Attachment 1

Meeting Agenda
BOARD OF DIRECTORS
Lakeshore Regional Entity
December 15, 2022 – 1:00 PM
GVSU Muskegon Innovation Hub
200 Viridian Dr, Muskegon, MI 49440

1. Welcome and Introductions –
   - Mr. Richard Kanten (Representing OCCMH)
2. Roll Call/Conflict of Interest Question –
3. Public Comment (Limited to agenda items only)
4. Consent Items:
   Suggested Motion: To approve by consent the following items.
   - December 15, 2022, Board of Directors meeting agenda *(Attachment 1)*
   - November 17, 2022, Board of Directors meeting minutes *(Attachment 2)*

5. Closed Session
   Suggested Motion: To approve moving into a closed work session for the purpose of discussing legal strategies with LRE legal counsel regarding pending LRE legal cases

6. Community Advisory Panel (Previously Consumer Advisory Panel) *(Attachment 3)*
   Suggested Motion: To approve membership of Ms. Angie Kartes, Ms. Jennifer Larabee and Ms. Tamara Madison to the LRE Consumer Advisory Panel

7. Reports –
   a. LRE Leadership *(Attachment 4, 5, 6)*

8. Chairperson's Report – Mr. DeYoung
   a. December 7, 2022, Executive Committee *(Attachment 7)*

9. Reminder: LRE Board Meeting Schedule Change *(Attachment 8)*
10. Action Items –
    a. LRE Policies *(Attachment 9)*
       Suggested Motion: To approve LRE Policies:
       i. 1.3 Policy Promulgation
       ii. 4.4 Credentialing/Recredentialing
       iii. 4.7 Provider Dispute Resolution
       iv. Board Governance Policies:
           - 10.2 Committees
           - 10.4 Board Governance
           - 10.5 Code of Conduct
           - 10.12 Budget

- 10.13 Communication and Counsel
- 10.17 Management Delegation
- 10.19 Monitoring CEO Performance

b. LRE Mission and Vision Statement *(Attachment 10, 11)*
Suggested Motion: to approve the 2023 LRE Mission and Values statement as presented

c. LRE 2023 Corporate Compliance Plan *(Attachment 12)*
Suggested Motion: To approve the LRE 2023 Corporate Compliance as presented

d. LRE 2023 Risk Management Strategy *(Attachment 13)*
Suggested Motion: To approve the LRE 2023 Risk Management Strategy as presented

11. Financial Report and Funding Distribution – Ms. Chick *(Attachment 14)*
    a. FY2023, November Funds Distribution *(Attachment 15)*
    Suggested Motion: To approve the FY2023, November Funds Distribution as presented
    b. Statement of Activities as of 10/31/2022 with Variance Reports *(Attachment 16)*
    c. Bucket Report (*Attachment 17) –*

12. CEO Report – Ms. Marlatt-Dumas
13. Board Member Comments
14. Public Comment
15. Upcoming LRE Meetings
    - January 18, 2022 – LRE Executive Committee, 3:00 PM
    - January 25, 2022 – LRE Executive Board Meeting, 1:00 PM
16. Adjourn

LAKESHORE REGIONAL ENTITY

Meeting Minutes
BOARD OF DIRECTORS
Lakeshore Regional Entity
November 17, 2022 – 1:00 PM
GVSU Muskegon Innovation Hub, 200 Viridian Dr, Muskegon, MI 49440

WELCOME AND INTRODUCTIONS – Mr. DeYoung
Mr. DeYoung called the November 17, 2022, LRE Board meeting to order at 1:04 PM.

ROLL CALL/CONFLICT OF INTEREST QUESTION – Mr. DeYoung
In Attendance: Ron Bacon, Mark DeYoung, Matt Fenske, Linda Garzelloni, Sara Hogan, John Snider, Janet Thomas, Jane Verduin

Virtual Non-Exempt: Jack Greenfield, Alice Kelsey
Absent: Dawn Rodgers-DeFouw, Patricia Gardner, Ron Sanders, Stan Stek

PUBLIC COMMENT
None.

CONSENT ITEMS:
LRE 22-75 Motion: To approve by consent the following items.

- November 17, 2022, Board of Directors meeting agenda
- October 20, 2022, Board of Directors meeting minutes

Moved: Matt Fenske Support: John Snider
ROLL CALL VOTE
MOTION CARRIED

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

CHAIRPERSON'S REPORT
November 9, 2022, Executive Committee Meeting Minutes are included in packet for information.

ACTION ITEMS
LRE 22-76 Motion: To approve LRE Policies #

a. Medicaid Grievance and Appeals/Due Process
   This policy has been vetted by the CS ROAT and Operations Committee.

Moved: Ron Bacon Support: Janet Thomas
ROLL CALL VOTE
MOTION CARRIED

FINANCIAL REPORT AND FUNDING DISTRIBUTION

FY2022 September Funds Distribution

LRE 22-77 Motion: To approve the FY2022, October Funds Distribution as presented

Moved: Matt Fenske Support: John Snider
ROLL CALL VOTE
MOTION CARRIED

Statement of Activities as of 9/30/2022 with Variance Report-

Included in the Board packet for information.

- Ms. Chick notes that these are very preliminary reports and will not be complete until February when the final FSR is due.
- There is a separate reconciliation process for CCBHC, and we have not yet received the final reconciliation template. PIHPs are expecting to receive this on Monday. There is also a reconciliation between the PIHP and the state. This is also very preliminary until we receive the template.
- Amount in the ISF will not be known until February when we complete the year end FSR.
- LRE reports MC and HMP funds separate to the State although this revenue is not separated when sent to the CMHs. We have not seen a drop in enrollment as the public health emergency (PHE) is not yet suspended. The PHE has been extended until April 2023.

Member Bucket Reports-

Included in the Board packet for information.

- Ms. Chick notes that this is also a preliminary report as the CMHs have not yet closed their books for FY22.
- Does not include funds held for ISF or the $10.4 million lapse of DCW. Ms. Chick reports that at this point we are not projecting to have the Internal Services Fund (ISF), or MC savings fully funded or to lapse any funds back to the State.

CEO REPORT

Included in the Board packet for information.

- Dec action continues to move forward. December 2 is the due date for LRE to respond. LRE will ask for input from the Muskegon legal and Derek Miller. HW will also submit documentation for LRE to support the Dec action.
- LRE is working with N180 to find a mediation organization.
- LRE has been working with Wakely Actuarial firm. They are reviewing rates and completing an analysis of the regional ISF.
- N180 to have a presentation for LRE Board regarding the Kent County pilot program.

BOARD MEMBER COMMENTS

None.

PUBLIC COMMENT

None.

UPCOMING LRE MEETINGS

- December 7, 2022 – LRE Executive Committee, 3:00 PM
- December 8, 2022 – LRE Consumer Advisory Panel, 1:00 PM
- December 15, 2022 – LRE Executive Board Meeting, 1:00 PM

ADJOURN

Mr. DeYoung adjourned the November 17, 2022, LRE Board of Directors meeting at 1:46 PM.

Jane Verduin, Board Secretary

Minutes respectfully submitted by:
Marion Dyga, Executive Assistant

LAKESHORE REGIONAL ENTITY

CONSUMER ADVISORY PANEL MEETING NOTES

Thursday, December 8, 2022 – 1:00 PM to 3:00 PM

Virtual Teams Meeting or Call in

Present: Lynette B., John M., Sharon H., Lucinda S.
New Members: Jennifer L., Angie K., Tamara M.
CMH Staff: Sam Potter (N180), Cathy Potter (OnPoint), Anna Bednarek (Ottawa), Kelly Betts (HW), Erika Eldredge (WM), Rachel Overkamp
LRE Staff: Stephanie VanDerKooi, Michelle Aguiano, Mari Hesselink, Jim McCormick

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

2. New CAP Members
   Motion: To approve membership of Ms. Angie Kartes, Ms. Jennifer Larabee to the LRE Consumer Advisory Panel and to recommend to the full LRE Board to approve membership

   Moved: Lynette B. Support: Sharon H.
   MOTION CARRIED
   Unanimous

   Motion: To approve membership of Ms. Tamara Madison to the LRE Consumer Advisory Panel and to recommend to the full LRE Board to approve membership

   Moved: John M. Support: Sharon H.
   MOTION CARRIED
   Unanimous

3. Member Stories – Limit 5 minutes
    a. Member Experiences
       John had just started on the ACT for OnPoint during the last CAP meeting. He has completed the ACT training that shows how the team functions within the community and with the individuals that are using the services.
4. LRE Staff Members
    i. Don Avery and Jim McCormick – Provider Network Manager

Jim is a provider network manager for LRE. He is responsible for assuring oversight of the provider network including the CMHs and their provider network.

- Care Pathway for Inpatient Psych Feedback
  This is a project that LRE would like to have individuals that have lived experience review for feedback. Over the last year LRE has been implementing value-based contracts with inpatient hospitals. Although the CMHs hold those contracts the LRE negotiates rates for those services. Historically there has been an issue contracting with hospitals for these services. Previously the region has paid a flat fee per day. LRE would now like to move to having payment be tied to the quality of services not the number of days. This will shift away from quantity and will focus on quality of care. The belief is that if quality of care is better it will lessen the amount of time needed to stay in IP care which will save money.

  A care pathway is a decision tree that has measurable goals and standards, promotes evidence-based treatment, promotes coordination of care with and across the entire continuum, reduces confusion and variation, duplication and waste, supports efficiency and predictability and improves consumer satisfaction.

  Feedback:
  - There is a significant difference in care when individuals have MC versus private insurance. Quality of care is much better with private insurance.
  - During pretreatment and discharge there should be the right for self-determination and person-centered planning. These were not discussed during intake or discharge.
  - There are not enough beds available, and this is why people end up in the ER.
  - There are also roadblocks to having private insurance versus MC. There are services that are not available to private insurance individuals that are available for MC recipients.
  - While in IP there was a poor discharge planning and no follow-up.

  Action: Put back on the next agenda. If you have any additional information, contact Jim McCormick – jimm@lsre.org or Don Avery – dona@lsre.org

5. Consumer Advisory Panel

i. Rebranding of CAP Follow-up
   - The group had discussed renaming the Consumer Advisory Panel. The group has unanimously agreed on changing the name to Community Advisory Panel.

ii. CAP Brochure
   - This is being developed by LRE CS staff. The brochure will give information on who CAP is and what is done within the group.

iii. CAP Newsletter
   - The newsletter will be information gathered from individuals from the CAP group and the community. Mari will reach out to ask for feedback regarding content of the newsletter. Could show writings or artwork, what items are going on within the communities etc. Suggestions:
     - Information on how to apply for membership on CAP
     - Legislative information for lobbying etc.
     - Highlighted success stories of individuals in services
     - Available Training –
       - CIT
       - Smart911 (https://www.smart911.com/)

   - If there are any suggestions please submit ideas to Mari – marih@lsre.org, Michelle – michellea@lsre.org, or Marion – mariond@lsre.org

6. LRE Updates
   i. LRE Staffing Update
      - LRE has hired additional 2 financial analysis staff.
   ii. LRE Refresh Update
      - LRE has changed the color scheme and font of the organizational logo. Along with this the LRE website has been revamped to be more visibly attractive and user friendly. The logo and website will be launched at the same time and is currently on track to unveil prior to next week's Board meeting. Stephanie will go through the new website during the next CAP meeting.

   iii. LRE Board Meetings 2023 Schedule Change
      - Beginning January 2023, the LRE Board meetings will schedule will change from the 3rd Thursday of the month to the 4th Wednesday of the month. The meeting time has not changed and will Board meetings will still begin at 1:00 PM.

7. Regional Updates –
    i. LRE Strategic Planning Update
        - This vision and values statement will be brought to the LRE Board for approval in December. Stephanie will continue to work with KWB Strategies to complete the strategic plan.

    ii. MDHHS/LRE Settlement Agreement Update/Dec Action
        - The Dec action is moving forward, and we continue to work on the past liabilities for the CMHs.

8. State Updates –
    i. Shirkey Bills 597 and 598/Lame Duck Session
        - This was not taken to vote as there was not anything to attach it to.

9. LRE Board Meeting
   December 15, 2022 – LRE Board Meeting
   GVSU Muskegon Innovation Hub, 200 Viridian Dr, Muskegon, MI 49440
   Call-in information will be posted on the LRE website
10. Upcoming CAP Meetings for **2023** (2nd Thursday of every third month [Quarterly] - 1:00 pm to 3:00 pm)
    March 9, June 8, September 14, December 14

11. Other:
    - Tamara comments that she enjoyed the discussion items.

FUTURE AGENDA ITEMS

LAKESHORE REGIONAL ENTITY

Chief Operating Officer (Stephanie VanDerKooi)
December 15, 2022 - Report to the Board of Directors

Oversight Policy Board (OPB)- The Intergovernmental Agreement will expire December 31, 2022. This agreement is between the seven counties served in Region 3 and establishes the purpose and membership of the OPB. New agreements, that will be in effect 1/1/23 – 12/31/24, have been distributed to all county administrators. Currently, three have been returned.

Waiver Trainings: LRE was able to host two trainings with MDHHS staff. On December 7th Angelo Powell and Tammy Sattelberg from the Children's Coordinated Health Policy and Supports Bureau provided a Series Emotional Disturbance Wavier (SEDW) 101 training to more than 60 regional staff. On December 8th Angelo Powell, Emilia Brook, and Terri Nekoogar from Home and Community Based Services Policy & Implementation Section presented a Children's Waiver Program (CWP) 101 training to more than 75 individuals. MDHHS also announced they will be hosting a Waiver conference during this Fiscal Year after a three-year hiatus.

CCBHC (Certified Community Behavioral Health Center) – Meetings between the state and PIHPs are ongoing. The LRE hosts regional meetings with HealthWest and West Michigan CMH to ensure this project is operating smoothly.

Current CCBHC enrollments:
WMCMH: assigned in November: Medicaid: 209 and non-Medicaid 96
HW: assigned in November: Medicaid 27, non-Medicaid 14;

Website: The redesigned LRE website (www.lsre.org) is scheduled for launch on December 15. The website is more visually appealing, and the team has endeavored to make the site more user-friendly and easier to locate information.

November Report Submission Analysis:
In November, MDHHS sent a one-time request for a report on ACT/IDDT Teams. MDHHS had outdated LRE contacts, and the request was missed by the staff who need to complete this report. MDHHS has been provided updated contact information for this type of report request, and the report was completed the same day the appropriate LRE Staff was notified of the request.

TOTAL NUMBER OF NOVEMBER 2022 REPORTS 47	
Number of Late Reports	2
% Late reports	2%
Average Number of Days Late	3

Report Name	Report Type	Days Late	Reason
ACT/IDDT Team Survey	One time request	3	Late submission of report due to LRE staff missing email request for this one-time report. MDHHS had the incorrect LRE staff contact for this request, which has been updated.

AUTISM SERVICES/ Behavioral Health Treatment (BHT) – Justin Persoon

Over the past month, the Autism team continued to focus on finding solutions to provider staffing difficulties. ABA documents are complete and will be trained through Autism ROAT. Guidance from the Department on providing ABA services during school is being interpreted along with reporting requirements when WSA reporting sunsets next quarter. The team spent a significant time this month processing ABA service enrollments and discharges and providing technical assistance to CMHSPs.

Current Enrollments (Regional Total: 1,713)

CMHOC	HealthWest	Network 180	On Point	WMCMHS
281	149	1,112	129	42

CLINICAL/UM – Liz Totten

During the month of November, the UM/Clinical Department began to prepare for FY23 goals and projects identified in the Provider Focus Groups. With support and direction from the LRE, Regional UM Departments and all applicable staff prepared to shift to Continued Stay Review Criteria MCG 26th edition by completing training in two behavioral health modules within the MCG training system. The go-live date for the 26th edition is January 1, 2023.

The Michigan Legislature passed Public Act 658(8) of 2018, which requires the State of Michigan to implement a state-wide psychiatric bed registry with the support of a Psychiatric Bed Registry Advisory Committee. MiCARE will be used to fulfill the legislative requirements. All psychiatric facilities are required to provide bed availability on a basis as close to real time as possible. Our regions CMHSP's will utilize OPEN BEDS Platform to submit requests for admission to multiple providers and to track the status of these requests. OPEN BEDS Onboarding for Lakeshore region began early November and is still underway. LRE UM/Clinical Departments continues to work with the MiCare and CMHSPs to ensure a smooth onboarding process for all.

INTEGRATED HEALTHCARE – Tom Rocheleau

In November 2022, monthly joint care coordination meetings continue to take place with each of the six Medicaid Health Plans that serve the LRE region. In November, 44 consumers were discussed with their respective MHPs related to their potential or continued benefit from having an interactive care plan within the State's claims database, CC360, and subsequently improving the care they receive and their quality of life, removing barriers, and decreasing unnecessary utilization of crisis services. There were 9 consumers discussed with their MHPs, wherein an interactive care plan was not created, but joint collaboration took place resulting in a Single Episode of Care (SEC). In addition, 3 new interactive care plans were opened in November.

CUSTOMER SERVICES– Michelle Anguiano & Mari Hesselink

Please see the attached year-end report.

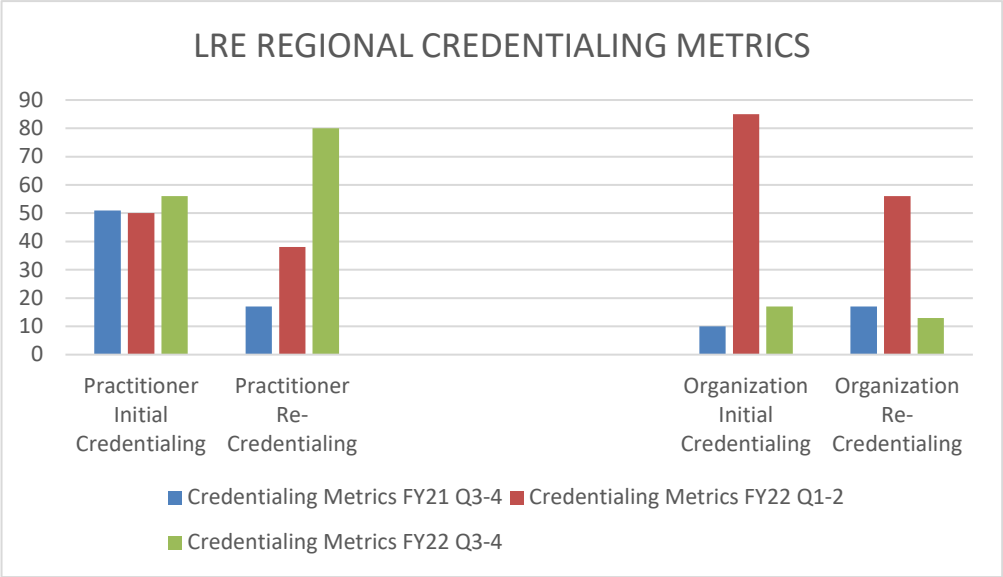
CREDENTIALING - Pam Bronson (Credentialing Specialist):

In November, the Credentialing Committee reviewed and approved eight organizational providers for credentialing/re-credentialing. The Universal Credentialing workgroup continues

to view live demonstrations of the CRM system and iron out details. MDHHS is anticipating a roll out of the new system possibly as early as April 2023.

Work is underway with LRE IT to compare providers receiving payment to the list of providers that have been credentialed; several providers were found that need to be credentialed. This has been instrumental in ensuring there is an accurate list of regional credentialed providers.

The Universal Credentialing Spreadsheet was submitted to MDHHS on November 15 (covering FY22 Q3 & Q4). Below is a cumulative graph of submissions made to MDHHS to date.



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

Provider Network has updated the Provider Common Contract to align with current PIHP/CMHSP contract requirements. The draft contract is now the CMHSP provider network staff to issue amendments. PNM recently presented two topics at the Improving Outcomes Conference in Grand Rapids.

- A joint presentation with NMRE and CentraWellness focusing on Network Adequacy Reporting..
- A presentation focused on LRE's development and implementation of value based agreements with two local inpatient psychiatric hospitals.

Both presentations were well attended and generated a great deal of discussion.

SUD TREATMENT - Amanda Tarantowski, SUD Treatment Manager

A charter for the SUD Rate group was developed. Women's Specialty Service (WSS) audits are complete. FY23 contract amendments were executed in November. Significant work was completed to prepare for the MDHHS audit for SUD Treatment. The final report from MDHHS is pending

SUD/GAMBLING PREVENTION – Amy Embury

Save the Date -Gambling Disorder Symposium - March is Problem Gambling Awareness Month. Michigan's 15th Annual Gambling Disorder Symposium will be held at Suburban Collection Showplace in Novi on March 13th. More details can be found at: Conferences & Training • CMHAM - Community Mental Health Association of Michigan

TalkSooner

Several members of the LRE regional core team for TalkSooner will be at the Kids & Family Expo @ Devos Place on January 28th to share the message of TalkSooner. Kids & Family Expo (devosplace.org)

SUD Prevention

TheTobacco Sales Regional Analysis for the LRE region completed by Refocus, LLC is attached to this report

The Michigan Legislature has appropriated a total of $3 million dollars for the Marihuana Operation and Oversight Grants. The grants, which are available to Michigan counties, will be approved by the Department of Licensing and Regulatory Affairs, Cannabis Regulatory Agency for education, communication, and outreach regarding the Michigan Medical Marihuana Act, 2008 IL, MCL 333.26421 to 333.26430 and the Michigan Regulation and Taxation of Marihuana Act, 2018, IL 1, MCL 333.27951 to 333.27967. Grants provided under this section must not be used for law enforcement purposes. Grant Information (michigan.gov)

The amount of funds available to each county are posted on the Cannabis Regulatory Agency website County Allocations FY2023 (michigan.gov)

The potential grant amounts available are calculated based on the proportion of the number of registry identification cards issued or renewed in the county as of September 30, 2022.

The chart below reflects funding available to counties in the Lakeshore Region for the past several years. This funding is distributed through the county level and Prevention Providers throughout the LRE have been available to help provide planning, programming, and technical assistance.

County:	Funding Available FY 20:	Funding Available FY 21:	Funding Available FY 22:	Funding Available FY 23:
Allegan	$55,109	$64,494	$67,685	$61,534
Kent	$93,678	$97,687	$106,065	$95,745
Lake	$3,147	$3,185	$2,933	$2,425
Mason	$7,101	$4,940	$5,145	$4,465
Muskegon	$34,837	$35,178	$35,116	$34,135
Oceana	$14,815	$16,435	$13,043	$11,507
Ottawa	$37,148	$37,694	$40,544	$38,637

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

Habilitation Supports Waiver (HSW)

Following is a chart of overdue recertifications and guardian consents. Recertifications are due annually and guardian consents are due every three years.

	CMHOC	HW	N180	ONPPOINT	WMCMHS
Overdue Certifications	1	0	9	0	3
Overdue Guardian Consents	2	2	0	5	2
Inactive Consumers		1	2	2	

Region 3 filled open slots in November with 3 clients from Network 180 and 1 from CMHOC. There are currently no open slots for December enrollment. We have 10 complete packets and 10 packets that are pending due to goals, objectives, or other updates needed to required documents. Following is a chart of slot utilization in region 3.

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

Reminder that the enrollment deadline is always the 15th of the month. If the LRE is not notified of a disenrollment right away, we could miss the deadline for the month and therefore the payment while we have people waiting to be enrolled. For example, if we have a death in December and we don't find out about it until June we have missed out on 5 months of payments.

The public health emergency was extended in October for another 3 months. This puts the expiration of the appendix K flexibilities out into the summer of 2023.

Children's Waiver Program (CWP)

83 children are open and enrolled in the Children's Waiver Program for November. There are four children, all from Kent County, who have been invited to enroll on the Children's waiver. A One prescreen was submitted in November by Network 180. MDHHS has indicated that they again using the weighing list as all additional slots have been filled. There are currently three prescreens from Region 3 on the weighing list (Ottawa, On Point, and Network 180) and have not yet been invited to join the CWP. The 3 prescreens that are on the weighing list were all submitted in October.

	CMHOC	HealthWest	Network 180	On Point	WMCMHS
# Enrolled	11	7	61	3	1

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

MDHHS Updates:

- MDHHS's deadline extension request was approved on 9/30/22. This extends the deadline for iSPA compliance to 10/1/2023. It is expected that all iSPA cases are enrolled in the WSA by that date.
- The final Policy Bulletin was released on 11/1, but has not yet been updated in MPM. MDHHS is hoping policy updates will be in the MPM by April.

- As of 10/1/22 all regions in the state should be actively enrolling existing and incoming eligible iSPA Cases.
    - Cases do not need to be enrolled if the service is already covered under another waiver, EPSDT if under 21, or the CCBHC.
    - MDHHS is understaffed in this department, so approved cases in the WSA is slow. We currently have 120+ cases waiting in the MDHHS queue for approval. A new analyst should be starting in January to assist with this.

Regional Updates:

- The Regional iSPA Workgroup has been meeting monthly with representation from each CMHSP (also attend regular statewide meetings).
- CMHSPs are working on identifying cases to be enrolled through their EHRs, and ensuring they have appropriate staff to assist with entering cases.
- There were additional WSA Operational Trainings held in late November and December which many of the new iSPA users from our Region attended.
- The MDHHS iSPA Specialist, Monica Erickson, will be attending our Regional iSPA meeting in February to offer region specific Technical Assistance and to answer any questions we may have related to the iSPA.

SEDW (Series Emotional Disturbance Waiver):

- There are currently have 70 open cases.
    - Allegan – 3
    - HealthWest – 14
    - Network180 – 35
    - Ottawa – 15
    - West MI – 3

LAKESHORE
REGIONAL ENTITY

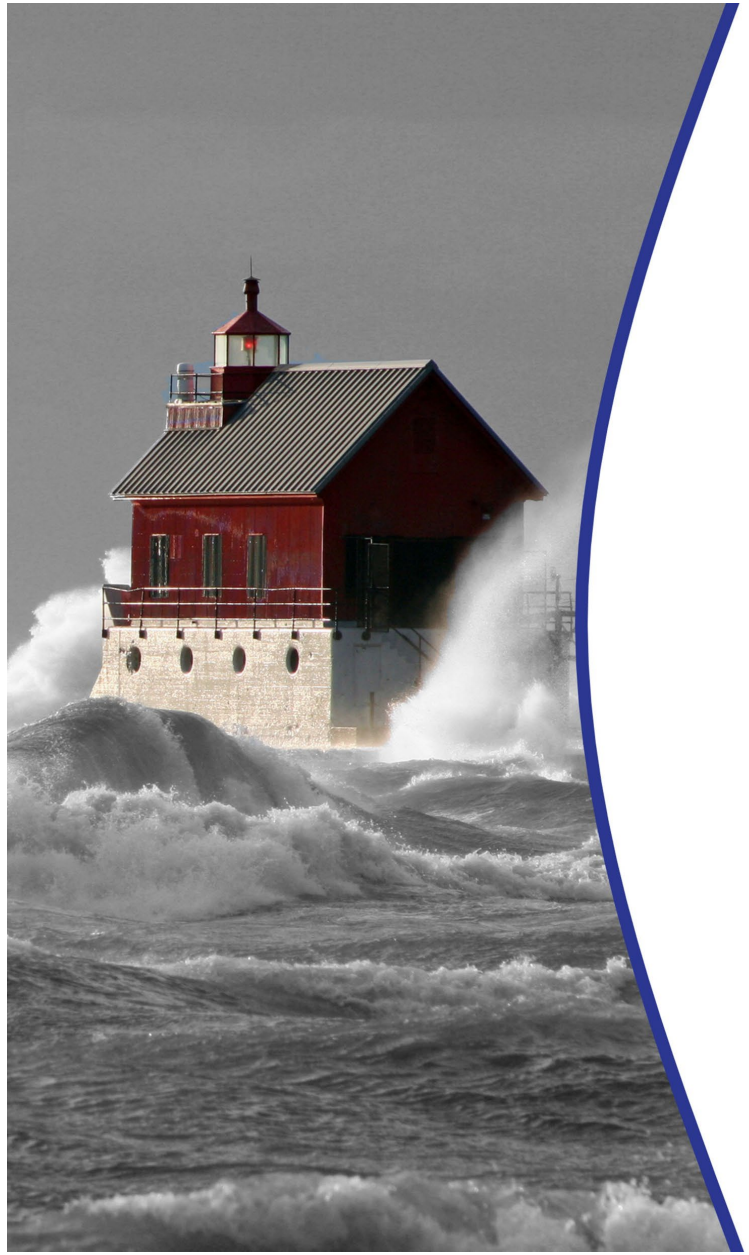
Customer Services

FY22 Annual Review

LAKESHORE REGIONAL ENTITY

Agenda

1. Grievance Data
2. Appeals and State Fair Hearing Data
3. Customer Service Phone Calls
4. Customer Satisfaction Survey
5. Goals for 2023

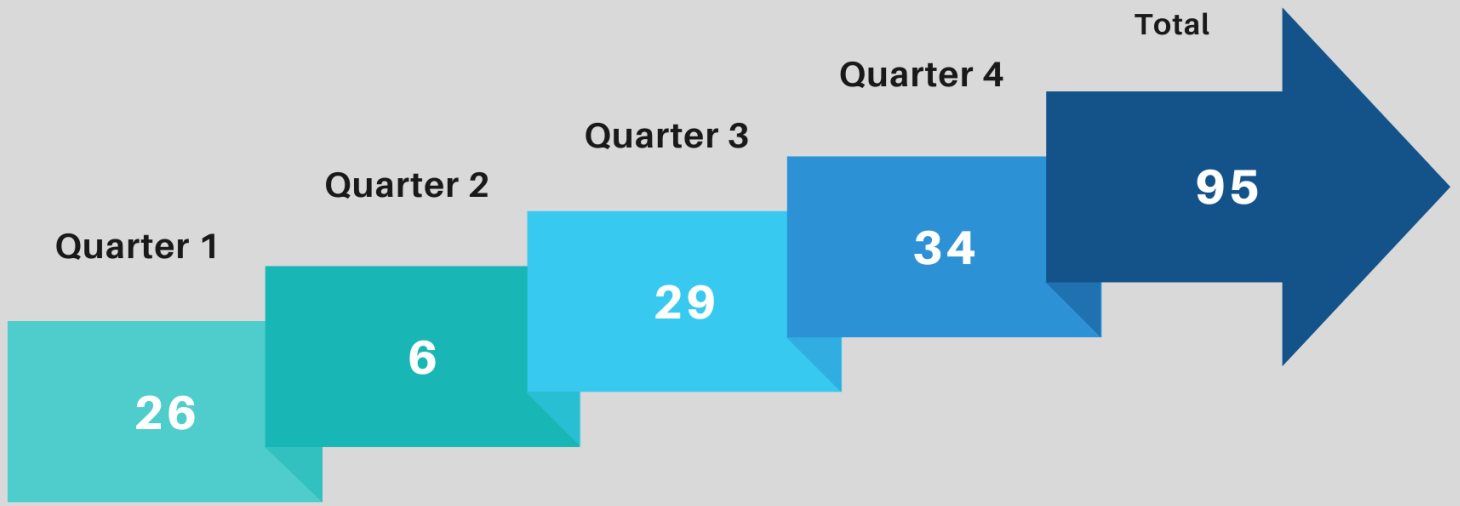


Customer **Services** Transition

The **Lakeshore Regional Entity** transitioned customer services from Beacon in April 2022. Since that time:

- CS ROAT has met monthly to enhance the regional connection with customer services staff.
- Customer Satisfaction Survey has created a workgroup to review the survey and the regional process.
- The LRE Consumer Advisory Panel has doubled in size.

