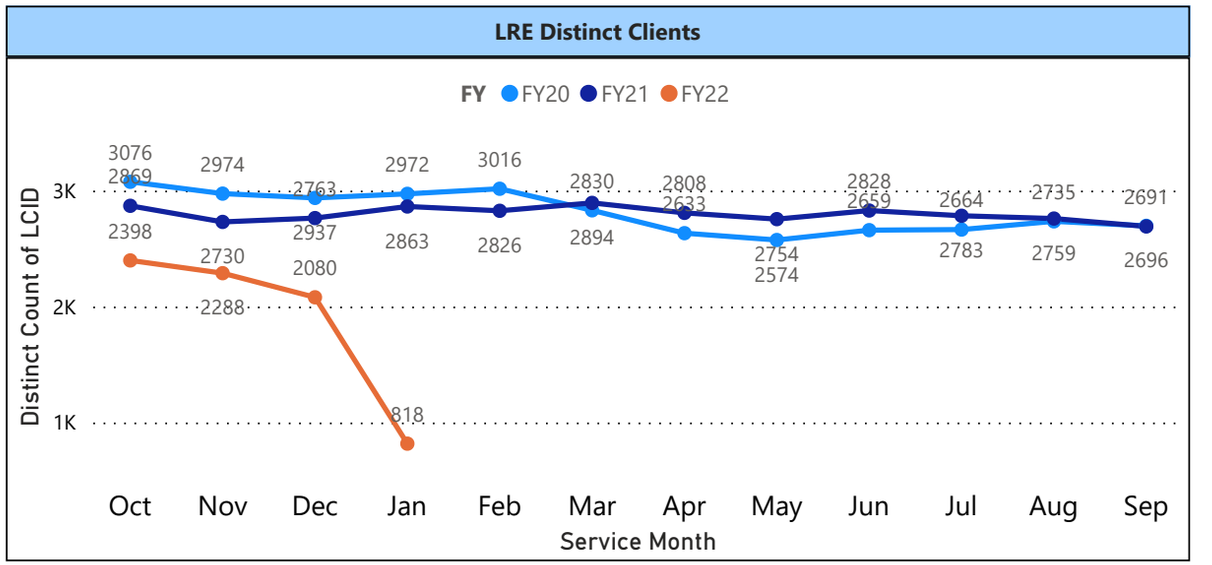
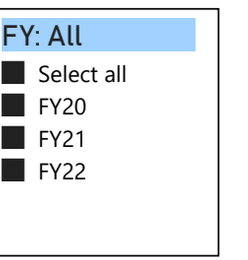
Latest ProcessDate

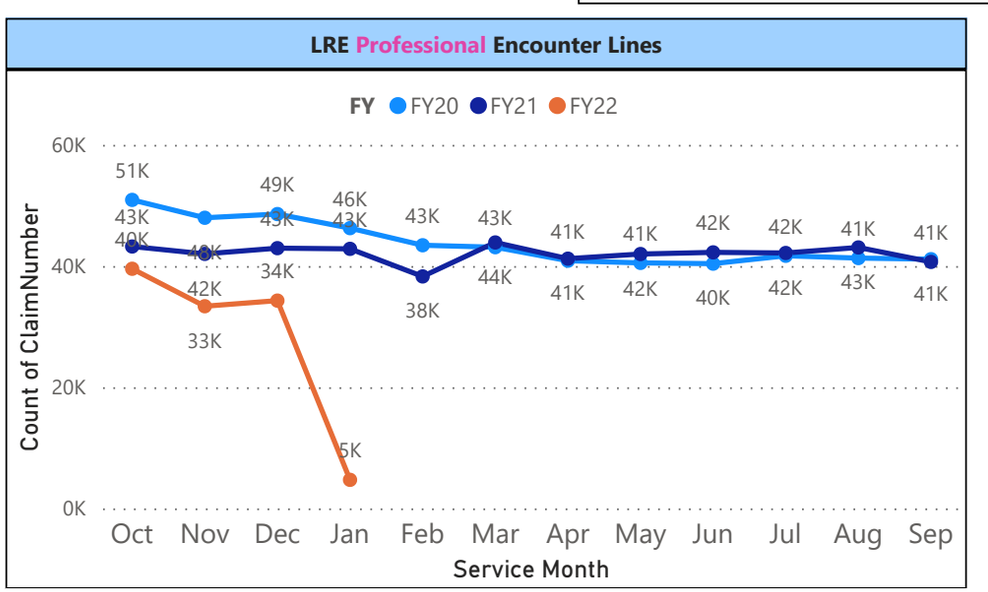
LAKESHORE REGIONAL ENTITY

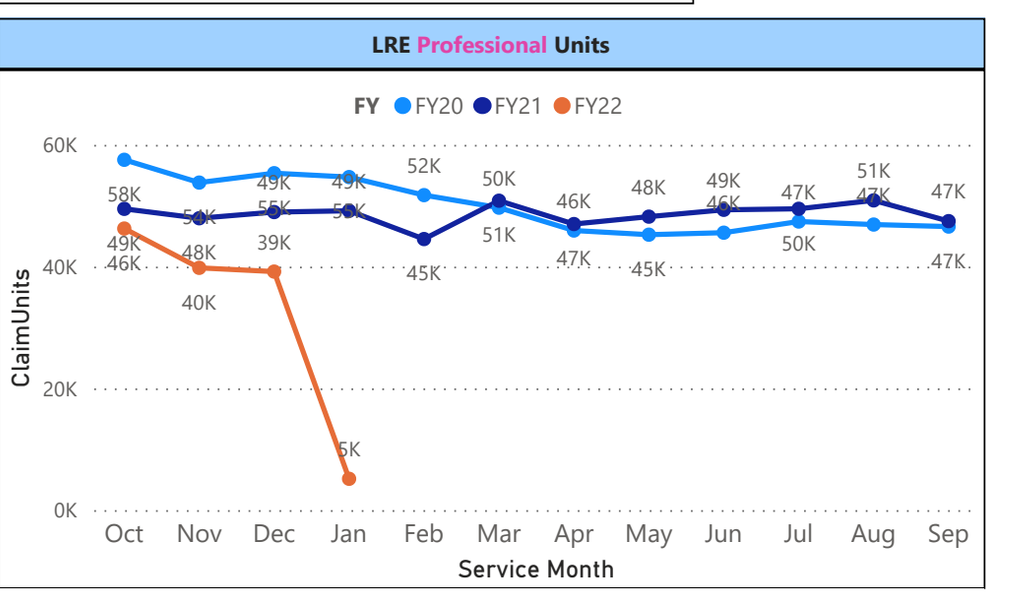
# LRE

## Substance Use Disorder

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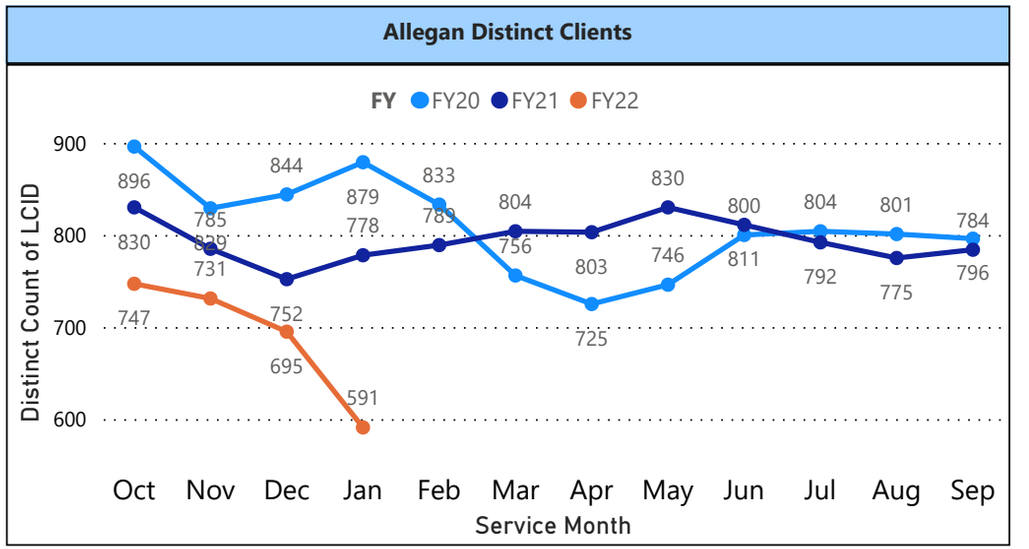
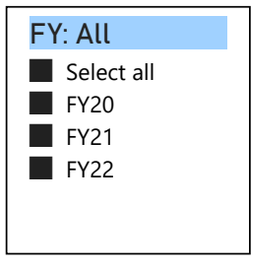
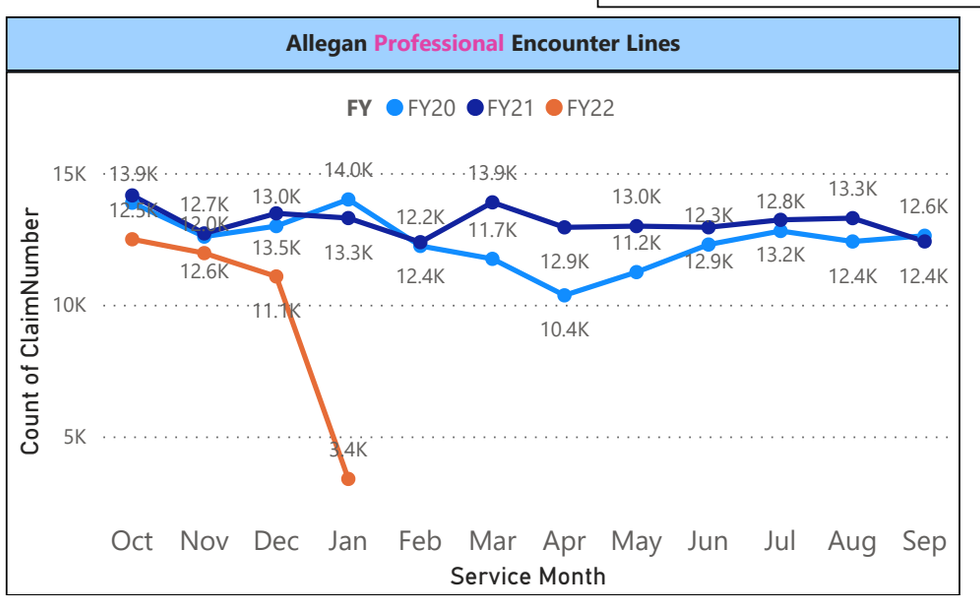
Latest ProcessDate

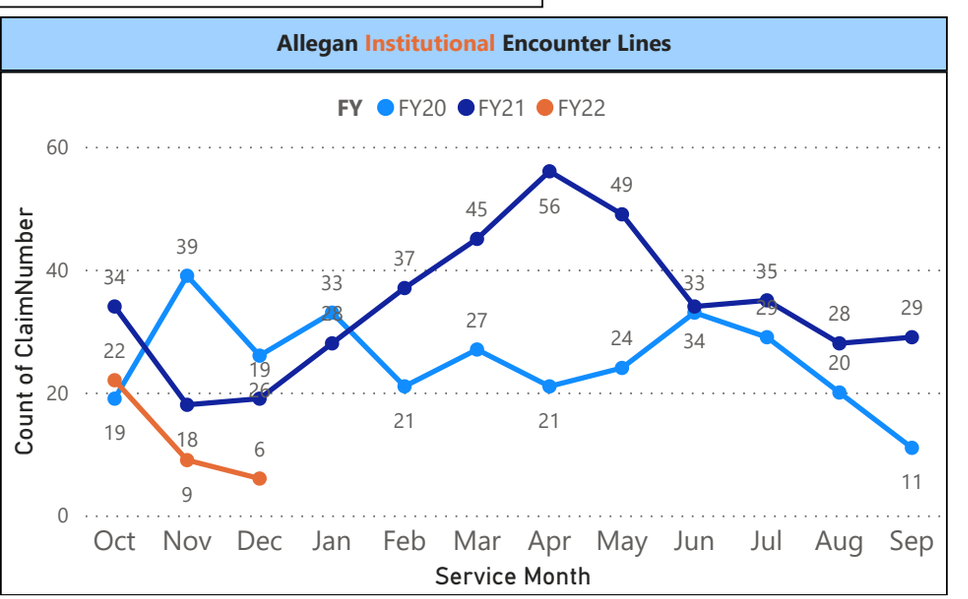
LAKESHORE REGIONAL ENTITY

# Allegan Behavioral Health

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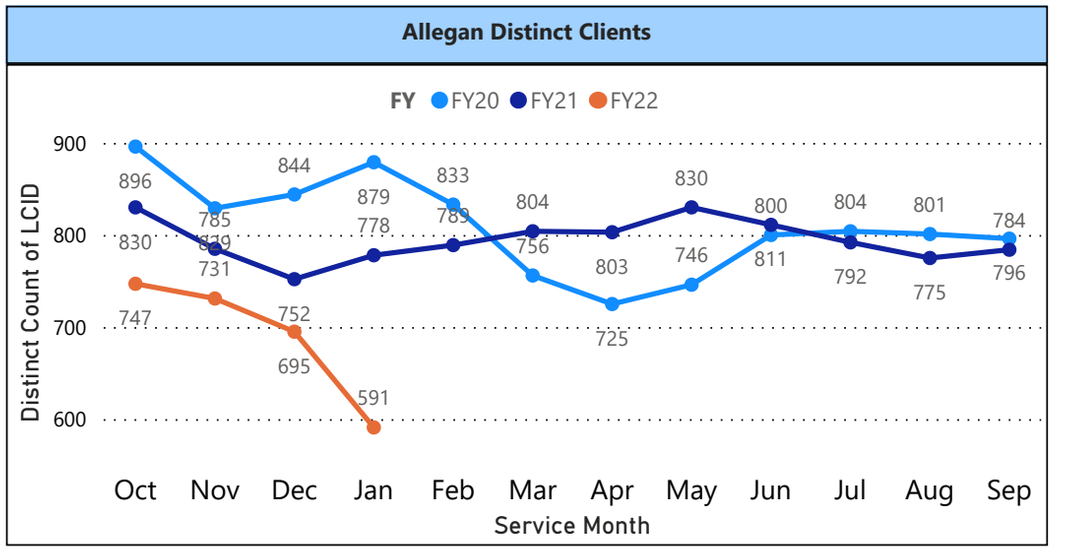
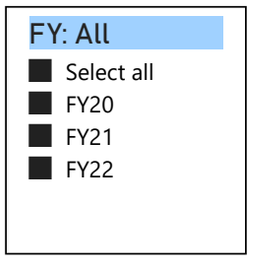
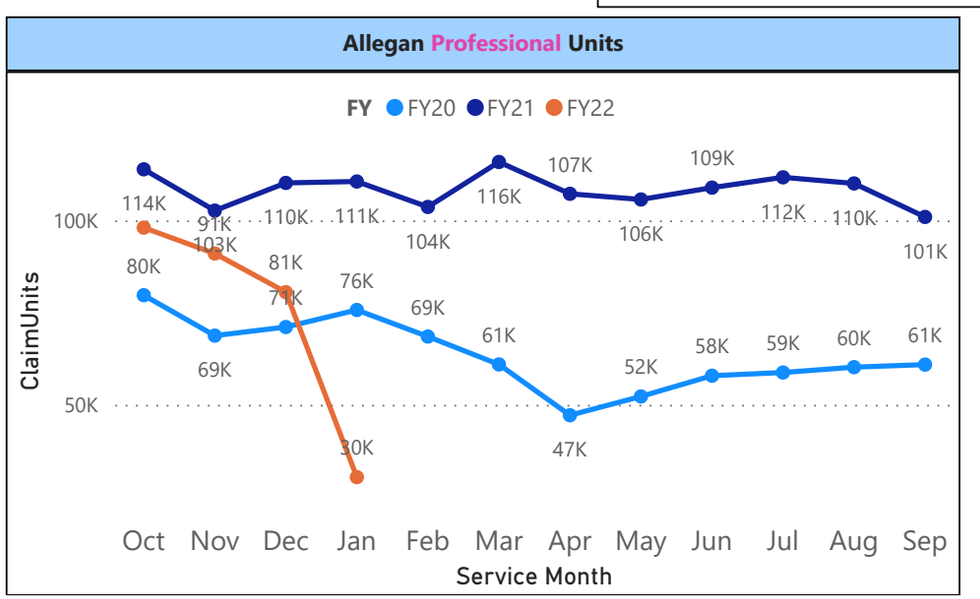
Latest ProcessDate

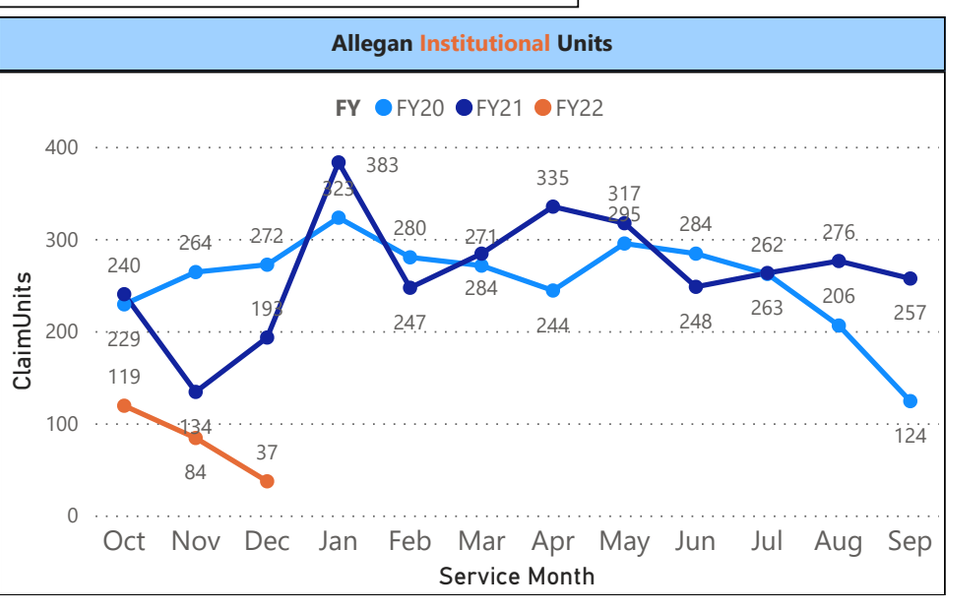
LAKESHORE REGIONAL ENTITY

# Allegan Behavioral Health

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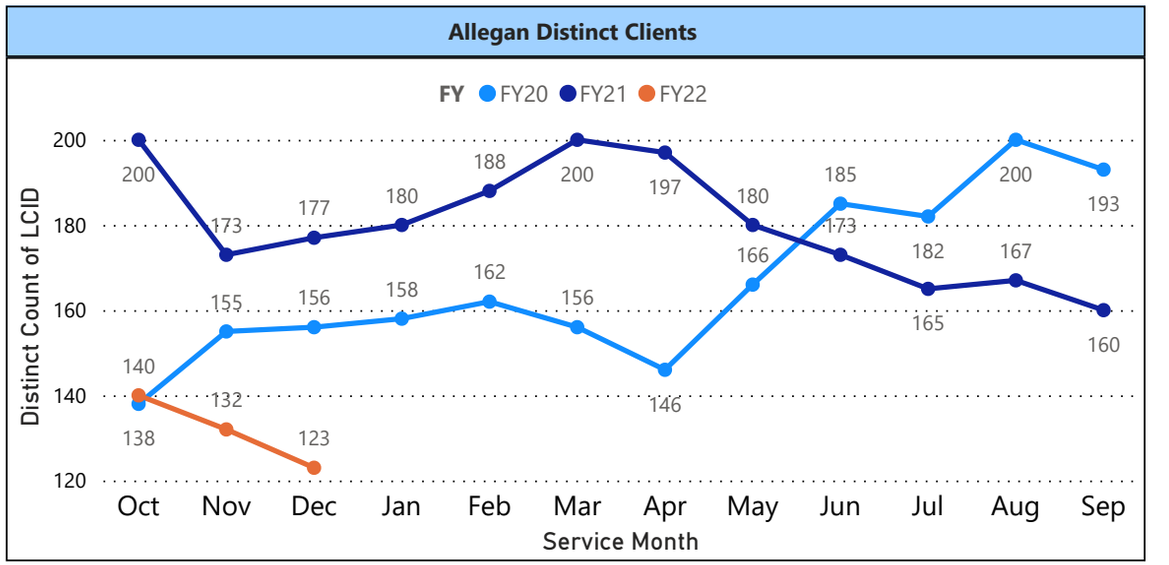
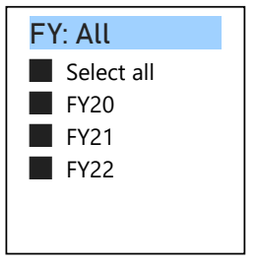
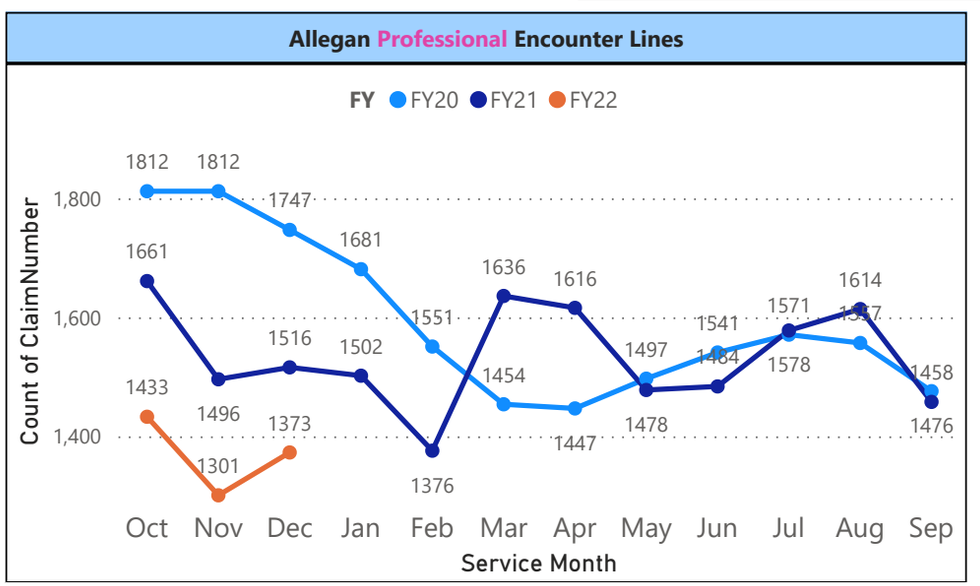
Latest ProcessDate

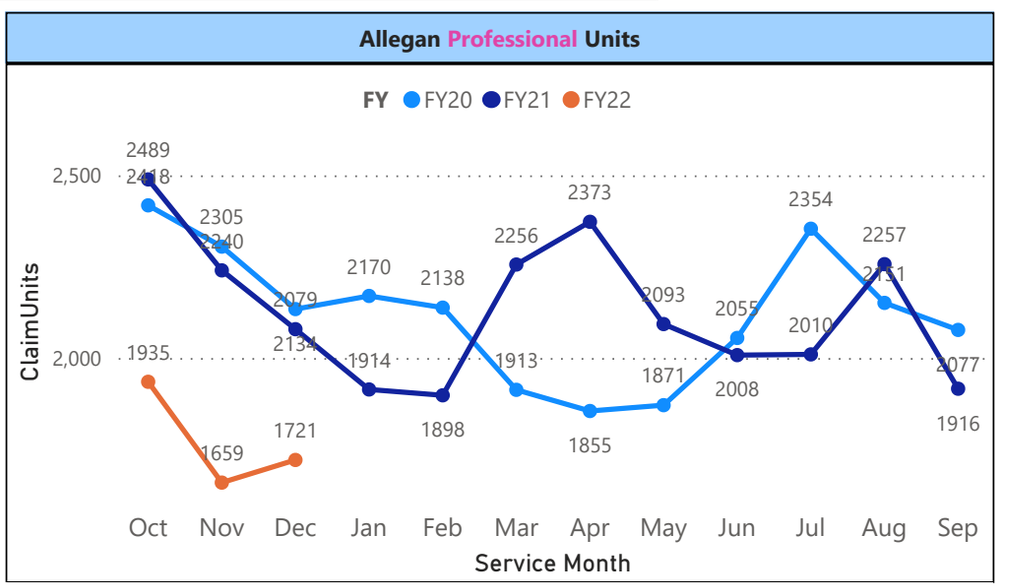
LAKESHORE REGIONAL ENTITY

# Allegan
## Substance Use Disorder

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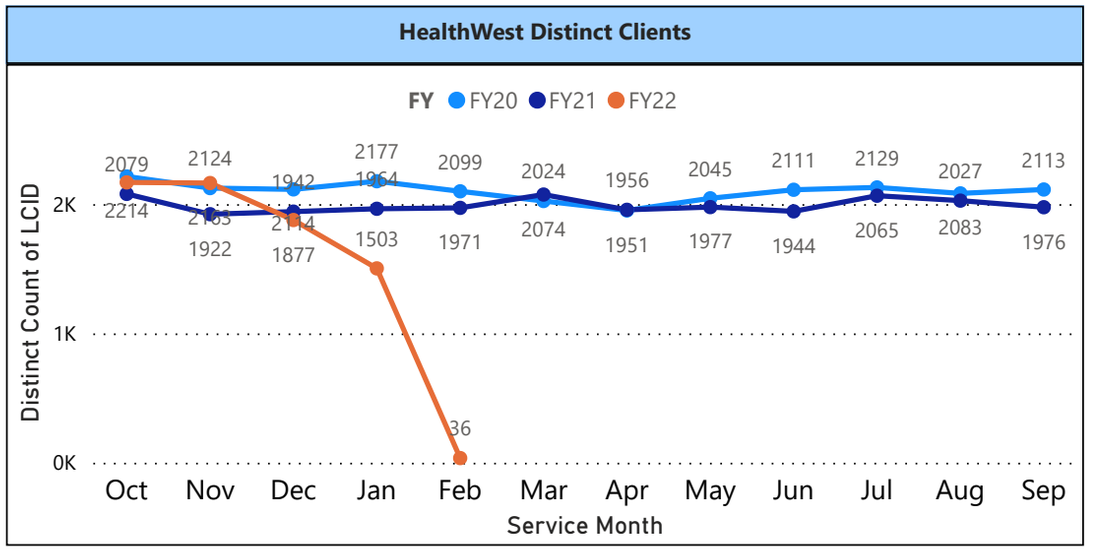
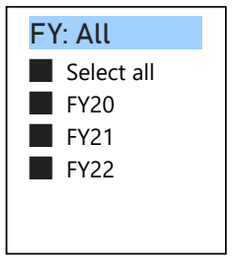
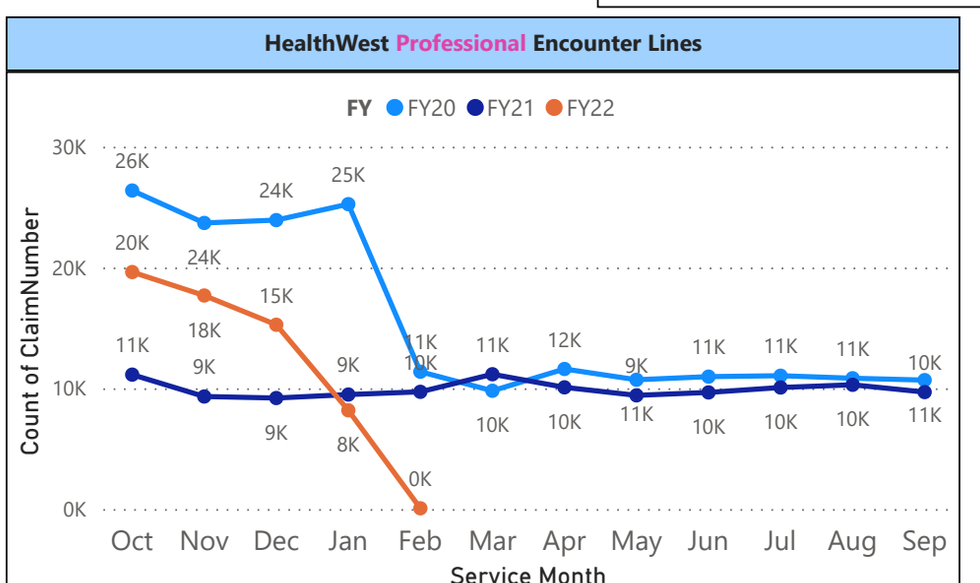
Latest ProcessDate

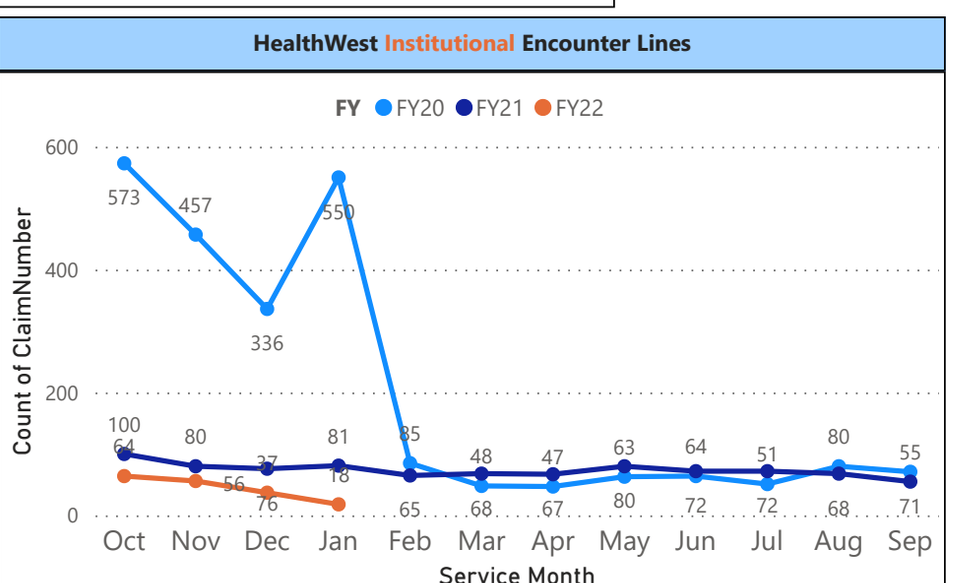
LAKESHORE REGIONAL ENTITY

# HealthWest
## Behavioral Health

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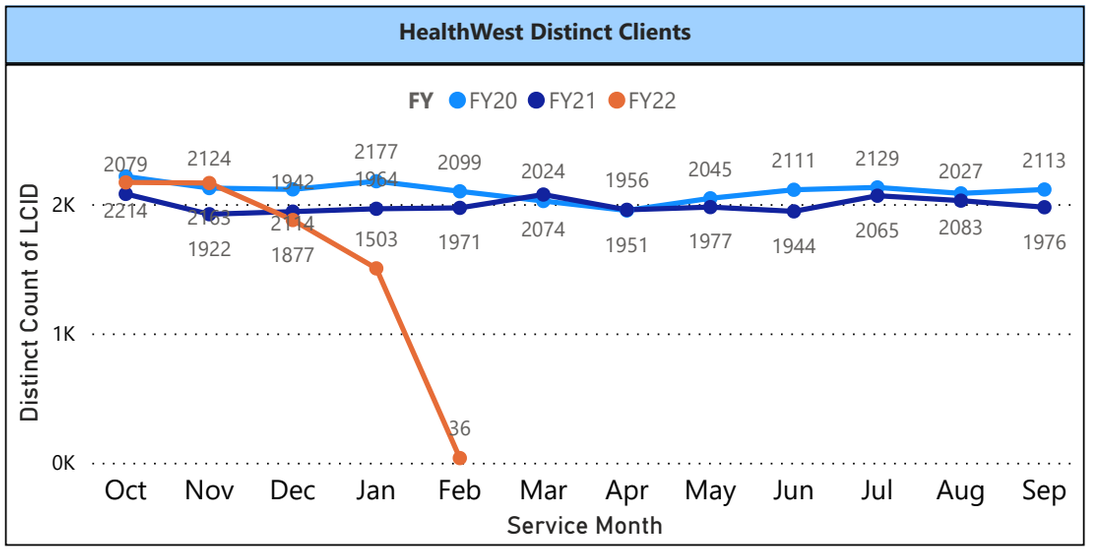
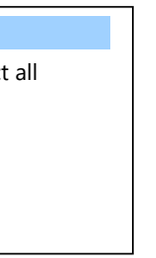
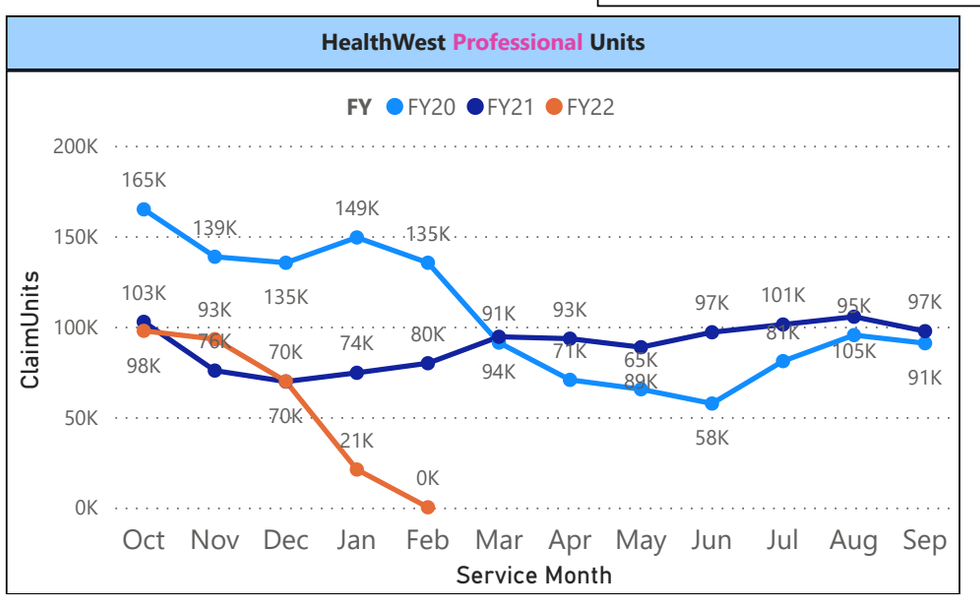
Latest ProcessDate

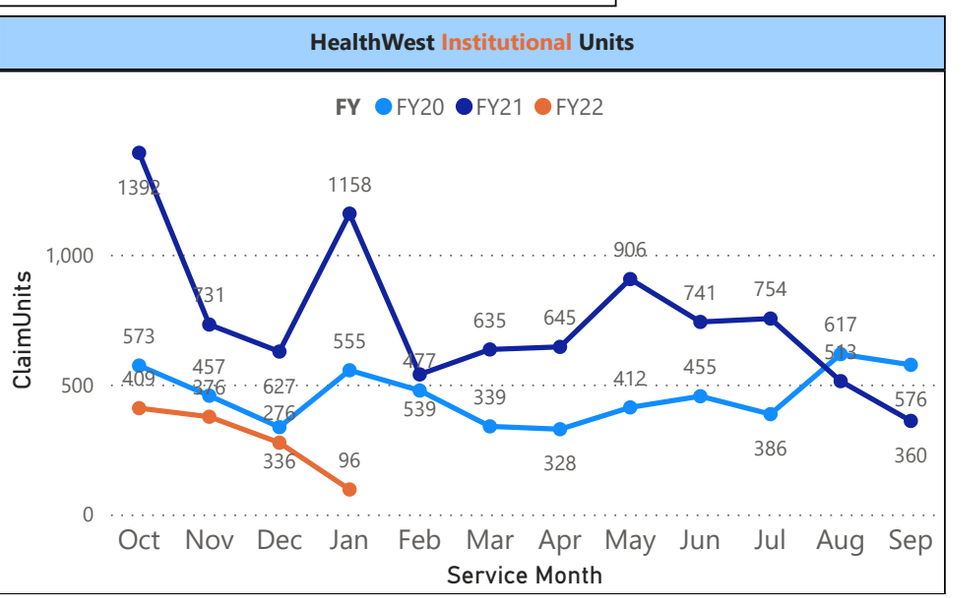
LAKESHORE REGIONAL ENTITY

# HealthWest
## Behavioral Health

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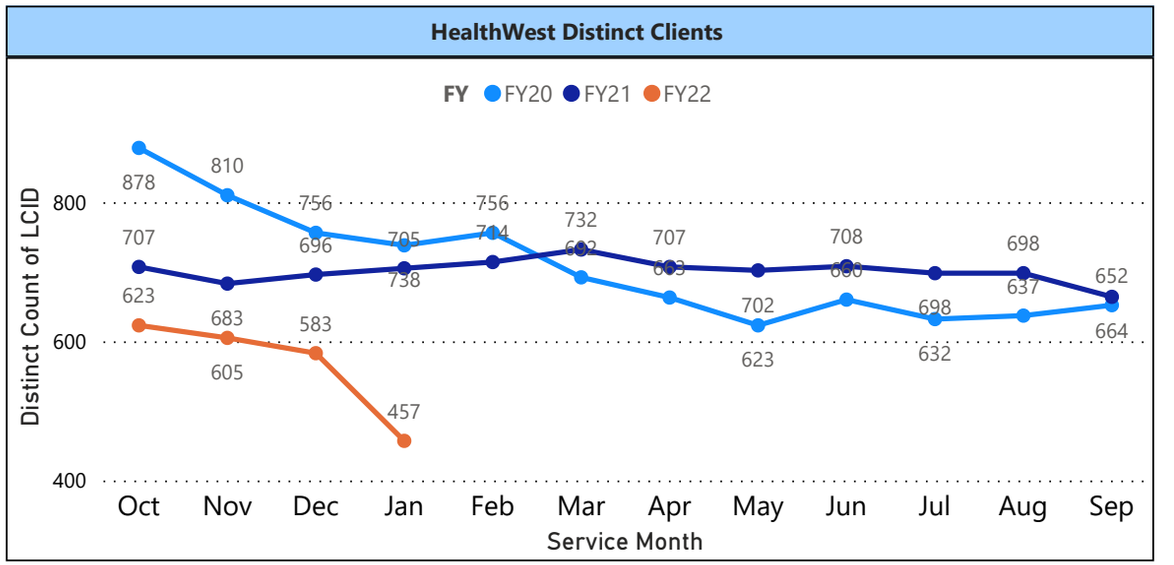
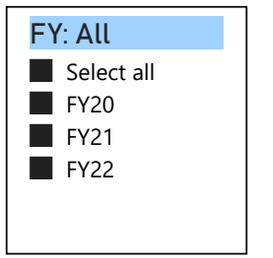
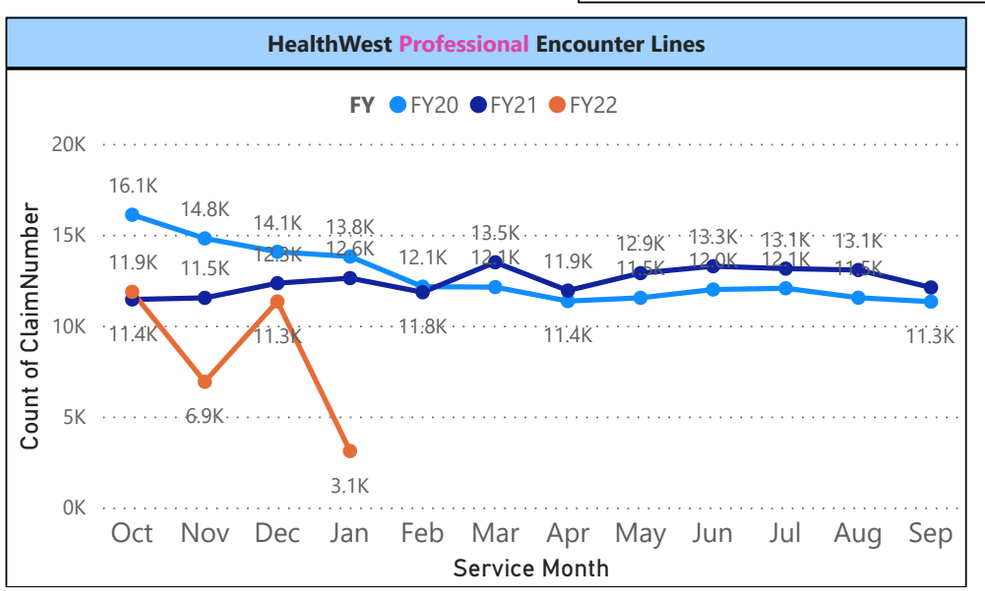
Latest ProcessDate

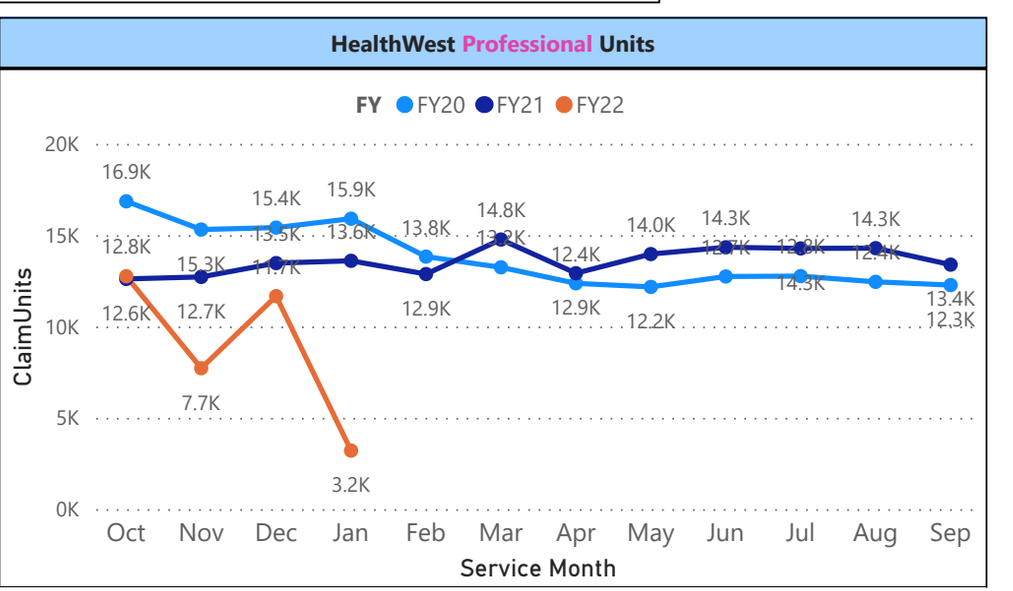
LAKESHORE REGIONAL ENTITY

# HealthWest
## Substance Use Disorder

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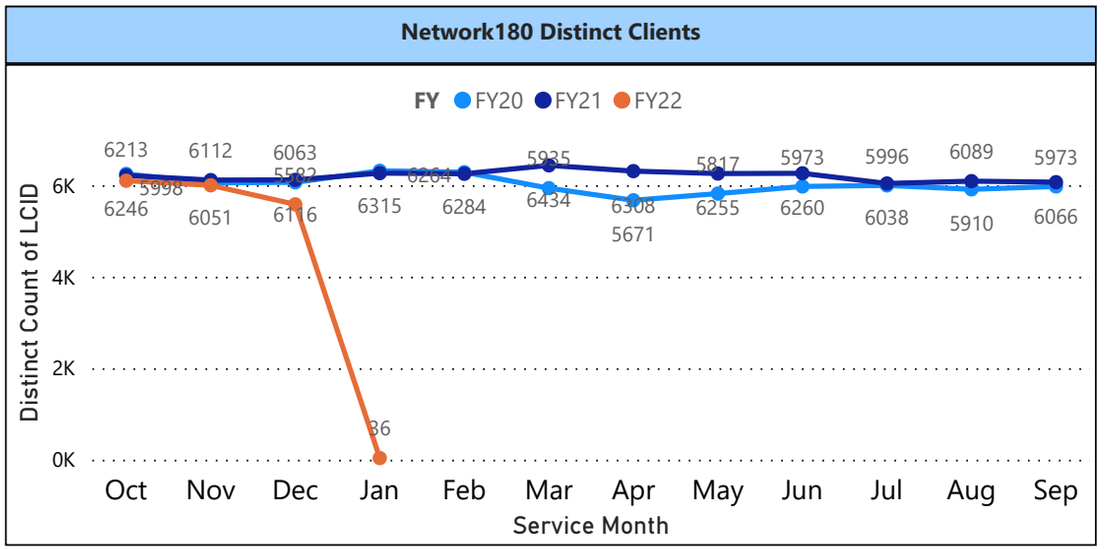
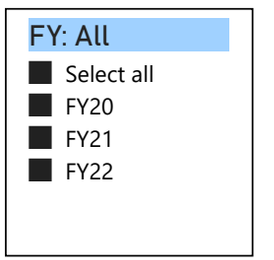
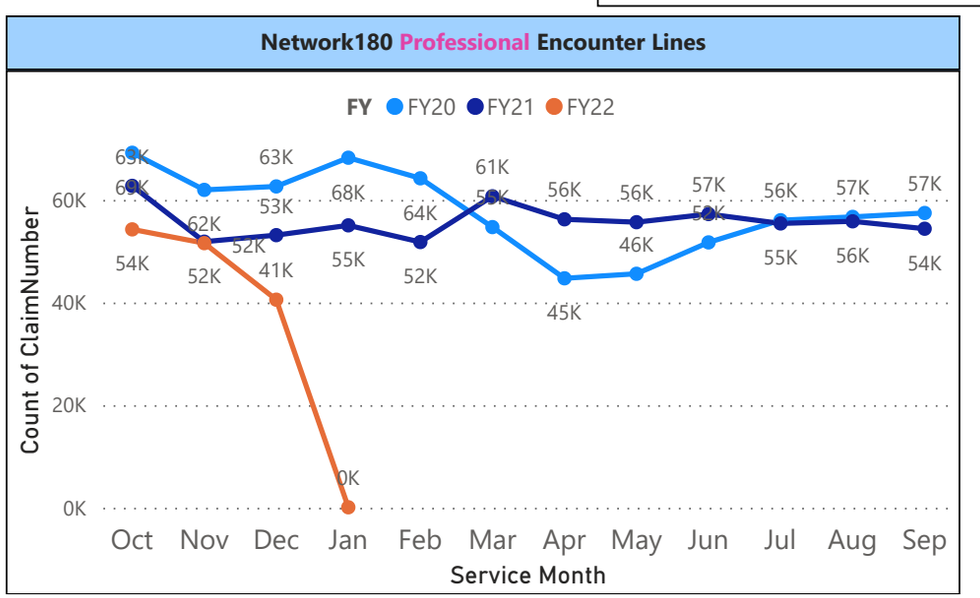
Latest ProcessDate

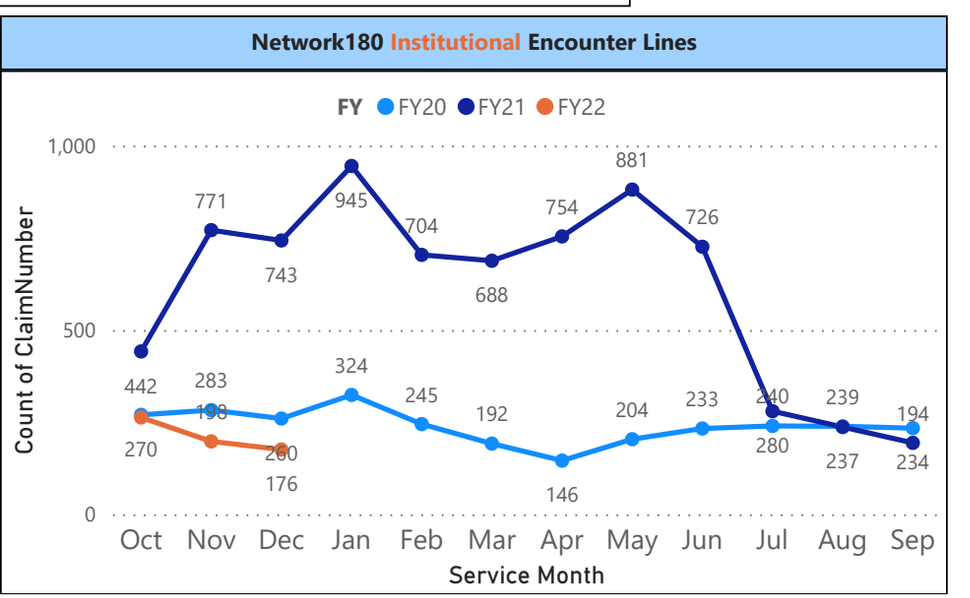
LAKESHORE REGIONAL ENTITY

# Network180
## Behavioral Health

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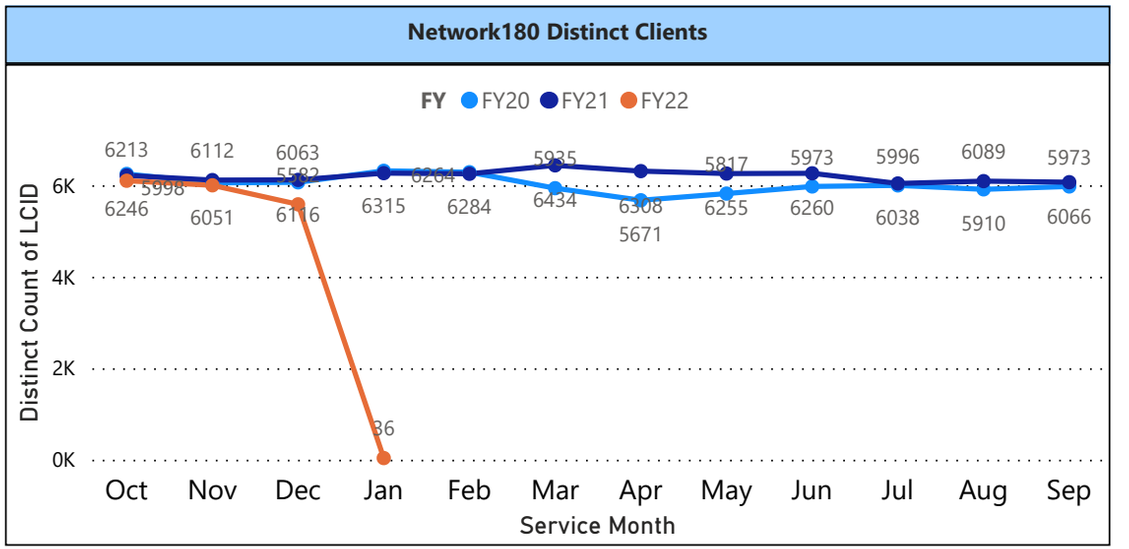
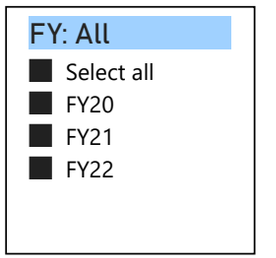
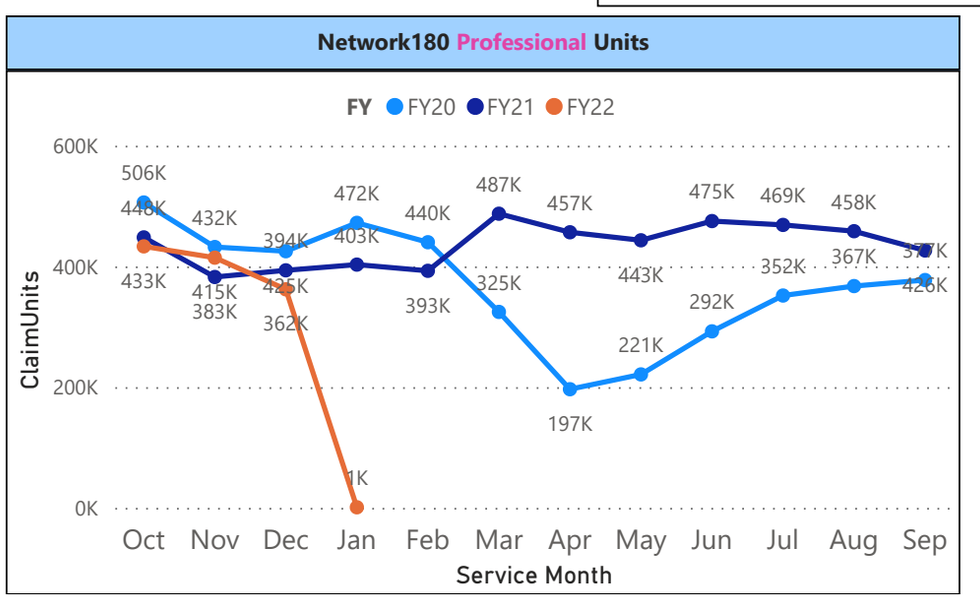
Latest ProcessDate