Grievances: 10/1/21-10/1/22



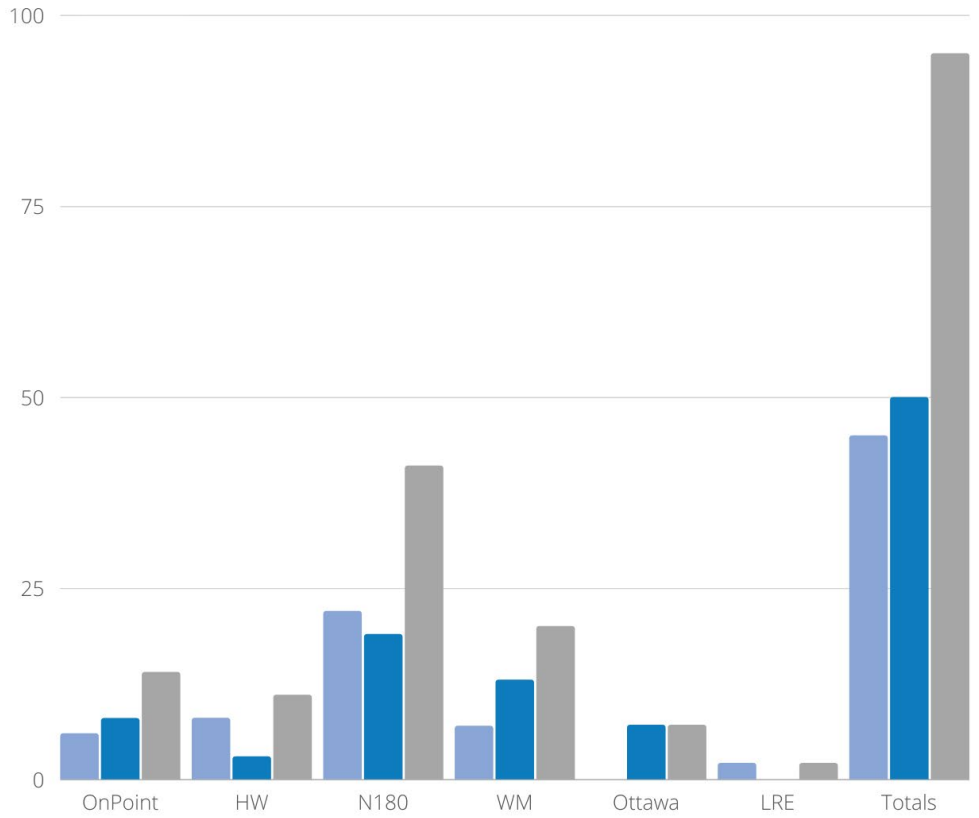
LAKESHORE REGIONAL ENTITY

Grievances by CMHSP

Substantiated
The preponderance of evidence supports the complaint occurred.

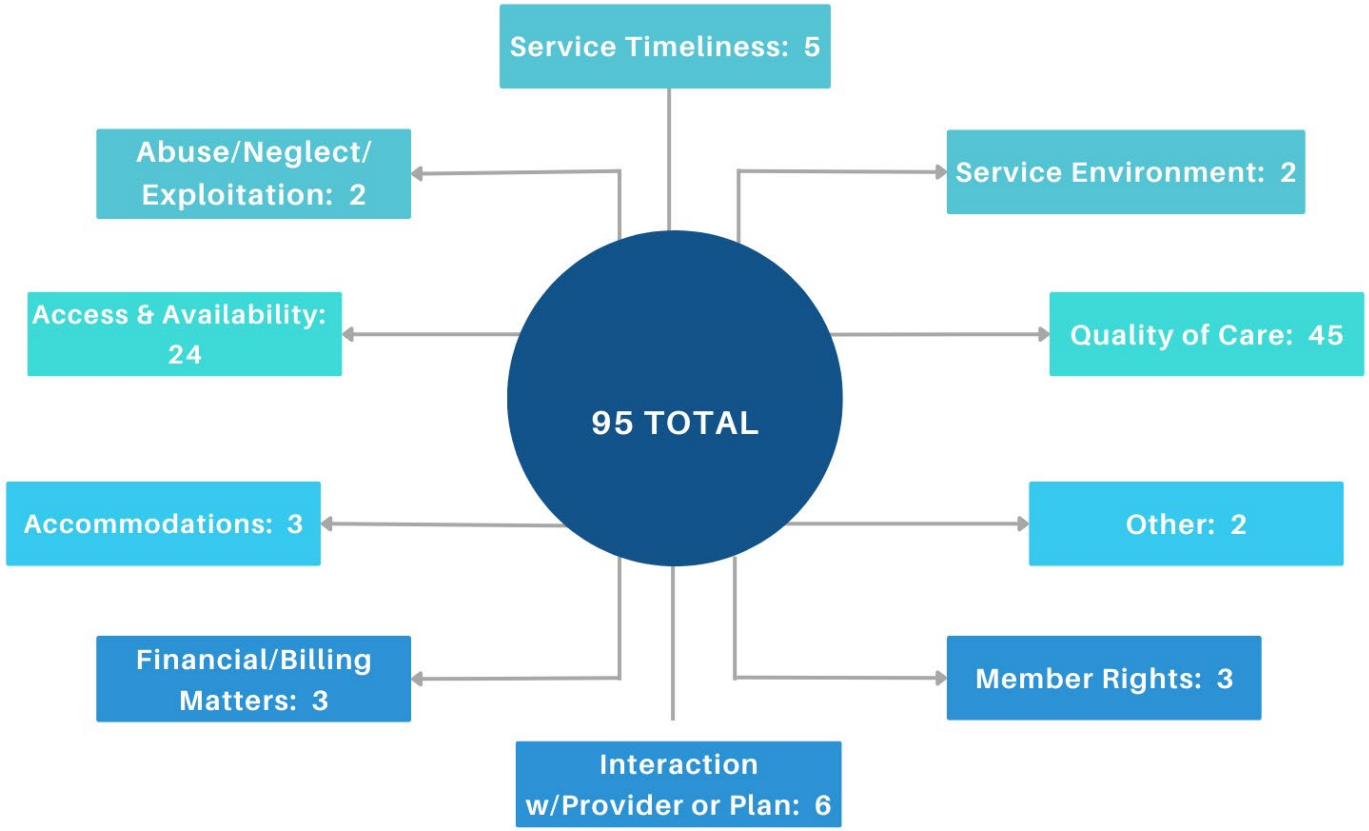
Unsubstantiated
The preponderance of evidence does NOT support the complaint occurred.

Totals
Total number of Grievances at each CMHSP.