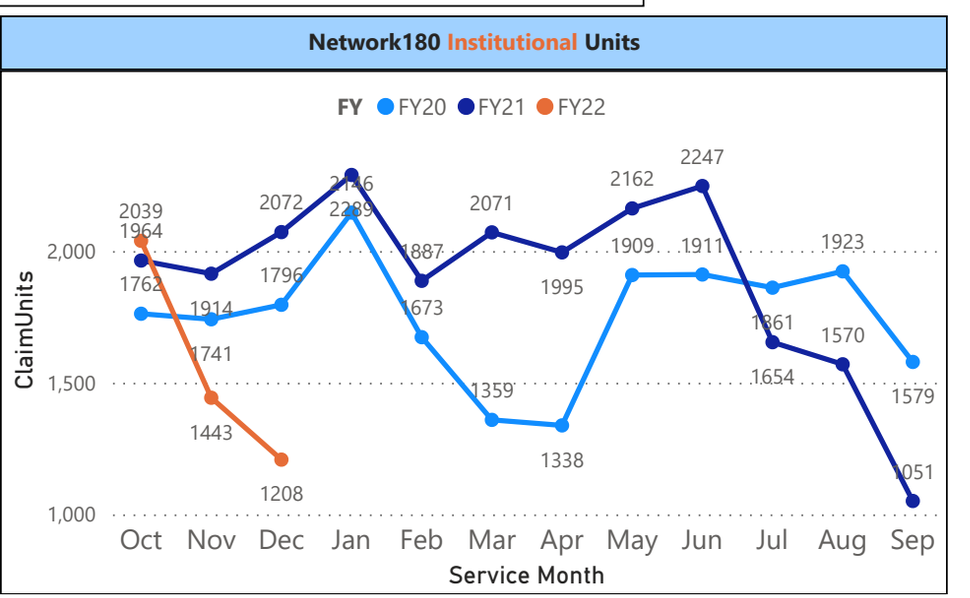
LAKESHORE REGIONAL ENTITY

# Network180
## Behavioral Health

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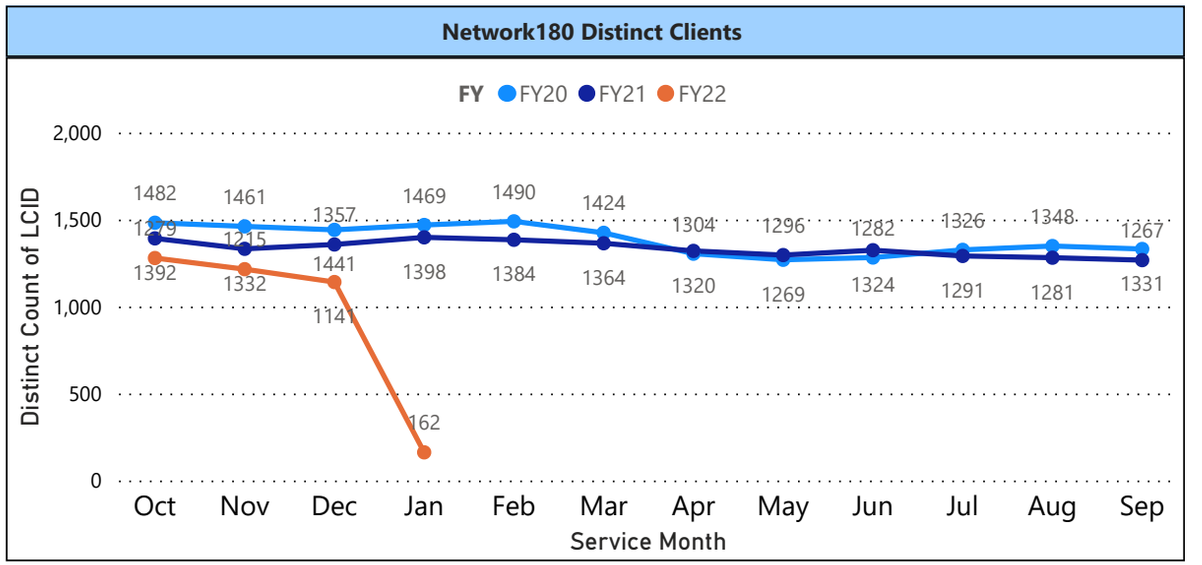
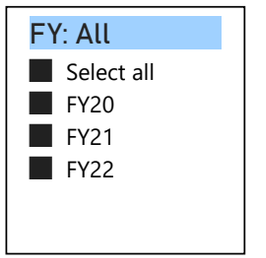
Latest ProcessDate

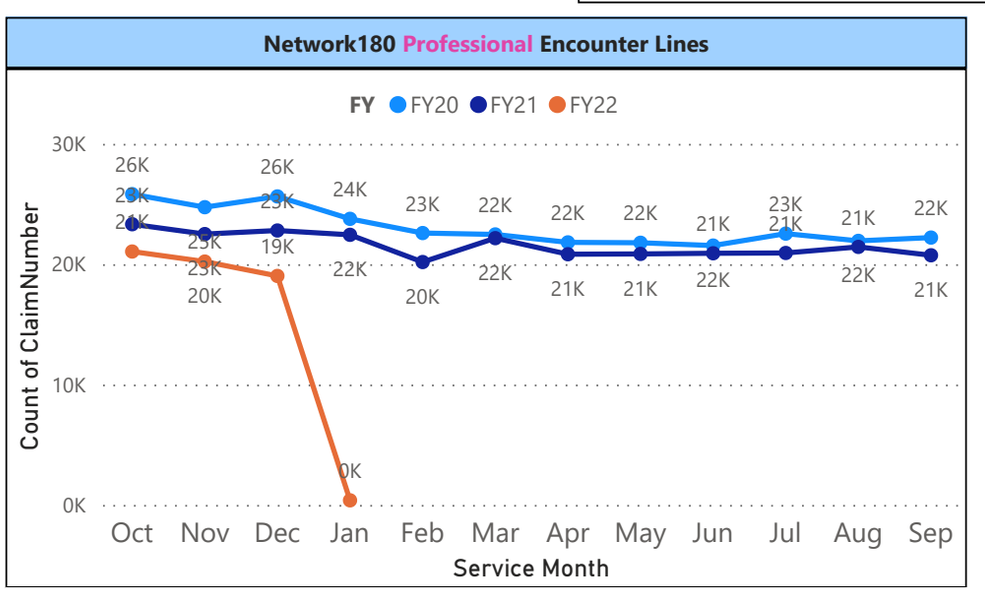
LAKESHORE REGIONAL ENTITY

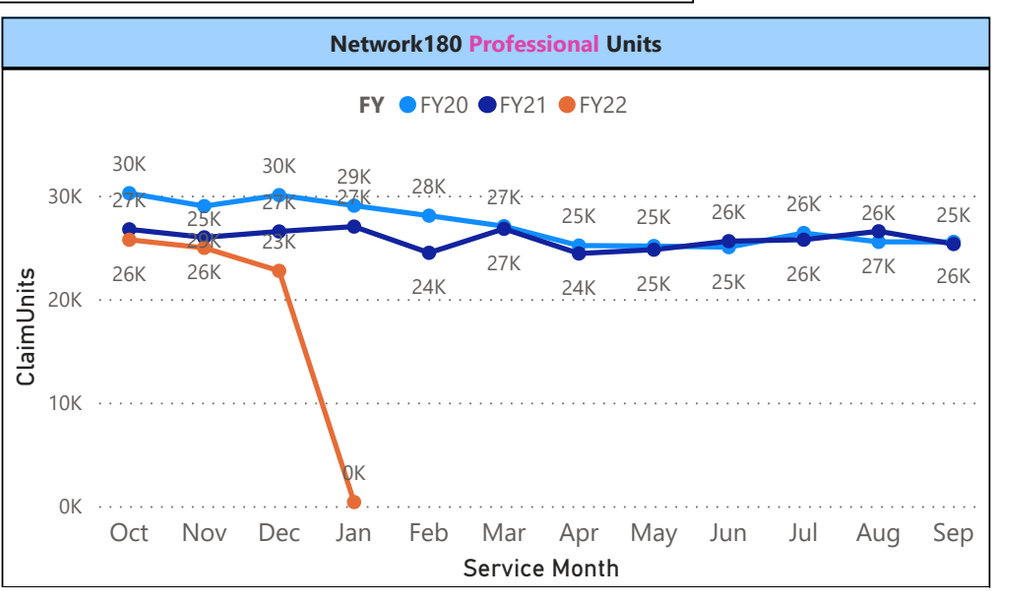
# Network180

## Substance Use Disorder

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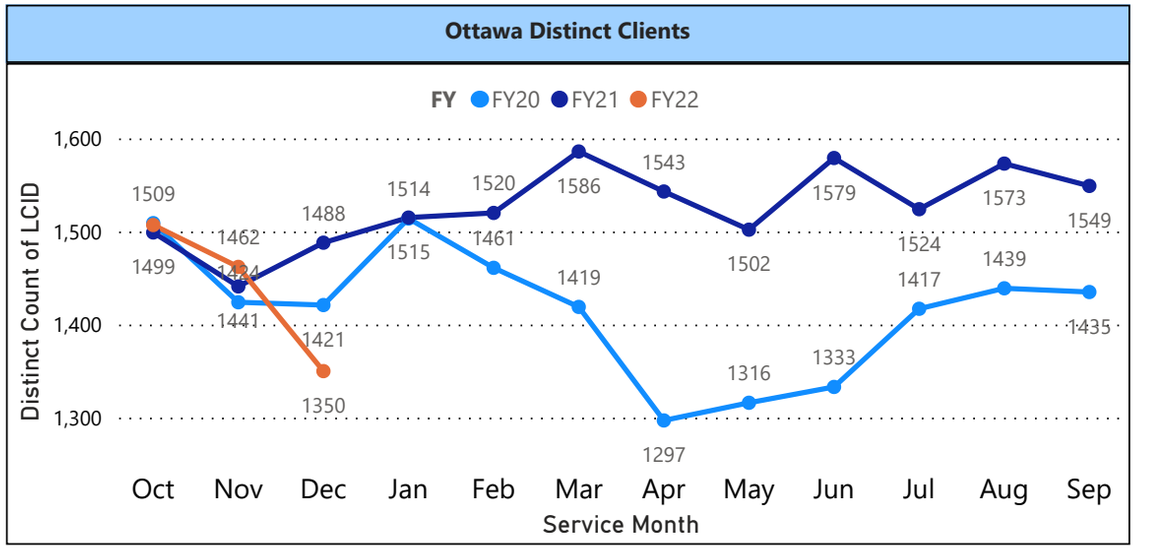
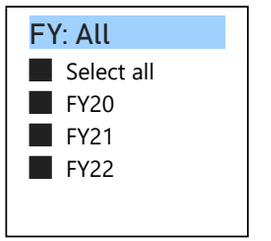
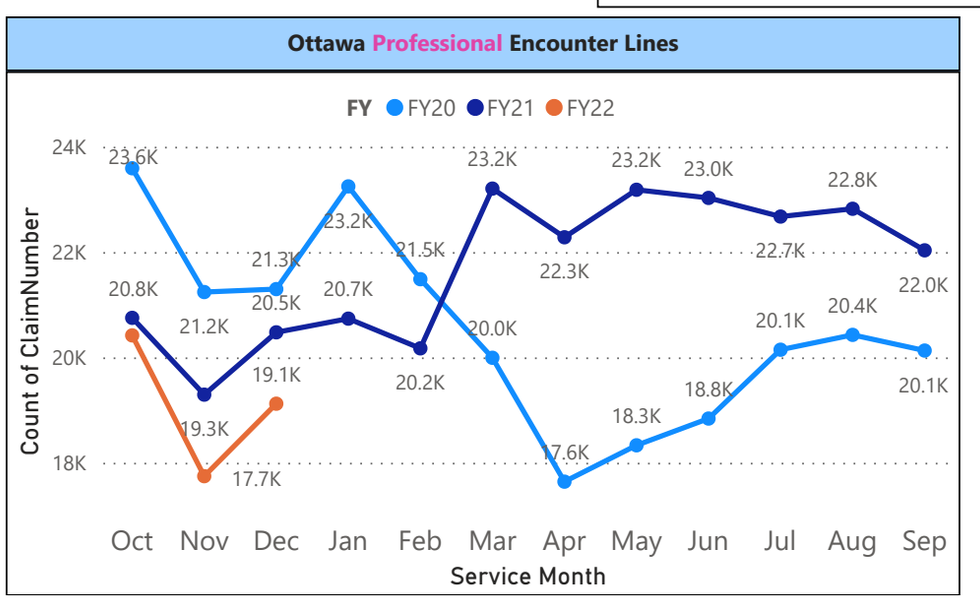
Latest ProcessDate

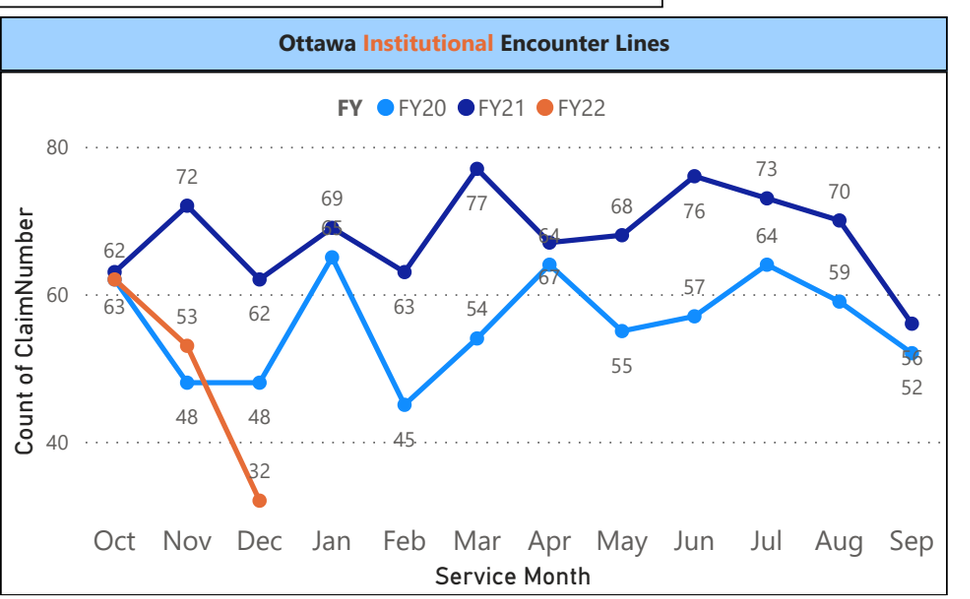
LAKESHORE REGIONAL ENTITY

# Ottawa
## Behavioral Health

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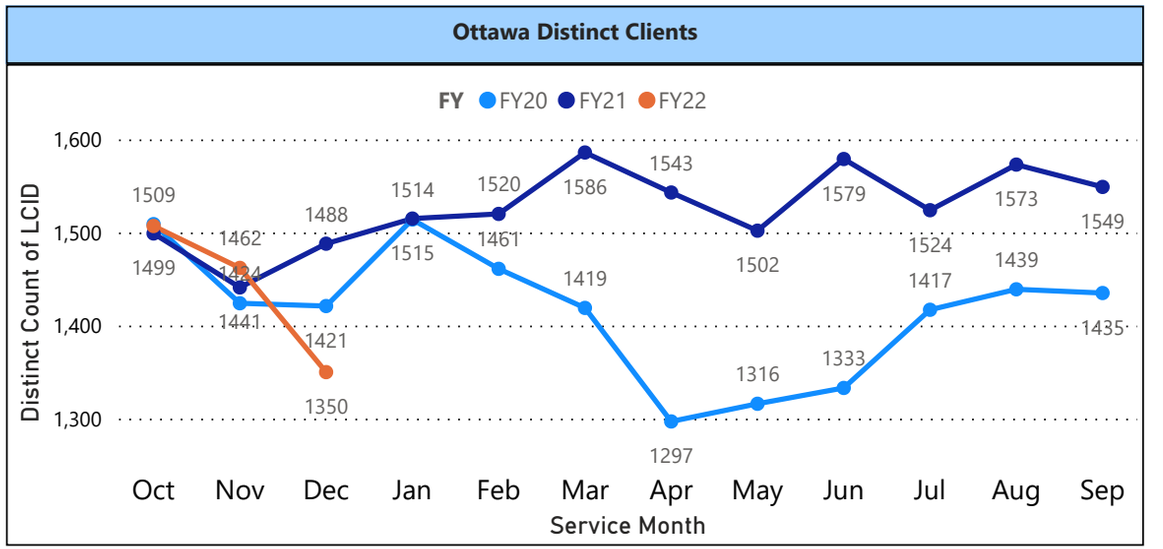
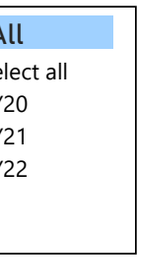
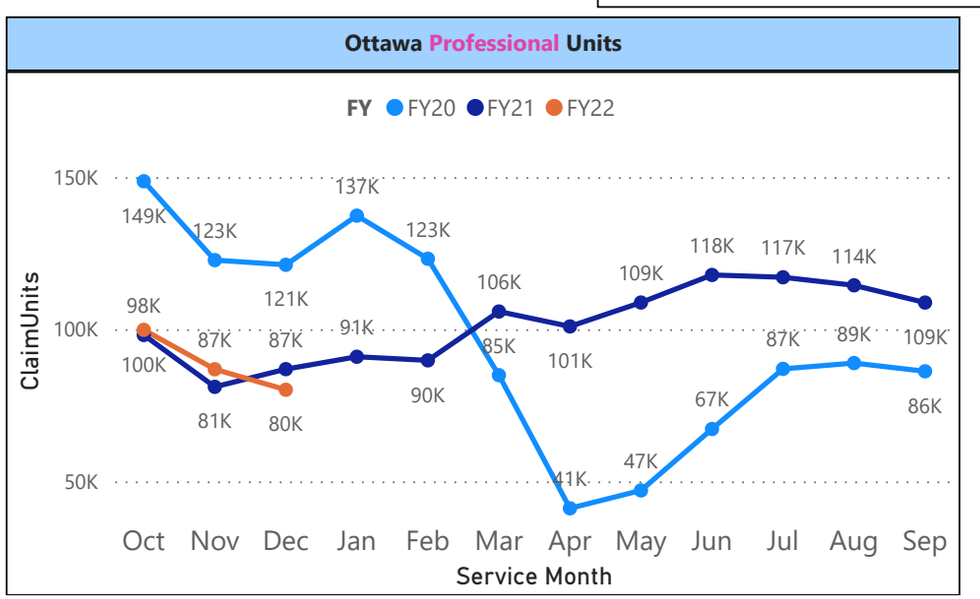
Latest ProcessDate

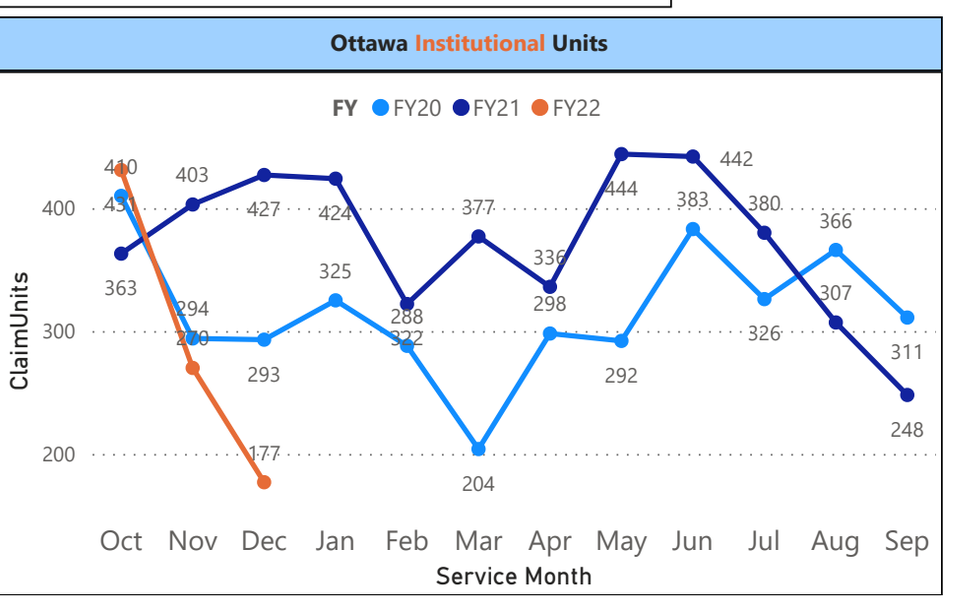
LAKESHORE REGIONAL ENTITY

# Ottawa Behavioral Health

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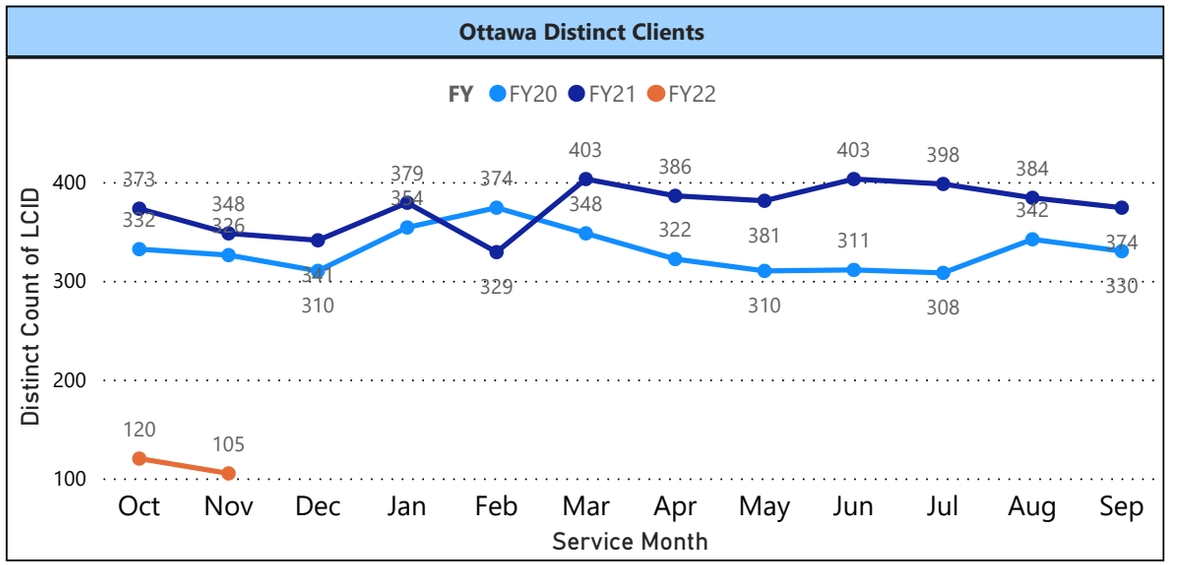
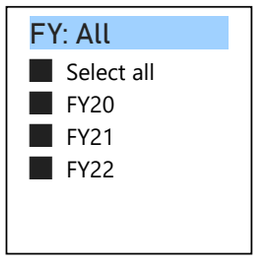
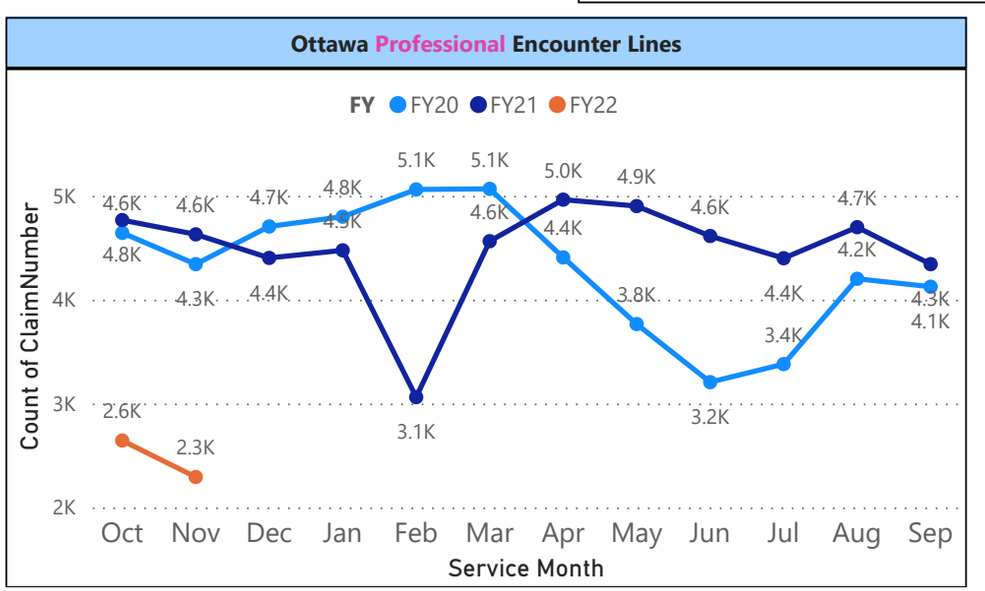
Latest ProcessDate