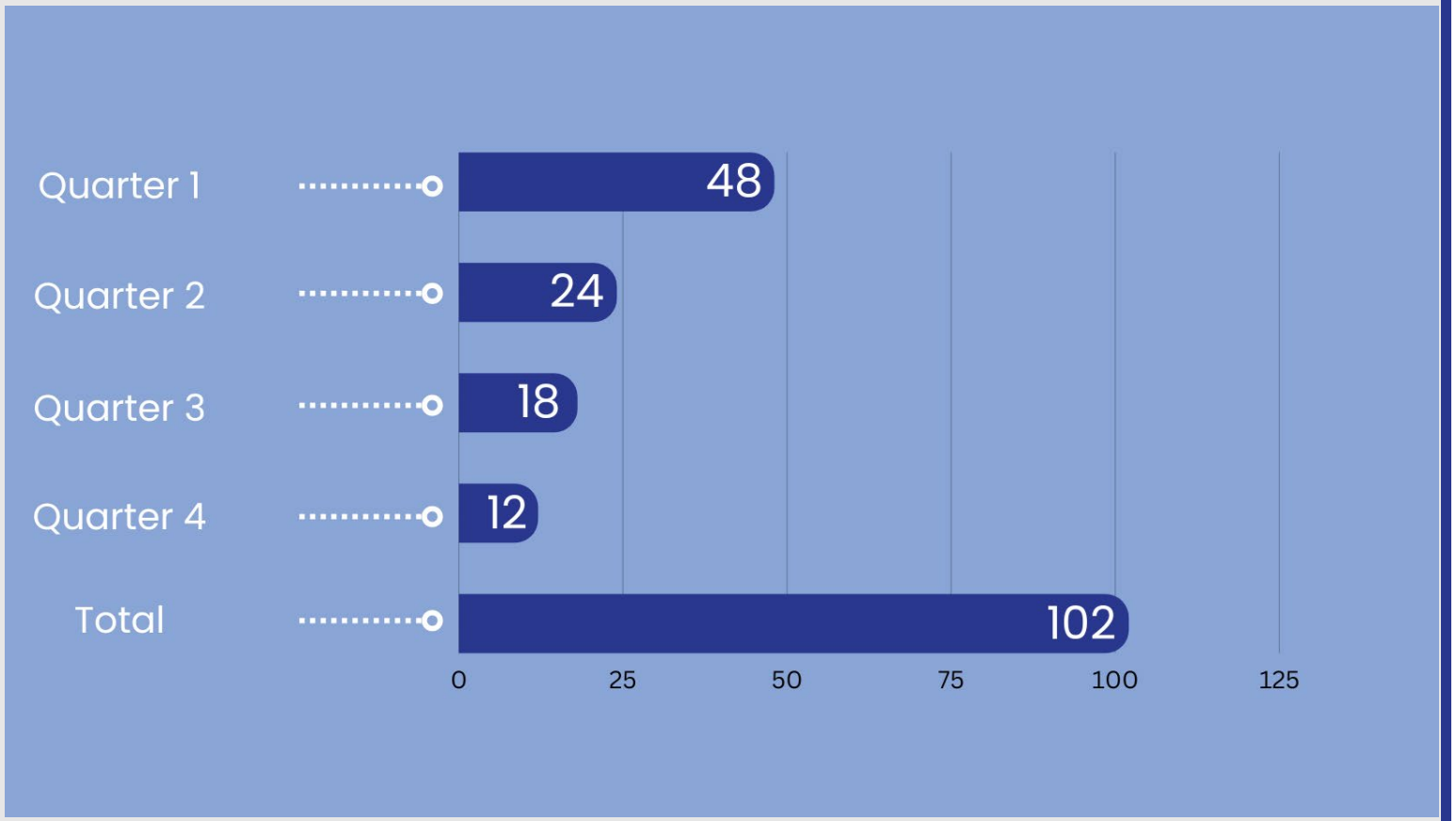
LAKESHORE REGIONAL ENTITY

Grievances by Category

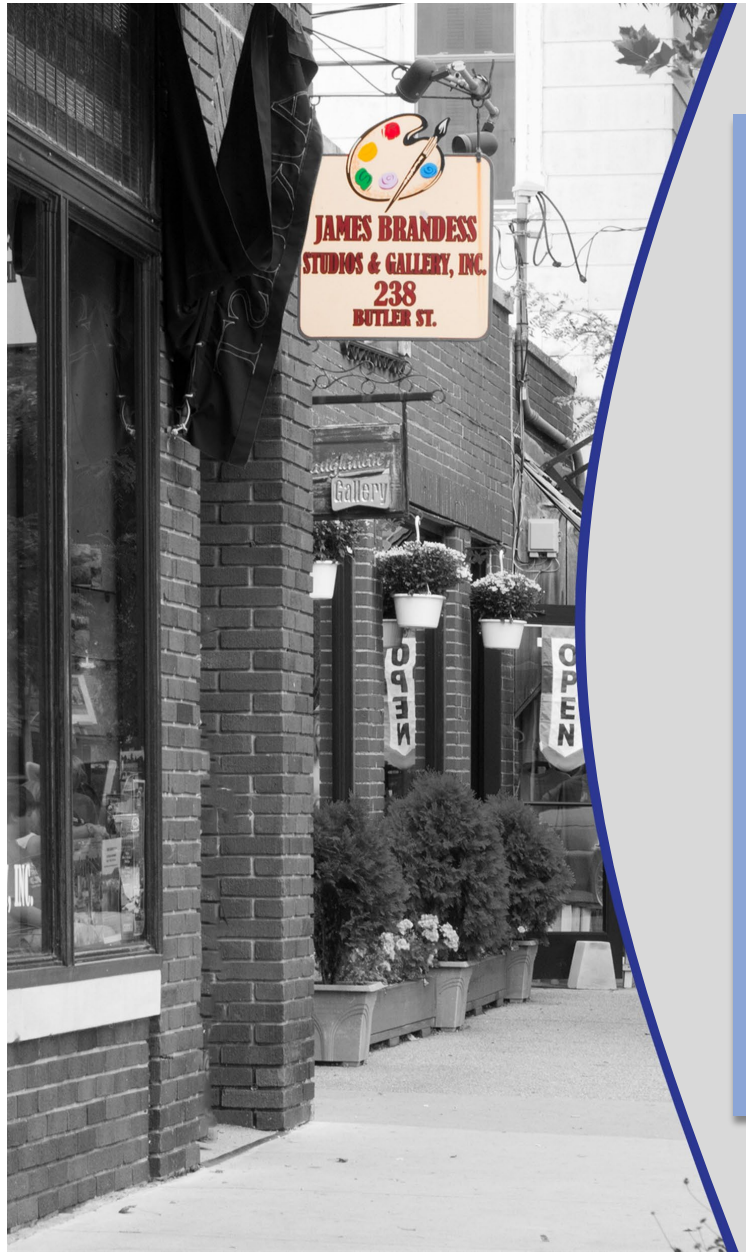


LAKESHORE REGIONAL ENTITY

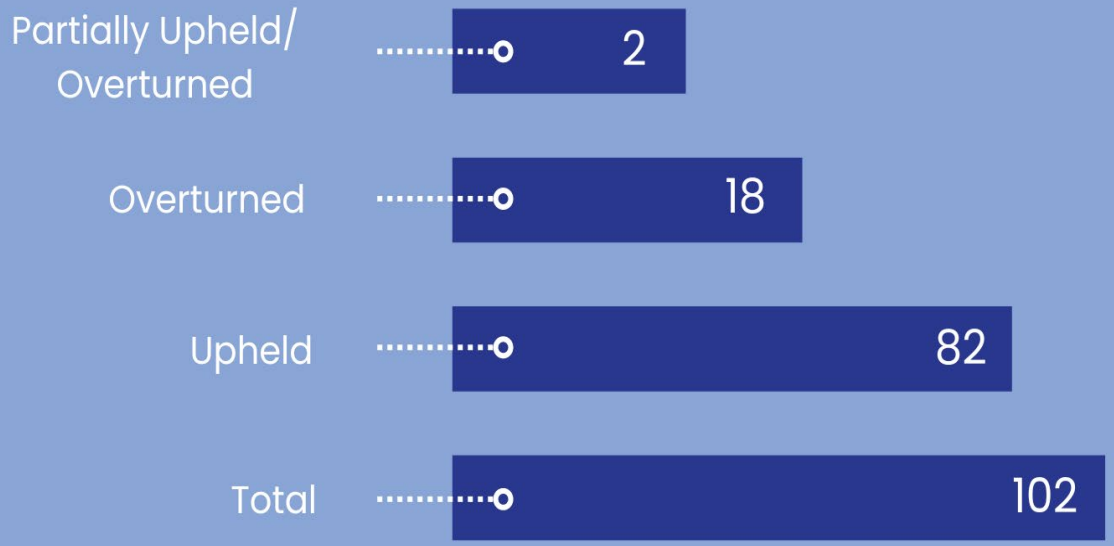
Appeals: 10/1/21-10/1/22



LAKESHORE REGIONAL ENTITY



Appeals by Decision



LAKESHORE REGIONAL ENTITY

Appeals by CMHSP

OnPoint: 2

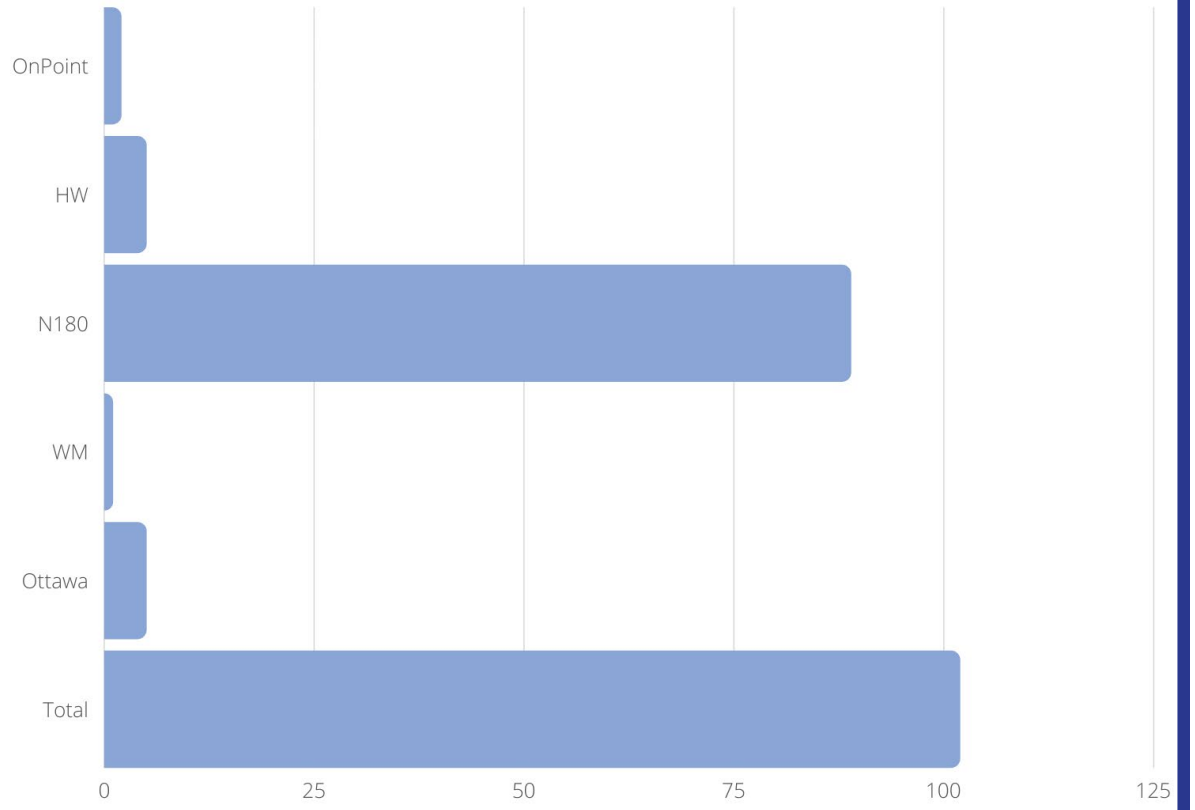
HW: 5

N180: 89

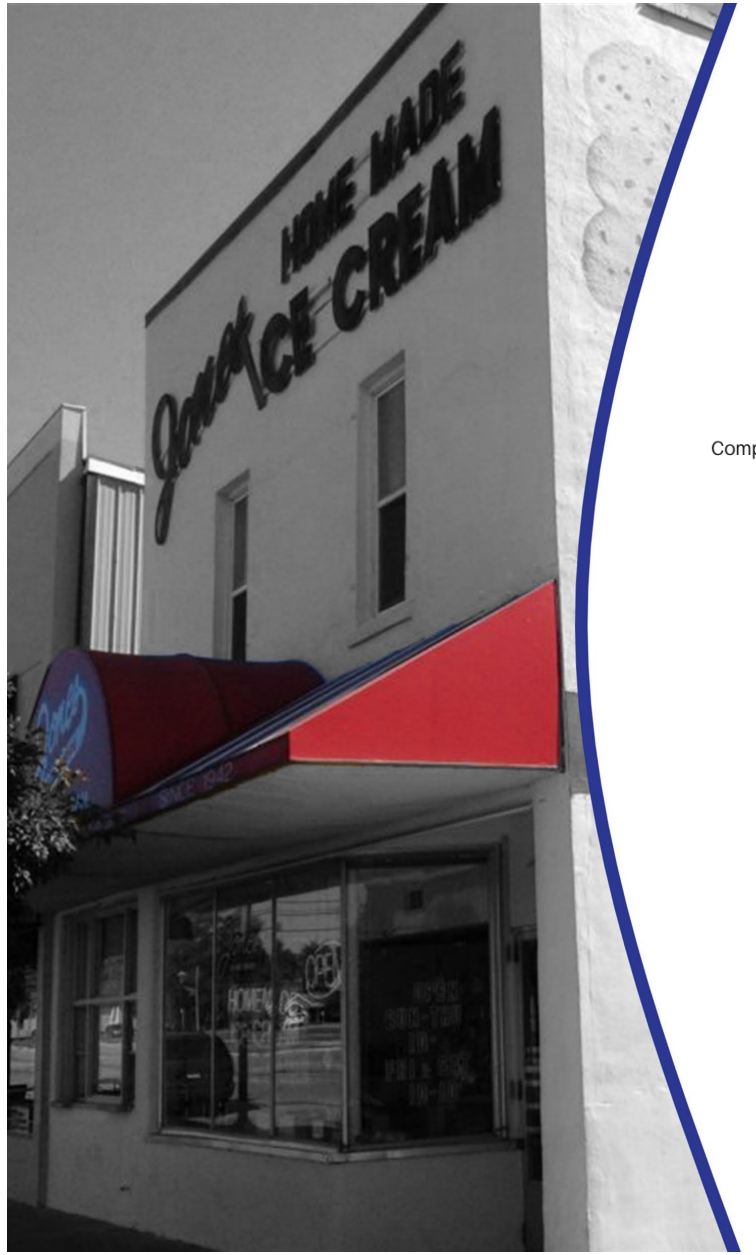
WM: 1

Ottawa: 5

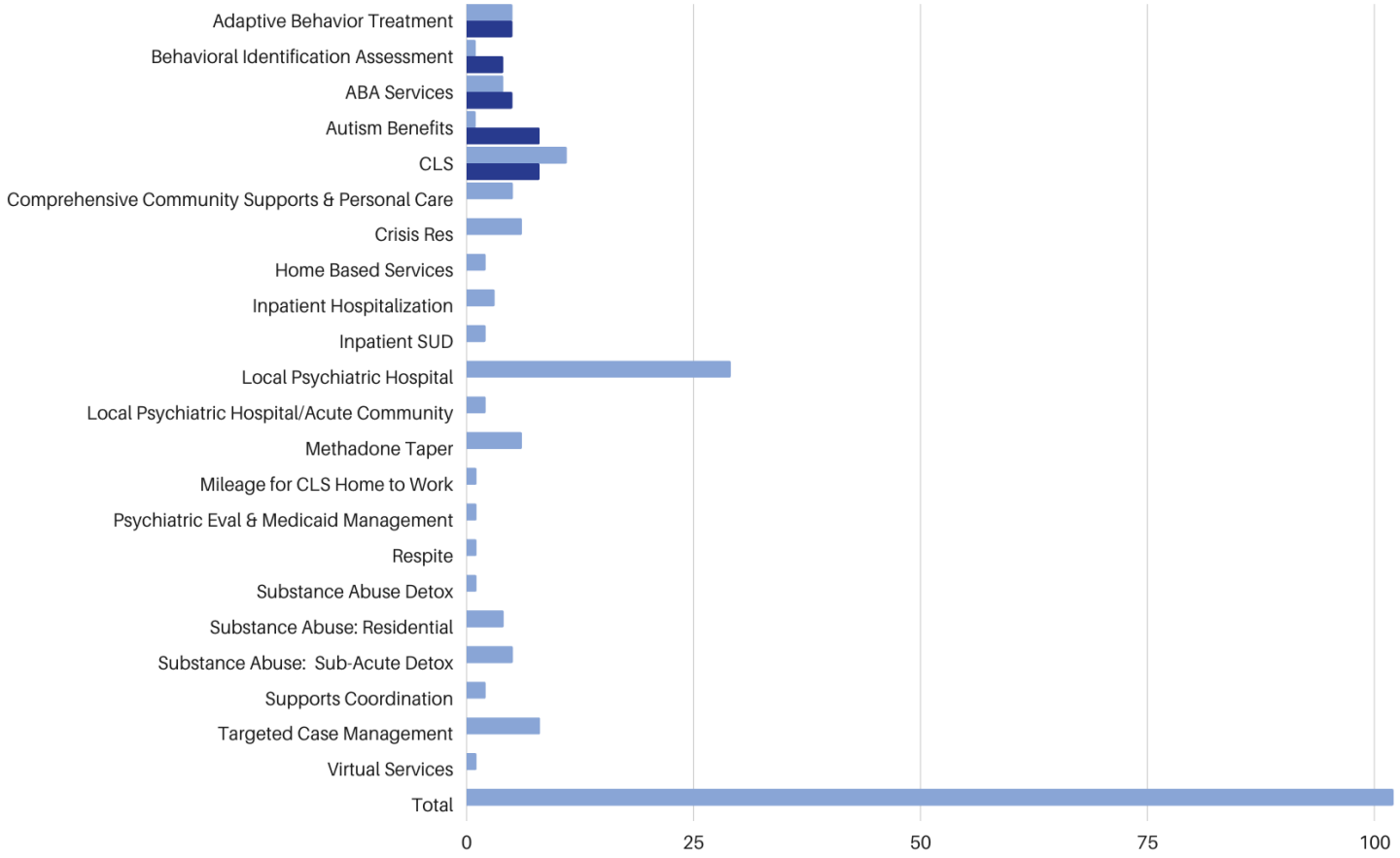
Totals: 102



LAKESHORE REGIONAL ENTITY



Appeals by Service

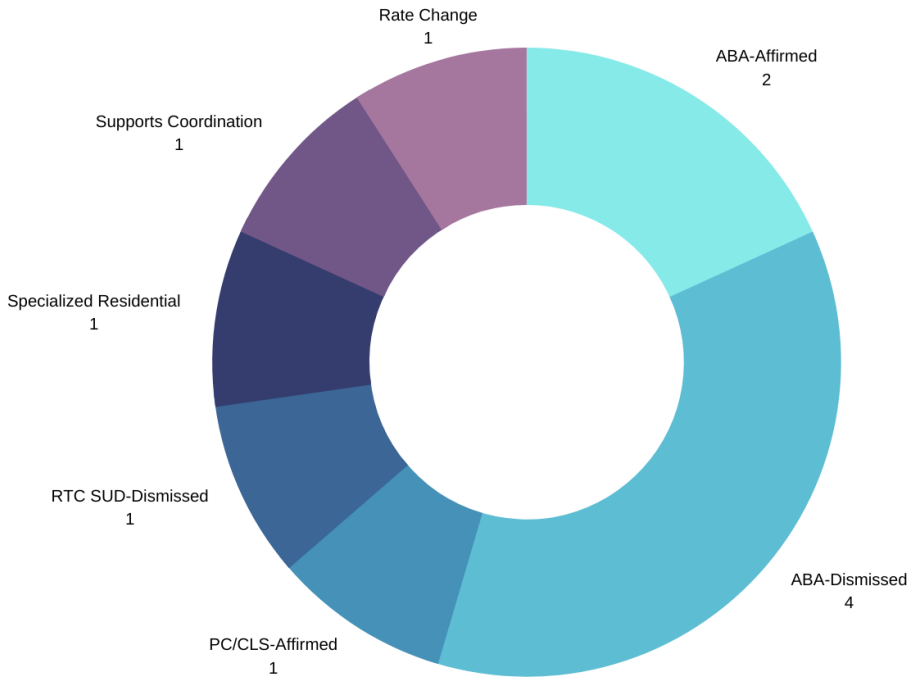


LAKESHORE REGIONAL ENTITY

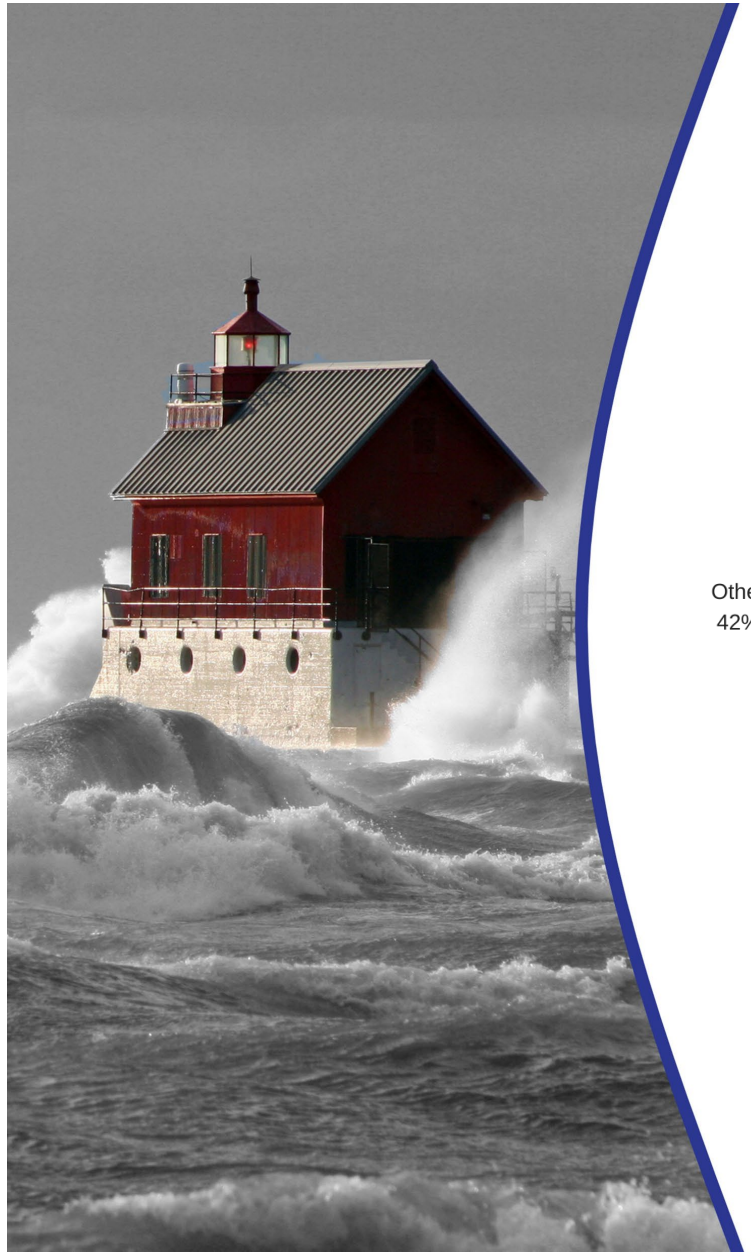
State Fair Hearing Data

STATE FAIR HEARING DATA

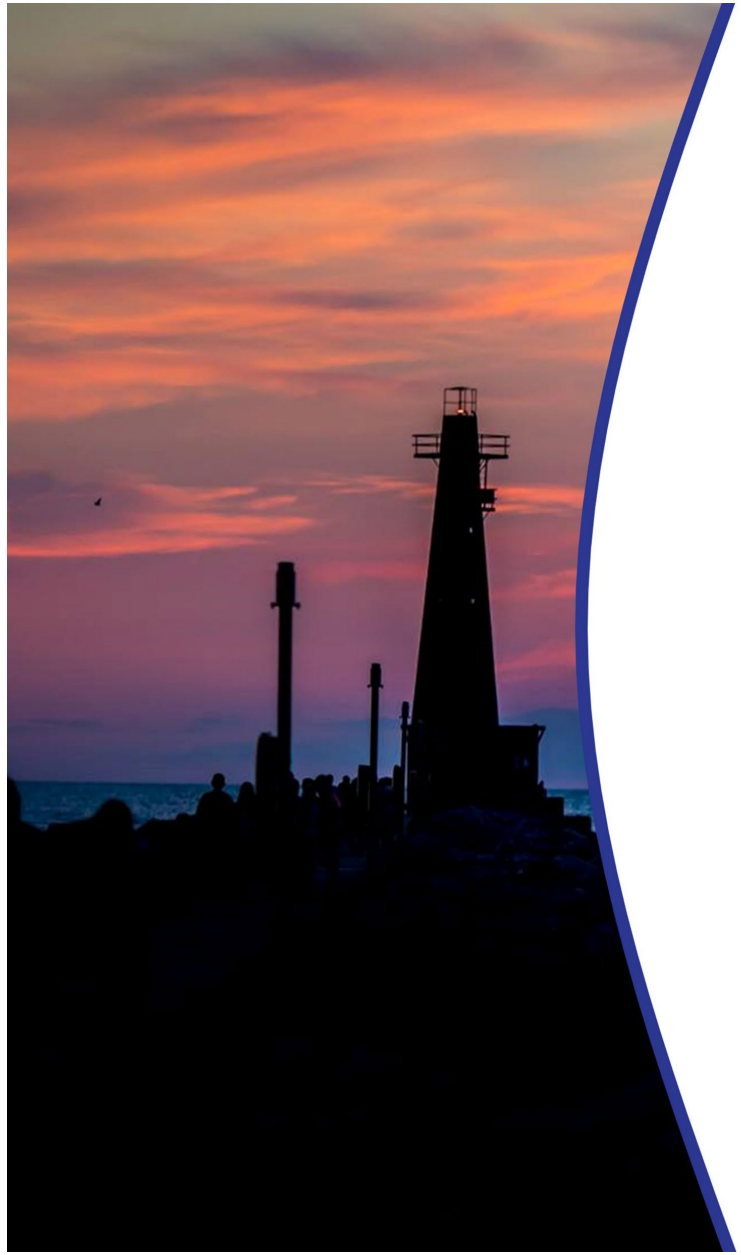
- ABA-AFFIRMED
- ABA-DISMISSED
- PC/CLS-AFFIRMED
- RTC SUD-DISMISSED
- SPECIALIZED RES-DISMISSED
- SUPPORTS COORDINATION-AFFIRMED
- RATE CHANGE-AFFIRMED



LAKESHORE REGIONAL ENTITY



Customer Service Phone Calls



Customer Satisfaction Survey

- CSS workgroup has been established
- Review of the survey and the format have taken place
- Review of the data has been provided to all CMHSP's

FY22 Results by **CMHSP**

LAKESHORE REGIONAL ENTITY

Fiscal Year Results by CMHSP

FY Filters Selected
- FY: ALL

Access and Availability - Average Scores

CMHSP	First Service	Other Svcs Choices	Staff Returned Calls	Services Times Good	Services Good Location
Allegan	4.9	2.8	4.3	5.2	5.1
HealthWest	2.6	2.6	5.0	5.1	5.0
Network 180	5.3	4.0	4.8	5.3	5.3
Ottawa	4.9	3.4	4.3	5.1	5.1
West Michigan	4.4	3.1	4.6	4.6	4.8
LRE	**4.8**	**3.7**	**4.7**	**5.2**	**5.2**

Quality - Average Scores

CMHSP	I Decided Goals	I Feel Included	Comfortable Asking Questions	Staff Helped with Questions	Staff Accepted Me
Allegan	5.1	5.2	5.1	4.9	5.4
HealthWest	4.9	5.1	5.3	5.1	5.0
Network 180	5.2	5.3	5.4	5.2	5.4
Ottawa	5.0	5.1	5.1	4.8	5.3
West Michigan	4.8	4.7	4.6	4.3	4.7
LRE	**5.1**	**5.2**	**5.3**	**5.1**	**5.3**

Long Term Services - Average Scores

CMHSP	Satisfied with CSM	Satisfied with Housing	Team Works Well	Svcs Helped Relationships
Allegan	4.9	4.9	5.0	4.3
HealthWest	2.5	0.0	2.5	2.4
Network 180	4.7	4.2	4.6	4.4
Ottawa	5.1	5.0	5.1	4.8
West Michigan	4.6	4.3	4.3	4.3
LRE	**4.5**	**3.9**	**4.4**	**4.3**

Telehealth - Average Scores

CMHSP	How Many by Telehealth	Telehealth Frequency	Able to Use Telehealth	Staff Helped with Telehealth	Like to Use Telehealth	Satisfied with Telehealth
Allegan	4.0	Some	3.7	2.6	3.4	3.4
HealthWest	1.0	None	0.0	0.0	0.0	0.0
Network 180	3.4	Few	3.7	3.4	3.3	3.5
Ottawa	3.5	Some	3.4	2.9	2.9	3.2
West Michigan	4.0	Some	4.1	3.7	3.5	3.8
LRE	**3.5**	**Few**	**3.2**	**2.9**	**2.8**	**3.0**

Outcomes - Average Scores

CMHSP	Services Helped	Satisfied with Services
Allegan	4.9	5.1
HealthWest	5.0	5.1
Network 180	5.2	5.3
Ottawa	5.0	5.1
West Michigan	4.5	4.6
LRE	**5.1**	**5.2**

Overall - Average Scores

CMHSP	Access & Availability	Quality	Long Term Services	Telehealth	Outcomes	Overall
Allegan	4.8	5.3	5.3	4.6	5.2	5.1
HealthWest	5.1	5.2	5.2	NaN	5.2	5.2
Network 180	5.3	5.5	5.3	4.9	5.4	5.3
Ottawa	5.1	5.4	5.3	4.7	5.3	5.2
West Michigan	5.1	5.4	5.2	4.9	5.4	5.2
Total LRE	**5.3**	**5.4**	**5.3**	**4.9**	**5.4**	**5.3**

LAKESHORE REGIONAL ENTITY

CS Timeline

Q1 — Oct-Feb

Beacon handling grievance and appeals through contract

Q2 — Feb-April

Grievances were extremely low

Contract with Beacon not renewed

Beacon in the process of training LRE staff

CS ROAT created

Q3 — May-July

LRE begins to oversee customer services

Customer Service calls rise

HSAG review

Q4 — Aug-Oct

New provider dispute policy

Adding to the CS team

Begin creation of audits for grievance and appeals

LAKESHORE REGIONAL ENTITY

Goals for 2023

For the **Region**

- Begin grievance, appeals and NABD audits
- Grievance & Appeals Power BI
- Begin Regional Training Workgroup

Within the **Region**

- Create a solid Consumer Advisory Panel
- Create solid data
- Create consistency throughout the region
- Communicate effectively

LAKESHORE REGIONAL ENTITY

Summary

There have been many changes in the past year with the LRE taking over customer services duties. The region has been helpful to solidify a smooth transition. It is the goal to provide consistency throughout the region in compliance with the state mandates. We will continue to strive for excellence and provide helpful data to ensure consumers needs are being met.

Next year we will continue to work on regional consistency and providing helpful data to return to your CMHSP to help provide the best services possible.

LAKESHORE REGIONAL ENTITY

Thank **You**

Thanks to your commitment to provide quality customer service, we know next year will be **even better** than the last.

We look forward to continuing to **work together**.

Sincerely

LRE Customer Services Staff

LAKESHORE REGIONAL ENTITY

LAKESHORE
REGIONAL ENTITY

LAKESHORE REGIONAL ENTITY

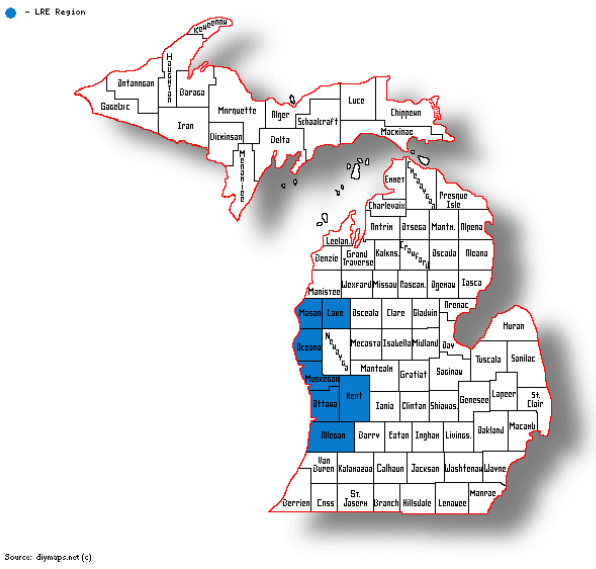
2012-2022

Tobacco Sales Compliance Regional Analysis

LAKESHORE REGIONAL ENTITY

BY REFOCUS, L.L.C.

Tobacco Compliance Checks Longitudinal Analysis, 2012-2022



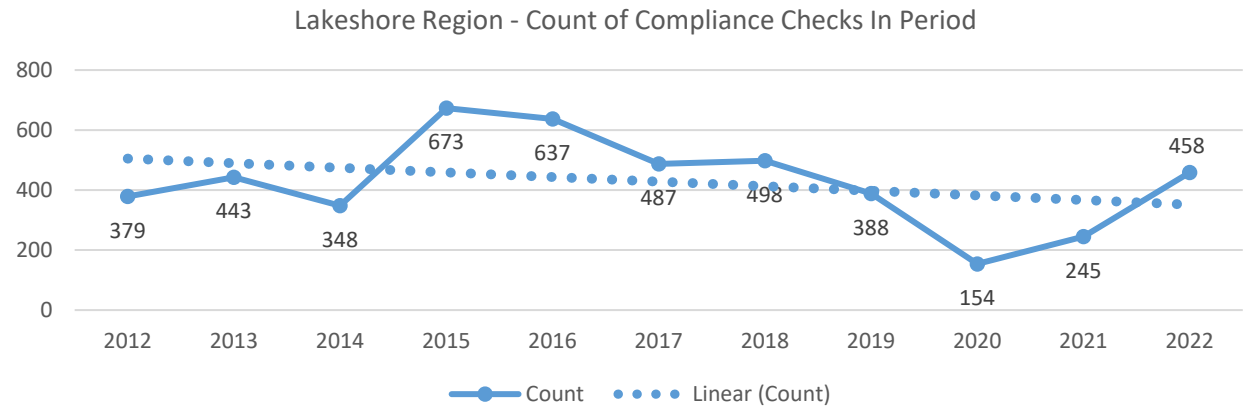
The Lakeshore Regional Entity (LRE) manages Medicaid, Michigan General Fund, and Substance Use Treatment Block Grant funding for Behavioral Health services in a seven-county region along the Lake Michigan shoreline in west Michigan. As a part of its mission, LRE supports county-level substance abuse prevention coalitions in each of its constituent counties. A part of this support is provided through the "No Cigs For Our Kids" campaign, which focuses on educating tobacco vendors in the region regarding the importance of compliance with the Youth Tobacco Act. Funding enables substance abuse prevention coalitions in the region to work with local law enforcement agencies to ensure that tobacco sales establishments do not sell tobacco products to persons under age 21. These compliance checks have been occurring in several of the region's counties since 2011 and, over the last six years have occurred in each of the region's seven counties. The purpose of this analysis is to utilize the data that each county has collected through the compliance check process to analyze results, find possible trends, make recommendations for improvements to the compliance check process, and ensure compliance with the Synar Amendment of 1992. "In July 1992, Congress enacted the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act (PL 102-321), which includes an amendment (section 1926) aimed at decreasing youth access to tobacco. This amendment, named for its sponsor, Congressman Mike Synar of Oklahoma, requires states … to enact and enforce laws prohibiting the sale or distribution of tobacco products to individuals under the age of 18. States must comply with the Synar Amendment in order to receive their full Substance Abuse Prevention and Treatment Block Grant (SABG) awards."[1] Among other standards, the Synar Regulations require that states conduct annual, unannounced inspections that provide a valid probability sample of tobacco sales outlets accessible to minors. The regulations also require that the non-compliance rate in the state be no more than twenty percent (20%). In 2022, Governor Gretchen Whitmer signed into Michigan law the Tobacco 21 legislation, which raised the minimum legal sale of tobacco products, vapor products, and alternative nicotine products from 18 to 21, in alignment with federal law. With this new law in place, persons acting as tobacco sales decoys can now be up to age 20 years.

This analysis was completed by ReFocus, L.L.C. (referred to in this document as "the evaluators") under contract with LRE. In 2016 the evaluators gathered all non-Synar (with police involvement) and Synar (without police involvement) compliance check records that could be provided by each county as far into the past as data was available. The evaluators then merged all counties' data into a single database that will support ongoing evaluation efforts in the future. It should be noted that several counties collected information about the compliance check results in different formats and the scope of the

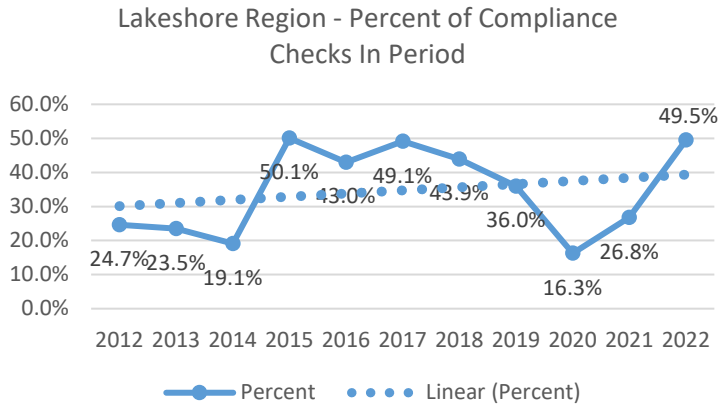
[1] https://www.samhsa.gov/synar/about

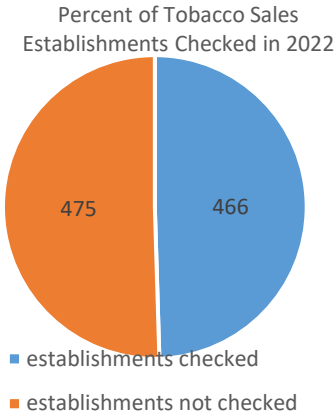
information collected differed significantly. Thus, the evaluators had to painstakingly work with the data on a cell-by-cell basis to ensure it was reliably brought into a single database. Following this process, LRE worked with the evaluators and county coalitions to develop a uniform dataset to be collected at each compliance check.

This analysis includes all **non-Synar** compliance checks reported to the evaluators between fiscal years 2012 and 2022. The graph below displays the total count of non-Synar compliance checks in the region. The solid blue line displays shifts in the actual number of non-Synar compliance checks completed during each fiscal year. The dotted blue line displays the trend across all years reported. It shows a decrease over time. There was a significant decrease in the count of compliance checks completed during fiscal years 2020 and 2021. This was the result of the continued impact of the COVID-19 pandemic. During 2021 four of the seven counties did not complete non-Synar compliance checks. The count of compliance checks rebounded in 2022, with all counties reporting activity.



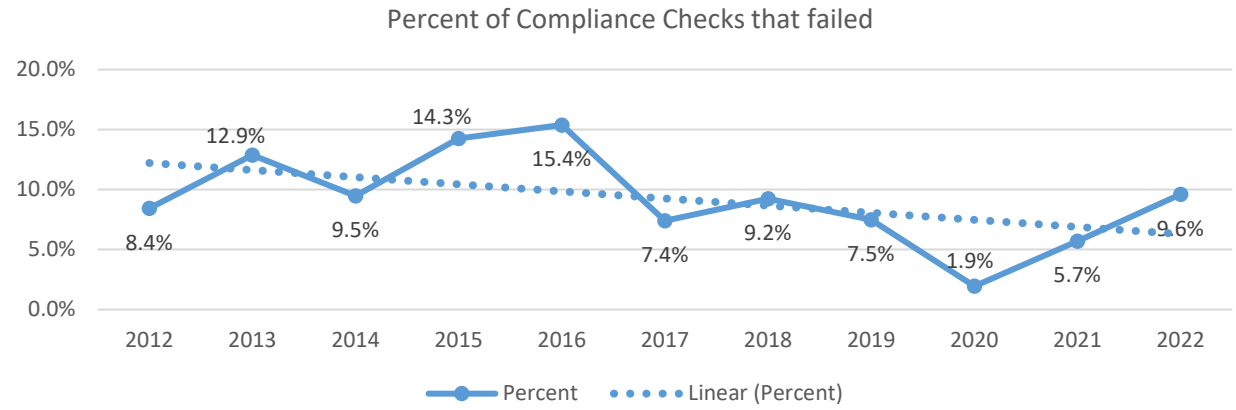
The graphs below display a different picture of the scope of compliance checks (see Attachment A for county and annual detail). They show the count and percentage of tobacco sales establishments that were checked during each year. The percentage of tobacco-selling establishments checked hit a high of 50.1% in 2015. This year the percentage of establishments checked rebounded to nearly that same level to 49.5%.





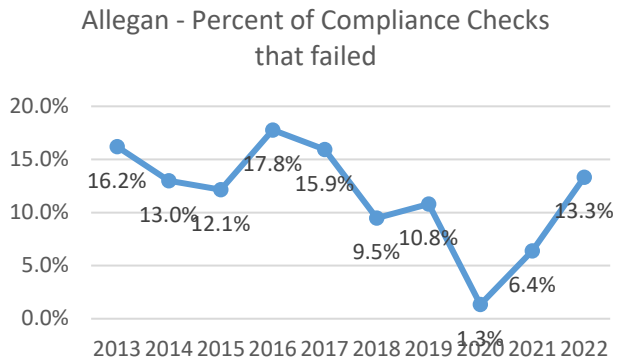
Tobacco Compliance Checks Longitudinal Analysis, 2012-2022

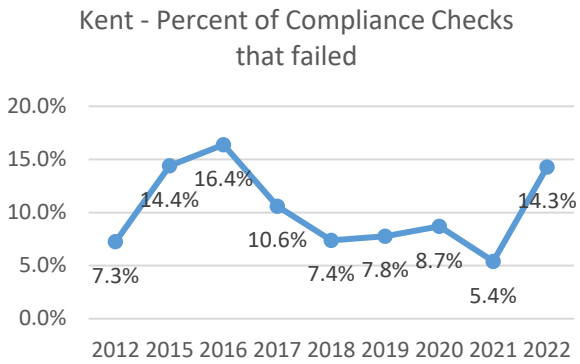
The graph below displays the percentage of compliance checks reported per year in the LRE region that failed. Tobacco sales to minors have remained below the twenty percent (20%) threshold established by the Synar Amendment since 2012, with the current percentage being 9.6%. In 2022 all counties in the LRE region performed below the threshold established by the Synar Amendment.



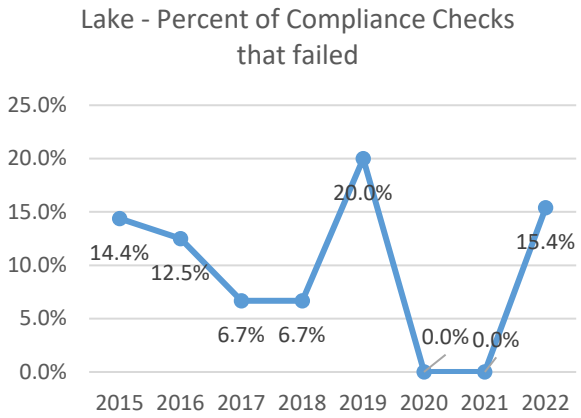
While the percentage of compliance checks that failed increased substantially in 2022 over the previous two years' results, It should be noted that the ability to use decoys over the age of 17 has an impact on these results. Of the 44 fails in the region, 32 of them (72.7%) had a decoy that was age 18 or older.

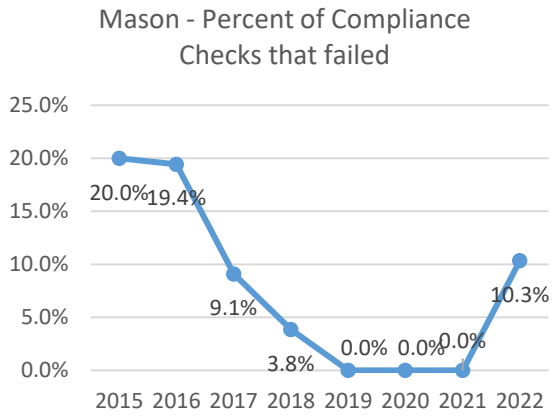
The graphs below display this same information for each county.

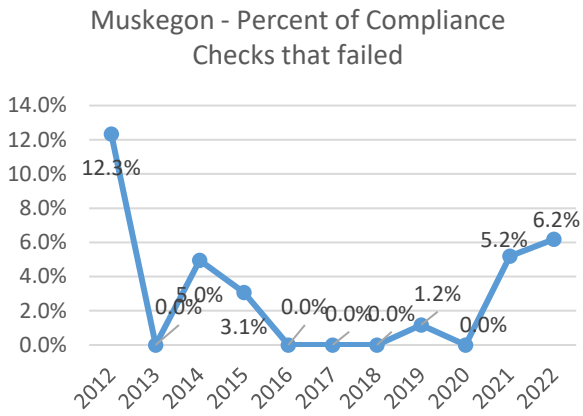


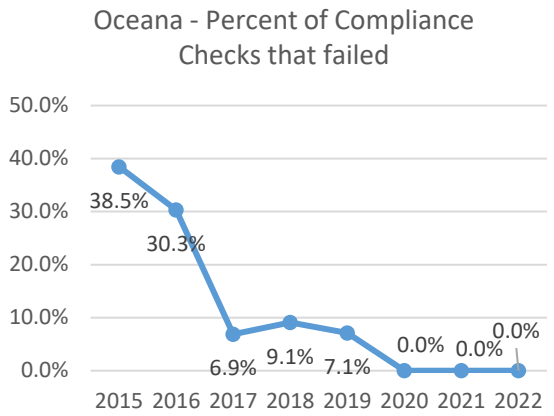


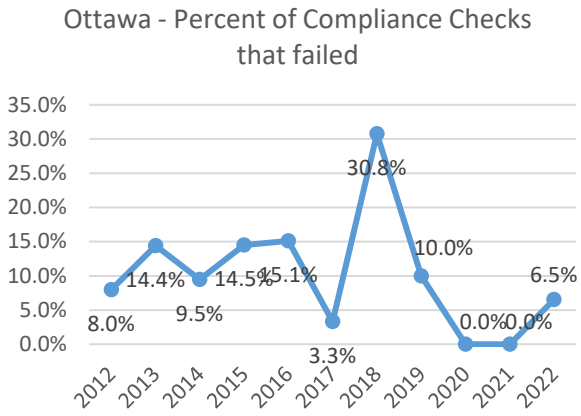
Tobacco Compliance Checks Longitudinal Analysis, 2012-2022











These graphs show that the fail rate went up in all LRE counties except Oceana, where there were no fails in 2022. All counties (except Lake) used a decoy age 18 or older for at least some of their compliance checks.

The chart below displays information regarding the environmental conditions at the tobacco sales establishments that failed compliance checks in the LRE region in 2022 (see Attachment B for county-level data by year). This information uses the revised retail categories established by the State of Michigan in 2017. It shows that 43.2% of compliance check fails occurred at a gas station and nearly thirty-nine percent (38.6%) occurred in the category of "other" (predominantly convenience stores).

Tobacco Compliance Checks Longitudinal Analysis, 2012-2022

FY2022	Count of Failed Compliance Checks	Of Fails, Percent at Gas Station	Of Fails, Percent at Tobacco Store	Of Fails, Percent at Restaurant	Of Fails, Percent at Hotel	Of Fails, Percent at Grocery Store	Of Fails, Percent at Drug Store	Of Fails, Percent at Other
Allegan	14	21.43%	0.00%	7.14%	0.00%	42.86%	0.00%	28.57%
Kent	12	83.33%	0.00%	0.00%	0.00%	8.33%	0.00%	50.00%
Lake	2	0.00%	0.00%	0.00%	0.00%	50.00%	0.00%	50.00%
Mason	3	33.33%	0.00%	0.00%	0.00%	0.00%	0.00%	66.67%
Muskegon	6	16.67%	16.67%	0.00%	0.00%	33.33%	0.00%	33.33%
Oceana	0	-	-	-	-	-	-	-
Ottawa	7	57.14%	0.00%	14.29%	0.00%	0.00%	0.00%	28.57%
LRE Region	44	43.18%	2.27%	4.55%	0.00%	22.73%	0.00%	38.64%

Tobacco Compliance Checks Longitudinal Analysis, 2012-2022

ATTACHMENT A:

FY2022	County Population (2020 Census)	Count of Tobacco sales establishments	Tobacco sales establishments per 10,000 citizens	Count of Tobacco sales establishments checked (Non-Synar)	Percent of Tobacco sales establishments checked	Count of Non-Synar Compliance Checks	Ave Times Establishments were checked	Count of Failed Compliance Checks	Failed compliance checks per 10,000 citizens	Percent of compliance checks that failed
Allegan	120502	97	0.87	95	97.9%	105	1.11	14	0.1257	13.3%
Kent	657974	433	0.72	109	25.2%	84	0.77	12	0.0199	14.3%
Lake	12096	19	1.65	15	78.9%	13	0.87	2	0.1733	15.4%
Mason	29052	39	1.36	29	74.4%	29	1.00	3	0.1045	10.3%
Muskegon	175824	152	0.88	95	62.5%	97	1.02	6	0.0348	6.2%
Oceana	26659	36	1.35	22	61.1%	23	1.05	0	0.0000	0.0%
Ottawa	296200	165	0.63	101	61.2%	107	1.06	7	0.0265	6.5%
LRE Region	1318307	941	0.77	466	49.5%	458	0.98	44	0.0362	9.6%

FY2021	County Population (2020 Census)	Count of Tobacco sales establishments	Tobacco sales establishments per 10,000 citizens	Count of Tobacco sales establishments checked (Non-Synar)	Percent of Tobacco sales establishments checked	Count of Non-Synar Compliance Checks	Ave Times Establishments were checked	Count of Failed Compliance Checks	Failed compliance checks per 10,000 citizens	Percent of compliance checks that failed
Allegan	120502	98	0.88	94	95.9%	94	1.00	6	0.0539	6.4%
Kent	657974	443	0.74	74	16.7%	74	1.00	4	0.0066	5.4%
Lake	12096	19	1.65	0	0.0%	0	#DIV/0!	0	0.0000	#DIV/0!
Mason	29052	27	0.94	0	0.0%	0	#DIV/0!	0	0.0000	#DIV/0!
Muskegon	175824	64	0.37	59	92.2%	77	1.31	4	0.0232	5.2%
Oceana	26659	33	1.24	0	0.0%	0	#DIV/0!	0	0.0000	#DIV/0!
Ottawa	296200	163	0.62	0	0.0%	0	#DIV/0!	0	0.0000	#DIV/0!
LRE Region	1318307	847	0.70	227	26.8%	245	1.08	14	0.0115	5.7%

Lakeshore Regional Entity

Tobacco Compliance Checks Longitudinal Analysis, 2012-2022

FY2020	County Population (2010 Census)	Count of Tobacco sales establishments	Tobacco sales establishments per 10,000 citizens	Count of Tobacco sales establishments checked (Non-Synar)	Percent of Tobacco sales establishments checked	Count of Non-Synar Compliance Checks	Ave Times Establishments were checked	Count of Failed Compliance Checks	Failed compliance checks per 10,000 citizens	Percent of compliance checks that failed
Allegan	111408	92	0.83	75	81.5%	75	1.00	1	0.0090	1.3%
Kent	602622	444	0.74	23	5.2%	23	1.00	2	0.0033	8.7%
Lake	11539	16	1.39	5	31.3%	5	1.00	0	0.0000	0.0%
Mason	28705	34	1.18	5	14.7%	5	1.00	0	0.0000	0.0%
Muskegon	172188	153	0.89	23	15.0%	23	1.00	0	0.0000	0.0%
Oceana	26570	32	1.20	9	28.1%	10	1.11	0	0.0000	0.0%
Ottawa	263801	170	0.64	13	7.6%	13	1.00	0	0.0000	0.0%
LRE Region	1216833	941	0.77	153	16.3%	154	1.01	3	0.0025	1.9%

FY2019	County Population (2010 Census)	Count of Tobacco sales establishments	Tobacco sales establishments per 10,000 citizens	Count of Tobacco sales establishments checked (Non-Synar)	Percent of Tobacco sales establishments checked	Count of Non-Synar Compliance Checks	Ave Times Establishments were checked	Count of Failed Compliance Checks	Failed compliance checks per 10,000 citizens	Percent of compliance checks that failed
Allegan	111408	92	0.83	89	96.7%	111	1.25	12	0.11	10.8%
Kent	602622	443	0.74	100	22.6%	103	1.03	8	0.01	7.8%
Lake	11539	16	1.39	9	56.3%	10	1.11	2	0.17	20.0%
Mason	28705	34	1.18	15	44.1%	15	1.00	0	0.00	0.0%
Muskegon	172188	152	0.88	66	43.4%	85	1.29	1	0.01	1.2%
Oceana	26570	32	1.20	14	43.8%	14	1.00	1	0.04	7.1%
Ottawa	263801	168	0.64	44	26.2%	50	1.14	5	0.02	10.0%
LRE Region	1216833	937	0.77	337	36.0%	388	1.15	29	0.02	7.5%

Lakeshore Regional Entity

Tobacco Compliance Checks Longitudinal Analysis, 2012-2022

FY2018	County Population (2010 Census)	Count of Tobacco sales establishments	Tobacco sales establishments per 10,000 citizens	Count of Tobacco sales establishments checked (Non-Synar)	Percent of Tobacco sales establishments checked	Count of Non-Synar Compliance Checks	Ave Times Establishments were checked	Count of Failed Compliance Checks	Failed compliance checks per 10,000 citizens	Percent of compliance checks that failed
Allegan	111408	91	0.82	71	78.0%	95	1.34	9	0.08	9.5%
Kent	602622	444	0.74	182	41.0%	230	1.26	17	0.03	7.4%
Lake	11539	16	1.39	15	93.8%	15	1.00	1	0.09	6.7%
Mason	28705	34	1.18	26	76.5%	26	1.00	1	0.03	3.8%
Muskegon	172188	149	0.87	43	28.9%	58	1.35	0	0.00	0.0%
Oceana	26570	32	1.20	22	68.8%	22	1.00	2	0.08	9.1%
Ottawa	263801	167	0.63	51	30.5%	52	1.02	16	0.06	30.8%
LRE Region	1216833	933	0.77	410	43.9%	498	1.21	46	0.04	9.2%

FY2017	County Population (2010 Census)	Count of Tobacco sales establishments	Tobacco sales establishments per 10,000 citizens	Count of Tobacco sales establishments checked (Non-Synar)	Percent of Tobacco sales establishments checked	Count of Non-Synar Compliance Checks	Ave Times Establishments were checked	Count of Failed Compliance Checks	Failed compliance checks per 10,000 citizens	Percent of compliance checks that failed
Allegan	111408	90	0.81	68	75.6%	69	1.01	11	0.10	15.9%
Kent	602622	439	0.73	149	33.9%	151	1.01	16	0.03	10.6%
Lake	11539	16	1.39	14	87.5%	15	1.07	1	0.09	6.7%
Mason	28705	34	1.18	33	97.1%	33	1.00	3	0.10	9.1%
Muskegon	172188	151	0.88	73	48.3%	99	1.36	0	0.00	0.0%
Oceana	26570	32	1.20	29	90.6%	29	1.00	2	0.08	6.9%
Ottawa	263801	166	0.63	90	54.2%	91	1.01	3	0.01	3.3%
LRE Region	1216833	928	0.76	456	49.1%	487	1.07	36	0.03	7.4%

Tobacco Compliance Checks Longitudinal Analysis, 2012-2022

FY2016	County Population (2010 Census)	Count of Tobacco sales establishments	Tobacco sales establishments per 10,000 citizens	Count of Tobacco sales establishments checked	Percent of Tobacco sales establishments checked	Count of Compliance Checks	Ave Times Establishments were checked	Count of Failed Compliance Checks	Failed compliance checks per 10,000 citizens	Percent of compliance checks that failed
Allegan	111408	90	0.81	89	98.9%	135	1.52	24	0.22	17.8%
Kent	602622	536	0.89	193	36.0%	238	1.23	39	0.06	16.4%
Lake	11539	16	1.39	16	100.0%	16	1.00	2	0.17	12.5%
Mason	28705	31	1.08	30	96.8%	36	1.20	7	0.24	19.4%
Muskegon	172188	149	0.87	65	43.6%	73	1.12	0	0.00	0.0%
Oceana	26570	32	1.20	29	90.6%	33	1.14	10	0.38	30.3%
Ottawa	263801	362	1.37	101	27.9%	106	1.05	16	0.06	15.1%
LRE Region	1216833	1216	1.00	523	43.0%	637	1.22	98	0.08	15.4%

FY2015	County Population (2010 Census)	Count of Tobacco sales establishments	Tobacco sales establishments per 10,000 citizens	Count of Tobacco sales establishments checked	Percent of Tobacco sales establishments checked	Count of Compliance Checks	Ave Times Establishments were checked	Count of Failed Compliance Checks	Failed compliance checks per 10,000 citizens	Percent of compliance checks that failed
Allegan	111408	90	0.81	88	97.8%	107	1.22	13	0.12	12.1%
Kent	602622	536	0.89	262	48.9%	271	1.03	39	0.06	14.4%
Lake	11539	16	1.39	15	93.8%	15	1.00	3	0.26	20.0%
Mason	28705	31	1.08	32	103.2%	32	1.00	10	0.35	31.3%
Muskegon	172188	149	0.87	74	49.7%	98	1.32	3	0.02	3.1%
Oceana	26570	32	1.20	26	81.3%	26	1.00	10	0.38	38.5%
Ottawa	263801	362	1.37	112	30.9%	124	1.11	18	0.07	14.5%
LRE Region	1216833	1216	1.00	609	50.1%	673	1.11	96	0.08	14.3%

Tobacco Compliance Checks Longitudinal Analysis, 2012-2022

ATTACHMENT B:

FY2022	Count of Failed Compliance Checks	Of Fails, Percent at Gas Station	Of Fails, Percent at Tobacco Store	Of Fails, Percent at Restaurant	Of Fails, Percent at Hotel	Of Fails, Percent at Grocery Store	Of Fails, Percent at Drug Store	Of Fails, Percent at Other
Allegan	14	21.43%	0.00%	7.14%	0.00%	42.86%	0.00%	28.57%
Kent	12	83.33%	0.00%	0.00%	0.00%	8.33%	0.00%	50.00%
Lake	2	0.00%	0.00%	0.00%	0.00%	50.00%	0.00%	50.00%
Mason	3	33.33%	0.00%	0.00%	0.00%	0.00%	0.00%	66.67%
Muskegon	6	16.67%	16.67%	0.00%	0.00%	33.33%	0.00%	33.33%
Oceana	0	-	-	-	-	-	-	-
Ottawa	7	57.14%	0.00%	14.29%	0.00%	0.00%	0.00%	28.57%
LRE Region	44	43.18%	2.27%	4.55%	0.00%	22.73%	0.00%	38.64%

FY2021	Count of Failed Compliance Checks	Of Fails, Percent at Gas Station	Of Fails, Percent at Tobacco Store	Of Fails, Percent at Restaurant	Of Fails, Percent at Hotel	Of Fails, Percent at Grocery Store	Of Fails, Percent at Drug Store	Of Fails, Percent at Other
Allegan	6	33.33%	0.00%	0.00%	0.00%	16.67%	0.00%	50.00%
Kent	4	0.00%	0.00%	0.00%	0.00%	25.00%	0.00%	75.00%
Lake	0	-	-	-	-	-	-	-
Mason	0	-	-	-	-	-	-	-
Muskegon	4	50.00%	0.00%	25.00%	0.00%	0.00%	0.00%	25.00%
Oceana	0	-	-	-	-	-	-	-
Ottawa	0	-	-	-	-	-	-	-
LRE Region	14	28.57%	0.00%	7.14%	0.00%	14.29%	0.00%	50.00%

Lakeshore Regional Entity

Tobacco Compliance Checks Longitudinal Analysis, 2012-2022

FY2020	Count of Failed Compliance Checks	Of Fails, Percent at Gas Station	Of Fails, Percent at Tobacco Store	Of Fails, Percent at Restaurant	Of Fails, Percent at Hotel	Of Fails, Percent at Grocery Store	Of Fails, Percent at Drug Store	Of Fails, Percent at Other
Allegan	1	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Kent	2	50.00%	0.00%	0.00%	0.00%	0.00%	0.00%	50.00%
Lake	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mason	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Muskegon	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Oceana	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ottawa	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
LRE Region	2	66.67%	0.00%	0.00%	0.00%	0.00%	0.00%	33.00%

FY2019	Count of Failed Compliance Checks	Of Fails, Percent at Gas Station	Of Fails, Percent at Tobacco Store	Of Fails, Percent at Restaurant	Of Fails, Percent at Hotel	Of Fails, Percent at Grocery Store	Of Fails, Percent at Drug Store	Of Fails, Percent at Other
Allegan	12	25.00%	0.00%	0.00%	0.00%	25.00%	0.00%	50.00%
Kent	8	25.00%	0.00%	0.00%	0.00%	0.00%	50.00%	25.00%
Lake	2	50.00%	0.00%	0.00%	0.00%	0.00%	0.00%	50.00%
Mason	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Muskegon	1	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Oceana	1	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%
Ottawa	5	40.00%	0.00%	0.00%	0.00%	0.00%	0.00%	60.00%
LRE Region	29	31.03%	0.00%	0.00%	0.00%	10.34%	13.79%	44.83%

Lakeshore Regional Entity

Tobacco Compliance Checks Longitudinal Analysis, 2012-2022

FY2018	Count of Failed Compliance Checks	Of Fails, Percent at Grocery Store	Of Fails, Percent at Convenience Store	Of Fails, Percent at Gas Station	Of Fails, Percent at Restaurant	Of Fails, Percent at Bar/Lounge	Of Fails, Percent at Pharmacy	Of Fails, Percent at Bowling Alley	Of Fails, Percent at Liquor Store	Of Fails, Percent at Tobacco Store/Shop	Of Fails, Percent at Retail/Dept. Store
Allegan	9	11.11%	11.11%	66.67%	0.00%	0.00%	66.67%	0.00%	0.00%	0.00%	0.00%
Kent	17	11.76%	47.06%	29.41%	0.00%	0.00%	11.76%	0.00%	0.00%	0.00%	0.00%
Lake	1	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Mason	1	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Muskegon	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Oceana	2	0.00%	50.00%	50.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Ottawa	16	25.00%	37.50%	62.50%	0.00%	0.00%	6.25%	0.00%	6.25%	0.00%	0.00%
LRE Region	46	15.22%	36.96%	50.00%	0.00%	0.00%	19.57%	0.00%	2.17%	0.00%	0.00%

FY2017	Count of Failed Compliance Checks	Of Fails, Percent at Grocery Store	Of Fails, Percent at Convenience Store	Of Fails, Percent at Gas Station	Of Fails, Percent at Restaurant	Of Fails, Percent at Bar/Lounge	Of Fails, Percent at Pharmacy	Of Fails, Percent at Bowling Alley	Of Fails, Percent at Liquor Store	Of Fails, Percent at Tobacco Store/Shop	Of Fails, Percent at Retail/Dept. Store
Allegan	11	27.27%	18.18%	45.45%	9.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Kent	16	6.25%	25.00%	62.50%	0.00%	0.00%	0.00%	0.00%	0.00%	6.25%	0.00%
Lake	1	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Mason	3	33.33%	66.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Muskegon	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Oceana	2	0.00%	50.00%	50.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Ottawa	3	0.00%	66.67%	33.33%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
LRE Region	35	14.29%	34.29%	51.43%	2.86%	0.00%	0.00%	0.00%	0.00%	2.86%	0.00%

Lakeshore Regional Entity

Tobacco Compliance Checks Longitudinal Analysis, 2012-2022

FY2016	Count of Failed Compliance Checks	Of Fails, Count where clerk was male	Of Fails, Percent where clerk was male	Of Fails, Percent where clerk was female	Of Fails, Percent at Grocery Store	Of Fails, Percent at Convenience Store	Of Fails, Percent at Gas Station	Of Fails, Percent at Restaurant	Of Fails, Percent at Bar/Lounge	Of Fails, Percent at Pharmacy	Of Fails, Percent at Bowling Alley	Of Fails, Percent at Liquor Store	Of Fails, Percent at Tobacco Store/Shop	Of Fails, Percent at Retail/Dept. Store
Allegan	24	17	70.83%	29.17%	25.00%	20.83%	50.00%	0.00%	0.00%	0.00%	0.00%	4.17%	0.00%	0.00%
Kent	39	4	10.26%	89.74%	2.56%	25.64%	46.15%	0.00%	0.00%	10.26%	0.00%	0.00%	0.00%	0.00%
Lake	2	2	100.00%	0.00%	0.00%	50.00%	50.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Mason	7	6	85.71%	14.29%	14.29%	14.29%	57.14%	0.00%	0.00%	0.00%	0.00%	14.29%	0.00%	0.00%
Muskegon	0		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/a
Oceana	10	8	80.00%	20.00%	20.00%	20.00%	60.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Ottawa	16	7	43.75%	56.25%	0.00%	25.00%	62.50%	0.00%	0.00%	0.00%	0.00%	6.25%	0.00%	6.25%
LRE Region	98	44	44.90%	55.10%	10.20%	23.47%	52.04%	0.00%	0.00%	4.08%	0.00%	3.06%	0.00%	1.02%

FY2015	Count of Failed Compliance Checks	Of Fails, Count where clerk was male	Of Fails, Percent where clerk was male	Of Fails, Percent where clerk was female	Of Fails, Percent at Grocery Store	Of Fails, Percent at Convenience Store	Of Fails, Percent at Gas Station	Of Fails, Percent at Restaurant	Of Fails, Percent at Bar/Lounge	Of Fails, Percent at Pharmacy	Of Fails, Percent at Bowling Alley	Of Fails, Percent at Liquor Store	Of Fails, Percent at Tobacco Store/Shop	Of Fails, Percent at Retail/Dept. Store
Allegan	13	9	69.23%	30.77%	15.38%	23.08%	61.54%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Kent	39	18	46.15%	53.85%	10.26%	30.77%	51.28%	0.00%	0.00%	5.13%	0.00%	0.00%	0.00%	0.00%
Lake	3		0.00%	100.00%	0.00%	66.67%	33.33%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Mason	10		0.00%	100.00%	30.00%	40.00%	30.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Muskegon	3		0.00%	100.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Oceana	10		0.00%	100.00%	30.00%	50.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	20.00%
Ottawa	18	6	33.33%	66.67%	11.11%	27.78%	61.11%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
LRE Region	96	33	34.38%	65.63%	14.58%	32.29%	47.92%	0.00%	0.00%	2.08%	0.00%	0.00%	0.00%	2.08%

Lakeshore Regional Entity

Tobacco Compliance Checks Longitudinal Analysis, 2012-2022

FY2014	Count of Failed Compliance Checks	Of Fails, Count where clerk was male	Of Fails, Percent where clerk was male	Of Fails, Percent where clerk was female	Of Fails, Percent at Grocery Store	Of Fails, Percent at Convenience Store	Of Fails, Percent at Gas Station	Of Fails, Percent at Restaurant	Of Fails, Percent at Bar/Lounge	Of Fails, Percent at Pharmacy	Of Fails, Percent at Bowling Alley	Of Fails, Percent at Liquor Store	Of Fails, Percent at Tobacco Store/Shop	Of Fails, Percent at Retail/Dept. Store
Allegan	17	14	82.35%	17.65%	0.00%	17.65%	82.35%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Muskegon	5		0.00%	100.00%	0.00%	20.00%	80.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Ottawa	11	4	36.36%	63.64%	0.00%	27.27%	72.73%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
LRE Region	33	18	54.55%	45.45%	0.00%	21.21%	78.79%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

FY2013	Count of Failed Compliance Checks	Of Fails, Count where clerk was male	Of Fails, Percent where clerk was male	Of Fails, Percent where clerk was female	Of Fails, Percent at Grocery Store	Of Fails, Percent at Convenience Store	Of Fails, Percent at Gas Station	Of Fails, Percent at Restaurant	Of Fails, Percent at Bar/Lounge	Of Fails, Percent at Pharmacy	Of Fails, Percent at Bowling Alley	Of Fails, Percent at Liquor Store	Of Fails, Percent at Tobacco Store/Shop	Of Fails, Percent at Retail/Dept. Store
Allegan	23	17	73.91%	26.09%	4.35%	34.78%	60.87%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Ottawa	34	19	55.88%	44.12%	2.94%	17.65%	73.53%	0.00%	0.00%	0.00%	0.00%	2.94%	2.94%	0.00%
LRE Region	57	36	63.16%	36.84%	3.51%	24.56%	68.42%	0.00%	0.00%	0.00%	0.00%	1.75%	1.75%	0.00%

FY2012	Count of Failed Compliance Checks	Of Fails, Count where clerk was male	Of Fails, Percent where clerk was male	Of Fails, Percent where clerk was female	Of Fails, Percent at Grocery Store	Of Fails, Percent at Convenience Store	Of Fails, Percent at Gas Station	Of Fails, Percent at Restaurant	Of Fails, Percent at Bar/Lounge	Of Fails, Percent at Pharmacy	Of Fails, Percent at Bowling Alley	Of Fails, Percent at Liquor Store	Of Fails, Percent at Tobacco Store/Shop	Of Fails, Percent at Retail/Dept. Store
Kent	14		0.00%	100.00%	7.14%	35.71%	35.71%	7.14%	0.00%	0.00%	0.00%	14.29%	0.00%	0.00%
Muskegon	9		0.00%	100.00%	0.00%	33.33%	66.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Ottawa	9	5	55.56%	44.44%	0.00%	22.22%	44.44%	0.00%	0.00%	11.11%	0.00%	22.22%	0.00%	0.00%
LRE Region	32	5	15.63%	84.38%	3.13%	31.25%	46.88%	3.13%	0.00%	3.13%	0.00%	12.50%	0.00%	0.00%

LAKESHORE REGIONAL ENTITY

Information Officer Report – December 2022

Summary:

1. **MCIS Software**:
   Currently in development, PCE Systems is working to develop our new Critical Incident and Risk Events data upload pathway. After critical incident data is accepted into the PIHP system it will be validated, stored, and forwarded to the MDHHS CRM system via their critical incidents **A**pplication **P**rogram **I**nterface (**API**).

2. **Data Analytics and Reporting:**
   New efforts currently underway in this area include:
   - Additional visualizations are being added to the regional LOCUS assessment dashboard (via feedback from the LRE Clinical ROAT group and per recommendations from the MDHHS led state-wide LOCUS workgroup).
   - Mild/Moderate breakout has been added to the CCBHC Dashboard.

3. **FY22 data reporting to MDHHS**:
   FY22 Encounter reporting overall is showing good volumes from HealthWest, Ottawa and West Michigan CMH through September, which would be expected at this point. All CMHs are heavily focused on getting FY22 data fully complete and accurate over the next two months to ensure that MDHHS FY24 Medicaid rate setting is calculated using complete and accurate data. Please see also the encounter graphs attached.
   FY23 Encounter reporting is showing good volumes for October 2022, as would be expected at this point in time.

   FY22 BH-TEDS: BH-TEDS reporting volumes for FY22 related records continue to come in. However, recent MDHHS completeness stats calculated on 11/30/2022 show that we are below the 95% standard (at **94.10 %**) for the Mental Health measure. We are above standard on the other 2 measures. See "Additional Details" on page 2 for further information. Please see also the MDHHS calculated measures on pages 2-3 below.
   FY23 BH-TEDS: MDHHS will begin BH-TEDS completeness reporting for FY23 related records later this month.

4. **Encounter Data Validation (EDV) Audit announced**:
   HSAG has been contracted by MDHHS to conduct an **E**ncounter **D**ata **V**alidation (**EDV**) of all the Michigan managed care entities, including PIHPs, in SFY 2023. More information will be forthcoming in the future on this **EDV** activity. However, HSAG has already reached out to confirm that the contacts points they have on file for all of the External Quality Review activities are still current. The **EDV** activity will apparently involve that same group of individuals.

   Also recently announced: Kathy Haines (DHHS) to retire in early 2023 f. As Manager of the Performance Measure and Evaluation Section within the Behavioral Health and Developmental Disabilities Administration (BHDDA), Kathy has long been a key MDHHS staff member coordinating and monitoring

activities around the Performance Measure Validation audits, Data quality and completeness, Medicaid rate setting, and many other key plan performance and data quality monitoring activities. Her position is being replaced by multiple staff. Responsibilities that she carried associated regarding oversight of PIHP/BHDDA encounter data is slated to be handled in the future by staff on the physical healthcare side of the department, where they routinely have regular meetings with data submitters to discuss the quality of the encounter data being submitted.

It is clear that there will be more rigorous and detailed monitoring of encounter data in the future than PIHPs have experienced in the past.

Additional Details:

FY22 BHTEDS: Several CMHs are individually below standard on the Mental Health measure. They have open plans of correction already in place regarding BHTEDS data submission as part of their annual IT site review.

As CMHSPs begin to evaluate MDHHS "Missing BHTEDS" lists, two issues have come to light already:

1) Some SUD clients have been flagged as having "SUD Missing BHTEDS", but we strongly believe they are not missing. These have been reported for follow-up, and MDHHS is investigating to find out why these are appearing on the "missing list".
2) One CMH identified that some SUD encounters were mistakenly sent as Mental Health encounters. This could be artificially inflating their assessed rate of "Missing Mental Health BHTEDS". Correction of those encounters is under way.

Mental Health BHTEDS – FY22 Completeness by PIHP Region, as of 11/30/2022:

FY22 MH Encounters w/BH-TEDS records

Encounters: 10/01/2021 - 09/30/2022*			BH-TEDS: 07/01/2020 - 11/30/2022
		Distinct Count of Individuals With	
Region Name	Submitter ID	Non-H0002 & Non-Crisis, Non-OBRA Assessment & Non-Transportation Encounters	Non-H0002, Non-Crisis, Non-Health Home, Non-OBRA Assessment & Non-Transportation Encounters But NO BH-TEDS Record Since 07/01/2020	Current Completion Rate
CMH Partnership of SE MI	00XT	11,555	463	95.99%
Detroit/Wayne	00XH	60,790	4,657	92.34%
Lakeshore Regional Entity	00ZI	21,166	1,248	94.10%
Macomb	00GX	13,411	391	97.08%
Mid-State Health Network	0107	43,203	1,477	96.58%
NorthCare Network	0101	6,454	50	99.23%
Northern MI Regional Entity	0108	13,140	307	97.66%
Oakland	0058	23,849	1,105	95.37%
Region 10	0109	19,752	155	99.22%
Southwest MI Behavioral Health	0102	22,576	866	96.16%
Statewide		235,896	10,719	95.46%

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

*Encounters = All MH encounters **excluding**: A0080, A0090, A0100, A0110, A0120, A0130, A0140, A0170, A0425, A0427, H0002, H2011, H2034, Q3014, S0209, S0215, S0280, S0281, S9484, T1023, T1040, T2001-T2005 ,90839, 90840, 99304-99310

Crisis Only Mental Health BHTEDS – FY22 Completeness by PIHP Region, as of 11/30/2022:

FY22 Crisis Encounters w/BH-TEDS records				
Encounters: 10/01/2021 - 09/30/2022**		BH-TEDS: 07/01/2020 - 11/30/2022		
		Distinct Count of Individuals With		
Region Name	Submitter ID	Crisis Encounters	Crisis Encounters But NO BH-TEDS Record Since 07/01/2020	Completion Rate
CMH Partnership of SE MI	00XT	2,602	102	96.08%
Detroit/Wayne	00XH	9,857	89	99.10%
Lakeshore Regional Entity	00ZI	6,647	259	96.10%
Macomb	00GX	1,870	22	98.82%
Mid-State Health Network	0107	11,873	410	96.55%
NorthCare Network	0101	2,163	4	99.82%
Northern MI Regional Entity	0108	4,762	206	95.67%
Oakland	0058	3,426	13	99.62%
Region 10	0109	2,227	96	95.69%
Southwest MI Behavioral Health	0102	4,103	65	98.42%
Statewide		49,530	1,266	97.44%
Key				
95.00+ = Compliant		**Encounters include H2011, S9484, T1023, 90839, 90840		
90.00-94.99				
85.00-89.99				
<85.00				

Substance Use Disorder BHTEDS – FY22 Completeness by PIHP Region, as of 11/30/2022:

FY22 SUD Encounters w/BH-TEDS records				
SUD Encounters from 10/01/2021-09/30/2022***		Does Not Have Open Admission at Time of Encounter as of 11/30/2022		
		Distinct Count of Individuals With		
Region Name	Submitter ID	Non-Health Home Encounters	Non-Health Home Encounters But NO BH-TEDS Record	Completion Rate
CMH Partnership of SE MI	00XT	2,829	104	96.32%
Detroit/Wayne	00XH	7,901	6	99.92%
Lakeshore Regional Entity	00ZI	5,717	220	96.15%
Macomb	00GX	3,770	54	98.57%
Mid-State Health Network	0107	10,192	206	97.98%
NorthCare Network	0101	1,847	40	97.83%
Northern MI Regional Entity	0108	3,795	85	97.76%
Oakland	0058	3,351	41	98.78%
Region 10	0109	5,415	153	97.17%
Salvation Army	002Y	NO FY22 Encounters Submitted Yet at 09/30/2022		
Southwest MI Behavioral Health	0102	5,959	409	93.14%
Statewide		50,776	1,318	97.40%
Key				
95.00+ = Compliant		***Encounters = All SUD encounters **excluding** H2034, S0280 & T1040		
90.00-94.99				
85.00-89.99				
<85.00				

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.