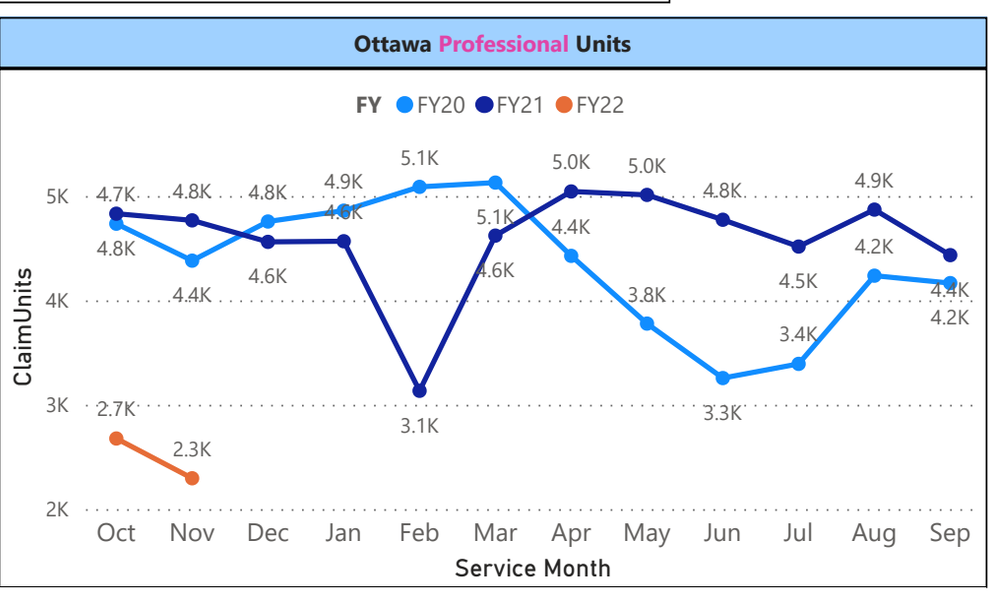
LAKESHORE REGIONAL ENTITY

# Ottawa
## Substance Use Disorder

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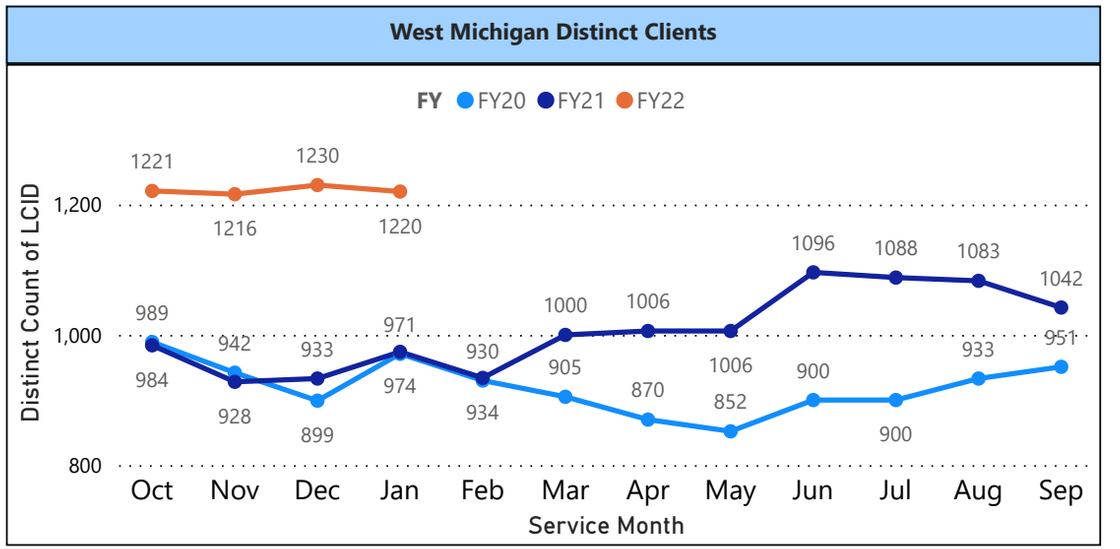
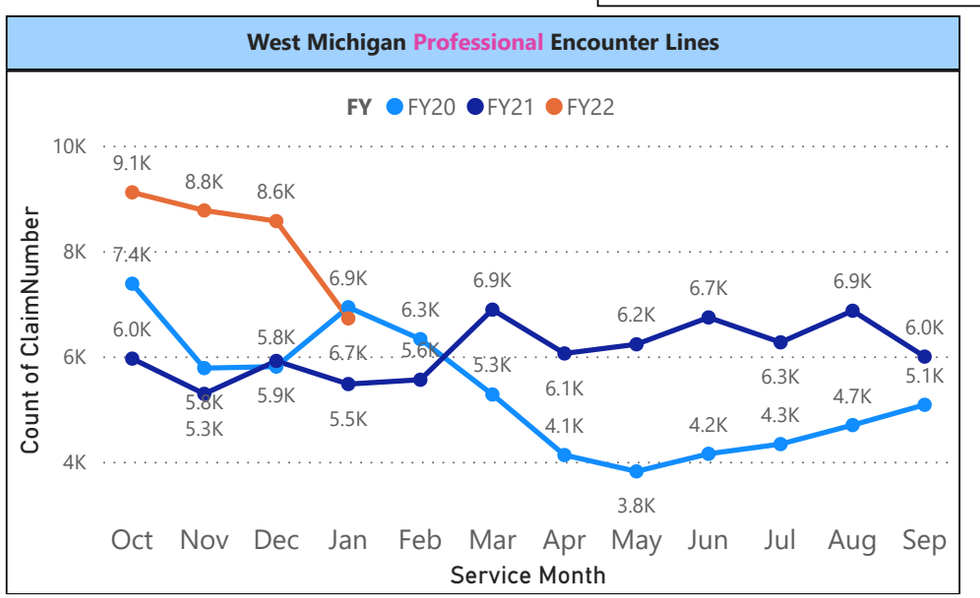
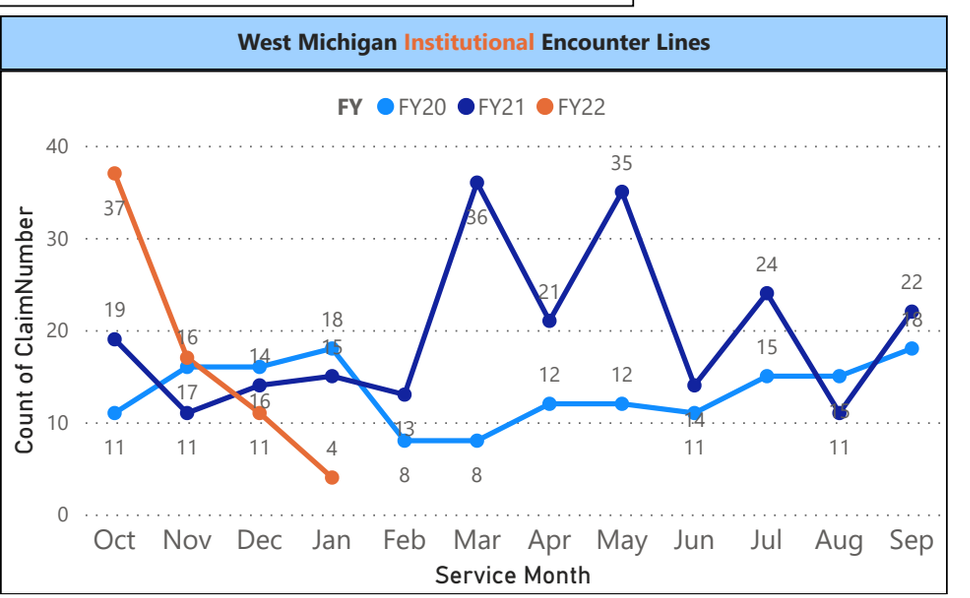
Latest ProcessDate

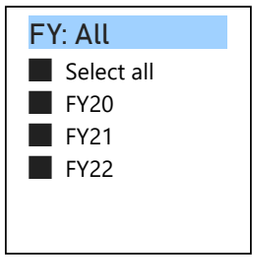
LAKESHORE REGIONAL ENTITY

# West Michigan Behavioral Health

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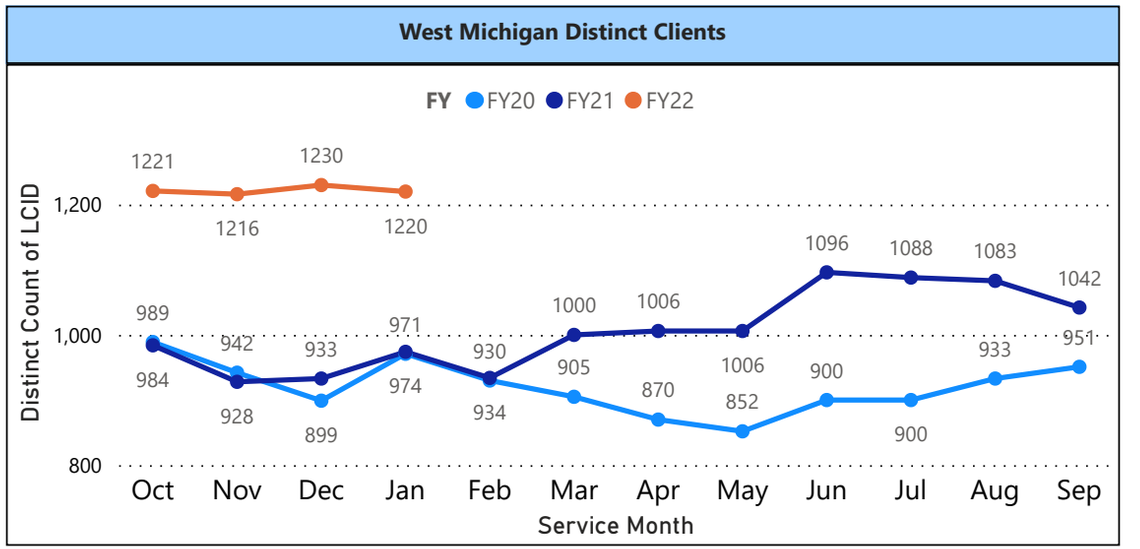
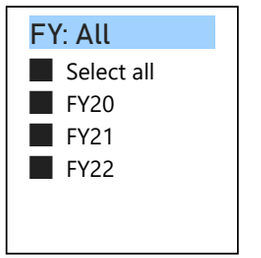
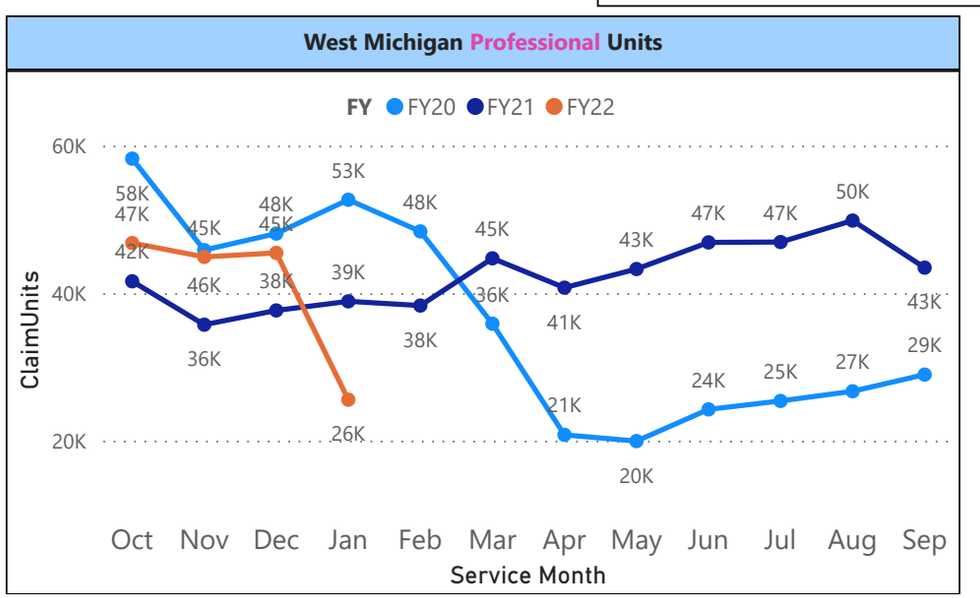
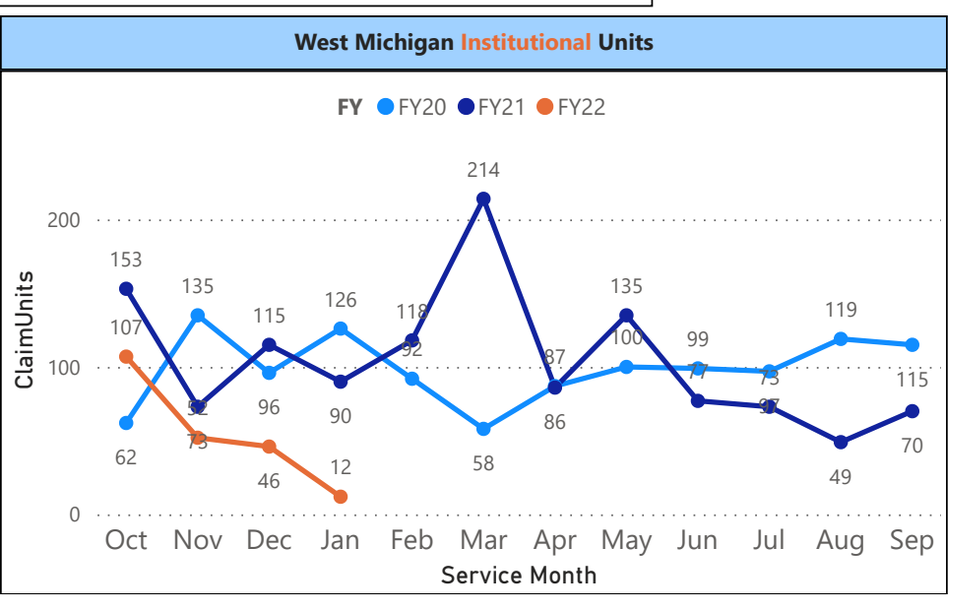
LAKESHORE REGIONAL ENTITY

# West Michigan Behavioral Health

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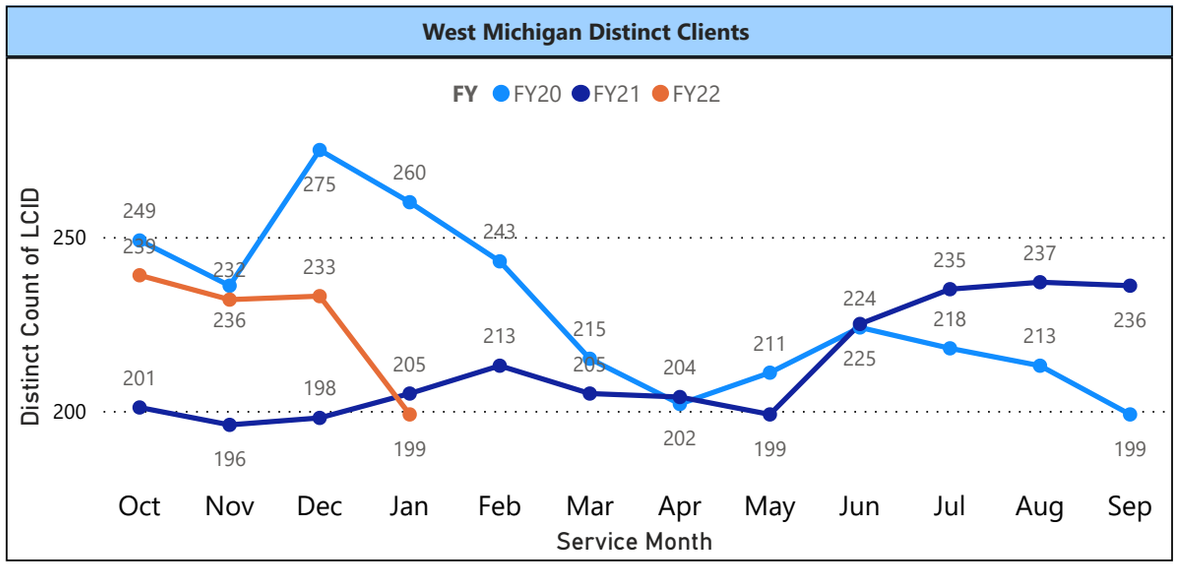
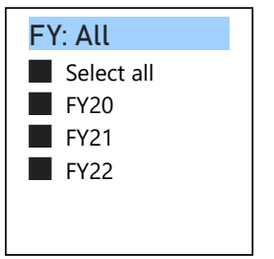
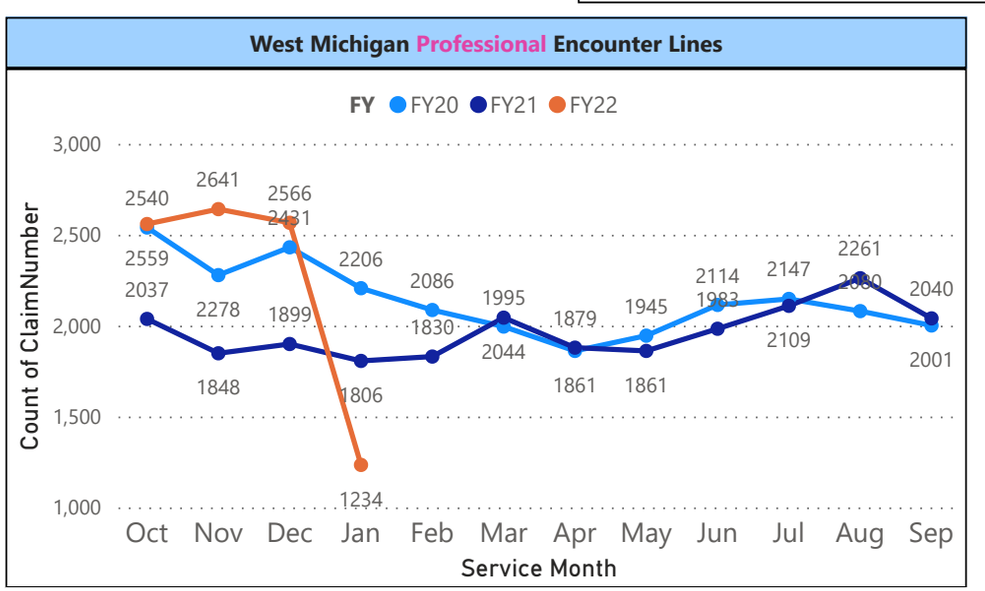
Latest ProcessDate

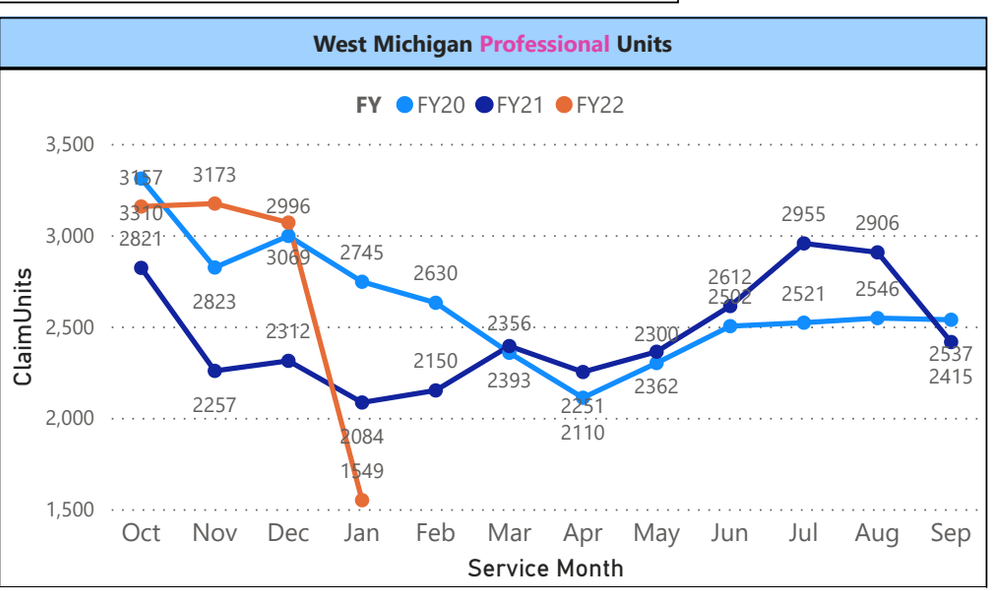
LAKESHORE REGIONAL ENTITY

# West Michigan
## Substance Use Disorder

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# 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

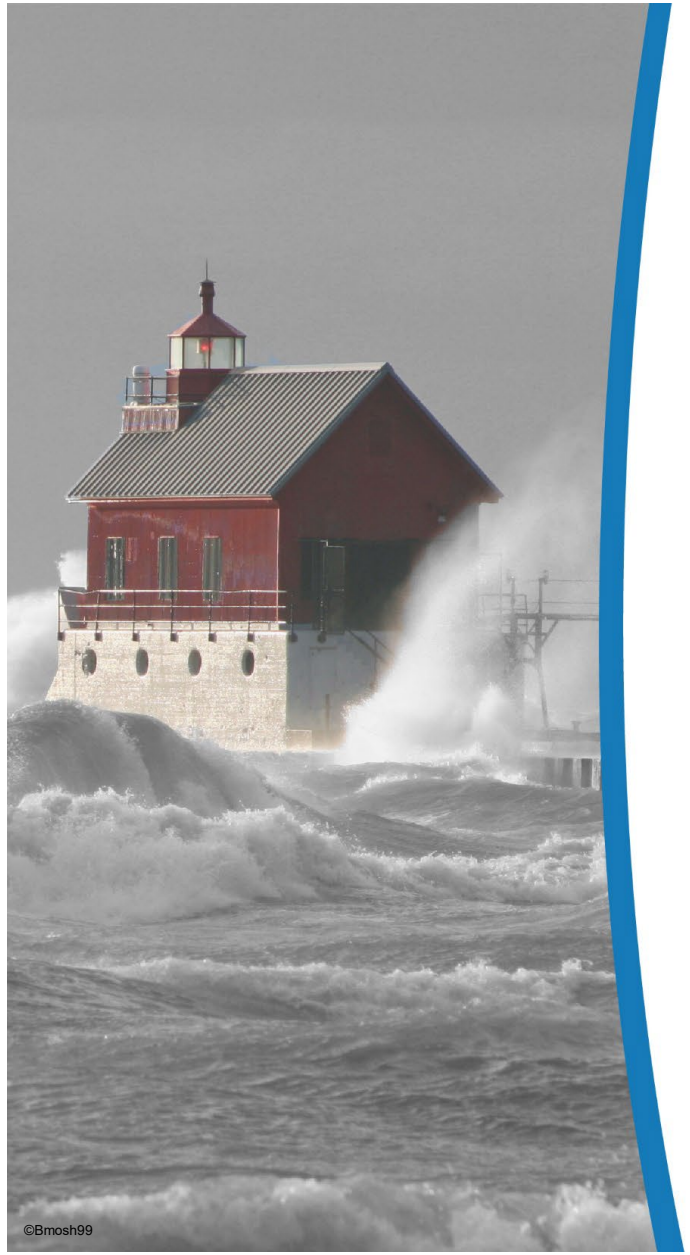
***Professional Lines and Units:*** TransactionType = Professional

***Institutional Lines and Units:*** TransactionType = Institutional

***Fiscal Year:*** FY

# QAPIP Annual Effectiveness Review
## February 17, 2022

LAKESHORE REGIONAL ENTITY




QAPIP

MMBPIS

CIRE

MEV

SITE REVIEWS

BEHAVIOR TREATMENT PLAN REVIEW

CUSTOMER SATISFACTION SURVEY


# QAPIP

## Validation of Performance Measures

- Validated LRE's Performance Measures
- No concerns with Eligibility Data, Data Control Processes, Claim/Encounter Data
- Recommended Review of Reporting Logic and Additional Completeness Checks
- Sufficient Oversite of CMHSPs

## Validation of PIP

Diabetes Monitoring for People with Diabetes and Schizophrenia

- *Met* Validation Score for 91% of Critical Evaluation Elements
- Met Validation Score for 90% of Overall Evaluation Elements
- Achieved Statistically Significant Improvement over Baseline, but Improvement was not Sustained

## Compliance Review

- Standards I – VI ➔ 65 Elements
- 52/63 (82%) Elements Met
- CAP Submitted and Accepted
  - 4 out of 12 with no Recommendations
  - 8 out of 12 with Recommendations Related to Timing


# Scorecard

## MMBPIS

- LRE *Met* MMBPIS Standards for Each Quarter of FY21

## CIRE

- Homicides and Arrests Declined
- All Other CI & RE Increased
- Sentinel Events Increased

## MEV

- Reviewed 578 Encounters Totaling ~ $120,000
- Recoupment was 1.7% ($2,013.96)


# Scorecard

## SITE REVIEWS

- Desk Audits Returned Excellent Results
- Delivered Good Overall Results Despite Pandemic
- Identified Improvement Opportunities
- Plans of Correction Approved and Monitoring

## BTPR

- Increase in *Harm to Others* and 911 Calls
- Variability in Physical Management Incidents

## CSS

- Scale 1 to 6, with 6 as *Strongly Agree*
- LRE Overall Score was 5.17

Attachment 9


# QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

## FY21 QAPIP Annual Effectiveness Report

## February 10, 2022

Reviewed by Executive Team:

Reviewed by Board of Directors:

## LAKESHORE REGIONAL ENTITY – FY21 QUALITY IMPROVEMENT PLAN REVIEW

The following report provides an annual review of key performance areas for the LRE and its CMHSP Partners. The first two pages are an overall summary of these key areas, while the rest of the report provides further explanation.