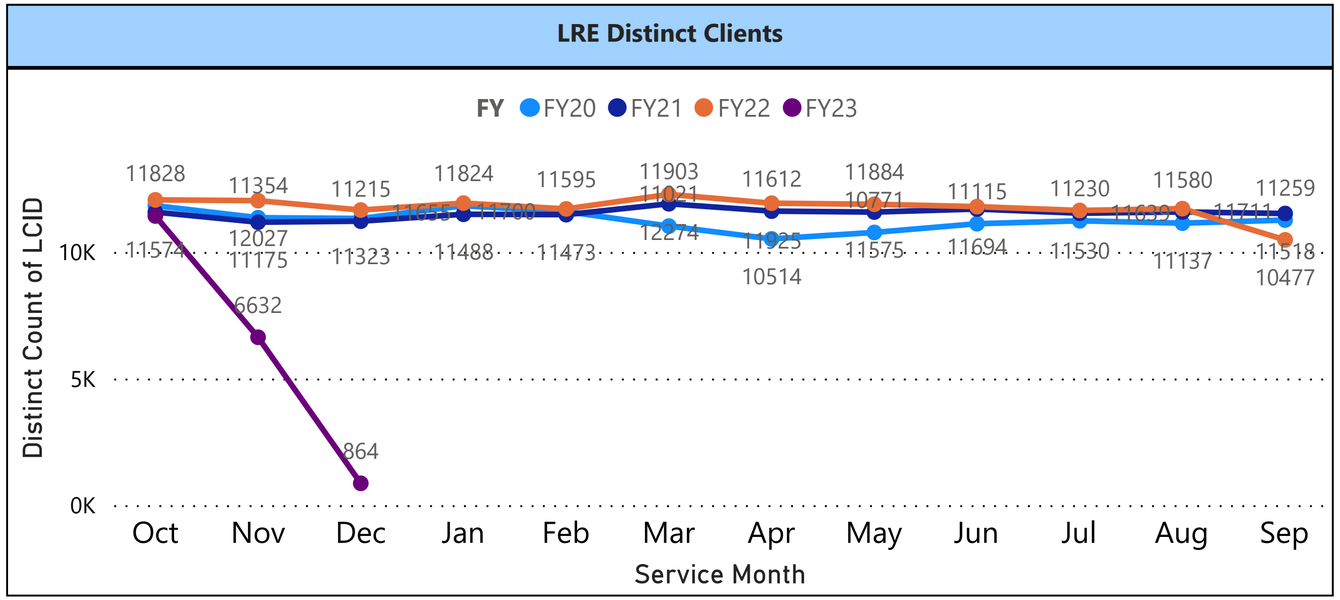
Reports in Dashboard:

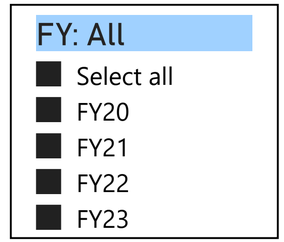
1. **LRE - MH Lines** - Shows distinct client count and mental health encounter line totals for both Professional and Institutional type transactions for the LRE as a whole.
2. **LRE - MH Units** - Shows distinct client count and mental health encounter claim unit totals for both Professional and Institutional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

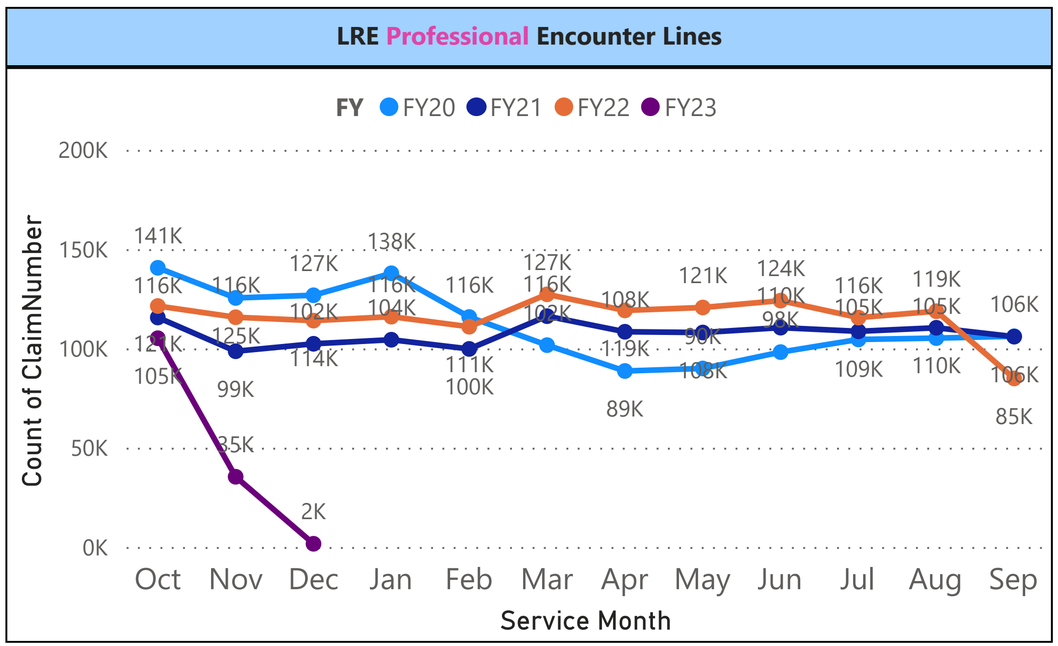
Notes: Items 4-6 above are repeated for each individual CMHSP.

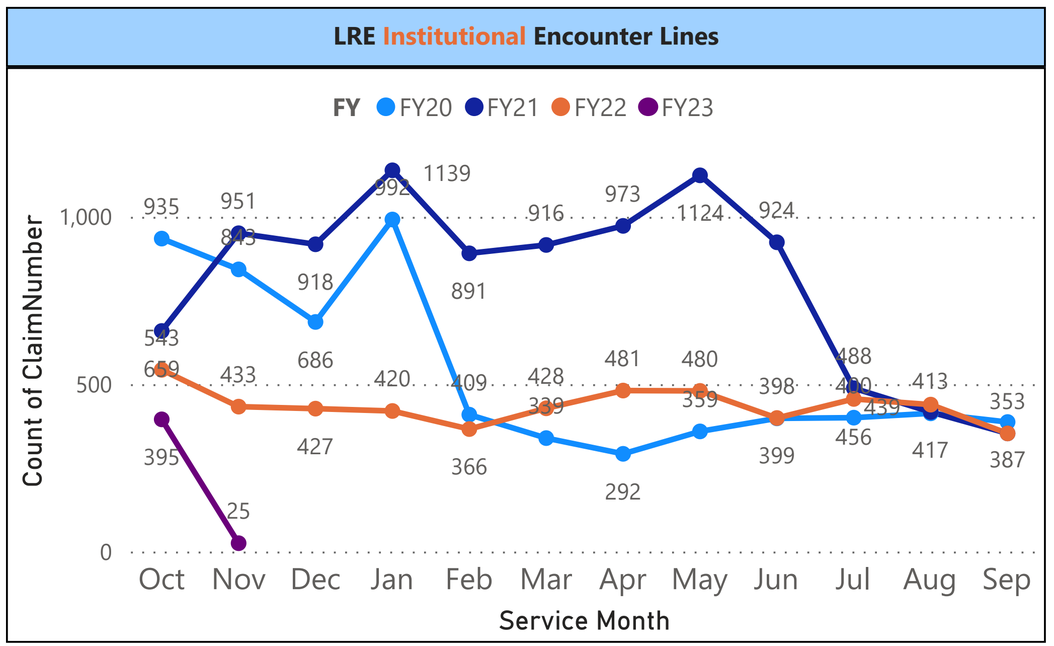
LAKESHORE REGIONAL ENTITY

LRE
Behavioral Health









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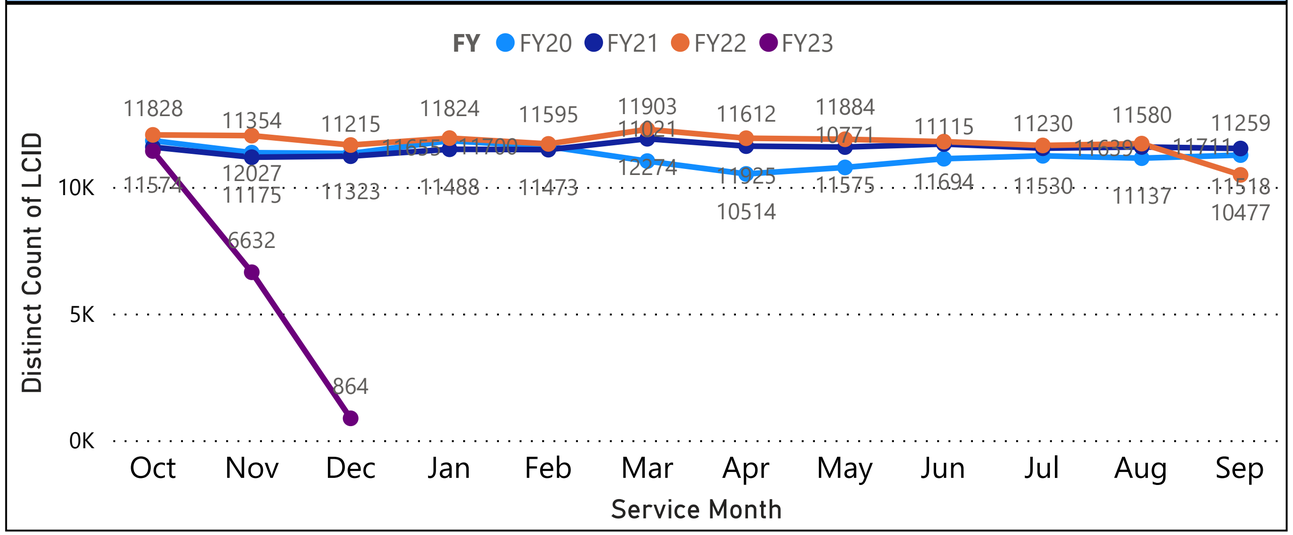
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

LRE
Behavioral Health

LRE Distinct Clients



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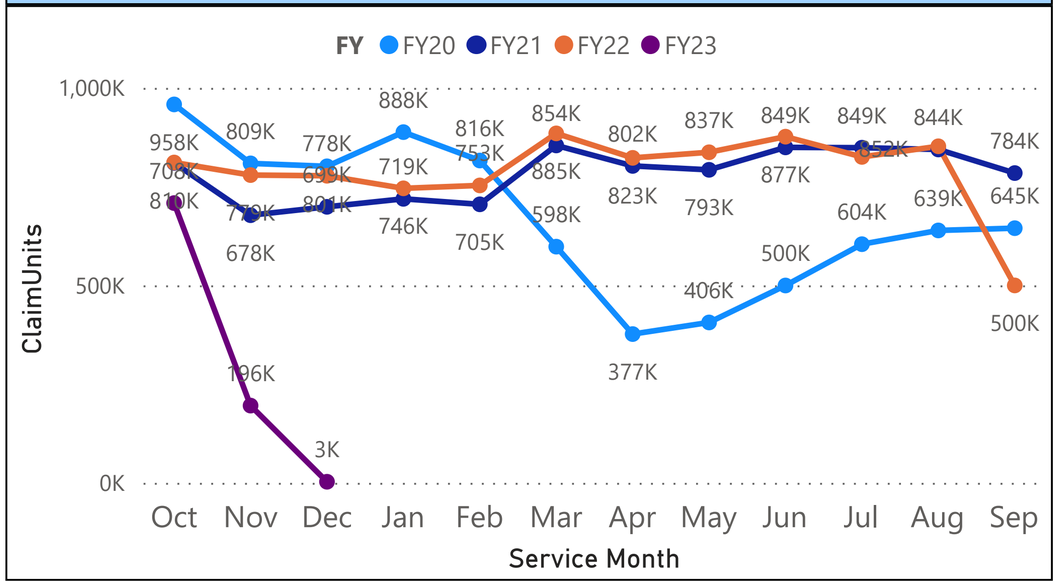
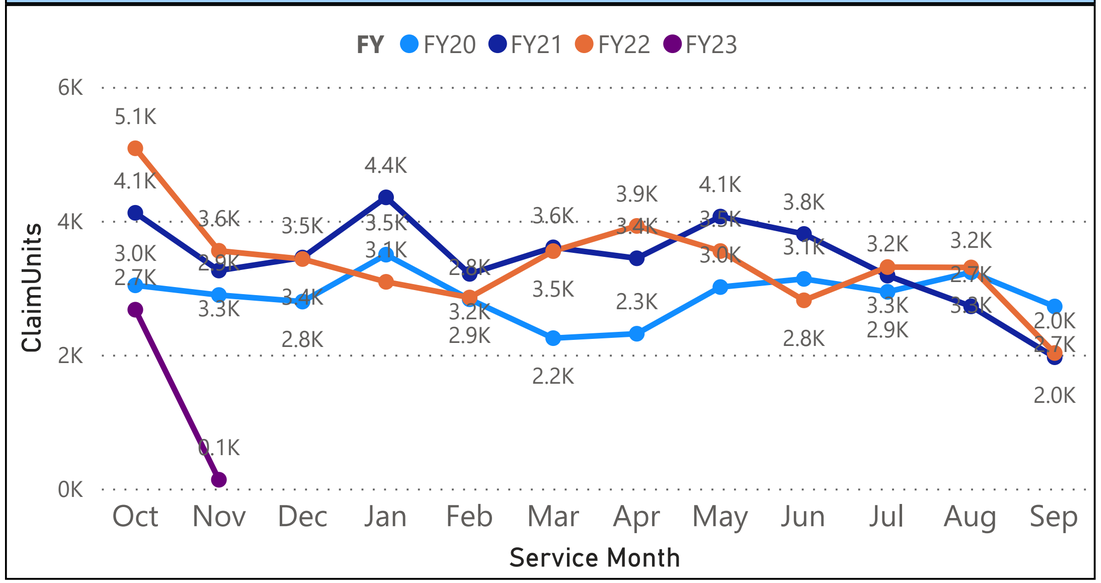
- Select all
- FY20
- FY21
- FY22
- FY23

LRE Professional Units



LRE Institutional Units



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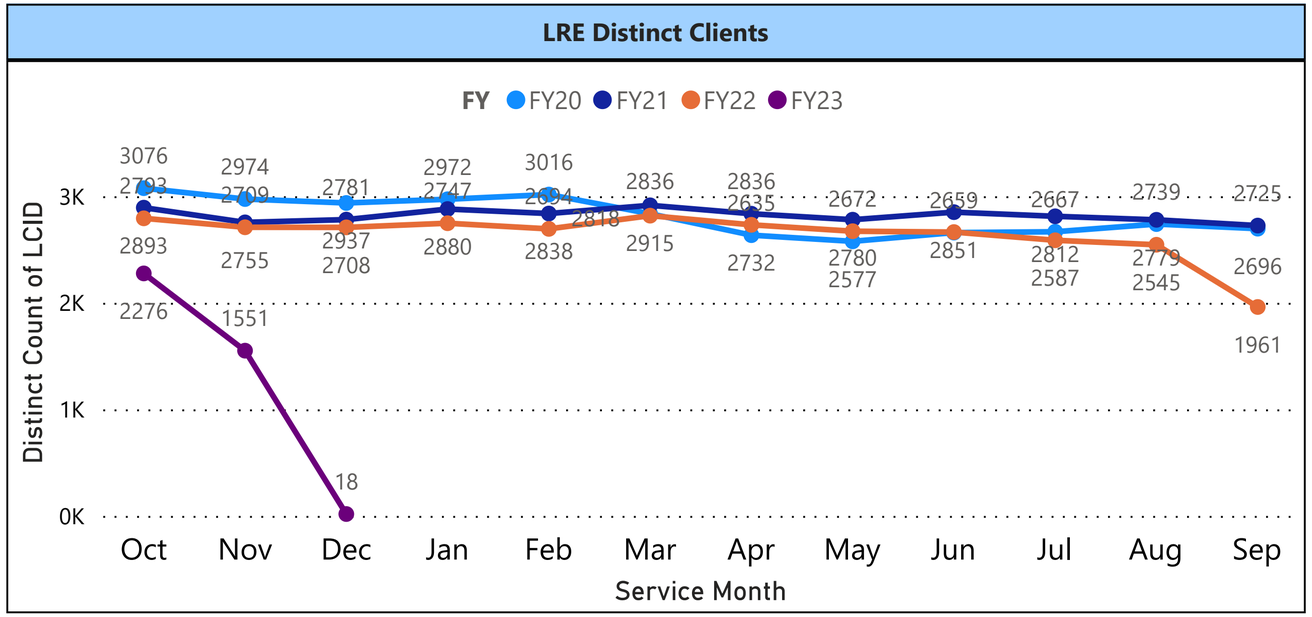
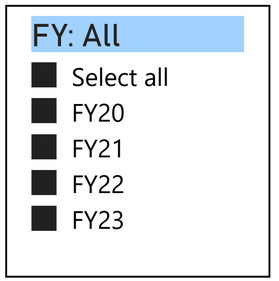
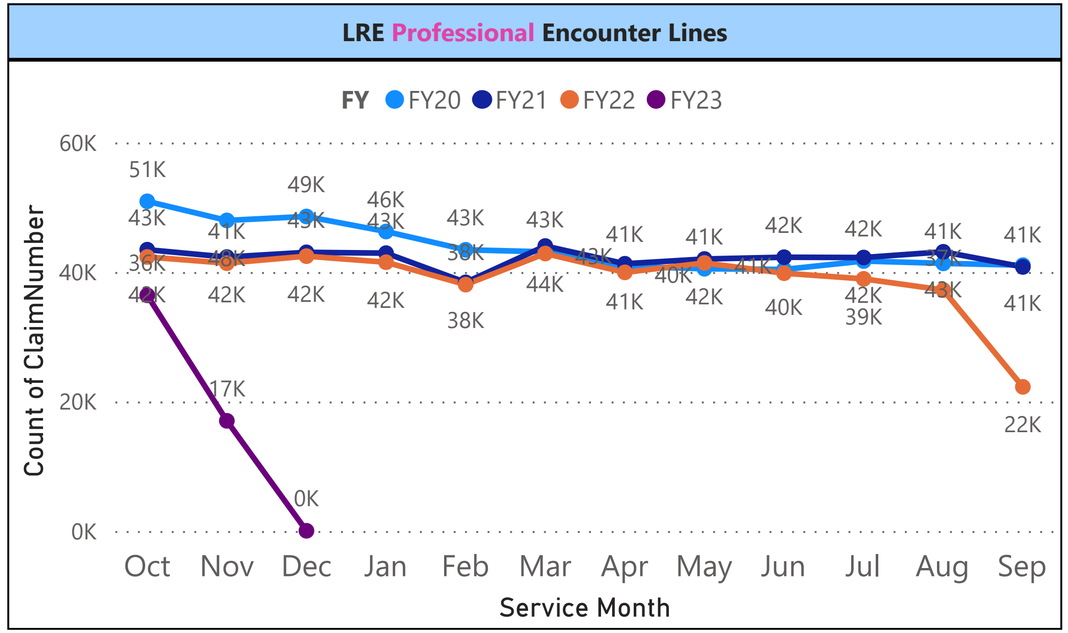
Latest ProcessDate

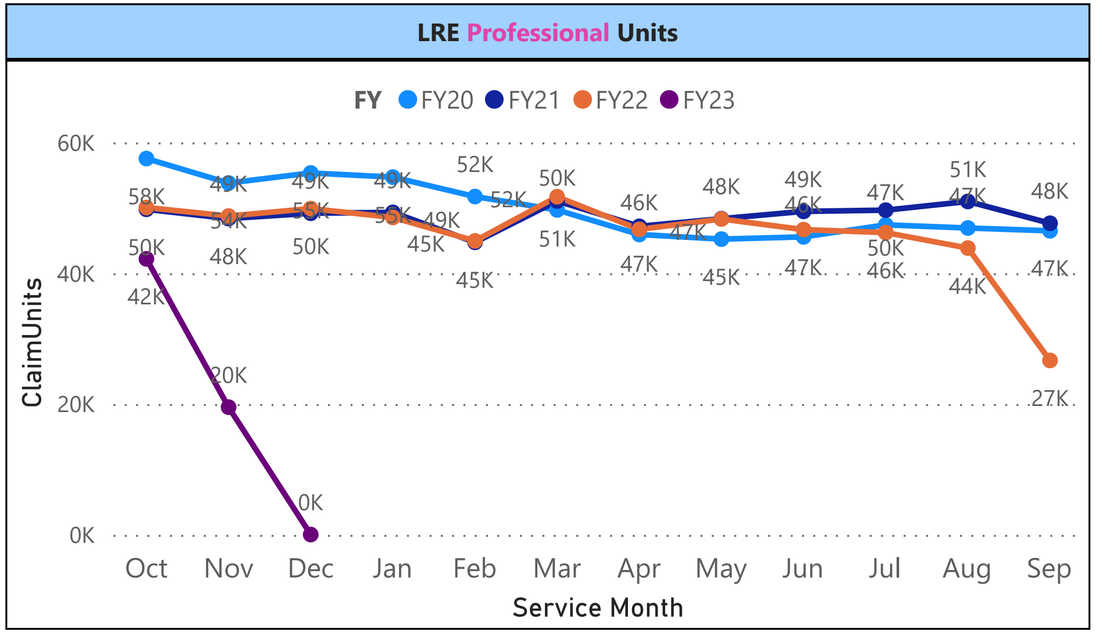
LAKESHORE REGIONAL ENTITY

LRE
Substance Use Disorder









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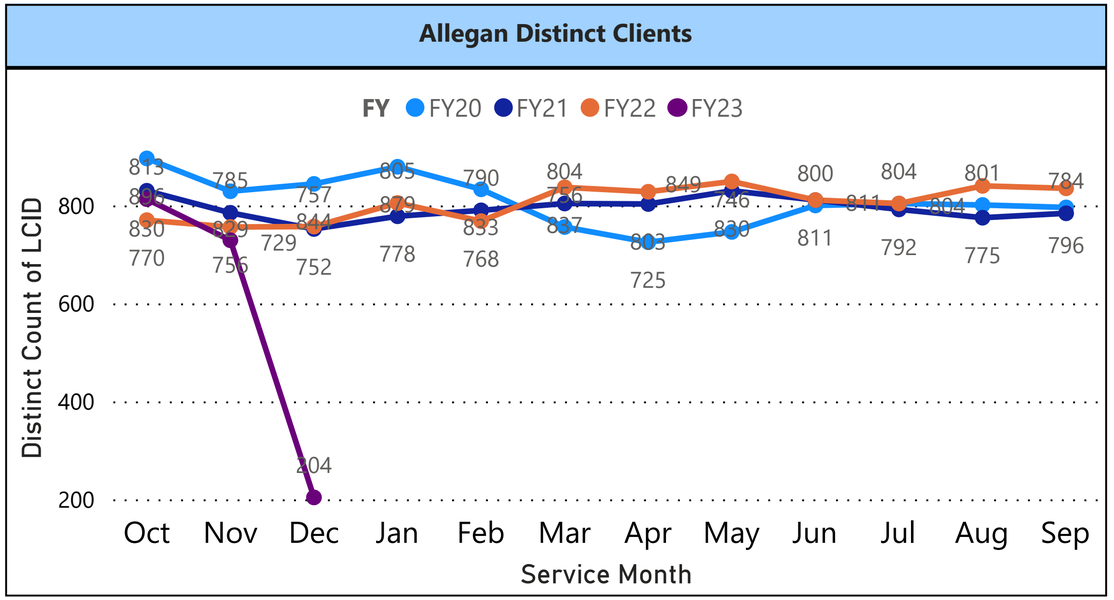
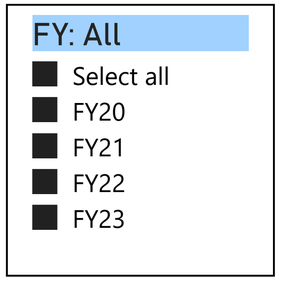
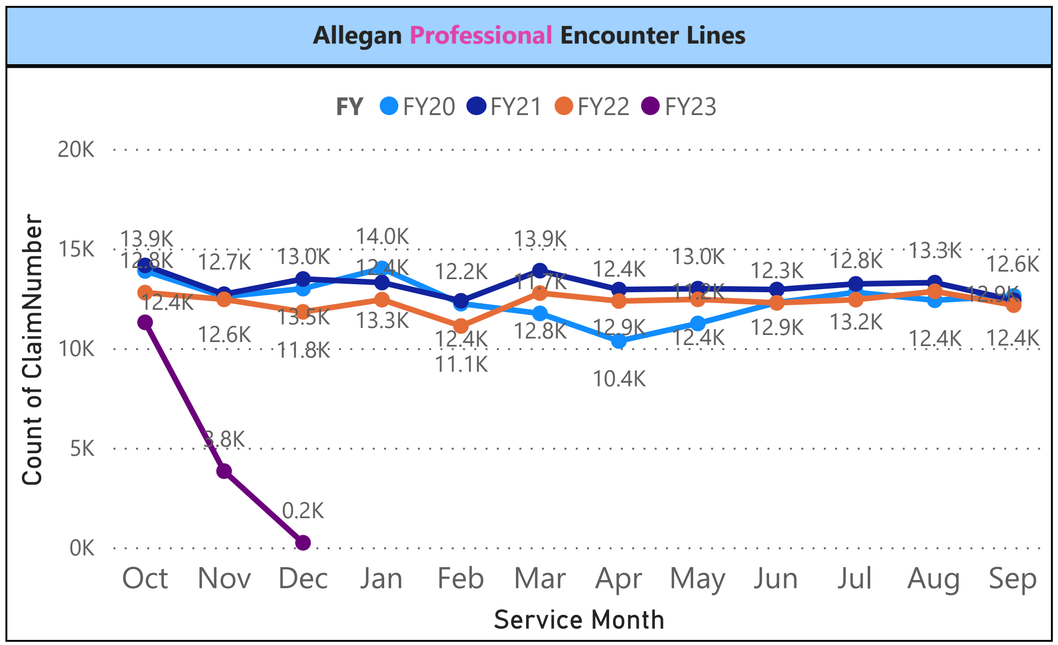
Latest ProcessDate

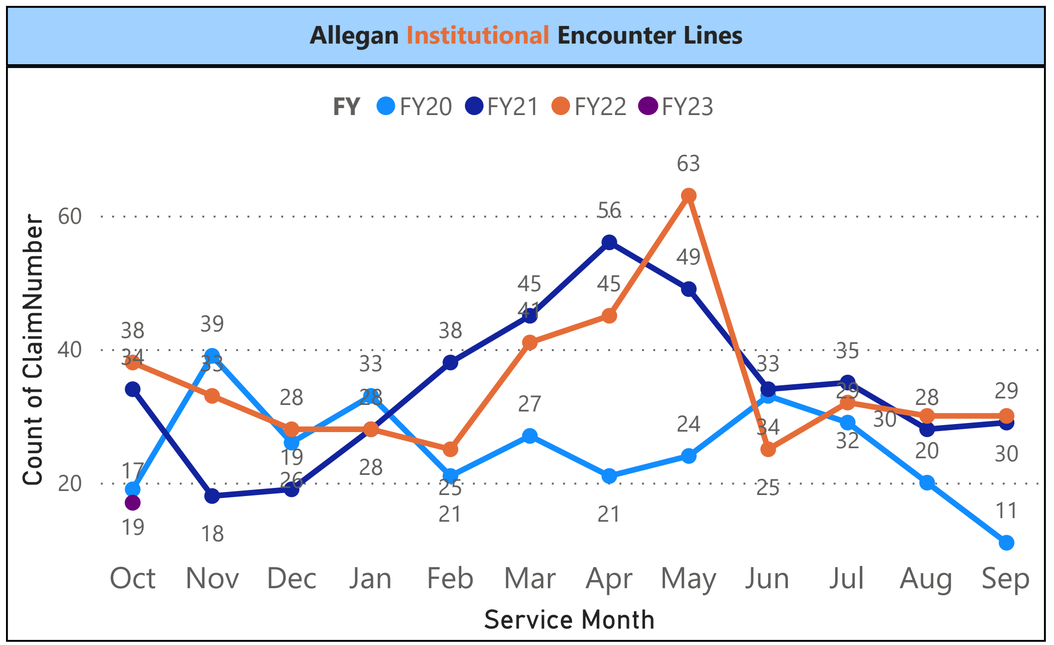
LAKESHORE REGIONAL ENTITY

Allegan Behavioral Health









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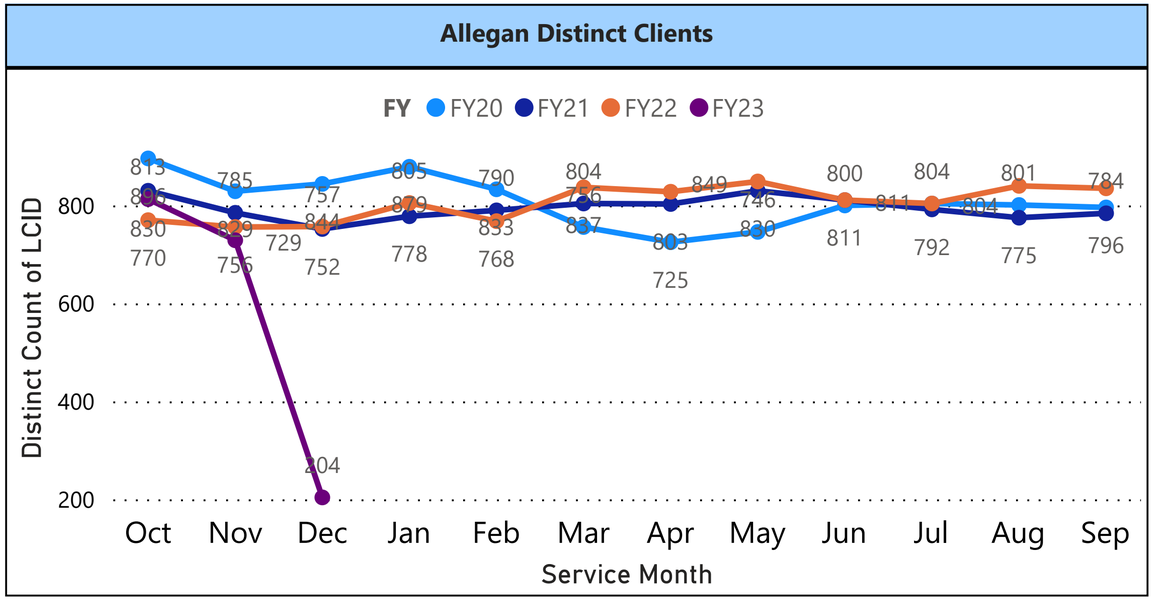
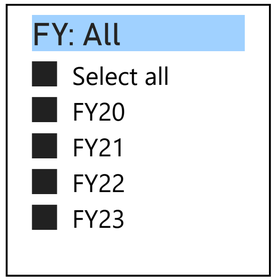
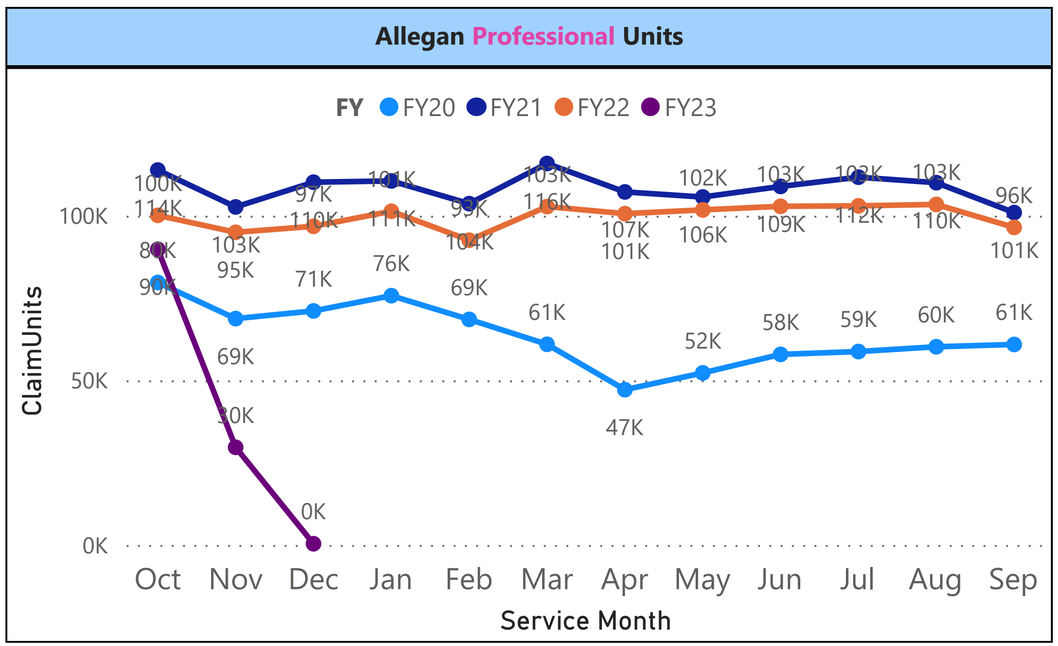
Latest ProcessDate

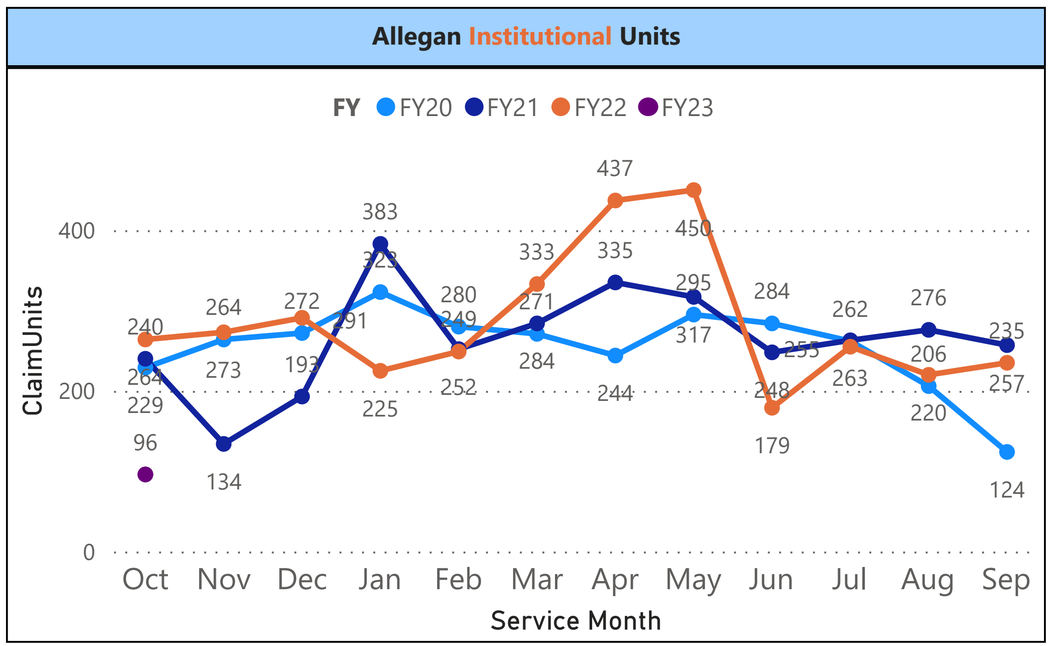
LAKESHORE REGIONAL ENTITY

Allegan Behavioral Health









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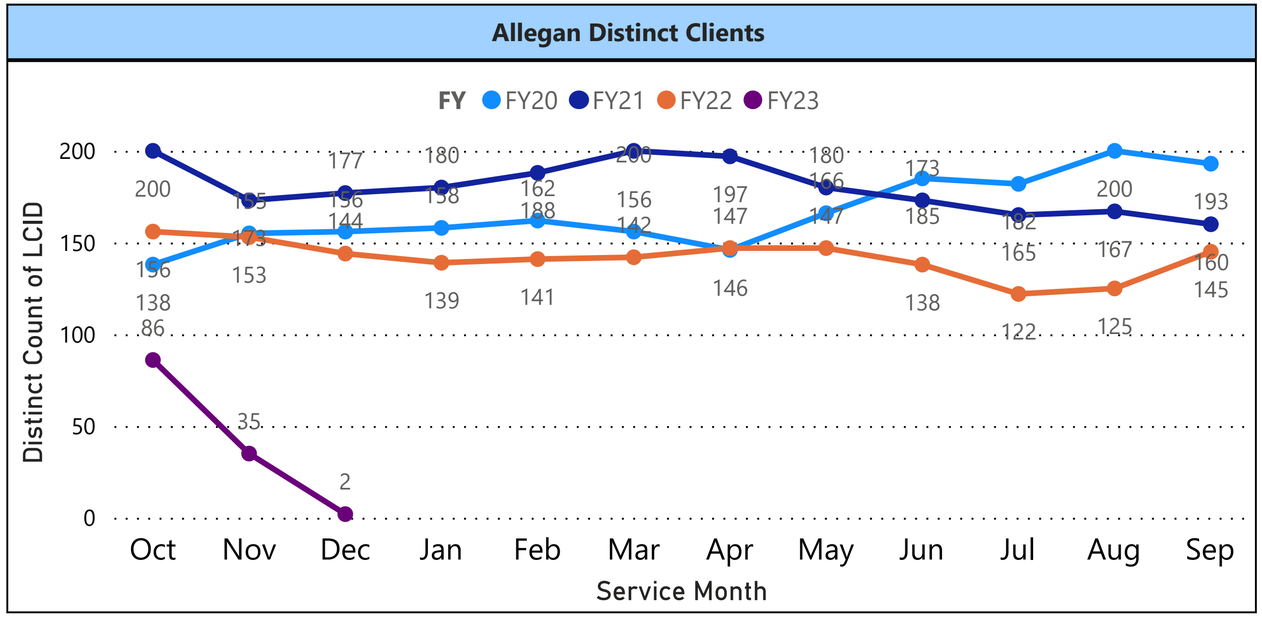
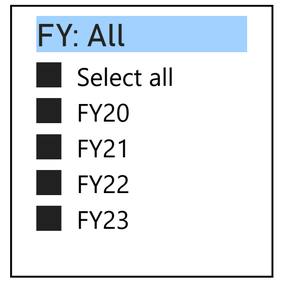
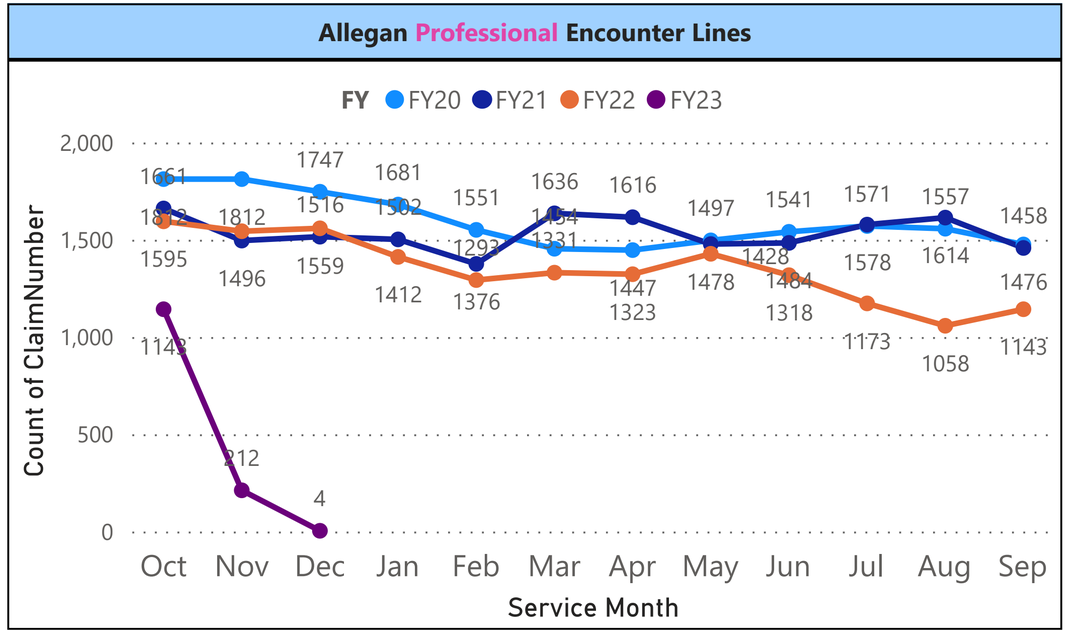
Latest ProcessDate

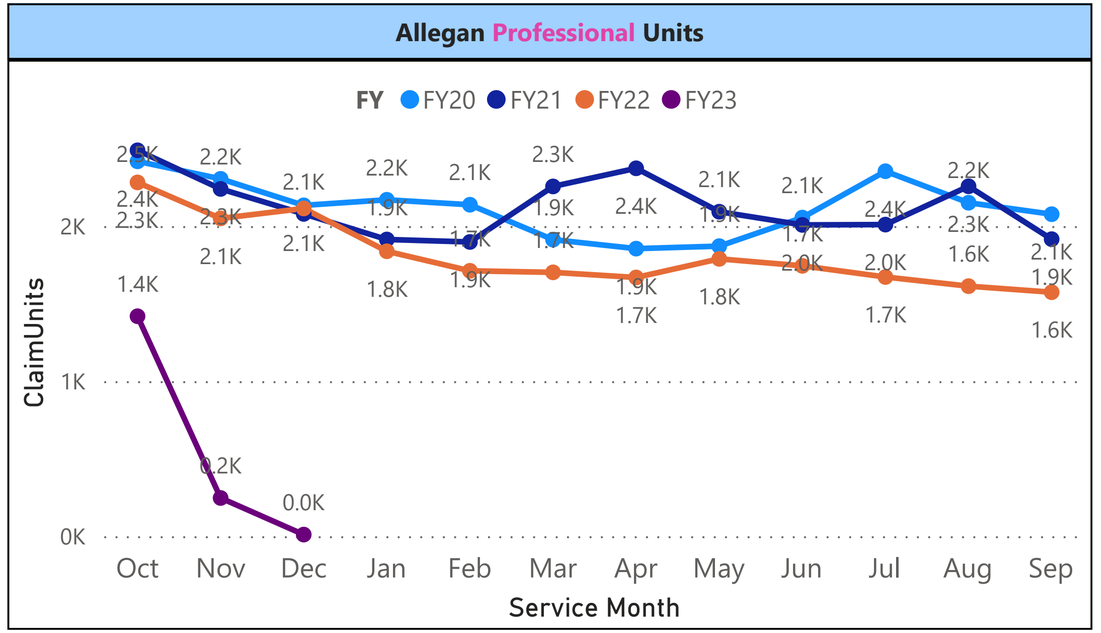
LAKESHORE REGIONAL ENTITY

Allegan
Substance Use Disorder









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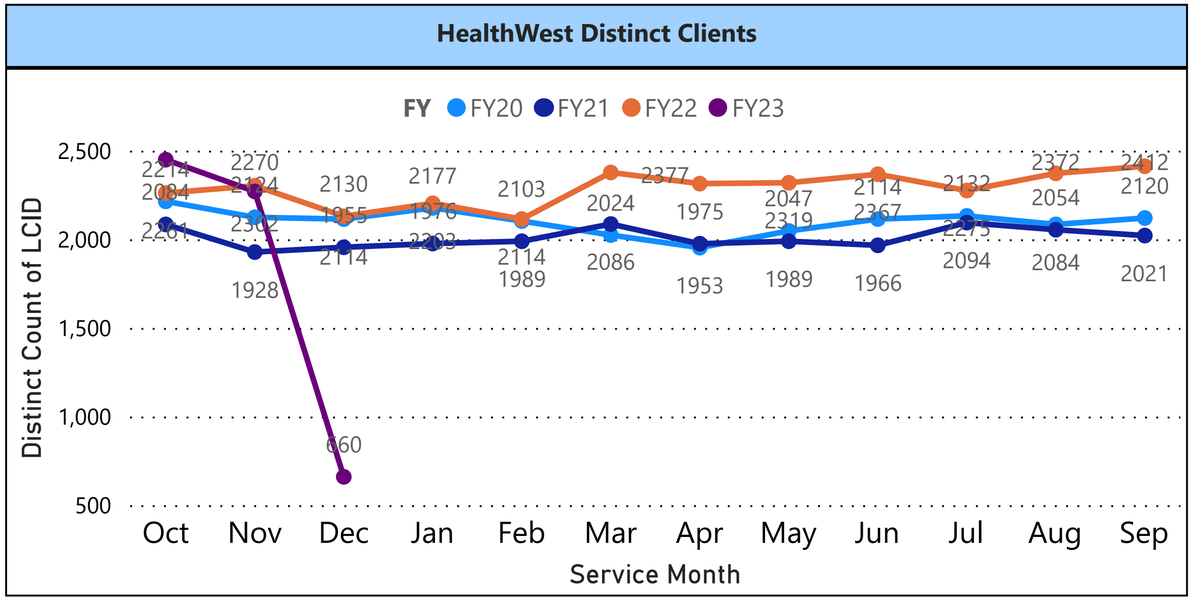
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

HealthWest Behavioral Health



FY: All
- Select all
- FY20
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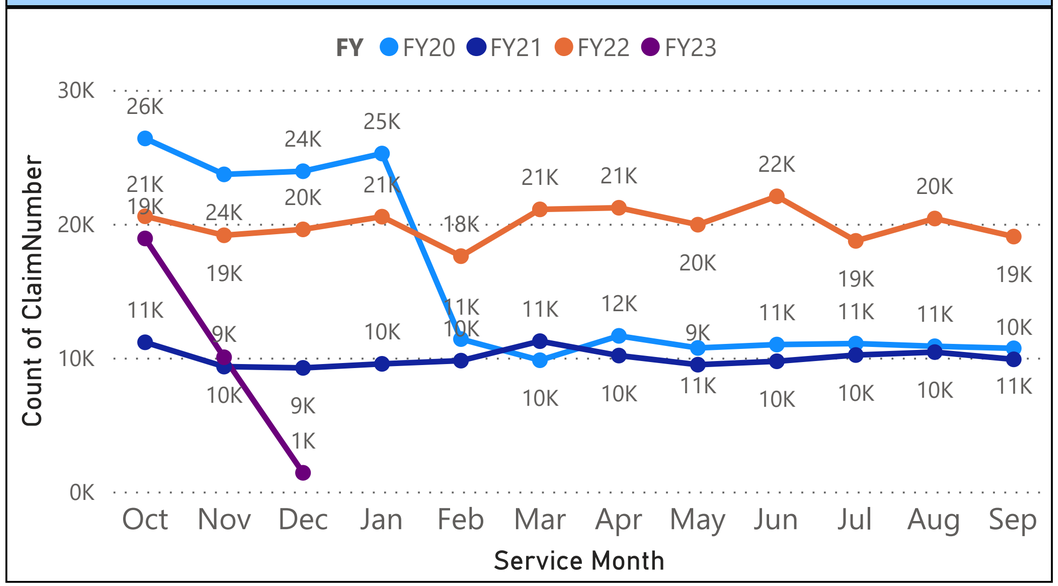
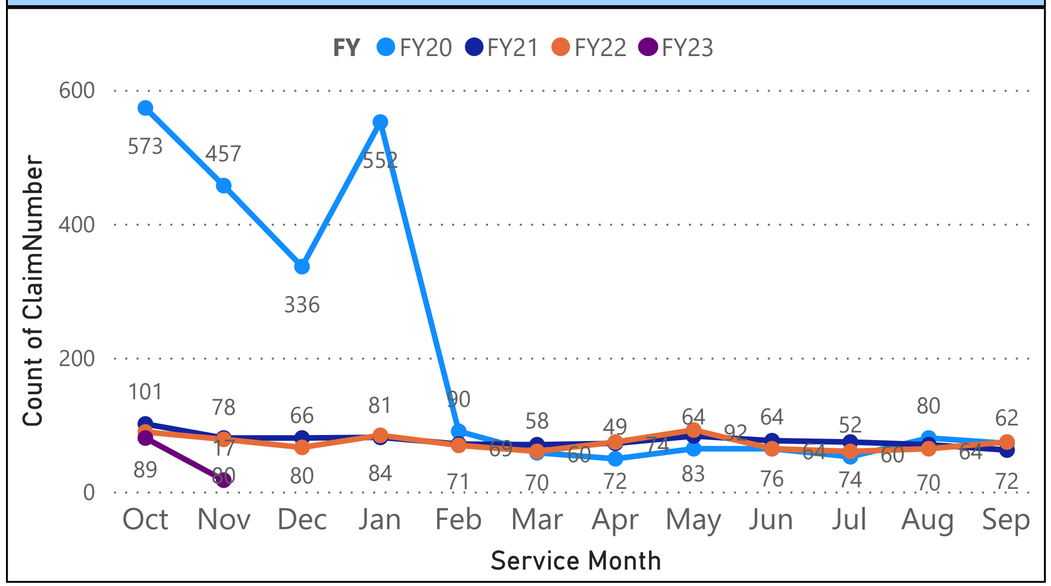
- FY23





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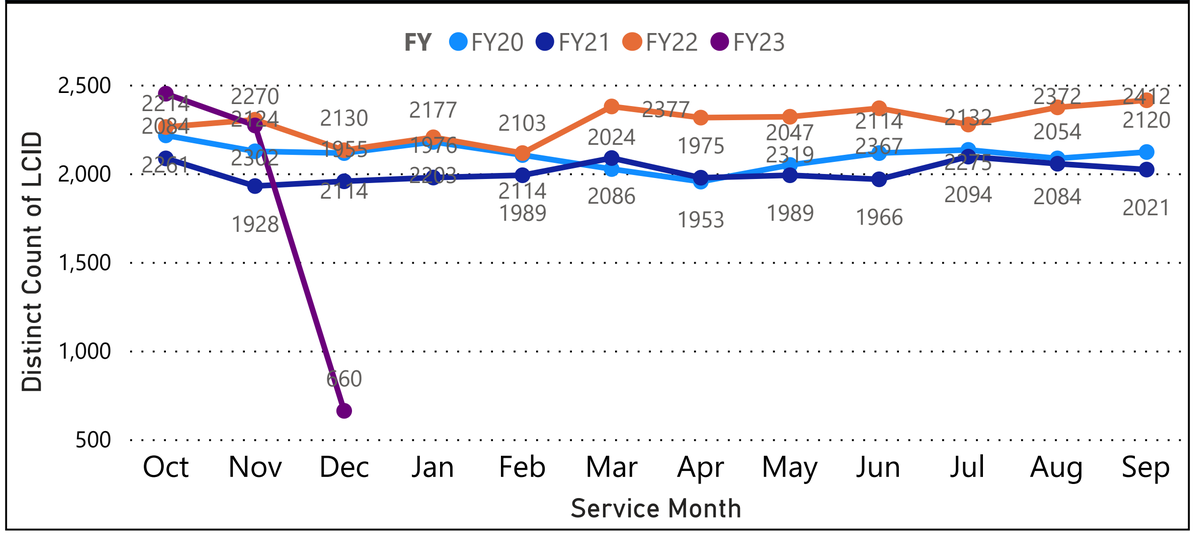
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

HealthWest Behavioral Health

HealthWest Distinct Clients



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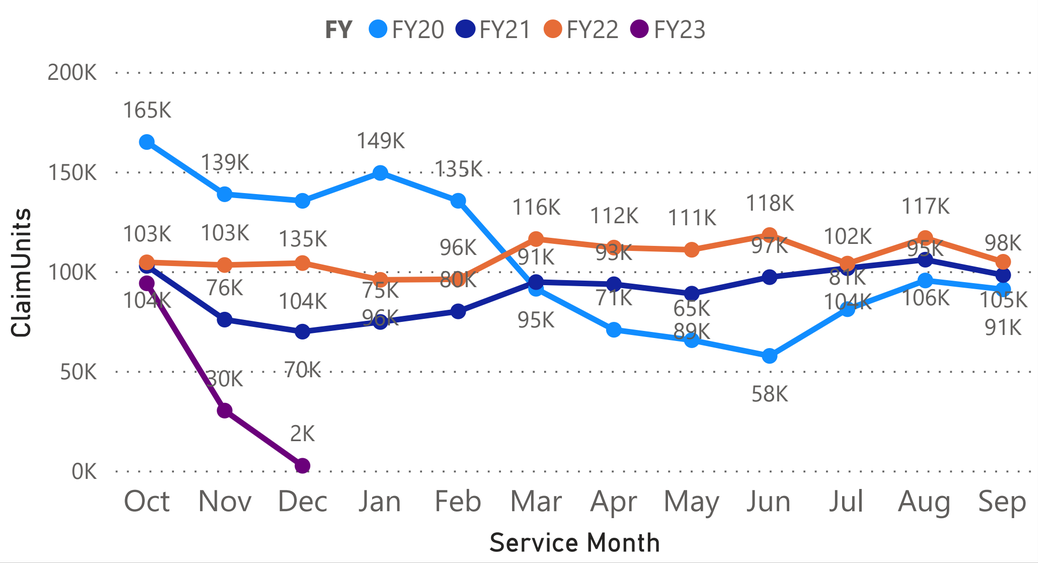
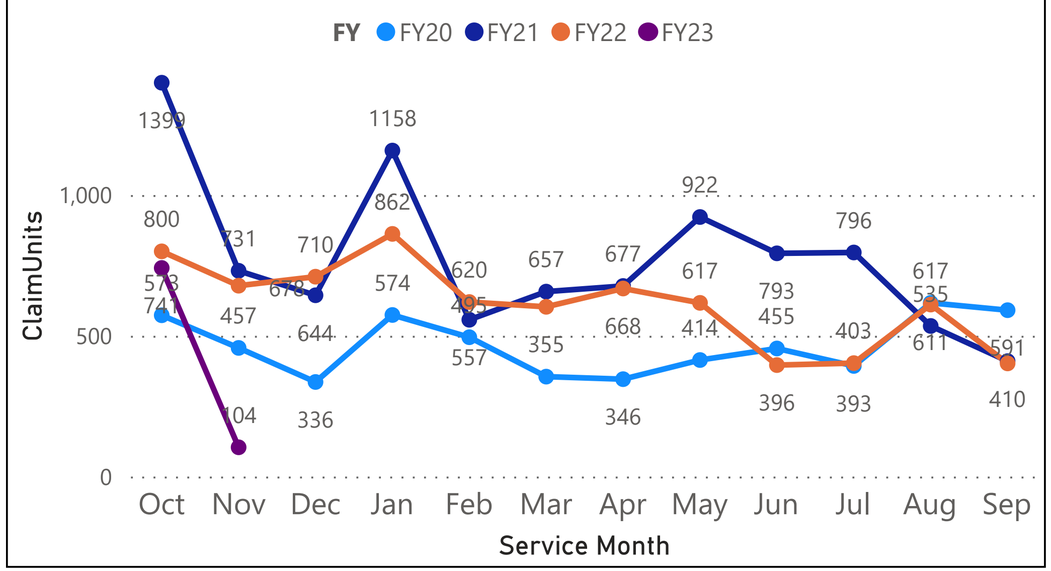
- FY20
- FY21
- FY22
- FY23

HealthWest Professional Units



HealthWest Institutional Units



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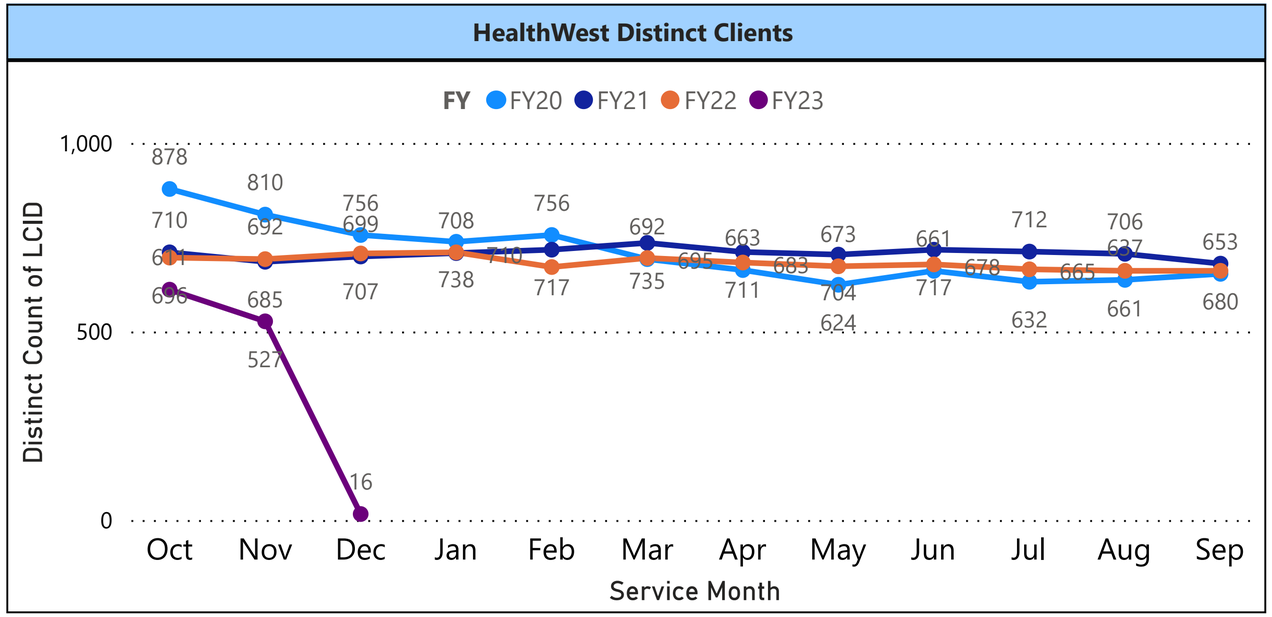
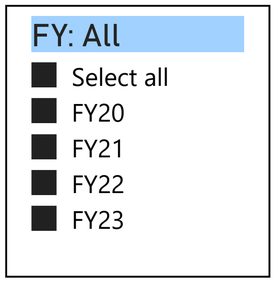
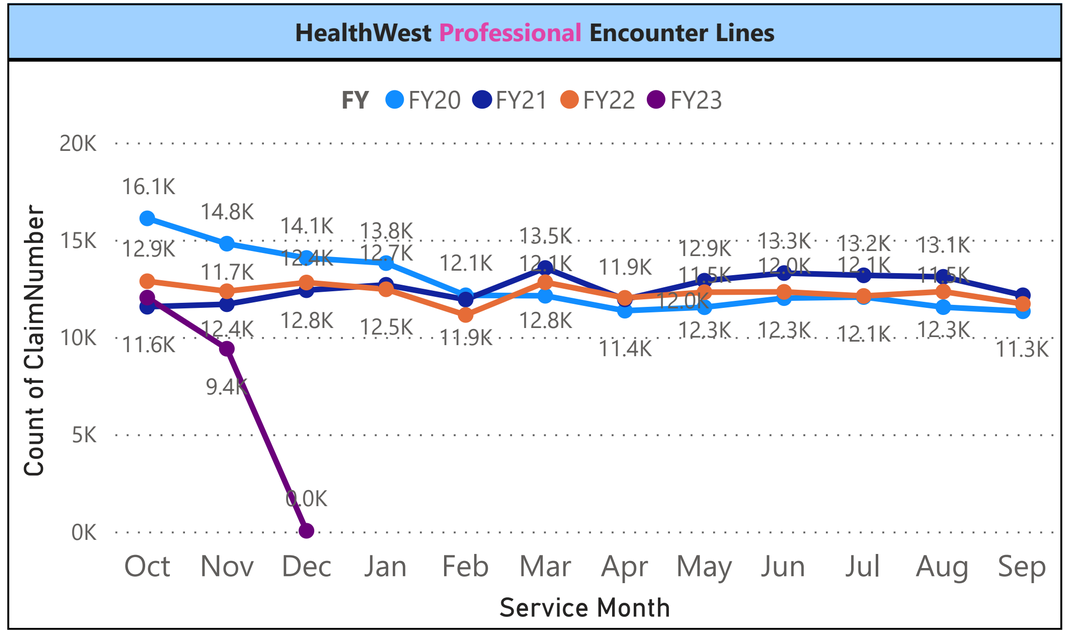
Latest ProcessDate