**CMHSP Annual Site Review:** References findings from the LRE's review of each CMHSP.

The Beacon QI Team revised / improved the annual CMHSP Site Review process for FY20, this revised site review process continued into FY21.

- Desk Audit Sections were updated to match the HSAG review of the LRE more closely
- Additional questions related to Person Centered Planning were added to the chart review
- Credentialing and Training review was updated based on feedback from HSAG
- CWP and SED Waivers are now part of the site review process.

As this is a more intensive review and many changes to the process and forms were made, the scores for FY20 are considered baseline and not compared to previous years. FY21 Scores are compared to FY20 scores in this report. CMHSP's overall scores for FY 2021 ranged from 86.8% to 96.6%. LRE considers the CMHSP Annual Site Review to be an overall strength for the region. During the Annual Site Review there were a few systemic issues found, that require ongoing attention:

1) Services provided are not consistent with the Individual Plan of Service (IPOS)
2) Goals and Objectives are not always clear and measurable
3) Direct service staff do not always receive required IPOS training.

**Performance Measures:** References the required state performance indicators (MMBPIS).

The percentage of MMBPIS Indicators that met MDHHS Standards improved from 74% in FY 2019 to 88% in FY2020 to 100% in FY2021.

Starting April 2020, LRE implemented the MDHHS revised indicators for both Indicators 2 and 3. MDHHS removed the required 95% Standard for these indicators. As part of the revisions, exceptions are no longer permitted. Due to the change in methodology, the 3rd and 4th quarter scores for Indicators 2 & 3 are not included in the overall annual percentage.

One of the QAPIP Goals for FY2022 is to improve or maintain regional performance on all MMBPIS indicators.

**Medicaid Verification:** References LRE review of Medicaid claims validation process.

The LRE conducted a random sample review of 578 claims. Twenty-one of the reviewed claims were found to require recoupment for a total of $2,013.96 (1.7% of claims reviewed). Primary reasons for recoupment were:

- Issues with the service not being supported by a current IPOS
- Individual falling off Medicaid eligibility
- No proof the service was provided for the billed date of service.

**Critical Incidents and Risk Events:** Critical Incidents reports include deaths, medication errors, injuries resulting in ED or Hospitalization, and Risk Events reports includes harm to self, harm to others, police calls, physical management, and frequent hospitalizations:

In FY 21, there were 391 critical incidents and 666 risk events reported to the LRE. Quarterly data was reviewed by the LRE QI ROAT and at the BHO Quality of Care Committee.

There were no trends identified for immediate action, and monitoring will continue.

**Satisfaction:** References a regional survey

Overall, in FY21 consumers rated services higher than 5 on a 6-point scale. Consumers appear satisfied with the services they received. The QI ROAT and the Consumer Advisory Panel is utilized to further strategize in these areas. In response to the HSAG FY20 review, a regional workgroup was convened to revise existing survey questions and develop new questions for the survey. The new survey was distributed to consumers starting in December 2020.

**External Reviews (Health Services Advisory Group):** References reviews for Performance Measure Validation, Performance Improvement Project Validation, and HSAG Compliance review.

- Validation of Performance Measures:

  LRE performance measures data and BH Teds were validated for FY21. HSAG determined that the data control processes in place at LRE were acceptable. HSAG had no major concerns with how LRE received and processed claim/encounter data for submission to MDHH

- Validation of Performance Improvement Project:
  In FY21, the "*Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)* PIP received a *Met* validation score for 91 percent of critical evaluation elements, 90 percent for the overall evaluation elements across all steps, and a *Not Met* validation status. LRE collected and reported accurate study indicator results using a systematic data collection process and conducted appropriate statistical testing for comparison between measurement periods. The PIHP used appropriate quality improvement tool(s) in the identification and prioritization of barriers. LRE implemented timely interventions; however, at Remeasurement 2, the PIHP was unable to maintain the statistically significant improvement achieved during the first remeasurement."

- HSAG Compliance Review:
  Compliance reviews are on a three-year cycle. HSAG reviews half of the Standards each year for two years and the third year is for Plan of Correction follow-up. FY21 is the 1st year of the Compliance Review cycle.

**OUTCOMES DETAIL SUMMARY**

**CMHSP Site Review**

In FY2021, the LRE conducted the7th Annual Site Review for each of the five CMHSPs. The LRE CMHSP Site Review is an intensive and comprehensive review process. The following categories are included in the CMHSP Site Review process:

- Administration/Managed Care Functions
- Program Specific Reviews
- Information Technology
- Training and Credentialing
    - CMHSP Staff

    - Autism Staff (Added in FY16)
    - HabWaiver Staff (Added in FY17)
    - SED Waiver Staff (Added in FY20)
    - Child Waiver Staff (Added in FY 20)
- Chart Review
    - CMHSP Charts (36)
    - Autism Charts Additional Questions (3 Autism Charts)
    - HabWaiver Charts Additional Questions (3 HabWaiver Charts)
    - SED Waiver Charts Additional Questions (Added in FY20)
    - Child Waiver Charts Additional Questions (Added in FY20)
- MMBPIS Source Documentation Validation
- Critical Incident & Risk Event Source Data Validation (Added in FY17)
- Sentinel Event and Unexpected Death process reviewed
- HCBS Review (Added in FY19)

Evaluation of Site Review Data

Using 95% as a performance benchmark, a review of the site review summary results for each of the CMHSPs yields the following:

CMHSP Site Review Overall Scores:

Overall, in FY21 each of the CMHSPs did well with their individual Site Reviews. The total CMHSP Site Review scores ranged from 86.8% to 93.6%. The CMHSP Annual Site Review Desk Audit and other review forms were revised for FY2020 with continued use in 2021. The focus of the review is on processes instead of Policy/Procedures. As there were many changes to the process and forms, the scores for FY20 are considered baseline and not compared to previous years.

| CMHSP Annual Site Review Overall Scores | | |
|---|---|---|
| | **FY2020** | **FY2021** |
| **Allegan** | 92.5% | 93.21% |
| **HealthWest** | 91.2% | 86.8% |
| **Network 180** | 96.7% | 93.6% |
| **Ottawa** | 92.9% | 93.6% |
| **West Michigan** | 94.9% | 91.7% |

CMHSP Site Review Administrative / Managed Care Functions Finding:

The Administrative / Managed Care Function review from the CMHSP Site Review is completed as a desk audit. There are 20 different Standards in this review. All five CMHSPs did well in this portion of the Site Review.

| CMHSP Site Review Administrative / Managed Care Functions: | | |
|---|---|---|
| | **FY2020** | **FY2021** |
| **Allegan** | 98.0% | 97.3% |
| **HealthWest** | 93.4% | 97.6% |

| | | |
|---|---|---|
| **Network 180** | 99.2% | 98.4% |
| **Ottawa** | 97.6% | 99.5% |
| **West Michigan** | 98.0% | 99.1% |

Person Centered Plan and Documentation Standard and Chart Review:

The Person-Centered Plan and Documentation Standard is one of the Standards from the Administrative / Managed Care Function Desk Audit. During the site reviews, QI Staff found that all five CMHSPs' Policy and written Procedures for Person Centered Planning are well written and include the required elements. Chart reviews however, identified several issues such as:

- Goals /objectives were not individualized
- Goals and objectives were not always measurable
- Plans did not regularly tie back to the individual's stated Hopes, Dreams and Desires
- Progress Notes do not consistently tie back to the individual's goals and objectives

Improving the Person-Centered Planning processes continues to be a priority of the QI Team for both CMHSPs and Provider Site Reviews. The following chart shows the scores by CMHSP for the Person-Centered Plan and Documentation Standards compared to scores received for the completed chart reviews

| Chart Review Overall Findings:<br>Person Centered Plan and Documentation Standards | | | | |
|---|---|---|---|---|
| | **FY2020** | | **FY2021** | |
| | **Desk Audit** | **Chart Review** | **Desk Audit** | **Chart Review** |
| **Allegan** | 98.4% | 94.69% | 90.0% | 95.94% |
| **HealthWest** | 94.3% | 91.55% | 100% | 87.8% |
| **Network 180** | 100% | 95.88% | 100% | 94.0% |
| **Ottawa** | 91.7% | 88.98% | 97.5% | 92.2% |
| **West Michigan** | 95.2% | 95.13% | 92.1% | 94.5% |

Chart Review Question: Service Delivery Consistent with Plan Findings:

Service Delivery Consistent with Plan was monitored closely in FY21. There are several components to this chart review question. It is reviewing whether the individual received services as authorized in IPOS for scope, amount, and duration. As this question did not change for FY20, comparison previous years can be made. It is noted that Allegan CMH made improvement from FY20 to FY21, the other four CMHSPs scores decreased.

| Chart Review Findings:<br>Service Delivery Consistent with Plan | | | |
|---|---|---|---|
| | **FY19** | **FY20** | **FY21** |
| **Allegan** | 96.4% | 88.55% | 95.94% |
| **HealthWest** | 98.7% | 85.91% | 69.3% |
| **Network 180** | 90.2% | 93.51% | 86.7% |
| **Ottawa** | 94.6% | 89.16% | 74.7% |
| **West Michigan** | 97.4% | 95.60% | 89.87% |

**Waiver Specific Chart Review Questions Findings**

Autism Waiver

The Autism Specific Chart Questions were added to the Site Review Process in FY16. As these questions did not change in FY21, score comparison to previous years is provided in the chart below. FY2021 review findings from the Autism Specific Chart Review Questions indicate systematic issues for four of the five CMHSPs. Three CMHSPs made improvement in this area for FY21. Plans of Correction were requested and completed by four CMHSPs. The LRE Waiver Coordinator and Team will continue to monitor closely during FY22.

| Chart Review Findings: Autism Specific Chart Questions Review | | | |
|---|---|---|---|
| | **FY19** | **FY20** | **FY21** |
| **Allegan** | 83.% | 69.70% | 79.76% |
| **HealthWest** | 91.1% | 90.91% | 93.59% |
| **Network 180** | 89% | 56.06% | 87.2% |
| **Ottawa** | 89.8% | 74.21% | 50.0% |
| **West Michigan** | 96.7% | 100% | 95.0% |

HabWaiver

The HabWaiver Specific Chart Questions were added to the Site Review Process in FY17. In reviewing the scores, three CMHSPs scores are lower this year. It is further noted that Ottawa CMHSP has received a score of 100% for the last three years and West Michigan the last two years. Plans of Correction for were requested and completed by three CMHSPs. The LRE Waiver Coordinator and Team will continue to monitor closely during FY21.

| Chart Review Findings: HabWaiver Specific Chart Questions Review | | | |
|---|---|---|---|
| | **FY19** | **FY20** | **FY21** |
| **Allegan** | 88.64% | 88.1% | 37.5% |
| **HealthWest** | NA | 90.6% | 83.3% |
| **Network 180** | 82.7% | 95.7% | 88.9% |
| **Ottawa** | 100% | 100% | 100% |
| **West Michigan** | 97.96% | 100% | 100% |

Child Waiver

The Child Waiver Specific Chart Questions were added to the Site Review Process in FY20. In reviewing the scores from FY2021 two CMHSPs show lower scores than previous years. It is further noted that Ottawa CMHSP has received a score of 100% for the last two years. Plans of Correction for were requested and completed by three CMHSPs. The LRE Waiver Coordinator and Team will continue to monitor closely during FY22.

| Chart Review Findings: Child Waiver Specific Chart Questions Review | | | |
|---|---|---|---|
| | **FY19** | **FY20** | **FY21** |
| **Allegan** | NA | 82.4% | 91.7% |
| **HealthWest** | NA | 90.6% | 48.8% |
| **Network 180** | NA | 95.7% | 86.0% |
| **Ottawa** | NA | 100% | 100% |
| **West Michigan** | NA | 100% | 83.3% |

SED Waiver

The HabWaiver Specific Chart Questions were added to the Site Review Process in FY20. In reviewing the scores from FY2021, Allegan CMH showed improvement. It is further noted that Ottawa CMHSP has received a score of 100% for the last two years. Plans of Correction for were requested and completed by two CMHSPs. The LRE Waiver Coordinator and Team will continue to monitor closely during FY22.

| Chart Review Findings: SED Waiver Specific Chart Questions Review | | | |
|---|---|---|---|
| | **FY19** | **FY20** | **FY21** |
| **Allegan** | NA | 91.5% | 100% |
| **HealthWest** | NA | 90.6% | 0% |
| **Network 180** | NA | 95.7% | 88.9% |
| **Ottawa** | NA | 100% | 100% |
| **West Michigan** | NA | NA | NA |

Staff Training and HR Review

The Staff Training and HR review is completed during the CMHSP Site Review. QI Specialist completes the internal CMHSP staff audits and the LRE Autism/HabWaiver Coordinator completes the Autism, HabWaiver, Child Waiver and SED Waiver Reviews. The chart below indicates three of the five CMHSP met the majority of the internal CMHSP Staff review in FY2021. The review of Waiver Staff found issues with staff training and credentialing. There appears to be more training issues with external, especially direct care worker staff, then internal CMHSP staff.

| CMHSP Staff Review | | | | | Autism Staff Review | | | | Hab Waiver Staff Review | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **FY19** | **FY20** | **FY21** | | **FY19** | **FY20** | **FY21** | | **FY19** | **FY20** | **FY21** |
| **Allegan** | 97.2% | 86.9% | 91.4% | | 89% | 98.0% | 82.3% | | 64.9% | 81.7% | 87.52% |
| **HealthWest** | 89.2% | 89.8% | 93.6% | | NA | 97.8% | 93.0% | | 88.9% | 75.0% | 75.1% |
| **Network 180** | 98.8% | 98.7% | 99.4% | | 83.4% | 93.5% | 77.7% | | 87.1% | 89.5% | 91.8% |
| **Ottawa** | 94.6% | 99.2% | 97.6% | | 98.0% | 96.2% | 85.7% | | 89.4% | 100% | 80.9% |
| **West Michigan** | 99.2% | 99.5% | 99.4% | | 88.3% | 100% | 85.9% | | 78.8% | 80.7% | 73.1% |

| CW Staff Review | | | | SED Staff Review | | |
|---|---|---|---|---|---|---|
| | **FY19** | **FY20** | **FY21** | **FY19** | **FY20** | **FY21** |
| **Allegan** | NA | 82.4% | 90.9% | NA | 33% | 84.6% |
| **HealthWest** | NA | 87.9% | 89.2% | NA | 75% | 98.6% |
| **Network 180** | NA | 92.5% | 96.6% | NA | 100% | 93.7% |
| **Ottawa** | NA | 93% | 83.5% | NA | NA | 93.6% |
| **West Michigan** | NA | 100% | 78.3% | NA | NA | 100% |

Issues found during the Training / Credentialing Review include:

- Due to Covid 19, some staff continued to have difficulty receiving trainings in FY2021
- Not all Staff receive specific IPOS Training prior to working with the individual. This includes new staff and long-term staff not receiving an IPOS specific training following an annual IPOS

- Not all Staff receive annual updates for required trainings, such as, Grievance and Appeals, HIPPA, Universal Precautions, etc.
- Not all Staff have Background Checks completed prior to hire.

See the completed LRE *CMHSP Site Reviews FY2021* for more details.

**Information Technology Review**

The Information Technology Review is an intensive and thorough review of the CMHSPs Information System and Processes completed by a LRE IT staff. For FY2021, the LRE CIO completed these reviews as part of the CMHSP Annual Site Review process.

The following chart show a comparison of the overall Information Technology Scores received for FY2021 compared to previous years. Improvement noted in four of the five CMHSPs scores, one CMHSPs scores remained the same for the last three years. Plans of Correction are required for any Standard not met.

| Information Technology Review | | | |
|---|---|---|---|
| | **FY19** | **FY20** | **FY21** |
| **Allegan** | 94.9% | 97.5% | 99.2% |
| **HealthWest** | 86.8% | 93.2% | 95.2% |
| **Network 180** | 95.7% | 98.3% | 100% |
| **Ottawa** | 99.2% | 99.2% | 99.2% |
| **West Michigan** | 99.2% | 94.1% | 100% |

**Performance Measures (MMBPIS)**

Overview:
There are a total of 19 indicators reported to MDHHS quarterly. The chart below reflects the number and percentage of indicators that met the 95 percent standard in FY19, FY20 and FY21. MDHHS implemented revised Indicator#2 and Indicator #3 starting on April 1, 2020. There is no longer an MDHHS required Standard for Indicator's 2 and 3. LRE has met the MDHHS Standards for Indicators 1, 4a, 4b, and 10 for the last 6 quarters.

| MMBPIS Findings:<br>Number / Percentage LRE Met MDHHS MMBPIS Standards<br>Note: Quarter 3 & 4 data was excluded for Indicators 2 and 3 | | | |
|---|---|---|---|
| | **FY19** | **FY20** | **FY21** |
| # of LRE Met MMBPIS Indicators | 56/76 | 46/52 | 28/28 |
| % of LRE Met MMBPIS Indicators | **73.6%** | **88.5%** | **100%** |

**FY21 LRE MMBPIS Summary**

The chart below reflects the number and percentage of FY21 Quarters in which LRE met MDHHS Standards for each indicator. It also demonstrates the four-quarter average LRE achieved for each indicator for FY21

| 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% | **97.3%** |
| | | Adult | 4 out of 4 | 100% | **98.0%** |
| | | | | | |
| 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 | | | 73.1% |
| | | MI Adult | | | 83.3% |
| | | DD Child | | | 63.9% |
| | | DD Adult | | | 74.5% |
| | | LRE Total | | | 76.6% |
| | | | | | |
| 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 | | | 80.9% |
| | | MI Adult | | | 72.8% |
| | | DD Child | | | 78.3% |
| | | DD Adult | | | 85.5% |
| | | LRE Total | | | 78.1% |
| | | | | | |
| 4a | **Follow-up Within 7 Days of Inpatient Discharge** | Children | 4 out of 4 | 100% | **96.9%** |
| | | Adults | 4 out of 4 | 100% | **96.4%** |
| | | | | | |
| 4b | **Follow-up Within 7 Days of SUD Discharge** | SUD | 4 out of 4 | 100% | **97.9%** |
| | | | | | |
| 10 | **Inpatient Recidivism** | Children | 4 out of 4 | 100% | **7.8%** |
| | | Adults | 4 out of 4 | 100% | **11.3%** |

**Medicaid Verification**

For FY21, the LRE completed Medicaid Verification audits semi-annually. The LRE uses software to draw a random sample of records for each CMHSP based on the total number of Medicaid billable claims submitted.

| **Date of Medicaid Verification Audit** | **Medication Verification Audit: Dates of Services Reviewed** | **Total Number of Claims Verified** |
|---|---|---|
| June – August 2021 | Oct 1, 2020 – Jan31, 2021 | 203 |
| Oct - Dec 2021 | Feb1, 2021--Sept 30, 2020 | 375 |

**Recoupment Information Data:**

The totals are an aggregate of all Medicaid Claims Verification Audits completed for FY21.

| | Total $ Medicaid Claims in pulled MV Encounter File | Total $ Reviewed | $ Amount Recouped | % Recoupment |
|---|---|---|---|---|
| TOTAL Recoupment FY21 Report 1 | 203 | $49,500.63 | $1,186.11 | 2.4% |
| TOTAL Recoupment FY21 Report 2 | 375 | $70,124.26 | $827.85 | 1.2% |
| TOTAL Recoupment FY2021 | 578 | $119,624.93 | $2,013.96 | 1.7% |

The following chart shows the number of claims reviewed by service type for FY2021. The totals are an aggregate of all Medicaid Claims Verification Audits completed for FY2021.

| ***Number of Reviews completed By Service Type: FY2021*** | | | | | | | |
|---|---|---|---|---|---|---|---|
| ACT | 16 | | Crisis Residential & Detox | 15 | | Respite | 9 |
| Assessment | 4 | | Home Based | 17 | | SUD Outpatient | 61 |
| Autism | 37 | | Methadone | 10 | | Supports Coordination | 174 |
| Behavior Treatment | 16 | | Outpatient Services | 75 | | Targeted Case Management | 86 |
| CLS | 16 | | Peer-delivered services | 3 | | Wrap Around | 7 |
| Crisis Intervention | 1 | | Personal Care | 1 | | | 0 |

The following shows the number of cases reviewed per population group for FY21

- MI Child 87
- MI Adult 213
- DD Child 67
- DD Adult 168
- SUD 43

**Summary of Medicaid Verification Review F21**

**Issues / Concerns Noted:**

Based on our FY21 reviews of the Medicaid Claims Verification audit report data, we discovered several areas of deficiencies which have been addressed on an ongoing basis throughout the year.

- The IPOS was either not submitted or not current for the date of service for five of the cases reviewed. (Recoupment required)
- The service / HCPC code was not listed in the IPOS for three of the cases reviewed (Recoupment required)
- One o of the encounters reviewed found that the individual was not Medicaid Eligible on the Date of Service. (Recoupment required)
- For two of the cases reviewed, supporting documentation was not found for the date of service. (Recoupment required)

- Reviewers found that one staff did not have the proper credentials to bill for the provided service. (Recoupment required)
- Reviewers also noted that five progress notes did not include credentials with signature. (Possible Plan of Correction will be needed)

**FY2021 Medicaid Verification Follow-up**

Based on FY2020 reviews of the Medicaid Claims Verification audit report data, several areas of deficiency were discovered. These have been addressed.

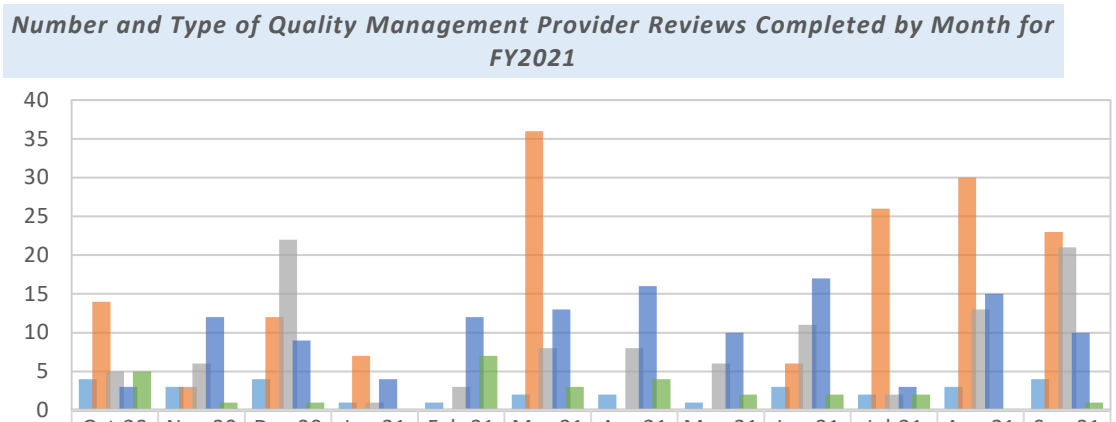
- When an individual is found not to be eligible for Medicaid Service on the Date of Service, QI Staff work closely with the CMHSP Contract Manager/ Financial Staff to verify the Medicaid status of the individual on the Date of Service. If the individual did not have Medicaid, a recoupment occurs. These cases are reviewed and monitored, looking for possible trends.
- Missing credentials with the staff signatures continued to be an issue especially during the first Medicaid Claims Verification Review for FY21 as there were 30 cases reviewed where credentials were missing. The second Medicaid Claims Verification Review for FY21 was better, with five cases reviewed missing credentials. This makes a total of 35 progress notes missing credentials, for the 2021 Medicaid Claims Verification Review. The CMHSP with the 30 cases missing staff credentials during the FY21 Report 1, found it to be a problem with their EMR and this was remediated.
- The LRE requires that any Medicaid Verification audit finding be reconciled. For those claims where a deficiency was discovered, the CMHSPs are responsible to recoup the Medicaid funds and to notify LRE in writing that this has occurred. For services provided by a contracted provider, the CMHSP initiates a claims adjustment and takes back the funds. For direct run services, claims incorrectly paid with Medicaid dollars are reversed and paid for with General Funds.
- Medicaid Claims Verification audit results are discussed first by the QI Team, and then brought to the QI ROAT, which includes membership from all five CMHSPs, as well as several provider agencies. Processes and issues are discussed, looking for trends or overlaying issues across the region.

**Medicaid Claims Verification Audit Future Plans:**

- QI Functions are now again the responsibility of LRE, as they no longer contract with BHO for these functions. LRE Administration is in the process of restructuring QI Processes and have hired a full- time staff dedicated to complete Medicaid Claims Verification Reviews on an ongoing basis.
- For FY2022, LRE QI Staff plans to complete the Medicaid Claims Verification Process at least semi-annually but is aiming for quarterly reviews. LRE Staff are currently in the process of revising the Medicaid Verification Claim review process. The revised review will still use a statistically sound, randomly selected sample based on all LRE Medicaid Encounter service lines but, will also pull all the Medicaid encounters for each individual selected for review during a specific time-period. LRE's purpose for this revision is ensure a more complete, thorough, comprehensive Medicaid Claims Verification process.