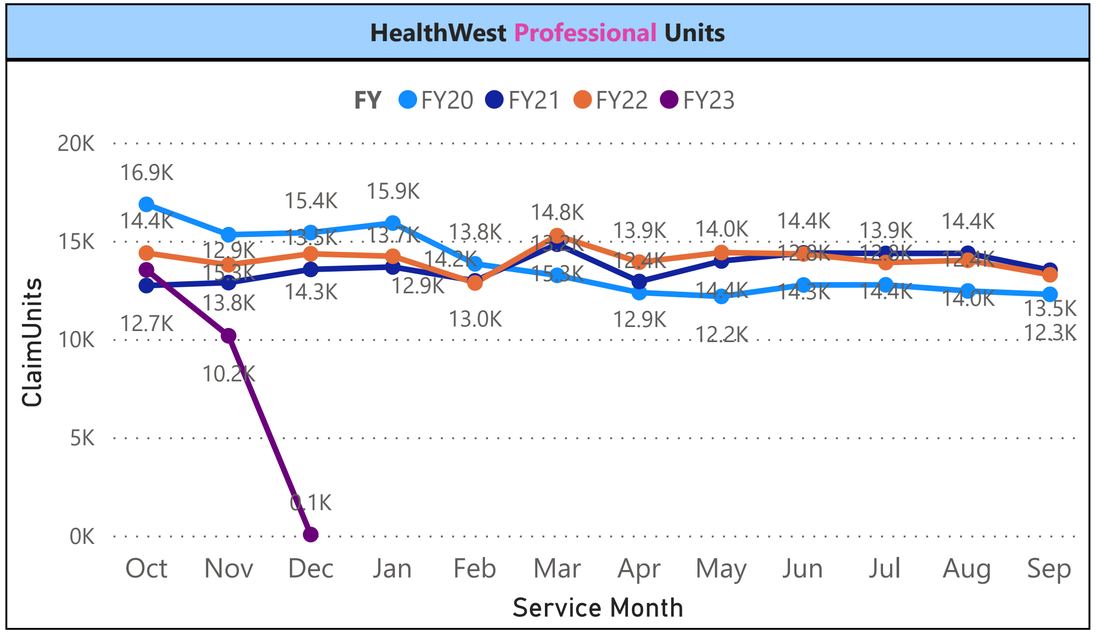
LAKESHORE REGIONAL ENTITY

HealthWest
Substance Use Disorder









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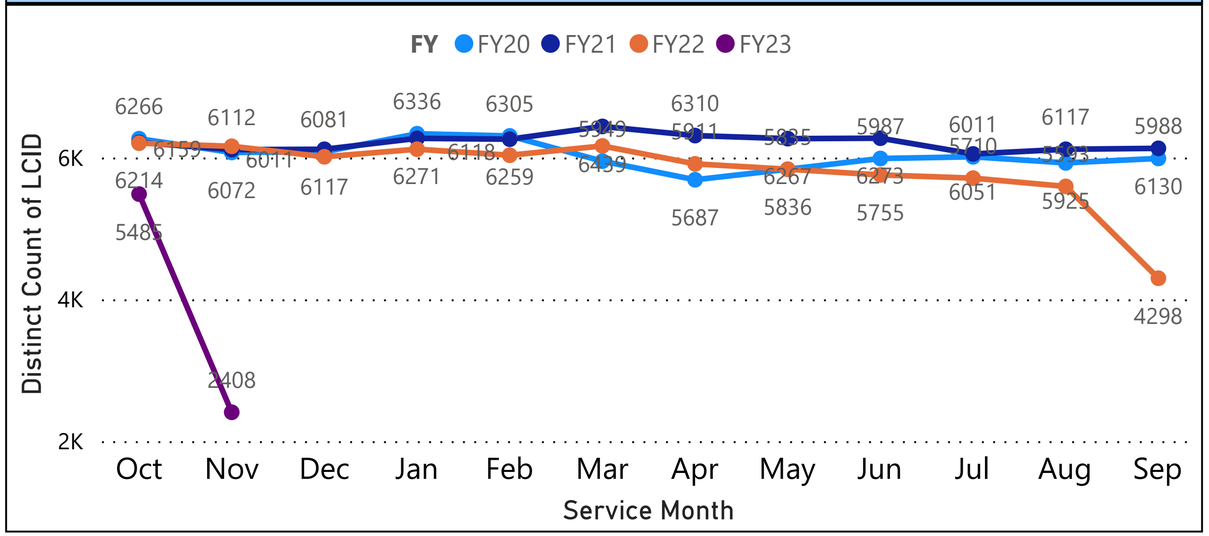
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

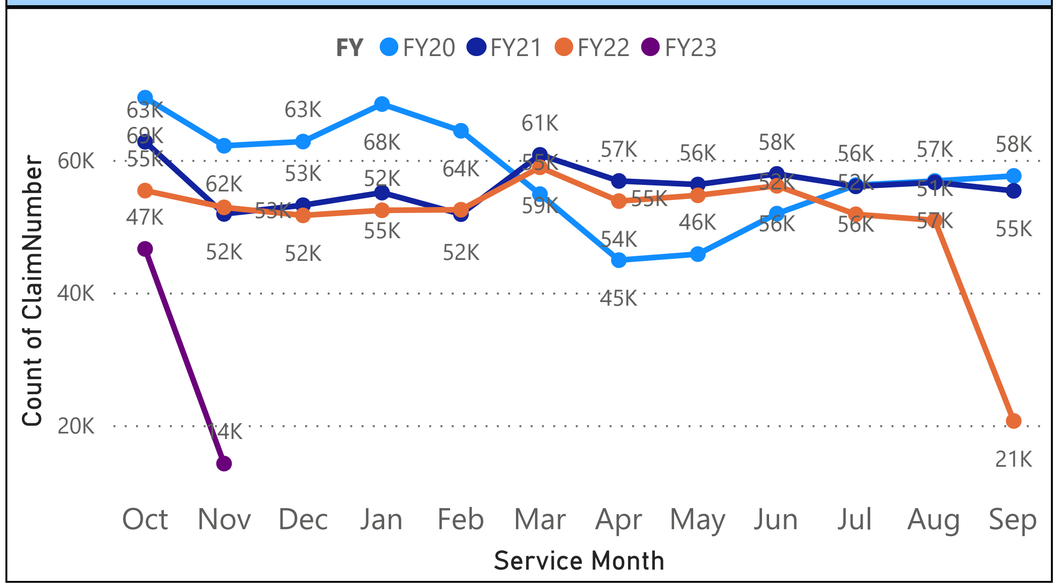
Network180 Behavioral Health

Network180 Distinct Clients

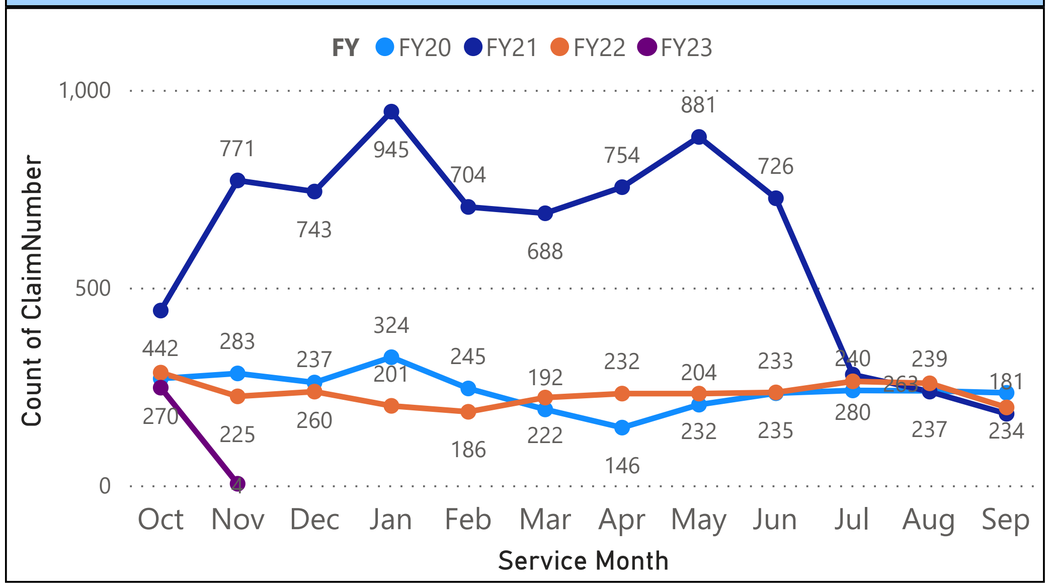


FY: All
- Select all
- FY20
- FY21
- FY22
- FY23

Network180 Professional Encounter Lines



Network180 Institutional Encounter Lines



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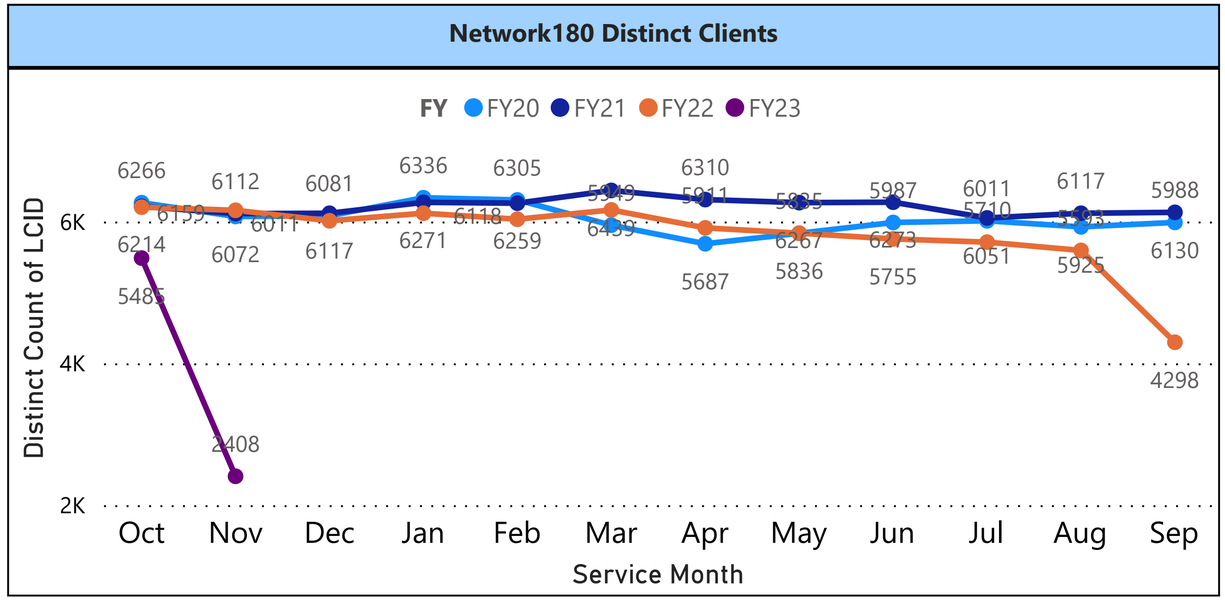
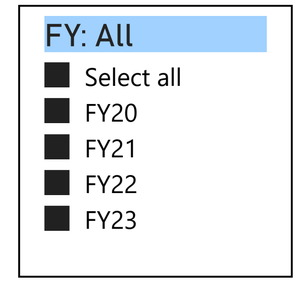
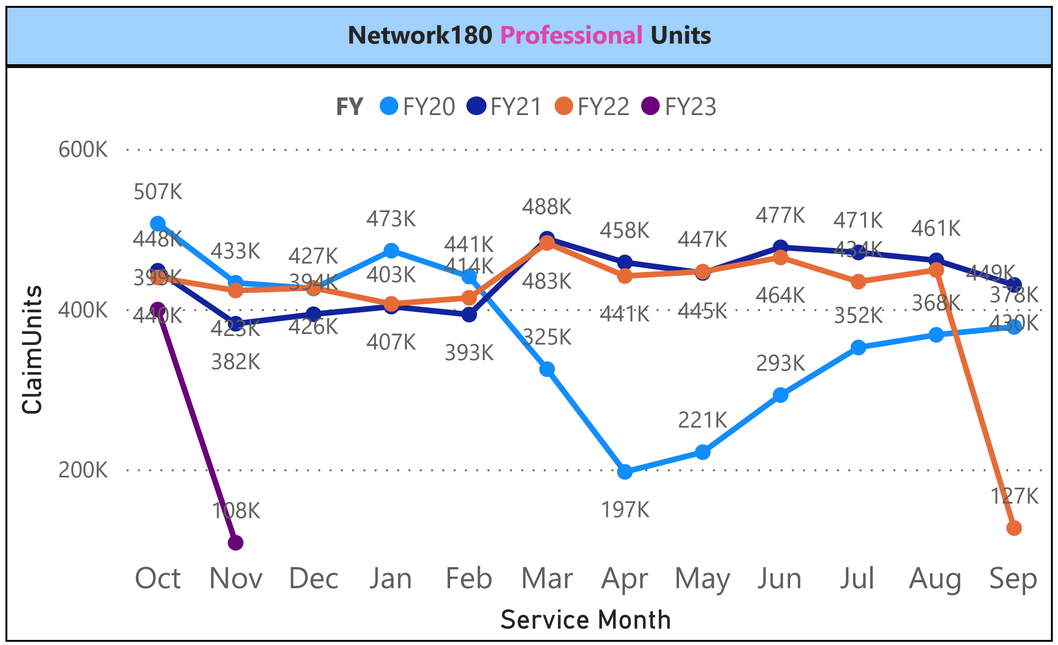
Latest ProcessDate

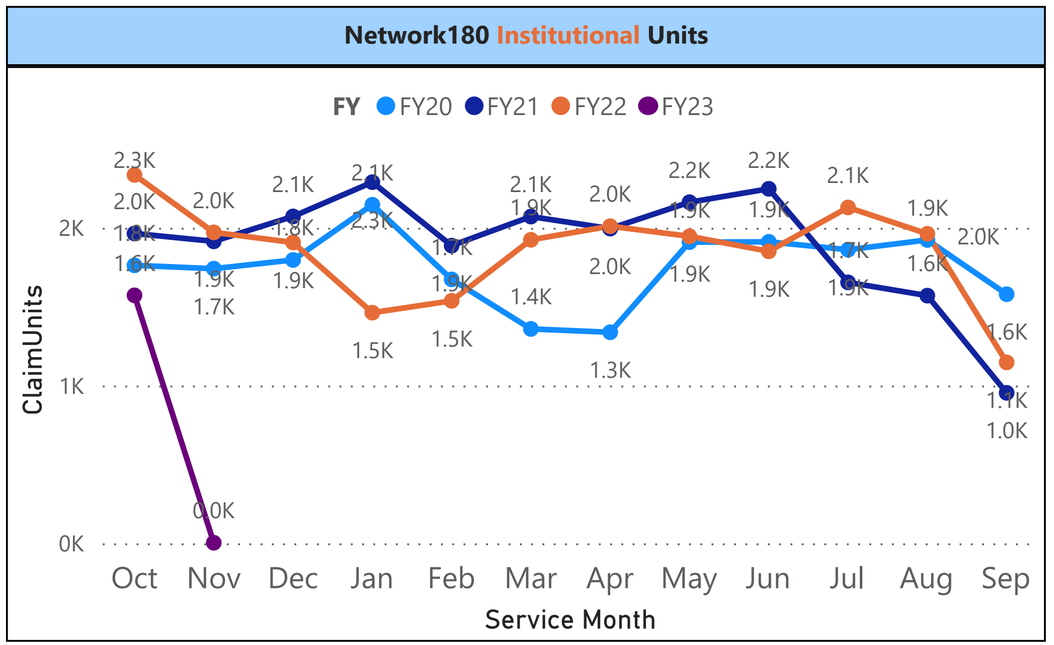
LAKESHORE REGIONAL ENTITY

Network180
Behavioral Health









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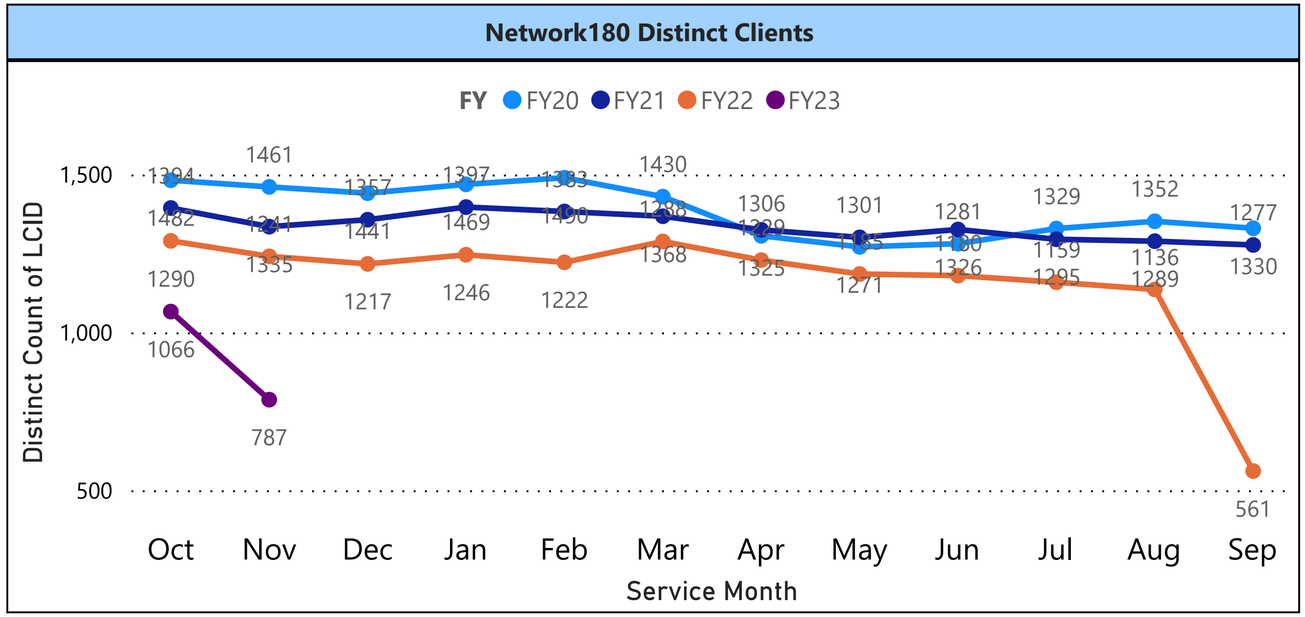
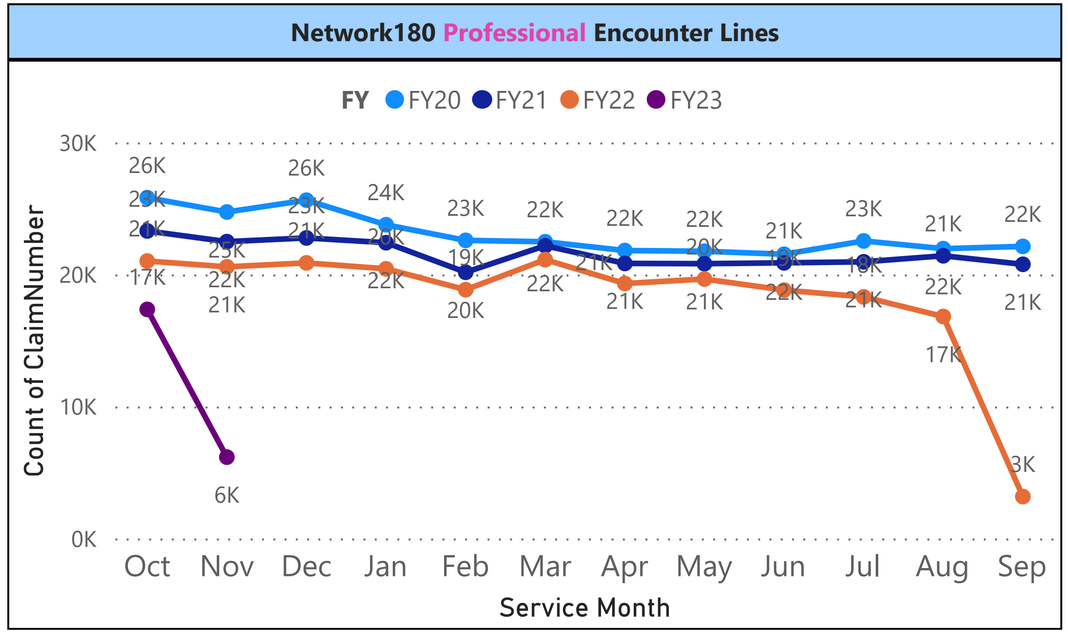
Latest ProcessDate

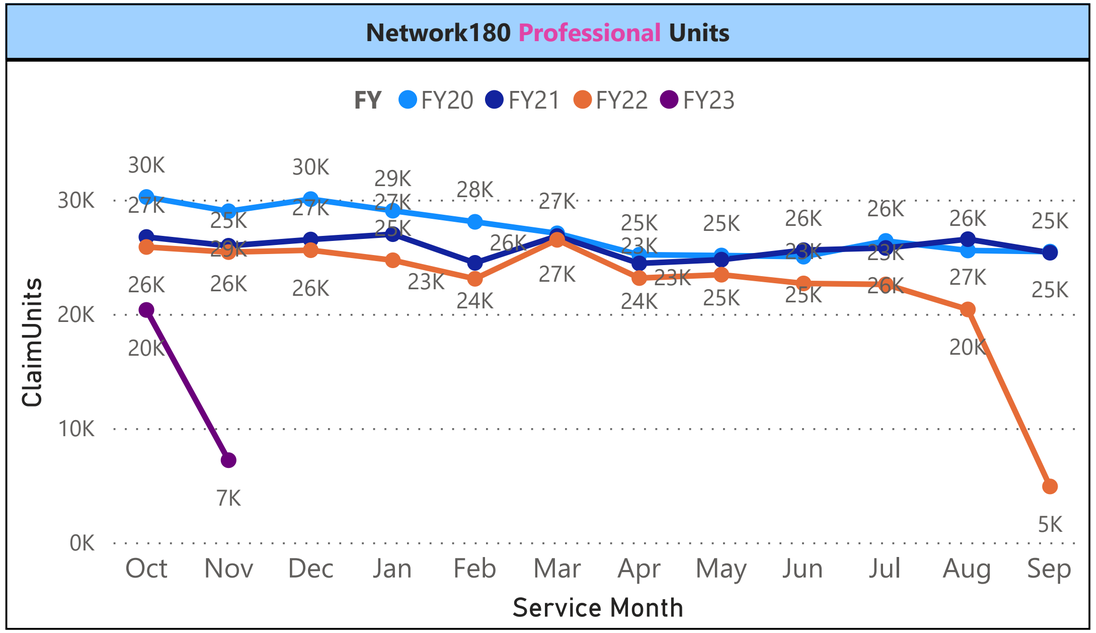
LAKESHORE REGIONAL ENTITY

Network180
Substance Use Disorder



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





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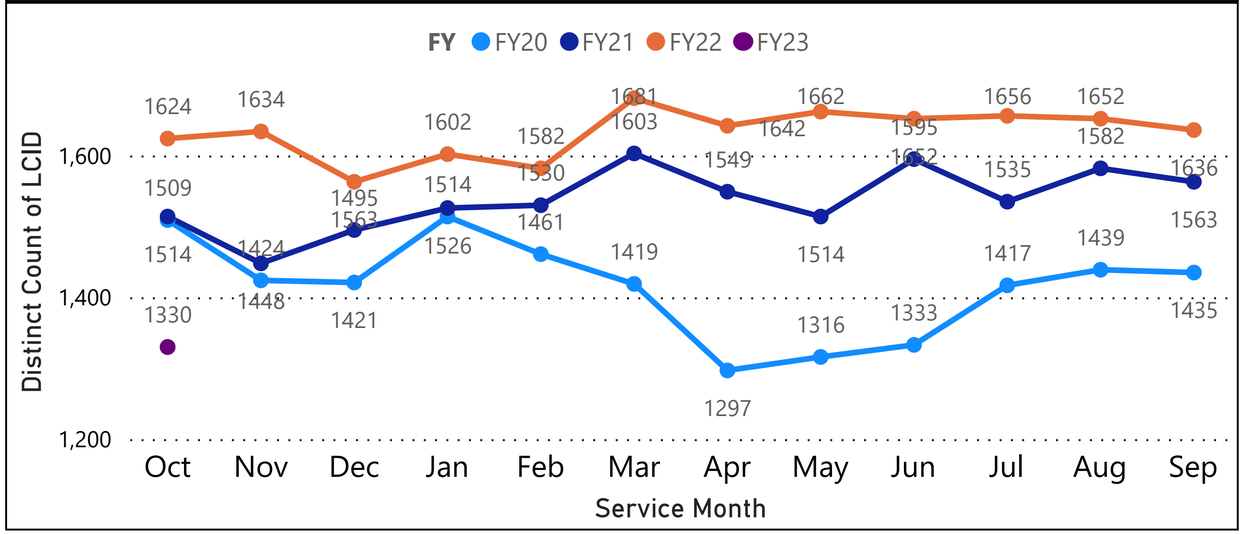
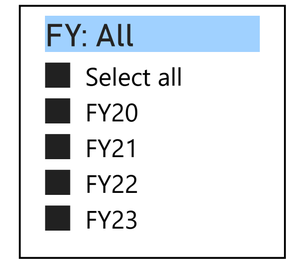
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