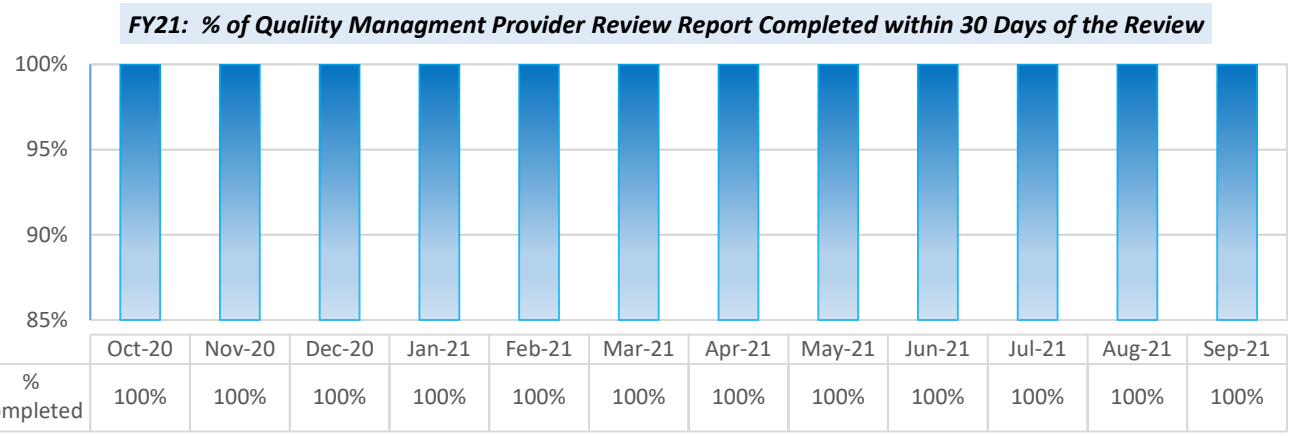
**Provider Site Reviews**

In FY21, Beacon QI Team completed annual site reviews for all regional contracted providers. Due to Covid-19, the QI Team changed from conducting in person site reviews to virtual site reviews starting May of 2020 and continuing through FY21.




| | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Agency | 4 | 3 | 4 | 1 | 1 | 2 | 2 | 1 | 3 | 2 | 3 | 4 |
| Agency Spec Res Homes | 14 | 3 | 12 | 7 | 0 | 36 | 0 | 0 | 6 | 26 | 30 | 23 |
| Agency Other Services | 5 | 6 | 22 | 1 | 3 | 8 | 8 | 6 | 11 | 2 | 13 | 21 |
| Indep Spec Res Homes | 3 | 12 | 9 | 4 | 12 | 13 | 16 | 10 | 17 | 3 | 15 | 10 |
| Indep Other Services | 5 | 1 | 1 | 0 | 7 | 3 | 4 | 2 | 2 | 2 | 0 | 1 |

For FY21, QI Team, completed all Provider Reviews within 30 days of completing the Provider review.




| | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % completed | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

**Critical Incident and Risk Event Reporting**

*Critical Incident Reporting*

Critical Incident Events are reported monthly. This includes data on critical incidents, number of deaths, type of deaths (suicide, natural causes, accidental causes, & homicide), required emergency medical treatment, emergency room visits due to injury, emergency room visits due to medication error, hospitalization due to injury, hospitalization due to medication error and arrests. This data is monitored monthly and with further investigation initiated as needed. This data is reported to MDHHS monthly.

The FY21 data reviewed indicates:

- There was a total of 391 Critical Incidents reported in FY21. This is an increase of 90 compared to the 299 reported in FY20.
- In FY21, there were 7 reported suicides for the Region as compared to the 2 reported in FY20. Ottawa and West Michigan both reported 2 suicides and N180 reported three suicides.
- There were 22 accidental deaths reported in FY21 compared to 14 reported last year.
- The number of reported injuries requiring medical care increased from 122 in FY20 to 177 in FY2021.
- The number of reported medication errors requiring medical care for FY2021 was 5. Last year2 were reported.
- The number of reported injuries requiring hospitalization increased from 10 in FY2020 with 20 reported events in FY21.
- There were 5 med errors requiring hospitalization this year compared to 2 the last year.
- Reported arrests decreased with 17 for FY21 compared to 34 for FY20.

See the completed LRE *Critical Event Monitoring for Oct 2020 – Sept 2021 dated 1/15/22 for more details*.

*Risk Events Reporting*

Risk Events data is reported monthly on all individuals receiving services at the time of the Event, who received either Supports Coordination, Case Management, Home Based Services (HBS) or Assertive Community Treatment (ACT) Services. Risk Event data includes the number of self-harm risk events, the number of harm to others risk events, the number of police calls, the number of emergency use of physical management and the number of individuals with 2 or more hospitalizations per year. Risk Event Data is not reported to MDHHS, however the PIHP is required to have a process for collecting, aggregating, monitoring trending, and follow-up of the events. The LRE reviews the Risk Event process at annual CMHSP Site Review.

The data reviewed indicates the overall rates for the region on Risk Events increased compared to last year's report:

- There were 666 reported Risk Events for FY21 compared to 510reported in FY20.
- There were 202 unduplicated individuals who had a reported risk event in FY2021 compared to 213 in FY20
- There were 83 reported "self- harm" Risk Events reported in FY2021 which was an increase of 22 events compared to the 61 reported in FY20.
- There were 14 "harm to others" Risk Events reported in FY21 which is an increase of 6 compared to the 8 instances reported in the FY20 Report.
- The number of reported "police call" Risk Events increased by 75 for FY2021 with 188 events reported.
- The number of reported "physical management" Risk Events increased for FY21. There were 340 reported in FY21compared to the 284 reported in FY20.
- The number of hospitalizations reported for individuals who had 2 or more hospitalizations within a 12-month period decreased from 42 reported in FY20 to 38 reported in FY21.
- Issue with HealthWest data noted, as HealthWest only reported 8 risk events for FY21

See the completed LRE *Risk Event Monitoring for Oct 2020 – Sept 2021 dated 1/15/22 for more details*

**Customer Services Grievances**

Individuals can file a grievance through their CMHSP Customer Service or through Beacon Customer Services. A monthly Customer Services meeting is held with representation from all five CMHSP and Beacon staff.

**FY21 Member Grievances**
**Includes Grievances Received/Processed by Beacon and CMHSPs**

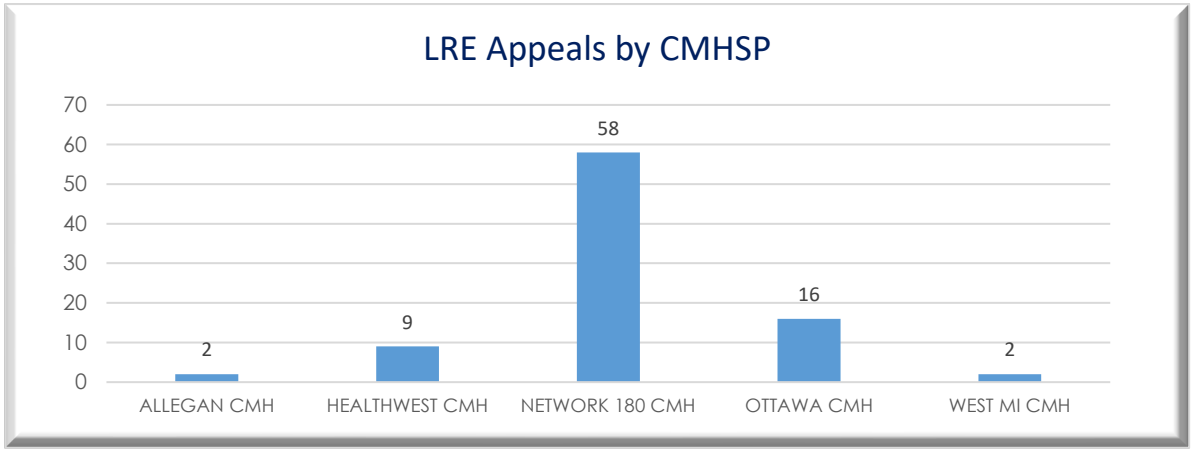
| FY 21- Substantiated Grievances | | | | | |
|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Grand Total |
| **NETWORK 180 CMH** | **3** | **9** | **5** | **3** | **20** |
| ACCESS AND AVAILABILITY | | 3 | | | 3 |
| INTERACTION WITH PROVIDER OR PLAN | 1 | 3 | 1 | | 5 |
| QUALITY OF CARE | 1 | 3 | 4 | 3 | 11 |
| SERVICE ENVIRONMENT | 1 | | | | 1 |
| | Q1 | Q2 | Q3 | Q4 | Grand Total |
| **OTTAWA CMH** | | **2** | **2** | | **4** |
| FINANCIAL OR BILLING MATTERS | | 1 | | | 1 |
| QUALITY OF CARE | | 1 | 2 | | 3 |
| **WEST MI CMH** | **4** | **5** | **1** | **3** | **13** |
| ACCESS AND AVAILABILITY | | | | 1 | 1 |
| INTERACTION WITH PROVIDER OR PLAN | 1 | | | | 1 |
| QUALITY OF CARE | 3 | 5 | 1 | 2 | 11 |
| **Grand Total** | **7** | **16** | **8** | **6** | **37** |

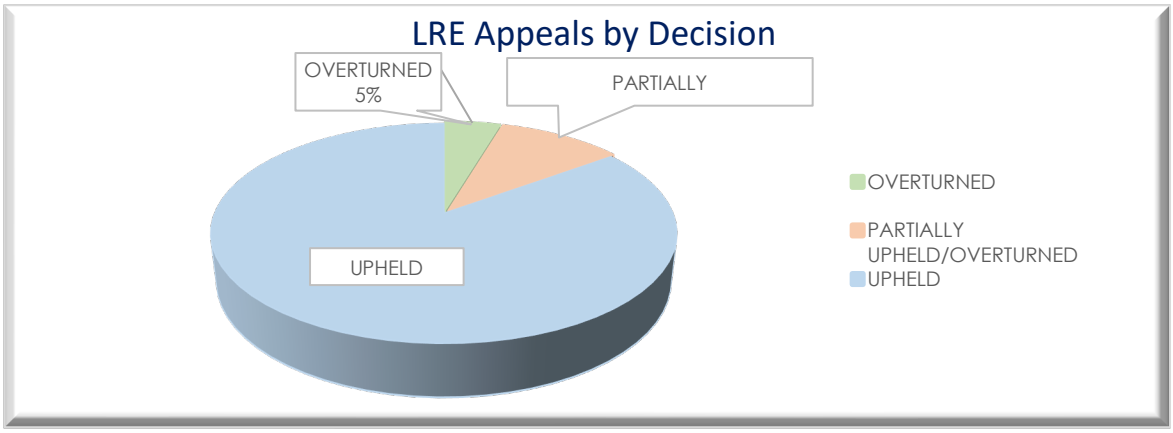
| FY21 – Unsubstantiated Grievances | | | | | |
|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Grand Total |
| **ALLEGAN CMH** | | **1** | | **1** | **2** |
| ACCESS AND AVAILABILITY | | 1 | | | 1 |
| QUALITY OF CARE | | | | 1 | 1 |
| **HEALTHWEST CMH** | | | **1** | **3** | **4** |
| ACCESS AND AVAILABILITY | | | 1 | 1 | 2 |
| INTERACTION WITH PROVIDER OR PLAN | | | | 2 | 2 |
| **NETWORK 180 CMH** | **4** | **1** | **7** | **12** | **24** |
| ACCESS AND AVAILABILITY | | 1 | 2 | 3 | 6 |
| FINANCIAL OR BILLING MATTERS | 1 | | 1 | 3 | 5 |
| INTERACTION WITH PROVIDER OR PLAN | 1 | 1 | | | 2 |
| OTHER | | | 1 | | 1 |
| QUALITY OF CARE | 2 | | 2 | 6 | 10 |

| | | | | | |
|---|---|---|---|---|---|
| SERVICE ENVIRONMENT | | | 1 | | 1 |
| **OTTAWA CMH** | | **4** | | **2** | **6** |
| ACCESS AND AVAILABILITY | | | | 1 | 1 |
| QUALITY OF CARE | | 4 | | 1 | 5 |
| **WEST MI CMH** | **1** | **2** | | **3** | **6** |
| ABUSE, NEGLECT, OR EXPLOITATION | | | | 1 | 1 |
| ACCESS AND AVAILABILITY | | | | 1 | 1 |
| INTERACTION WITH PROVIDER OR PLAN | 1 | | | | 1 |
| QUALITY OF CARE | | 2 | | 1 | 3 |
| **Grand Total** | **5** | **9** | **8** | **21** | **43** |

**FY21 Local Appeal Decisions by Agency 10/1/20 – 9/30/21**
**Appeals Processed by Beacon**

The LRE Appeals and Fair Hearings were completed by BHO for FY21. In FY22 LRE, will take the Appeal and Fair Hearing function back to the LRE under. The following FY21 data shows the number of Appeals by CMHSP and percentage of Appeal decisions by category.



**Satisfaction Survey Results**

In the June of FY20, LRE convened a Regional Satisfaction Survey Workgroup, with membership from each of the five CMHSPs, purpose was to develop and implement a revised Customer Satisfaction Survey meeting HSAG recommendations and provide the ability for the identification of areas of need within our Region. The goal of this workgroup was to have a completed revamped survey ready for implementation in FY21. This new LRE Customer Satisfaction Survey was implemented in December of 2021. The new satisfaction survey includes some of the questions from the previous LRE Satisfaction Survey plus the addition of more demographic information which includes service type, length of service, gender, age group and race/ethnicity.

The new survey includes questions for the following measures:

- Access and Availability
- Quality Measures
- Outcome Measures
- Long Term Service Measures
- Telehealth Service Measures

Power BI is now used to complete the satisfaction survey reports for the Region. This enables a platform for interactive reporting possibilities which we did not have with the previous satisfaction survey. Power BI will allow us to filter on any of the demographic fields or any question. This will provide us the ability to drill down and identify any issues, concerns, or trends by a CMHSP or the Region.

For FY 21 LRE Satisfaction Survey process shows that individuals within our Region are satisfied with the services they have received. The Overall aggregate scores by CMHSP show the following rating received. Scores are based on a Likert Scale of 1 to 6, with 6 being the best.

| CMHSP | Overall Score for FY21 |
|---|---|
| Allegan CMHSP | 5.04 |
| HealthWest | 5.17 |
| Network 180 | 5.23 |
| Ottawa CMHSP | 5.15 |
| West Michigan CMHSP | 5.30 |

**Behavior Treatment Review Committee Data**

Behavior Treatment data is collected from each of the CMHSP's Behavior Treatment Committees. This data is submitted to the LRE quarterly for aggregation, review, and monitoring. LRE Behavior Treatment Data Review Workgroup, which has membership from all five of the CMHSPs, was re-instated in FY20 (the Workgroup was put on hold in FY19 due to the transition to BHO). This workgroup has several purposes:

- Review and discuss data definitions to ensure that all five CMHSP's consistently use agreed upon data definitions in reporting the BTRC data.
- Discuss BTRC issues and concerns and reviews data reports for any changes or trends.

MDHHS no longer requires quarterly BTRC data submission, instead MDHHS has delegated the monitoring responsibility to the PIHP. For FY21, Quarterly BTRC Reports were submitted and reviewed by the QI ROAT. The

aggregate report reviewed, is always a rolling 8-quarter report, to allow for monitoring of trends/ issues. In addition to the QI ROAT quarterly review, the LRE/Beacon QI staff also monitor and review the Behavior Treatment Committee process at the annual CMIHSP Site Review.

In reviewing the BTRC data for individuals on the Habilitation Waiver (HSW) from FY21 it was found that:

- The number of individuals who had a Behavior Treatment Plan ranged from a low of 128 to a high of 164 between FY20 Quarter 1 and FY21 Quarter 4.
- For the eight quarters between FY20 Q1 and FY21 Q4, there were 42 Incidents of *Harm to Others* reported. This is an increase in the number of reported instances from the 20 reported in the previous eight quarters.
- The number of incidents of physical management per quarter varied significantly over the 8 quarters between FY20 Q1 and FY21 Q4, with a low of 5 to a high of 23. Ottawa CMHSP continues to report the most *Physical Management incidents, however number of instances are much lower than they were several years back.* LRE/Beacon QI will continue to closely monitor this area. In FY21, QI Staff also monitored each physical management incident by individual and the length of time for each incident.
- For the eight quarters between FY20 Q1 and FYY21 Q4, there were 16 Incidents of 911 calls reported. Nine of these instances were reported from West Michigan.

**HSAG Overview**

**Performance Improvement Project (PIP)**

The Performance Improvement Project developed and submitted to HSAG in 2018 continued through FY21. The LRE PIP for FY 2018 – FY 2020 is titled, "Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)." This PIP, per contract with MDHHS, requires validation from HSAG annually. LRE attained 100% validation for this PIP for FY2018 & FY2019; 95% in FY2020 with a score of 100% for the critical elements; and for FY21 received a score of 90% Evaluation Met and 91% for critical elements met. However, the LRE PIP was not validated because the PIP did not sustain statistically significant improvement which was achieved in FY20 but not in FY21.

The following is an excerpt from the FY20 HSAG Performance Improvement Project Validation Report: " The Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) PIP received a Met validation score for 91 percent of critical evaluation elements, 90 percent for the overall evaluation elements across all steps validated, and a Not Met validation status. LRE collected and reported accurate study indicator results using a systematic data collection process and conducted appropriate statistical testing for comparison between measurement periods. The PIHP used appropriate quality improvement tool(s) in the identification and prioritization of barriers. LRE implemented timely interventions; however, at Remeasurement 2, the PIHP was unable to maintain the statistically significant improvement achieved during the first remeasurement."

See the complete *HSAG 2020-2021 PIP Validation Report* for more details. "

**HSAG Performance Measurement Validation (PMV) Report**

LRE was reviewed by HSAG Performance Measurement Validation Staff via WebEx on June 14, 2020. This review involves the validation of LRE encounter data submission and processes, QI data submission and processes, and Michigan Mission Based Performance Indicator System data collection and report completion process. Validation results are as follows:

- HSAG had no concerns with LRE's receipt and processing of eligibility data.
- HSAG determined that the data control processes in place at LRE were acceptable

- HSAG had no major concerns with how LRE received and processed claim/encounter data for submission to MDHHS.
- HSAG found that LRE had sufficient oversight of its five affiliated CMHSPs; however, there are areas for improvement to ensure the CMHSPs have consistency in EMR data entry process amongst their staff members.
- HSAG had no significant concerns with how LRE received and processed claims and encounters as it relates to readiness for reporting the new indicators.
- HSAG validated LRE's Performance Measures, and all were reportable for FY21.
- Lakeshore developed a thorough mechanism to oversee the CMHSP tracking of Indicator #2e, which included a detailed reconciliation process to validate the data against programmed rules alignment with the MDHHS Codebook. Additional manual review was also performed to ensure accuracy of the tracking of expired requests.
- Lakeshore demonstrated appropriate oversight, implementation, and monitoring of the CAPs that had been implemented with its CMHSPs throughout the measurement period.

HSAG recommendations are as follows:

- HSAG recommends that the PIHP and the CMHSPs perform additional data quality and completeness checks before the data are submitted to the State. Multiple BH-TEDS records in the CMHSPs' EHRs contained conflicting values (e.g., unemployed, but listed as earning minimum wage or more).
- HSAG recommends that the PIHP identify and implement a mechanism through which it can monitor encounter data-dependent rate impact if the CMHSP's encounters are delayed.
- HSAG recommends the PIHP deploy reporting logic that identifies all cases where the service request date is equal to the assessment completion date and require each CMHSP to manually review for accuracy.
- HSAG states that even though the LRE has sufficient oversight of its five affiliated CMHSPs, areas for improvement still existed.

The above recommendations have been implemented at the LRE.

See the complete *HSAG 2021 Validation of Performance Measures report* for more details.

**HSAG Compliance Monitoring Report**

LRE was reviewed by HSAG Compliance Staff via WebEx in July 2021. Compliance reviews are on a three-year cycle. HSAG reviews half of the Standards each year for two years and the third year is for Plan of Correction follow-up. MDHHS has contracted with HSAG, as required by the Balanced Budget Act, to conduct an external quality review to ensure the PIHP's compliance with Medicaid managed care standards and the state contract. This quality review focuses on evaluating quality outcomes, the timeliness of / access to care, and services proved to Medicaid beneficiaries. The Compliance review has numerous regulations/requirements within 13 Standards. It is noted that HSAG has changed their review process from a review of written Policy and Procedures to a review that focuses on process to ensure the PIHP is implementing process per Federal and State rules. FY2021 was the 1st year of the HSAG review cycle. HSAG has updated their Standards and moved from the 17 previous Standard to 13 Standards starting in FY21. The following table shows the LRE Scores for FY21.

**Table 1-2—Summary of Standard Compliance Scores**

| Compliance Review Standard | | Total Elements | Total Applicable Elements | Number of Elements | | | Total Compliance Score |
|---|---|---|---|---|---|---|---|
| | | | | *M* | *NM* | *NA* | |
| I | Member Rights and Member Information | 19 | 19 | 17 | 2 | 0 | **89%** |
| II | Emergency and Poststabilization Services* | 10 | 10 | 10 | 0 | 0 | **100%** |
| III | Availability of Services | 7 | **7** | 5 | 2 | 0 | **71%** |
| IV | Assurances of Adequate Capacity and Services | 4 | 4 | 2 | 2 | 0 | **50%** |
| V | Coordination and Continuity of Care | 14 | 14 | 11 | 3 | 0 | **79%** |
| VI | Coverage and Authorization of Services | 11 | 11 | 8 | 3 | 0 | **73%** |
| | **Total** | **65** | **65** | **53** | **12** | **0** | **82%** |

***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.
*Performance in Standard II should be interpreted with caution as there were noted opportunities for all PIHPs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the PIHPs' services. The PIHPs' progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

LRE demonstrated compliance in 53 of 65 elements, with an overall compliance score of 82 percent, indicating that some program areas had the necessary policies, procedures, and initiatives in place to carry out many required functions of the contract, while other areas demonstrated opportunities for improvement to operationalize the elements required by federal and State regulations.

For any elements scored "Not Met," LRE was required to submit a CAP to bring the element into compliance with applicable standards. The CAP was written, sent to HSAG, and was approved. LRE Staff are currently working on updating policies, forms and procedures as required per the HSAG Compliance CAP.

See the complete *HSAG 2021 External Quality Review Compliance Monitoring Report* for more details.

**FY 2021 QAPIP EFFECTIVENESS REVIEW**

| QAPIP STANDARD | REVIEW FINDINGS | NOTES |
|---|---|---|
| 1) An adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP | Met | The LRE QAPIP describes the structure and function of the QI system. LRE implemented its QAPIP in FY 2021 according to established protocol. |
| 2) The components and activities of the QAPIP are clearly specified | Met | The LRE QAPIP includes all required components. Where necessary improvements or clarifications to the written plan identified during FY 2021, have been incorporated into the revised 2022 QAPIP. |
| 3) The role for recipients of services in the QAPIP | Met | The LRE Consumer Advisory Council is an advisory group of primary and secondary consumers served by the CMHSPs within the Region. This council assists and advises LRE staff in identifying issues and areas of concern related to regional service delivery and managed care operations. |
| 4) The mechanisms or procedures to be used for adopting and communicating process and outcome improvement | Met | The LRE CEO communicates activities related to process development and progress toward goals to the LRE Board of Directors. Additionally, providers and stakeholder are kept informed through monthly Provider Network ROAT meetings and newsletters that are distributed through the LRE website. |
| II. QAPIP must be accountable to a Governing Body that is a PIHP; includes | Met | The QAPIP is reviewed by LRE Leadership, Operations Committee and approved by the LRE Board. The FY21 plan included additional clarification on how the QI ROAT will escalate issues to the Operations Committee or Board as necessary to ensure high performance on all indicators. This language continued in the FY22 QAPIP |
| A. Oversight of QAPIP- There is documentation that the governing body has approved the QAPIP and an annual QI Plan | Met | The LRE Board approves the overall Regional Quality Improvement Plan, on an annual basis. QI Staff create an Annual Effectiveness Report. This summary report is completed and reviewed by the QI Team and presented to the QI ROAT, LRE Leadership, Operations Committee, LRE Board and the Consumer Advisory Council for information and feedback. This report is also be posted on the LRE Website. |
| B. QAPIP progress reports- Routinely receives written reports from the QAPIP describing performance improvement projects undertaken, the actions taken and the results of those actions | Met | The LRE Board has been receiving routine reports on compliance with state standards, including Critical Incident and Risk Event Report, MMBPIS and a CEO report which contains updates on Provider Site Reviews, Autism, HSAG Plans of Correction, etc. |
| C. QAPIP Annual Review- Formally reviews on a periodic basis a written report on the operation of the QAPIP | Met | QI Staff create an Annual Effectiveness Report. This summary report is completed and reviewed by the QI Team and presented to the QI ROAT, LRE Leadership, Operations Committee, LRE Board and the Consumer Advisory Council for information and feedback. This report is also be posted on the LRE Website |

| QAPIP STANDARD | REVIEW FINDINGS | NOTES |
|---|---|---|
| D. The Governing Body submits the written annual report to MDHHS by Feb 28th and will include a list of members of the Governing Body | Met | The FY21 Annual Effectiveness Report will be submitted to MDHHS by 2/28/22 as required. |
| III. Designated senior official responsible for the QAPIP implementation | Met | Per the QAPIP, for FY19, FY20 and FY21 the LRE CEO and BHO Quality Manager has administrative management and oversite of the QAPIP. This was changed in FY22 as the contract with BHO ended on 10/31/21. For FY22 the Chief Quality Officer is responsible for the QAPIP implementation. |
| IV. Active participation of providers and consumers in the QAPIP processes | Met | In FY21 there was representation on the QI ROAT from Consumers and the Provider Network. The LRE Consumer Advisory Panel is an advisory group of primary and secondary consumers served by the CMHSPs within the Region. This council assists and advises LRE staff in identifying issues and areas of concern related to regional service delivery and managed care operations. Stakeholder input is gathered from a variety of methods, including satisfaction surveys, Consumer Advisory Panel, public comment at Board meetings, etc. The Consumer Advisory Council does review the Annual Effectiveness Report and provides feedback. |
| V. Measures performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data | Met | The QI ROAT and the IT ROAT continue to ensure the reliability and validity of the data on these indicators across the region, and that these conform to "Validation of the Performance Measures" BBA protocols |
| A. Must utilize performance measures established by the department in the areas of access, efficiency and outcome and report data to the state as established | Met | LRE continues to monitor, analyze, and report performance measures as required by MDHHS. The region continues to work to improve areas identified as deficient. New indicators were adopted for FY2021 and monitored by the QI ROAT and MMBPIS Workgroup. |
| B. May establish and monitor other performance indicators specific to its own program for the purpose of identifying process improvement projects. | Met | The QI ROAT continues to monitor the LRE Key Performance Indicators (KPI's), and is responsible for oversight and performance improvement for these KPI's. The process for identifying issues for process improvement, developing a plan, and tracking improvement over time was a key component of the FY 2021 QAPIP and this will continue into FY2022. |

| QAPIP STANDARD | REVIEW FINDINGS | NOTES |
|---|---|---|
| VI. Utilize QAPIP to assure that it achieves minimum performance levels on performance indicators as established by the department and defined in the contract and analyzes the causes of negative statistical outliers when they occur. | Met | LRE QI continues to monitor the MMBPS Indicators, analyzes quarterly data for trends, reviews cases found out of compliance. CMHSPs not meeting MDHHS standards per quarter are required to complete a POC. LRE QI validate MMBPIS data quarterly by reviewing a sample of cases prior to submission. |
| VII. QAPIP includes affiliation-wide performance improvement projects that achieve demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction | Met | LRE conducted two performance improvement projects meeting Michigan QAPIP standards and BBA standards. One of the projects conducted was mandated by MDHHS and was reviewed and evaluated by HSAG for compliance with requirements. FY 21 was the end of the 3year HSAG PIP cycle. LRE received an overall score of 95%, however the Diabetes Monitoring PIP was not validated due to not sustaining the statistically significant improvement made in year 2. |
| A. Performance Improvement Projects must address clinical and non-clinical aspects of care | Met | The LRE conducts "performance improvement projects 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 (consumer) satisfaction." |
| 1. Clinical areas could include high-volume services, high- risk services, and continuity and coordination of care | Met | FY21 PIP addressed coordination of care and monitoring individuals with Diabetes and Schizophrenia. Currently in the process of developing new PIP starting in 2022 |
| 2. Non-clinical services may include appeals, grievances and trends and patterns of substantiated RR complaints, and access to, and availability of care | NA | Both PIPs addressed Coordination of Care |
| B. Project topics take into consideration prevalence of consumer conditions, demographics, and consumer interest | Met | The Consumer Advisory Panel provides input on goals, measures and potential project topics. |
| E. PIHP must engage in at least two projects during waiver renewal period | Met | The FY 2021 QAPIP clearly identified the process by which PIPs are selected and the specific projects chosen for FY 2018 – 21 cycles. The PIPs identified in FY2018 continued through FY2021. An additional PIP was added in FY2020 to monitor activity related to follow-up to hospitalization activity. LRE is currently choosing and developing two new PIPs to start in 2022. |

| QAPIP STANDARD | REVIEW FINDINGS | NOTES |
|---|---|---|
| VIII. QAPIP describes process of the review and follow-up of sentinel events and other critical incidents | Met | Activities conducted according to QAPIP. |
| A. Sentinel events must be reviewed and acted upon as appropriate (3 business days) | Met | Activities conducted according to QAPIP. Sentinel Events are reported as required by the CMHSPs. RCA occur at CMHSP and when completed sent to LRE for review. A thorough review of each CMHSP's Sentinel Event process occurs annually at CMH site review. |
| B. Persons involved in the review must have appropriate credentials relative to the event | Met | Staff involved in reviews have the appropriate credentials. LRE reviews each completed RCA and completes an overall Sentinel Event process review annually during the CMHSP Site Review. |
| C. All unexpected deaths of Medicaid beneficiaries must be reviewed and include: | Met | Activities conducted according to QAPIP. |
| 1. Screens of individual deaths with standard information | Met | QAPIP and PIHP policy and process includes all required information. |
| 2. Involvement of medical personnel in the mortality reviews | Met | Included in QAPIP, and PIHP / CMHSP policies and processes |
| 3. Documentation of the mortality review process, findings, and recommendations; Use of mortality information to address quality of care; Aggregation of mortality data over time to identify possible trends | Met | In FY2021, the Beacon Quality of Care Committee reviewed mortality trends. |
| D. Following immediate event notification to MDHHS, PIHP will submit information on relevant events through the Critical Incident Reporting System | Met | Critical Incident Events are reported monthly. This includes data on critical incidents, number of deaths, type of deaths (suicide, natural causes, accidental causes, & homicide), required emergency medical treatment, emergency room visits due to injury, emergency room visits due to med error, hospitalization due to injury, hospitalization due to med error and arrests. This data will continue to be monitored monthly and with further investigation initiated as needed. This data is reported to MDHHS on a monthly basis. |
| E. Critical Incident Reporting System- QAPIP must describe how the PIHP will analyze at least quarterly the critical incidents, sentinel events, and risk events to determine what action needs to be taken. | Met | The LRE /BHO analyzes at least quarterly the critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and prevent the occurrence of additional events and incidents. These events are reviewed by the QI ROAT quarterly. The CIRE Report is was brought to the LRE/Beacon Quality of Care Committee quarterly for FY21. Starting in FY22, data will be brought to the LRE CIRE Committee as well as the QI ROAT |

| QAPIP STANDARD | REVIEW FINDINGS | NOTES |
|---|---|---|
| F. Risk Events Management-<br>• Actions taken by individuals who receive services that cause harm to themselves<br>• Actions taken …that cause harm to others<br>• 2 or more unscheduled admissions to a medical hospital within 12 months.<br>• Written reports within 60 days for each death | Met | Risk Events are gathered on a monthly basis. This includes data on risk events reported by population group, number of self-harm risk events reported, number of harm to others risk events reported, number of police calls reported, number of emergency use of physical management and number of individuals with 2 or more hospitalizations per year. This data is monitored monthly and with further investigation initiated as needed. These events are reviewed by the QI ROAT quarterly. For FY21 the CIRE Report was brought to the LRE/Beacon Quality of Care Committee quarterly. Starting in 2022 this report will be monitored by the LRE CIRE Committee |
| IX. QAPIP quarterly reviews analyses of data from the behavior treatment review committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis. | Met | Behavior Treatment Data is collected quarterly at each of the CMHSP's Behavior Treatment Plan Review Committees. This data is aggregated quarterly and submitted to the LRE for review and monitoring. LRE has a Behavior Treatment Data Review Workgroup, which has membership from all five of the CMHSPs reviews and monitors the Behavior Treatment Data. For FY21, Beacon QI Manager meets with the CMHSPS representatives on a quarterly basis to review and discuss data collection, data definitions, and trending of data. The CMHSP Behavior Committee Process and Data is reviewed annually by the Beacon Quality Manager during the annual CMHSP Site Review. In FY2021, a region-wide report was developed focusing on physical management (per person and length of each intervention. For FY2022, the behavior Treatment data and workgroup will be monitored by LRE Chief Quality Officer and LRE Clinical Manager. |
| X. QAPIP includes periodic quantitative and qualitative assessments of member experiences with its services | Met | The LRE conducted all activities consistent with state requirements and as described in its QAPIP. HealthWest has not reported data for FY2019 and FY2020, which has resulted in incomplete regional data. A new survey was developed and implemented in FY2021. All five CMHSPs reported satisfaction survey data in 2021. |
| A. Must address issues of the quality, availability, and accessibility of care | Met | LRE Performance Indicators include quality, availability, and accessibility per MDHHS and BBA requirements. |
| B. As a result, the organization | | |
| 1. Takes specific action on individual cases as appropriate | Met | Activities conducted according to QAPIP for specific examples and individual cases as needed. |
| 2. Identifies and investigates sources of dissatisfaction | Met | For FY21 LRE/BHO conducted specific investigations of consumer and provider dissatisfaction per its policies and procedures. Starting in 2022, this task is moved back to the LRE Customer Services. |
| 3. Outlines systemic action steps to follow-up on the findings | Met | Individual corrective action and/or systemic Corrective Action plans were required as needed for the specific findings. |

| QAPIP STANDARD | REVIEW FINDINGS | NOTES |
|---|---|---|
| 4. Informs practitioners, providers, recipients of service and the governing body of assessment results | Met | Satisfaction Survey reports are reviewed by Leadership, QI ROAT, Customer Services and reviewed by the Consumer Advisory Council |
| C. Organization evaluates the effects of the above activities | Met | "The Plan-Do-Check-Study process is designed so that when any input or issue is identified, it is assigned to the appropriate ROAT, Workgroup or Committee for discussion and resolution. Depending on the subject matter, the input may simply be responded to, or the input could be elevated to a committee or project management plan. Once the input has been received, addressed and a resolution created, the results will be communicated within appropriate avenues." This expectation is documented in the QAPIP and appears to have been followed during FY 2021. |
| XI. QAPIP describes the process for the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines when there are nationally accepted or mutually agreed upon (MDHHS and PIHP) clinical standards, evidence-based practices, practice- based evidence, best practices, and promising practices | Met | The LRE Clinical Steering Committee was established to be the oversight body for the implementation and monitoring of practice guidelines in use by the member CMHSPs. The guidelines recommended for implementation are based upon State and National guidelines, when available, and are modified to fit LRE practice patterns. The current practice guidelines for the LRE are referenced in the LRE Clinical Practice Guidelines policy. Guidelines are reviewed annually or more often as indicated by UM/Clinical ROAT. Monitoring of established LRE guidelines is included as part of the CMHSP Annual Site Review |
| XII. QAPIP contains written procedures to determine whether physicians and other health care professionals are qualified to perform their services. Written procedures exist to ensure non-licensed providers are also qualified to do their job. Evidence of credentialing process. PIP must insure: | Met | The annual LRE site review of member CMHSPs and providers include verification that healthcare professionals are qualified to perform their services. Additionally, the review team ensures that there are appropriate policies and procedures in place to ensure non-licensed providers are qualified to perform their jobs. |
| 1. Staff possess the appropriate qualifications as outlined in their job descriptions, including<br>a. Educational background<br>b. Relevant work experience<br>c. Cultural Competence<br>d. Certification, registration, and licensure as required by law | Met | In FY21 LRE/BHO staff conducted credentialing reviews throughout the provider network including the annual CMHSP Site Review, to ensure these standards are met. For FY22, this process has been moved back to the LRE. |

| QAPIP STANDARD | REVIEW FINDINGS | NOTES |
|---|---|---|
| 2. Program shall train new personnel with regards, to their responsibilities, program policy, and operating procedures. | Met | Processes and procedure are in place to train new personnel as required. |
| 3. Program shall identify staff training needs and provide in- service training, continuing education, and staff development activities. | Met | Each LRE CMHSP is required to identify staff training needs and provide in-service training, continuing education and staff development activities. This process is reviewed during the annual CMHSP Site Review. |
| 1. XIII. Written QAPIP must address how it will verify whether services reimbursed by Medicaid were actually furnished to enrollees by affiliates, providers, and subcontractors. | Met | The QAPIP includes the Medicaid Event Verification Process, and LRE implemented these activities according to its plan and in conformance to state requirements. |
| 2. PIHP must annually submit its findings from this process and provide any follow up actions that were taken as a result of the findings. | Met | The LRE implemented these activities according to its policy and in compliance with MDHHS requirements. An annual report was submitted to MDHHS on 12/31/2021 |
| XIV. Organization operates a UM program | Met | While the details of the UM program are outside of the scope of this assessment, the LRE QAPIP does identify that LRE uses a UM policy, procedure, and annual UM Plan to assure appropriate delivery of services. Per the QAPIP, Utilization Management data is aggregated and reviewed by the QI ROAT and Clinical ROAT for trends and service improvement recommendations. Findings from this review indicate that some data such as MMBPIS (service access), Medicaid Verification (services consistent with plan), and Site Review results that pertain to UM were reviewed in the QI ROAT. The QI ROAT did not review other typical utilization reports such as number of persons served, hospitalization rates, or clinical outcome measures. |
| XV. PIHP annually monitors its provider network(s), including any affiliates or subcontractors to which it has delegated managed care functions. PIHP shall review and follow-up on any provider network monitoring of its subcontractors. | Met | For FY21, LRE/BHO annually monitored its provider network including service and support provisions. The Quality Monitoring Site Review (QMR) process is a systematic and comprehensive approach to monitor, benchmark, identify and implement improvements in the provision of mental health and substance abuse services to funded consumers. QAPIP provides a summary of this process. For FY22, this process will occur through the LRE. |

| QAPIP STANDARD | REVIEW FINDINGS | NOTES |
|---|---|---|
| XVI. PIHPs shall continuously evaluate its oversight of "vulnerable" people in order to determine opportunities for improving oversight of their care and their outcomes. | Met | QAPIP indicates LRE will "Conduct additional special targeted monitoring activities of people who are identified as vulnerable (as defined by MDHHS)" These cases are routinely identified during file reviews and outlier reviews. |
| PIHP shall review and approve plans of correction that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate interval. | Met | For FY21, the LRE/BHO QI Staff implemented this process according to the QAPIP. Starting in FY2022, this responsibility of this process was returned to the LRE. |

**EXECUTIVE COMMITTEE SUMMARY**
Wednesday, February 9, 2022, 3:00 PM

Present: Mark DeYoung, Peg Driesenga, Jane Verduin
Absent: Stan Stek, John Snider

WELCOME

i. February 9, 2022, Meeting Agenda
ii. January 12, 2022, Meeting Minutes

Moved: Jane Verduin Support: Mark DeYoung
MOTION CARRIED

The February 9, 2022, meeting agenda and the January 12, 2022, meeting minutes were accepted as presented.

BEACON CONTRACT TRANSITION UPDATE

- LRE met with Beacon's de-implementation team. They provided a PowerPoint explaining which function would be transitioning back to the LRE. LRE will move forward scheduling additional meetings, through June, with staff specific to those functions.
- LRE has developed a timeline of when functions will be transitioned back. Customer Services/Grievance and Appeals will be transitioned back as soon as possible.
- LRE staff have been meeting with Beacon staff to gather information for the transition. On February 15 LRE staff will have draft plans for each function that Ms. Marlatt-Dumas, CEO and Ms. VanDerKooi, COO will review and then the CMHs will review to make sure all areas are covered appropriately.

MDHHS SETTLEMENT/PAST LIABILITIES UPDATE

- Ms. Marlatt-Dumas signed the settlement agreement with MDHHS and then received another monthly contract. LRE legal sent a letter to the AG asking them to explain to MDHHS that we should have a full contract in place after agreeing to the settlement. The AG agreed and shortly after LRE was sent the full contract covering the last 8 months of this fiscal year.
- LRE met with Allen Jansen to discuss the historical deficit. He stated that he would schedule a meeting with LRE, himself and Elizabeth Hertel. We are still waiting on a response regarding our risk plan.
- LRE lawyers are continuing to work on strategies to move forward if we cannot come to an agreement regarding the deficit.

OPERATING AGREEMENT/BYLAWS REVISIONS

- Ms. Marlatt Dumas went through changes made in the Bylaws with EC and would like to schedule individual meetings to discuss and answer any questions with each board member. The bylaws will also be discussed during Work Session.
- There were changes that were made but those amended bylaws were never approved by the Board.
- As of now this region's funding methodology is 50% PMPM and 50% Historical. The bylaws state that Autism is supposed to be paid 100% PMPM but that is not how we are paying out those funds. We are not following the current approved bylaws.
    - As of now we are paying by enrollment.
    - When we move to full PMPM for Autism there would be a smoothing transition period over 3 years for the CMHs that would take a hit in funds.
    - The LRE would also help N180 to manage the Autism regarding UM and manage costs related to Autism.
        - Autism UM is at the CMH level, but the LRE has hired a BCBA, and we have a specialist that works at the LRE to work with N180.

BOARD MEETING TECH UPDATE

LRE IT staff attending will attend.

- Tablets – We will move to using tablets for Board documents and will quit printing paper packets. These will be turned in at the end of the Board meeting.
    - Mr. DeYoung would like the agenda printed out.
    - Ms. Dyga will print out a couple of packets, if needed.
- Sound System
    - LRE IT staff have put a new sound system in place for Board members and individuals that are virtual.

BOARD MEETING AGENDA ITEMS

- CEO Evaluation recommendation under EC meeting minutes.
- LRE Travel Policy

BOARD WORK SESSION AGENDA

- LRE Bylaws
- Possibly Operating Agreement

LRE CEO EVALUATION

LRE 22-07 Motion: To approve moving into close session for the purpose of reviewing the LRE CEOs Evaluation.

Moved: Jane Verduin Support: Peg Driesenga

MOTION CARRIED

LRE 22-07 Motion: To approve moving out of the closed session after reviewing the LRE CEOs Evaluation.
Moved: Peg Driesenga Support: Jane Verduin
MOTION CARRIED

The Executive Committee reviewed the CEO Evaluation with Ms. Marlatt-Dumas and are recommending moving out another month to discuss compensation.

OTHER

UPCOMING MEETINGS

- February 17, 2022 – LRE Executive Board Meeting, 1:00 PM
- March 9, 2022 – LRE Executive Committee, 3:00 PM
- March 10, 2022 – Consumer Advisory Panel, 1:00 PM
- March 17, 2022 – LRE Executive Board Meeting, 1:00 PM
  GVSU, Muskegon Innovation Hub, 200 Viridian Dr, Muskegon, MI 49440

ADJOURN

# Policy 2.11

| POLICY TITLE: TRAVEL | POLICY # 2.11 | ADAPTED FROM |
|---|---|---|
| **Topic Area:** FINANCE | Page **1** of **4** | **REVIEW DATES** |
| **Applies to:** Lakeshore Regional Entity | **ISSUED BY:** Chief Executive Officer | |
| **Review Cycle:** Annually | **APPROVED BY:** Board of Directors | |
| **Developed and Maintained by:** LRE Chief Financial Officer | | |
| **Supersedes:** N/A | **Effective Date:** | **Revised Date:** |

## I. POLICY

It is the policy of Lakeshore Regional Entity (LRE) that all reasonable expenses for official travel will be reimbursed in accordance with State and Federal laws and the guidelines set forth below. It is recognized that exceptions are on occasion, necessary. Such exceptions shall be approved, in advance, when possible, by the Chief Executive Officer (CEO).

A. All individuals are required to drive their own automobile in the course of their employment. Employees will be reimbursed at IRS Mileage Rate. Mileage will generally be computed from the employee's approved work site and shall be based on the approved GPS methodology. No transportation cost will be allowed between an employee's residence and the approved work site. When an employee originates work at a location other than their approved work site, mileage shall be reimbursed if the difference to the destination is greater than the distance to the approved work site. Reimbursement shall be based on the "lesser rule" in calculating the difference from travel to the approved work site. The approved work site of a Board member is determined to be their home and reimbursement shall be calculated from that starting location. Carpooling when appropriate is expected and only the employee whose personal automobile is utilized for the travel will be reimbursed for mileage.

Examples:

1. Employee's approved work site is LRE office. Employee goes to the LRE Board meeting location from the LRE office, which is 10 miles from the LRE office, and then returns to the LRE office. Employee will receive mileage reimbursement for 20 miles (10 miles from the LRE office to the Board Meeting location plus 10 miles from the Board Meeting location back to the office).
2. Employee's approved work site is LRE office. Employee leaves their home residence and goes to the LRE Board meeting location, which is 20 miles from their residence and 30 miles from the LRE office, then goes to the LRE office and then goes home. Employee will receive mileage reimbursement for 50 miles total (20 miles from the home residence to the Board Meeting location plus 30 miles

from the Board Meeting location back to the office).
3. Employee's approved work site is their home residence for COVID-19 purposes only. Employee leaves their home residence and goes the LRE Board meeting location, which is 20 miles from their residence and 30 miles from the LRE office, and then returns home. Employee will receive mileage reimbursement for 40 miles total (20 miles from the home residence to the Board Meeting location plus 20 miles from the Board Meeting location back to the office).
4. Employee's approved work site is their home residence for COVID-19 purposes only. Employee leaves their home residence and goes the LRE Board meeting location, which is 20 miles from their residence and 10 miles from the LRE office, and then returns home. Employee will receive mileage reimbursement for 20 miles total (10 miles from the LRE office to the Board Meeting location plus 10 miles from the Board Meeting location back to the office).
5. Employee's approved work site is their home residence, per their permanent remote work agreement. Employee leaves their home residence and goes the LRE Board meeting location, which is 100 miles from their residence and 10 miles from the LRE office, goes to the LRE office and returns home, which is 75 miles from the LRE office. Employee will receive mileage reimbursement for 185 miles total (100 miles from the home residence to the Board Meeting location plus 10 miles from the Board Meeting location back to the LRE office plus 75 miles back home).

B. Should employees/interns/Board members/volunteers attend pre-authorized meetings, conference, conventions, or seminars on behalf of LRE, the following shall apply:
   1. Travel by private automobile shall be reimbursed at the IRS mileage rate, provided reimbursement shall not exceed tourist air fare, plus an allowance to and from the airport.
   2. If travel is by common carrier, tourist fare will be reimbursed if receipts have been retained and submitted with the expense report.
   3. Reimbursement for meals plus tip will be allowed while traveling out-of-town to/ from or at the place of any meeting, conference, seminar, or convention at the lesser of the daily amount established by the Internal Revenue Service (IRS) or the daily per diem amount established by the LRE. Detailed receipts are required to be reimbursed (Credit slips not detailing items purchased are not acceptable). Claims for reimbursement of conference expenses (other than mileage) must be supported with adequate documentation (receipts) for reimbursement to be made. Documentation must include proof of payment: detailed credit card statement; original receipt from conference stating amount paid; or copy of personal check with registration documentation.
   4. Tolls will be reimbursed when it is necessary as part of the trip on behalf of LRE; taxi fare is reimbursable only if the trip was made by common carrier.
   5. Parking fees during the conference, convention, seminar, or meeting will be reimbursed if receipts are retained and submitted with the expense report.

6. Lodging costs and incidental expenses for overnight stays outside of the Greater Norton Shores Area or more than 75 miles from the employee's approved work site will be reimbursed for employees who are on LRE business lasting eight or more hours. An exception may be authorized by the Chief Executive Officer or designee. Employees who have a good reason for an exception are required to seek initial approval from their immediate supervisor, who will then forward the request to the CEO (or designee) indicating their rationale for support for an exception.

C. Expense reports shall be submitted to the Chief Financial Officer (CFO) or designee for payment after the appropriate Supervisor approvals and following the convention, conference, seminar, or meeting attended by the employee. A short explanation of each expense must accompany the expense report, along with receipts.

D. Expense Not Reimbursed: LRE does not reimburse expenses which are not pertinent to required travel unless specific advanced approval has been obtained in writing from the CEO and may include but is not limited to.
    1. Mileage from the employee's home to and from approved work site.
    2. Expenses associated with speeding or parking violations.
    3. Alcoholic beverages.

E. Expense submitted greater than 60 days: All reimbursement requests must be submitted within 60 days of the travel expense being incurred. Per the IRS Publication 463, "Travel, Entertainment, Gift, and Car Expenses," employees must adequately account to LRE for travel expenses within a reasonable period of time or the amount may become taxable. A reasonable period of time is defined as adequately accounting for your expenses within 60 days of them being incurred. Any reimbursement requests submitted after 60 days require approval of the Chief Executive Officer.

## II. PURPOSE

LRE recognizes that employees, interns, volunteers, and Board members may be required to travel on behalf of LRE. It is the intent of LRE to provide for the reasonable expenses associated with that travel.

## III. APPLICABILITY AND RESPONSIBILITY

This policy applies to LRE staff, interns, volunteers, and Board members.

## IV. MONITORING AND REVIEW

The Chief Financial Officer, in conjunction with the Chief Executive Officer, will review this policy on an annual basis.

## V. DEFINITIONS

**Airfare**: Cost of "coach" ticket. Employees will be expected to get advance coach tickets whenever possible. Airfare requests must have prior supervisory approval and Executive approval, in which case reimbursements will be granted for distances that would be

unreasonable, impractical or more costly to drive.

**Approved Work Site:** An employee's approved work site is the LRE office located in Norton Shores, MI or as indicated in the position assessment for permanent remote work and employee's remote work agreement (does not include remote work agreements due to COVID-19). Some employees, with variable assignments, may have a daily approved work site assignment, which is defined based on their established work schedule. For the purpose of this policy, the approved work site for Board members or volunteers is the address provided on their employment forms (or home).

**Carpooling:** an arrangement in which a group of people commute together by automobile.

**Common Carrier**: A person or a commercial enterprise that transports passengers or goods for a fee and establishes that their service is open to the general public. Typical examples include railroad, airline, and taxi service.

**Greater Norton Shores Area**: Within 75 miles from the LRE office in Norton Shores, MI

**IRS**: Internal Revenue Service

**Lesser Rule**: When travel from an employee's home to an alternate work location, or from an alternate location to home, transportation expenses must be reimbursed at the current mileage rate using the lesser of 1) Mileage between the employee's home and the alternate work location, or 2) Mileage between the employee's approved work site and the alternate work location.

**Lodging**: Hotel/motel expenses

## VI. RELATED POLICIES AND PROCEDURES

A. LRE Financial Policies and Procedures

## VII. REFERENCE/LEGAL AUTHORITY

A. IRS Mileage Rates: http://www.irs.gov/Tax-Professionals/Standard-Mileage-Rates
B. IRS Publication 463

## VIII. CHANGE LOG

| Date of Change | Description of Change | Responsible Party |
|---|---|---|
| | New | Chief Financial Officer |
| | | |
| | | |
| | | |

LAKESHORE REGIONAL ENTITY

# Lakeshore Regional Entity Board
# Financial Officer Report for February 2022

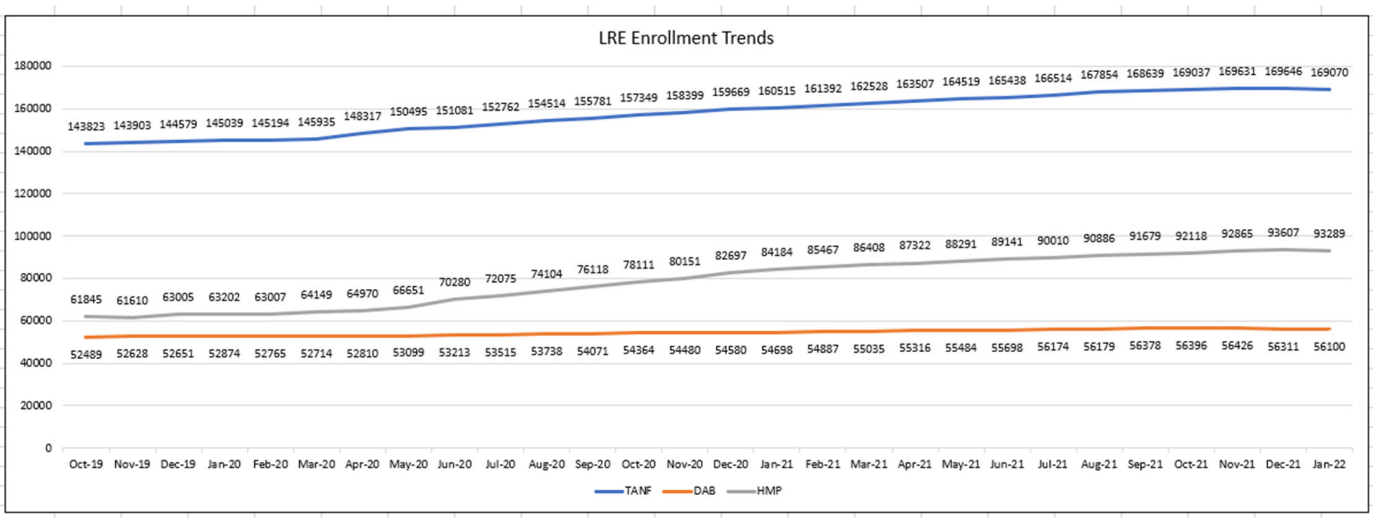
- **Disbursements Report** – A motion is requested to approve the January 2022 disbursements. A summary of those disbursements is included as an attachment.

- **Statement of Activities** – report through December is included as an attachment.

- **Bucket Report –** December 2021 Bucket Report is included as an attachment for today's meeting. Expense projections, as reported by each CMHSP, are noted. COVID has continued to impact spending, service demand, and staffing. An approximate surplus of $4 million regionally (Medicaid and HMP) is shown on this month's report, which does not include $27.3 million in surplus that is being withheld to put into the ISF/Medicaid Savings for FY22. The total regional surplus is projected to be $82.8 million, which includes FY20 ISF and Medicaid Savings of $13 million, budgeted FY21 ISF and Medicaid Savings of $35.7 million and budgeted FY22 ISF and Medicaid Savings of $27.3 million. The projected DCW lapse for the region is $7.2 million. Our region is projecting to receive approximately $18 million in total for DCW in FY22.

- **FY 2022 Revenue Projections** – Updated revenue and membership projections by program and CMHSP are below. This month's revenue projection includes an overall decrease of approximately $582 thousand. The decrease in revenue is primarily due to a decrease in the overall per member per month amount.

- **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 – January 2022. 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).


LRE Enrollment Trends
180000
160000
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143823 143903 144579 145039 145194 145935 148317 150495 151081 152762 154514 155781 157349 158399 159669 160515 161392 162528 163507 164519 165438 166514 167854 168639 169037 169631 169646 169070
61845 61610 63005 63202 63007 64149 64970 66651 70280 72075 74104 76118 78111 80151 82697 84184 85467 86408 87322 88291 89141 90010 90886 91679 92118 92865 93607 93289
52489 52628 52651 52874 52765 52714 52810 53099 53213 53515 53738 54071 54364 54480 54580 54698 54887 55035 55316 55484 55698 56174 56179 56378 56396 56426 56311 56100
Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22
TANF
DAB
HMP

LAKESHORE REGIONAL ENTITY

## FY 2022 Revenue Projection

### Total LRE

| | Budget Projection | Current Projection | Change |
|---|---|---|---|
| MCD - MH | $ 210,718,637 | $ 209,208,311 | $ (1,510,326) |
| MCD - SUD | $ 8,001,719 | $ 8,019,904 | $ 18,185 |
| HMP - MH | $ 29,893,170 | $ 31,706,343 | $ 1,813,173 |
| HMP - SUD | $ 17,253,882 | $ 18,044,048 | $ 790,165 |
| Autism | $ 40,680,921 | $ 41,018,941 | $ 338,020 |
| Waiver | $ 43,041,569 | $ 40,915,471 | $ (2,126,098) |
| LRE / Beacon Admin | $ 13,703,413 | $ 13,737,897 | $ 34,484 |
| ISF | $ 27,975,737 | $ 27,926,269 | $ (49,468) |
| IPA | $ 4,530,922 | $ 4,640,317 | $ 109,395 |
| **Total Region** | **$ 395,799,970** | **$ 395,217,501** | **$ (582,470)** |

### Total CMHSPs

| | Budget Projection | Current Projection | Change |
|---|---|---|---|
| Allegan | $ 31,540,674 | $ 31,201,073 | $ (339,602) |
| Healthwest | $ 67,233,116 | $ 66,984,198 | $ (248,918) |
| Network180 | $ 179,037,751 | $ 179,143,201 | $ 105,450 |
| Ottawa | $ 47,943,777 | $ 48,056,067 | $ 112,290 |
| West Michigan | $ 23,834,580 | $ 23,528,479 | $ (306,101) |
| **Total CMHSPs** | **$ 349,589,898** | **$ 348,913,018** | **$ (676,880)** |

| | Budget Projection | Current Projection | Change |
|---|---|---|---|
| Allegan | $ 100.52 | $ 97.50 | $ (3.02) |
| Healthwest | $ 90.98 | $ 89.02 | $ (1.96) |
| Network180 | $ 92.75 | $ 90.50 | $ (2.25) |
| Ottawa | $ 89.57 | $ 86.78 | $ (2.79) |
| West Michigan | $ 89.62 | $ 87.13 | $ (2.50) |
| **Total CMHSPs** | **$ 92.38** | **$ 90.02** | **$ (2.35)** |

### Member Month Projection

| | Budget Projection | Current Projection | Change |
|---|---|---|---|
| Allegan | 313,775 | 320,022 | 6,246 |
| Healthwest | 739,013 | 752,458 | 13,444 |
| Network180 | 1,930,418 | 1,979,533 | 49,115 |
| Ottawa | 535,257 | 553,778 | 18,521 |
| West Michigan | 265,944 | 270,054 | 4,110 |
| **Total Member Months** | **3,784,409** | **3,875,845** | **91,437** |

### CMHSPs Breakdown

| | Budget Projection | Current Projection | Change |
|---|---|---|---|
| **MCD - MH** | | | |
| Allegan | $ 18,771,464 | $ 18,605,587 | $ (165,877) |
| Healthwest | $ 43,407,881 | $ 43,074,553 | $ (333,328) |
| Network180 | $ 104,964,414 | $ 104,185,901 | $ (778,513) |
| Ottawa | $ 28,142,172 | $ 28,094,952 | $ (47,220) |
| West Michigan | $ 15,432,707 | $ 15,247,318 | $ (185,389) |
| **Total MCD - MH** | **$ 210,718,637** | **$ 209,208,311** | **$ (1,510,326)** |
| **MCD - SUD** | | | |
| Allegan | $ 657,600 | $ 656,525 | $ (1,074) |
| Healthwest | $ 1,728,516 | $ 1,726,126 | $ (2,390) |
| Network180 | $ 4,015,409 | $ 4,017,498 | $ 2,089 |
| Ottawa | $ 987,793 | $ 1,010,553 | $ 22,760 |
| West Michigan | $ 612,402 | $ 609,203 | $ (3,199) |
| **Total MCD - SUD** | **$ 8,001,719** | **$ 8,019,904** | **$ 18,185** |
| **HMP - MH** | | | |
| Allegan | $ 2,279,184 | $ 2,423,030 | $ 143,845 |
| Healthwest | $ 6,109,782 | $ 6,398,995 | $ 289,212 |
| Network180 | $ 15,209,606 | $ 16,159,692 | $ 950,086 |
| Ottawa | $ 4,121,180 | $ 4,448,702 | $ 327,521 |
| West Michigan | $ 2,173,416 | $ 2,275,925 | $ 102,509 |
| **Total HMP - MH** | **$ 29,893,170** | **$ 31,706,343** | **$ 1,813,173** |
| **HMP - SUD** | | | |
| Allegan | $ 1,297,699 | $ 1,363,308 | $ 65,609 |
| Healthwest | $ 3,634,023 | $ 3,757,887 | $ 123,863 |
| Network180 | $ 8,776,141 | $ 9,199,354 | $ 423,212 |
| Ottawa | $ 2,280,070 | $ 2,414,743 | $ 134,673 |
| West Michigan | $ 1,265,948 | $ 1,308,756 | $ 42,807 |
| **Total HMP - SUD** | **$ 17,253,882** | **$ 18,044,048** | **$ 790,165** |
| **Autism** | | | |
| Allegan | $ 3,372,448 | $ 3,400,470 | $ 28,022 |
| Healthwest | $ 2,717,486 | $ 2,740,065 | $ 22,580 |
| Network180 | $ 27,361,988 | $ 27,589,340 | $ 227,352 |
| Ottawa | $ 6,045,185 | $ 6,095,415 | $ 50,230 |
| West Michigan | $ 1,183,815 | $ 1,193,651 | $ 9,836 |
| **Total Autism** | **$ 40,680,921** | **$ 41,018,941** | **$ 338,020** |
| **Waiver** | | | |
| Allegan | $ 5,162,279 | $ 4,752,152 | $ (410,127) |
| Healthwest | $ 9,635,429 | $ 9,286,573 | $ (348,856) |
| Network180 | $ 18,710,193 | $ 17,991,417 | $ (718,775) |
| Ottawa | $ 6,367,378 | $ 5,991,703 | $ (375,674) |
| West Michigan | $ 3,166,291 | $ 2,893,626 | $ (272,666) |
| **Total Waiver** | **$ 43,041,569** | **$ 40,915,471** | **$ (2,126,098)** |

LAKESHORE REGIONAL ENTITY

**BOARD ACTION REQUEST**

**Subject : January 2022 Disbursements**

Meeting Date: February 17, 2021

**RECOMMENDED MOTION:**

To approve the January 2022 disbursements of $32,450,914.90 as presented.

**SUMMARY OF REQUEST/INFORMATION:**

| **Disbursements:** | |
|---|---|
| Allegan County CMH | $2,741,648.52 |
| Healthwest | $6,724,106.69 |
| Network 180 | $14,100,210.81 |
| Ottawa County CMH | $3,940,541.17 |
| West Michigan CMH | $2,236,951.88 |
| SUD Prevention Expenses | $226,766.91 |
| Local Match Payment | $996,595.20 |
| Hospital Reimbursement Adjuster (HRA) | $0.00 |
| SUD Public Act 2 (PA2) | $49,672.88 |
| Beacon Health Options | $957,837.26 |
| Administrative Expenses | $476,583.58 |
| **Total:** | **$32,450,914.90** |

95.57% 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:**

| | |
|---|---|
| $ | 27,530,237.54 |
| | $4,920,677.36 |
| | 17.87% |
| | |
| | $0.00 |
| | $0.00 |
| | $0.00 |
| | |
| | $29,743,459.07 |
| | $22,770,810.50 |
| | |
| | $6,972,648.57 |
| | 131% |
| | |
| | $6,972,648.57 |
| | -$2,051,971.21 |

Allegan County CMH
Healthwest
Network 180
Ottawa County CMH
West Michigan CMH

95.57%

Last month total
Change since last month

Quarterly Hospital Reimbursement Adjuster (HRA) Payment

Current Month Member Payments
Last Month Member Payments

CHANGE SINCE LAST MONTH

9%
23%
47%
13%
8%

Update from 2nd tab - ALSO UPDATE WORDING, AS NEEDED TO REMOVE HRA, TAXES, ETC.

LAKESHORE REGIONAL ENTITY

# Statement of Activities - Actual vs. Budget
## Fiscal Year 2021/2022
As of Date:12/31/21

| Change in Net Assets | Year Ending 12/31/2021 | 12/31/2021 | | |
|---|---|---|---|---|
| | FY22 Budget *Initial* | Budget to Date | Actual | Actual to Budget Variance |
| **Operating Revenues** | | | | |
| SUD Block Grant & State Opioid | 8,484,553 | 2,121,138 | 756,018 | (1,365,120) |
| Autism Revenue | 45,558,628 | 11,389,657 | 11,592,516 | 202,859 |
| PA 2 Liquor Tax | 4,199,550 | 1,049,888 | - | (1,049,888) |
| Interest Revenue | 21,476 | 5,369 | 21,083 | 15,714 |
| Peformance Bonus Incentive | 2,419,516 | 604,879 | - | (604,879) |
| Local Match Revenue (Members) | 2,040,096 | 510,024 | 340,016 | (170,008) |
| Hospital Rate Adjuster (HRA) | 10,377,547 | 2,594,387 | - | (2,594,387) |
| MH Block Grant - Veterans Navigator | 100,000 | 25,000 | 26,792 | 1,792 |
| Block Grants - HispBH/NatAm/TobCess/Clubhouse | 540,800 | 135,200 | 34,113 | (101,087) |
| Substance Use Gambling, MI Youth Tx & | 397,335 | 99,334 | 17,642 | (81,691) |
| DHS Incentive | 693,363 | 173,341 | - | (173,341) |
| Medicaid, HSW, SED, & Children's Waive | 288,842,209 | 72,210,552 | 74,928,216 | 2,717,664 |
| Healthy Michigan | 47,083,555 | 11,770,889 | 10,282,063 | (1,488,826) |
| CCBHC Supplemental Revenue | 0 | 0 | 2,348,207 | 2,348,207 |
| **Total Operating Revenues** | **410,758,628** | **102,689,657** | **100,346,667** | **(2,342,990)** |
| **Expenditures** | | | | |
| Salaries and Fringes | 3,132,587 | 783,147 | 568,908 | (214,239) |
| Office and Supplies Expense | 259,630 | 64,908 | 114,066 | 49,159 |
| Contractual and Consulting Expenses | 490,495 | 122,624 | 171,645 | 49,021 |
| MCIS | 305,200 | 76,300 | 73,800 | (2,500) |
| Data Analytics | 173,750 | 43,438 | 31,250 | (12,188) |
| Utilities/Conferences/Mileage/Misc Exps | 4,357,154 | 1,089,289 | 63,727 | (1,025,561) |
| Block Grants - Gambl/Veter/HispBH/NatAm/TobCes | 1,005,800 | 251,450 | 81,372 | (170,078) |
| Taxes, HRA, and Local Match | 15,765,596 | 3,941,399 | 1,293,588 | (2,647,811) |
| Prevention Expenses | 2,744,632 | 686,158 | 653,035 | (33,123) |
| Beacon Health Options - MCO Contract | 5,252,384 | 1,313,096 | 957,837 | (355,259) |
| Contribution to ISF/Savings | 27,337,724 | 6,834,431 | - | (6,834,431) |
| Direct Care Wage Lapse | 0 | 0 | - | - |
| Member Payments | 349,933,676 | 87,483,419 | 81,840,691 | (5,642,728) |
| **Total Expenditures** | **410,758,628** | **102,689,657** | **85,849,919** | **(16,839,738)** |
| **Total Change in Net Assets** | **0** | **0** | **14,496,748** | **14,496,748** |

LAKESHORE REGIONAL ENTITY

# Statement of Activities
# Budget to Actual Variance Report

**For the Period ending December 31, 2021**

**As of Date: 12/31/21**

## Operating Revenues

| | |
|---|---|
| SUD Block Grant | Grant revenues not received for December yet. |
| Autism Revenue | N/A - Closely aligned with the current budget projections. |
| PA 2 Liquor Tax | PA2 revenues are received after the Department of Treasury issues payments to the counties. Initial payments were made to counties in April and counties began to make payments to the LRE in May. |
| Interest Revenue | Actual interest revenue is coming in higher than anticipated. Will be adjusting in FY22 Amend 1. |
| Peformance Bonus Incentive | Revenue is received after the end of the fiscal year if health plan performance metrics are met. |
| Local Match Revenue (Members) | Only paid quarterly |
| Hospital Rate Adjuster (HRA) | Revenue is received quarterly. First quarter payment is expected in January. |
| MH Block Grant - Veterans Navigator | N/A - Closely aligned with the current budget projections. |
| Block Grants -HispBH/NatAm/TobCess/Clubhse | Grant revenues not received for December yet. |
| Sub Use Gambling Prev & MYTIE | Grant revenues not received for December yet. |
| DHS Incentive | Receive this revenue quarterly beginning in April. Amounts are based on encounter data that supports services to Foster Care and CPS children. |
| Medicaid B, B3 and HSW | Will be adjusting FY22 Amend 1. |
| Healthy Michigan | Will be adjusting FY22 Amend 1. |
| CCBHC Supplemental Revenue | Will be adjusting FY22 Amend 1. |

## Expenditures

| | |
|---|---|
| Salaries and Fringes | A significant portion of the additional salary expenses will not likely occur until after first quarter. Fringe expense adjustments will be made in FY22 Amend 1. |
| Office and Supplies Expense | Will be adjusting FY22 Amend 1. |
| Contractual & Consulting Expenses | Will be adjusting FY22 Amend 1. |
| MCIS | N/A - Closely aligned with the current budget projections. |
| Data Analytics | It is expected that the final expenses will align with the budget projections. |
| Utilities/Conf/Mleage/Misc Exps | Significant portions of this line item (Audit, Travel, Miscellaneous) are not anticipated until quarters three and four. This line item also includes the Beacon contract savings amounts which will be detailed during quarter three. |
| Block Grants -Veterans/HispBH/NatAm/TobCess | Most of these payments are billed to the LRE and paid by MDHHS 30-60 days in arrears. |
| Taxes, HRA and Local Match | IPA taxes and HRA are paid quarterly. |
| Prevention Expenses | Prevention expenses not yet fully received for December. |
| Beacon Health Options | It is expected that the final expenses will align with the budget projections. |
| Contribution to ISF | Not yet recorded |
| DCW Lapse | Actual lapse will be determined at year end. Projections not yet made for FY22. |
| Member Payments | Member payments are based on actual revenues received from MDHHS. CCBHC caused a delay in actual member payments in the first quarter. |

LAKESHORE REGIONAL ENTITY

Attachment 15

# FY2022 December Bucket Report - Full Year Projections

## Net Position By Member, By Fund Source

| Time Period | Mental Health (MH) Allegan | Healthwest | Network180 | Ottawa | West MI | LRE & MCO Admin | Total | Substance Use Disorder (SUD) Allegan | Healthwest | Network180 | Ottawa | West MI | LRE & MCO Admin | Total | MH & SUD Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Oct - December** | | | | | | | | | | | | | | | |
| Net Med: 1115/HSW/CW/SED | 1,201,466 | 1,603,547 | (1,176,556) | 1,099,576 | 380,687 | 628,633 | 3,737,353 | 607,169 | (142,319) | (812,170) | (42,956) | - | 113,879 | (276,397) | 3,460,956 |
| Net Med: HealthyMI | (129,348) | (335,919) | (2,060,630) | (70,521) | (341,679) | (103,749) | (3,041,846) | 1,208,826 | (283,218) | (1,422,438) | (145,939) | - | 166,906 | (475,863) | (3,517,709) |
| Net Autism | (348,182) | (768,097) | (5,427,046) | (764,793) | (153,801) | 50,568 | (7,411,351) | - | - | - | - | - | - | - | (7,411,351) |
| Net General Fund | (194,261) | - | 483,483 | 140,099 | (155,948) | - | 273,373 | - | - | - | - | - | - | - | 273,373 |
| Net Block Grant | - | - | - | - | - | - | - | 228,435 | (22,451) | - | (129,166) | - | 66,740 | 143,558 | 143,558 |
| Net PA2 | - | - | - | - | - | - | - | - | - | - | (10,659) | - | - | (10,659) | (10,659) |
| Net Medicaid Savings Proje | 448,154 | 1,048,406 | 2,472,308 | 685,287 | 359,789 | | 5,013,944 | 30,465 | 83,682 | 198,919 | 50,514 | 29,079 | | 392,658 | 5,406,603 |
| Net ISF Projection | 587,494 | 1,347,257 | 1,057,252 | 894,103 | 459,757 | - | 4,345,863 | 161,588 | 438,623 | 1,057,099 | 274,017 | 153,436 | - | 2,084,764 | 6,430,627 |
| Subtotal | 1,565,324 | 2,895,193 | (4,651,189) | 1,983,752 | 548,805 | 575,452 | 2,917,336 | 2,236,483 | 74,317 | (978,590) | (4,189) | 182,515 | 347,526 | 1,858,062 | 4,775,398 |
| **December** Full Year Projection | | | | | | | | | | | | | | | |
| Net Med: 1115/HSW/CW/SED | (224,137) | (1,243,206) | (10,762,128) | (872,443) | (779,182) | - | (13,881,096) | 238,097 | 637,768 | 768,818 | 115,515 | 69,792 | - | 1,829,991 | (12,051,105) |
| Net Med: DCW Lapse | 504,901 | (1,867,963) | (2,426,715) | (2,508,951) | (606,410) | - | (6,905,138) | - | (70,486) | (295,088) | - | - | - | (365,574) | (7,270,711) |
| Net Med: HealthyMI | 323,773 | 1,141,025 | (859,616) | 1,234,982 | 105,436 | - | 1,945,600 | 803,538 | 2,485,215 | 3,509,602 | 666,360 | 471,830 | - | 7,936,545 | 9,882,145 |
| Net Autism | 300,479 | (332,325) | 5,881,156 | 392,015 | (45,485) | - | 6,195,840 | - | - | - | - | - | - | - | 6,195,840 |
| Net General Fund | 433,626 | - | 1,441,195 | 82,876 | - | - | 1,957,697 | - | - | - | - | - | - | - | 1,957,697 |
| Net Block Grant | - | - | - | - | - | - | - | (343,534) | 621,395 | - | - | 165,633 | - | 443,494 | 443,494 |
| Net PA2 | - | - | - | - | - | - | - | - | 2,224 | - | - | 74,964 | - | 77,188 | 77,188 |
| Net Medicaid Savings Proje | 632,194 | 1,256,218 | 2,969,272 | 823,975 | 120,105 | | 5,801,764 | (36,453) | 99,991 | 238,033 | 60,576 | 348,125 | | 710,273 | 6,512,038 |
| Net ISF Projection | 2,349,978 | 5,389,027 | 12,687,059 | 3,576,413 | 1,839,028 | - | 25,841,505 | 161,588 | 438,623 | 1,057,099 | 274,017 | 153,436 | - | 2,084,764 | 27,926,269 |
| Total | 4,320,814 | 4,342,778 | 8,930,223 | 2,728,866 | 633,493 | - | 20,956,173 | 823,236 | 4,214,731 | 5,278,464 | 1,116,469 | 1,283,781 | - | 12,716,681 | 33,672,854 |
| Risk excluding DCW | 400,115 | (434,505) | (5,740,588) | 754,554 | (719,231) | - | (5,739,655) | 1,041,635 | 3,122,983 | 4,278,420 | 781,875 | 541,623 | - | 9,766,536 | 4,026,880 |
| %of Budget | 1.37% | -0.71% | -3.46% | 1.69% | -3.33% | 0.00% | -1.82% | 51.57% | 56.95% | 32.37% | 22.83% | 28.24% | 0.00% | 35.51% | *PENDING* |

**FY Changes in Projected Med/HMP Spending**

| | November 2021 MH | December 2021 MH | Difference | %of Budget | FY21 Spend | *Not Final FY21 Figures |
|---|---|---|---|---|---|---|
| Allegan | | 27,001,429 | 27,001,429 | 98.54% | 25,469,646 | |
| Healthwest | | 58,140,065 | 58,140,065 | 100.75% | 55,025,900 | |
| N180 | | 163,098,056 | 163,098,056 | 103.65% | 155,094,698 | |
| Ottawa | | 41,367,267 | 41,367,267 | 98.21% | 32,981,495 | |
| West MI | | 20,973,341 | 20,973,341 | 103.55% | 20,272,938 | |
| LRE & Beacon | | 9,993,664 | 9,993,664 | 100.00% | 9,391,031 | |
| | 294,193,478 | 320,573,822 | **320,573,822** | | **298,235,708** | |

| | November 2021 SUI | December 2021 SUD | Difference | %of Budget | FY21 Spend | *Not Final FY21 Figures |
|---|---|---|---|---|---|---|
| Allegan | | 978,198 | 978,198 | 48.43% | 1,586,665 | |
| Healthwest | | 2,361,030 | 2,361,030 | 43.05% | 4,079,154 | |
| N180 | | 8,938,432 | 8,938,432 | 67.63% | 8,098,231 | |
| Ottawa | | 2,643,421 | 2,643,421 | 77.17% | 1,850,758 | |
| West MI | | 1,376,336 | 1,376,336 | 71.76% | 1,342,753 | |
| LRE & Beacon | | 1,436,420 | 1,436,420 | 100.00% | 1,720,794 | |
| | 17,534,851 | 17,733,838 | **17,733,838** | | **18,678,355** | |

| | |
|---|---|
| Total Medicaid Surplus/(Deficit) Projection (Med 1115/HSW/CW/SED + Autism), Excluding DCW | (5,855,265) |
| Actual FY20 ISF | 2,420,925 |
| Actual FY20 Medicaid Savings | 10,625,499 |
| Budgeted FY21 ISF/Medicaid Savings Contribution | 35,733,826 |
| Budgeted FY21 ISF/Medicaid Savings Contribution | 27,337,724 |
| Total Reserves: | 76,117,974 |
| Projected Medicaid ISF/Savings At Year End: | 70,262,710 |
| Healthy Michigan Plan Surplus/(Deficit) Projection | 9,882,145 |
| Projected MDHHS Performance Bonus | 2,726,969 |
| Projected Reserve Total At Year End: | 82,871,824 |

| | |
|---|---|
| ISF @ 7.5% | $ 27,819,506.61 |
| Savings @ 7.5% | $ 27,819,506.61 |
| Total Max Allowed | $ 55,639,013.23 |