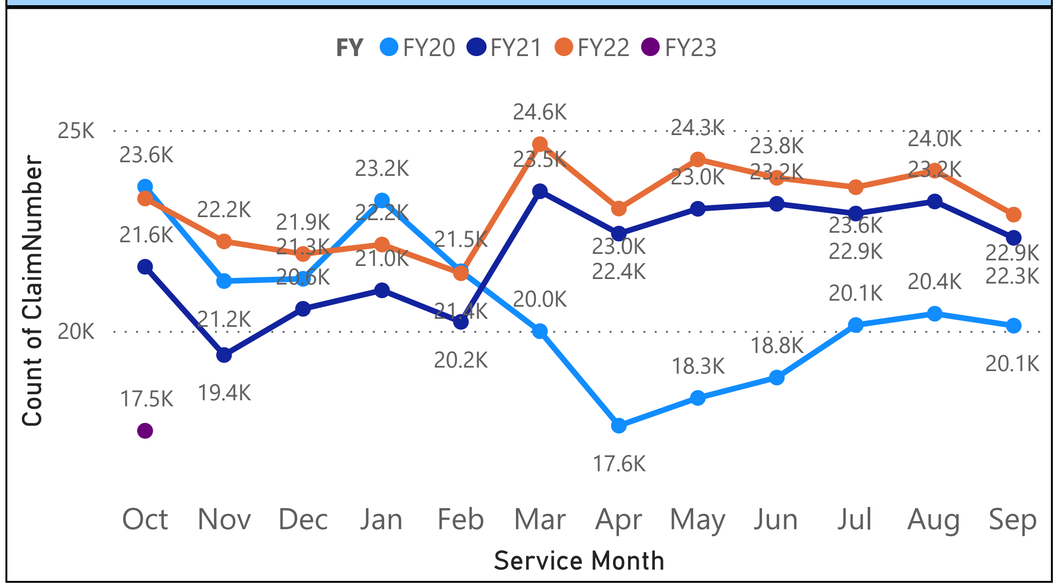
Ottawa Behavioral Health

Ottawa Distinct Clients

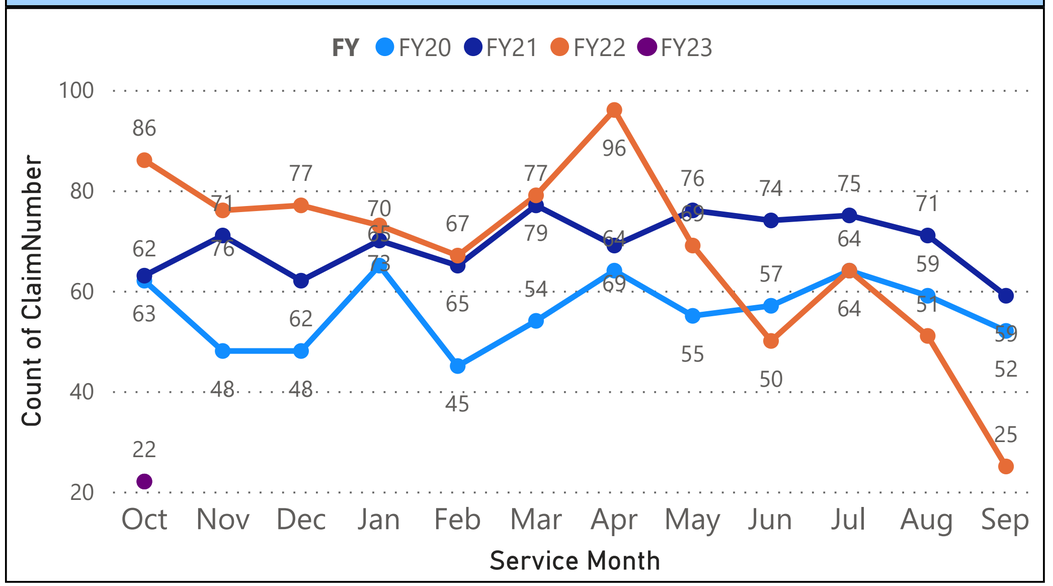




Ottawa Professional Encounter Lines



Ottawa Institutional Encounter Lines



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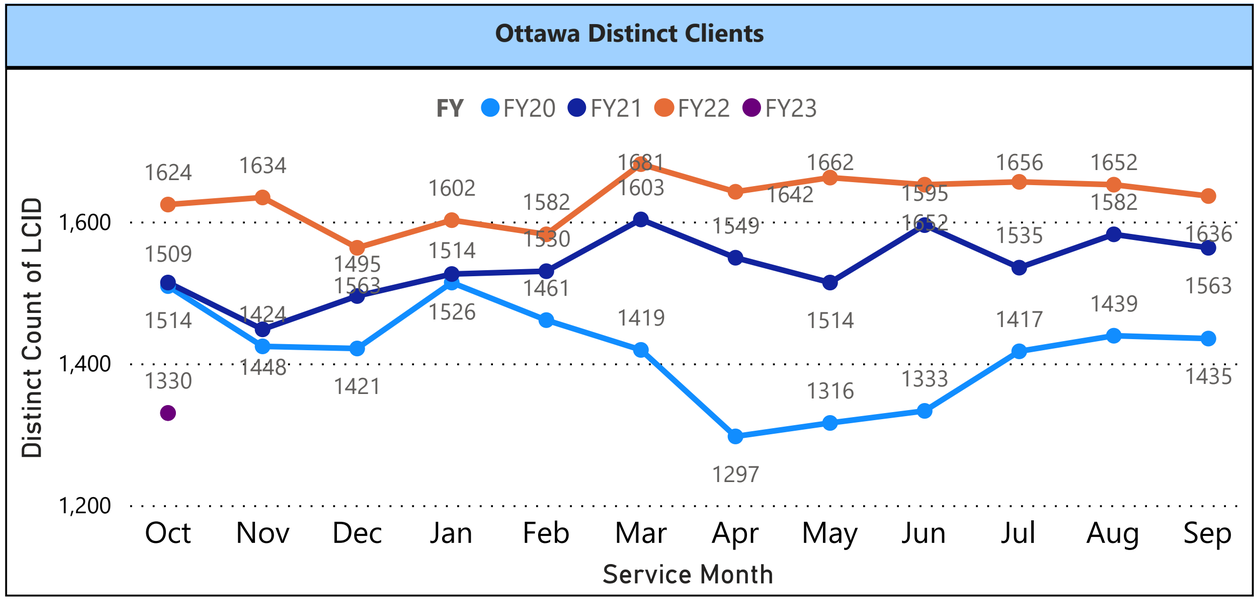
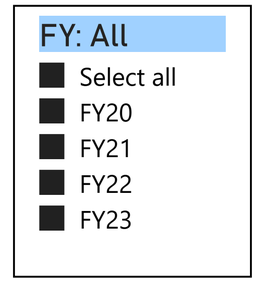
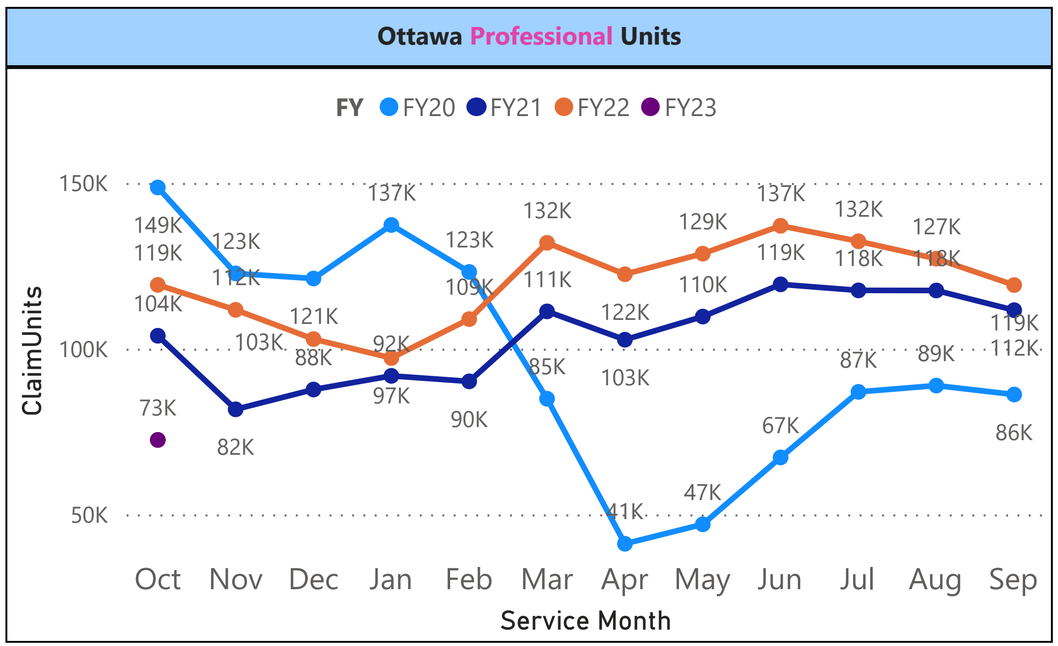
Latest ProcessDate

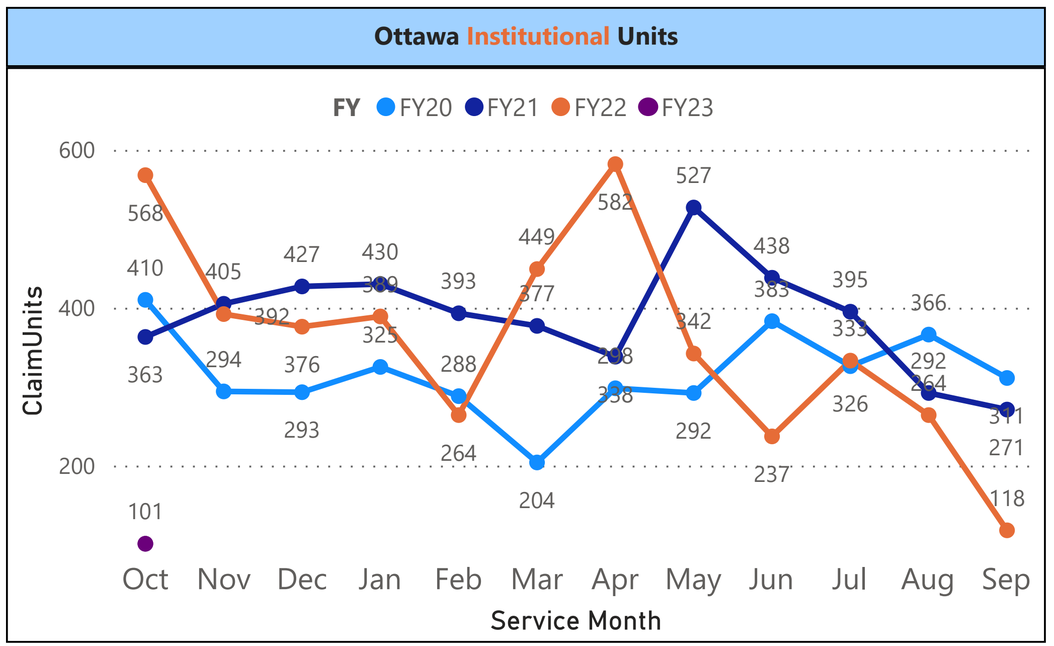
LAKESHORE REGIONAL ENTITY

Ottawa Behavioral Health









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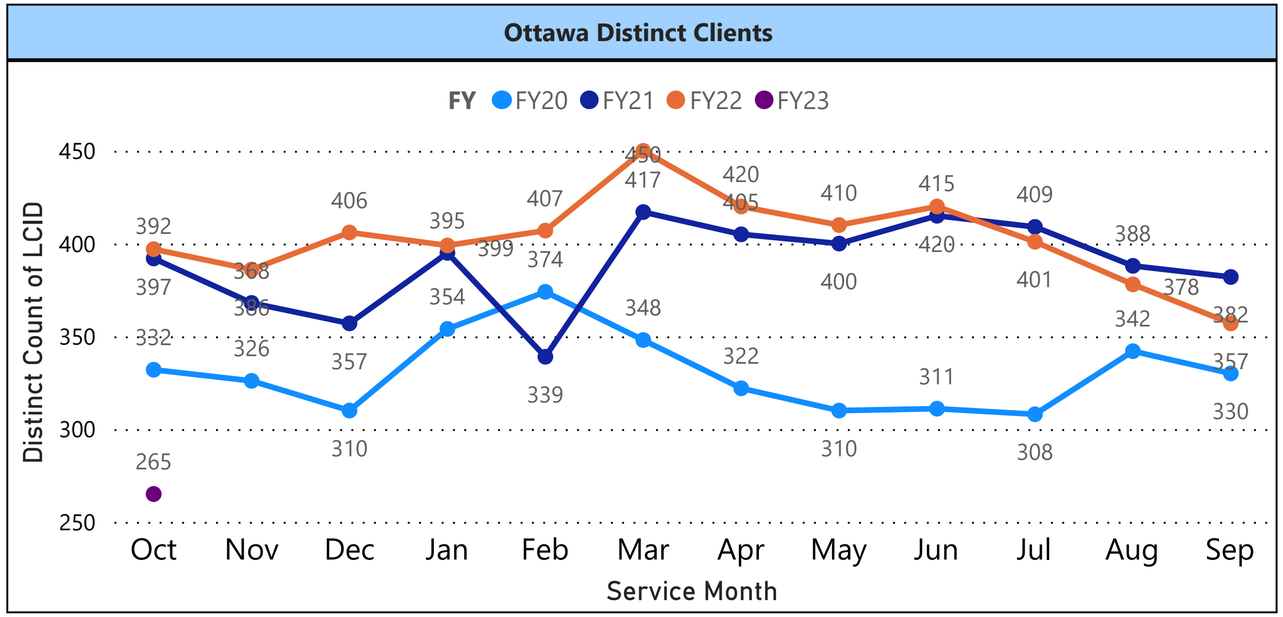
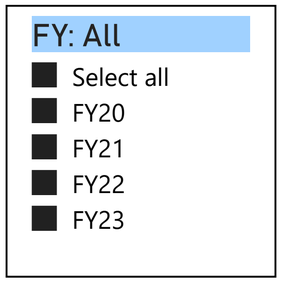
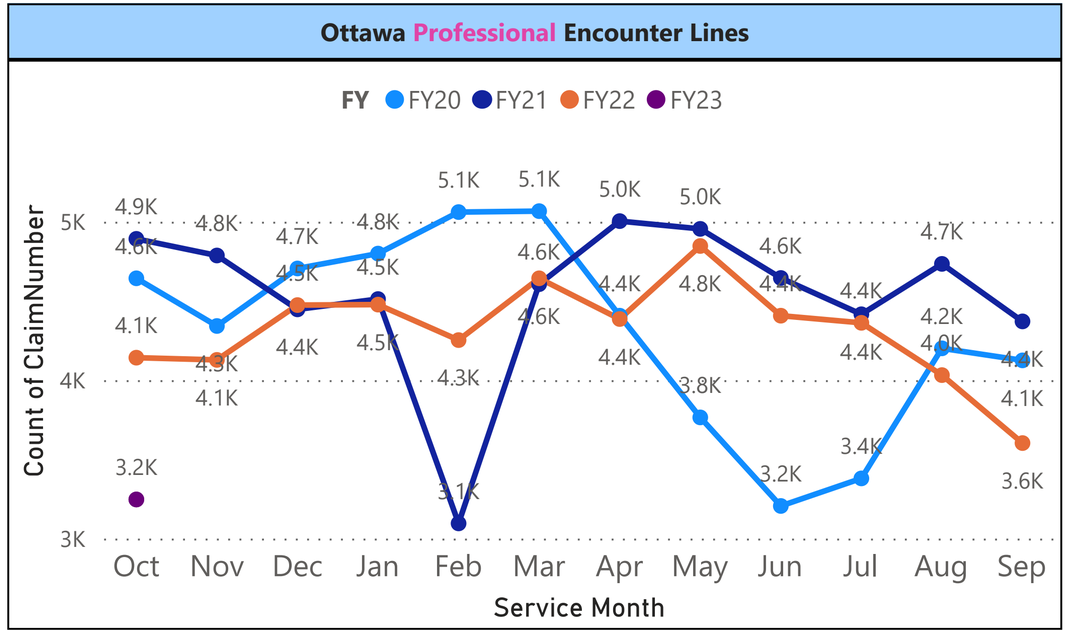
Latest ProcessDate

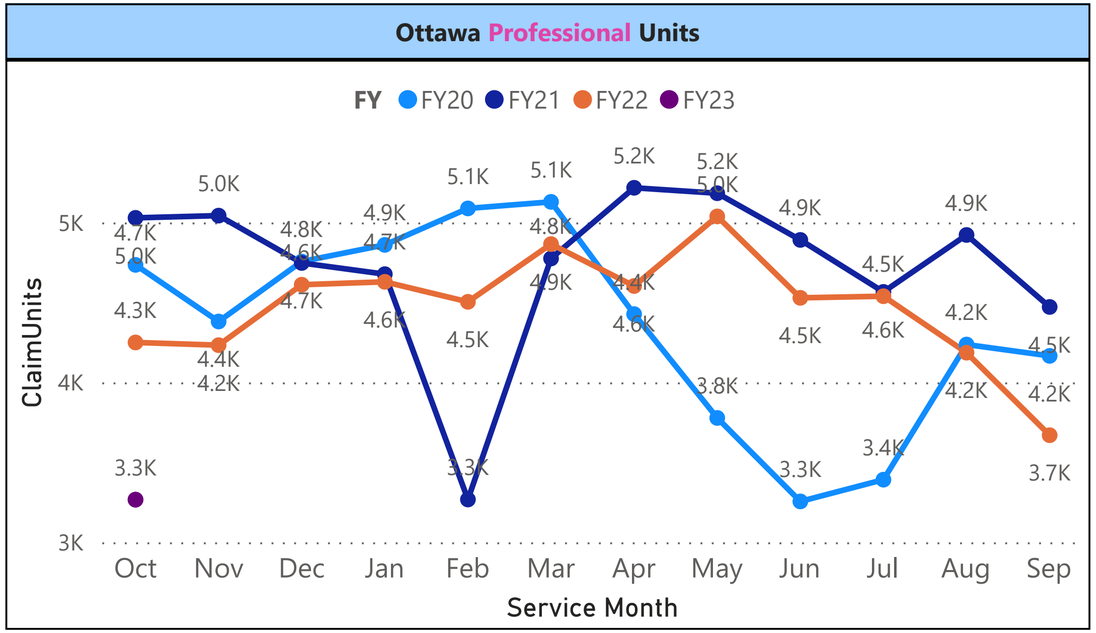
LAKESHORE REGIONAL ENTITY

Ottawa
Substance Use Disorder









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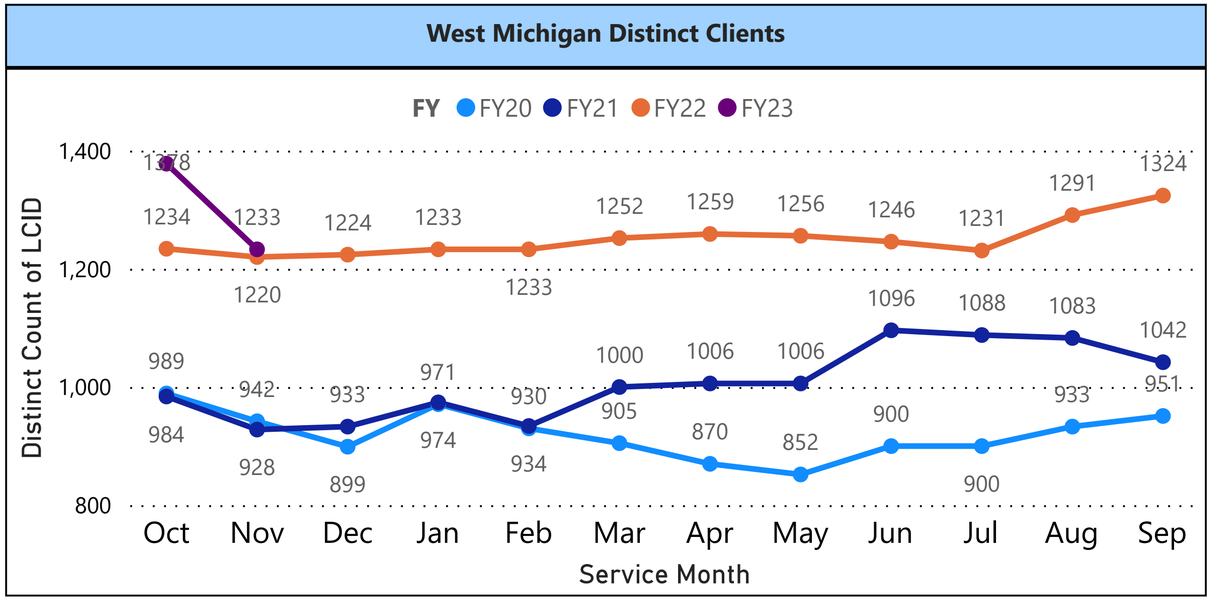
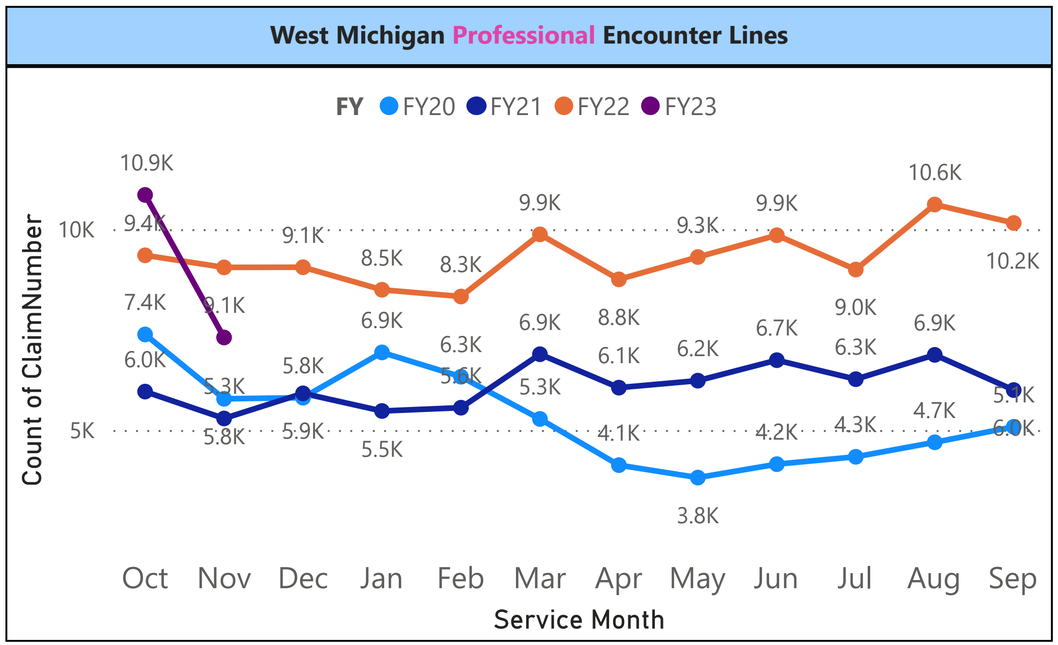
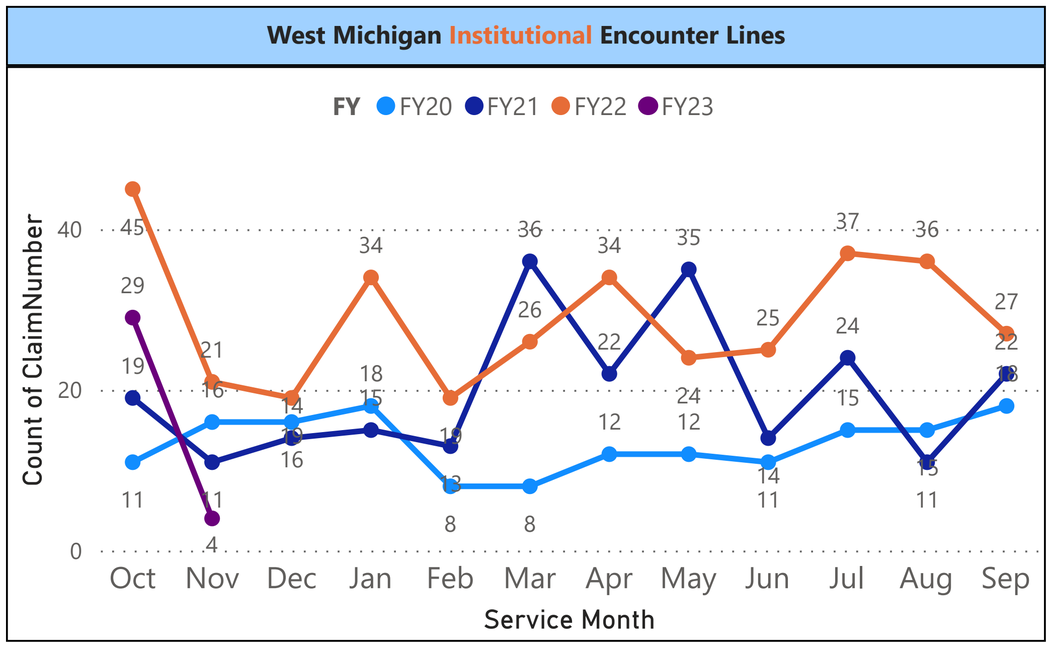
Latest ProcessDate

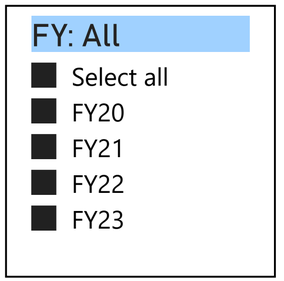
LAKESHORE REGIONAL ENTITY

West Michigan Behavioral Health









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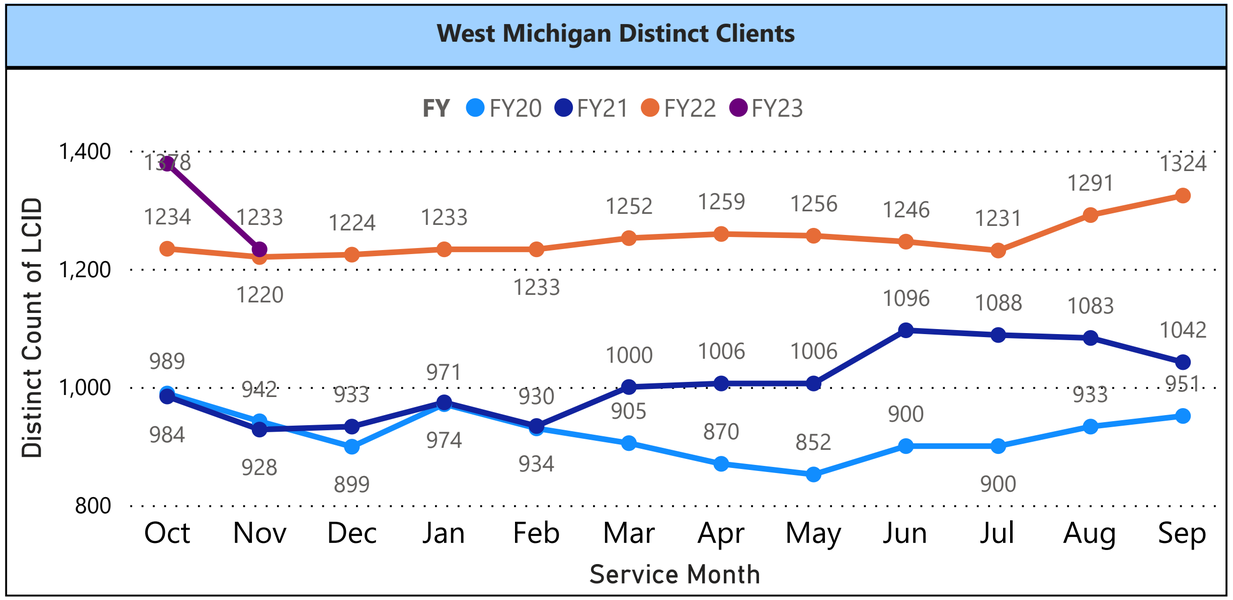
Latest ProcessDate

LAKESHORE REGIONAL ENTITY

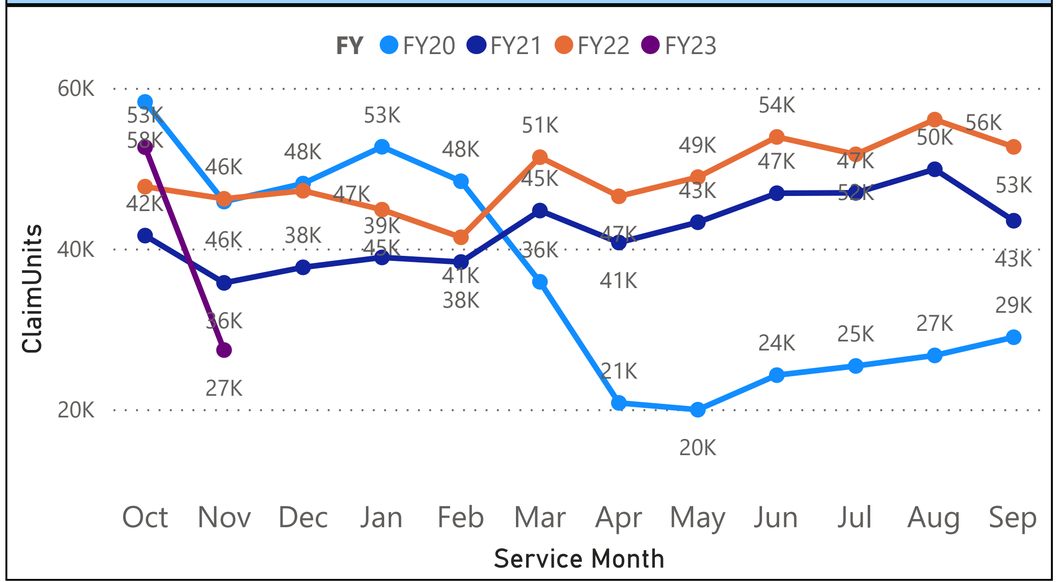
West Michigan Behavioral Health

West Michigan Distinct Clients

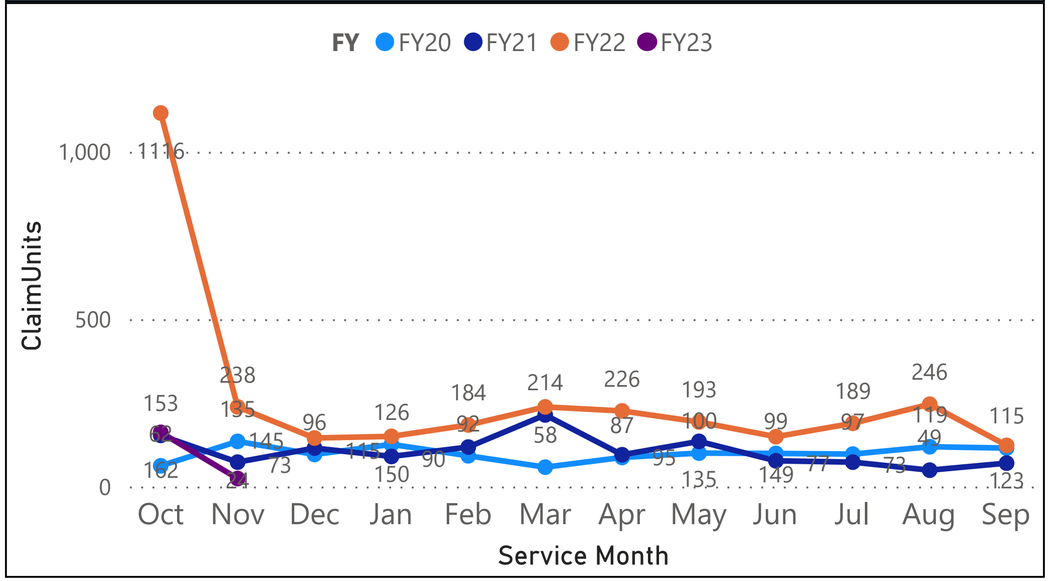


FY: All
- Select all
- FY20
- FY21
- FY22
- FY23

West Michigan Professional Units



West Michigan Institutional Units



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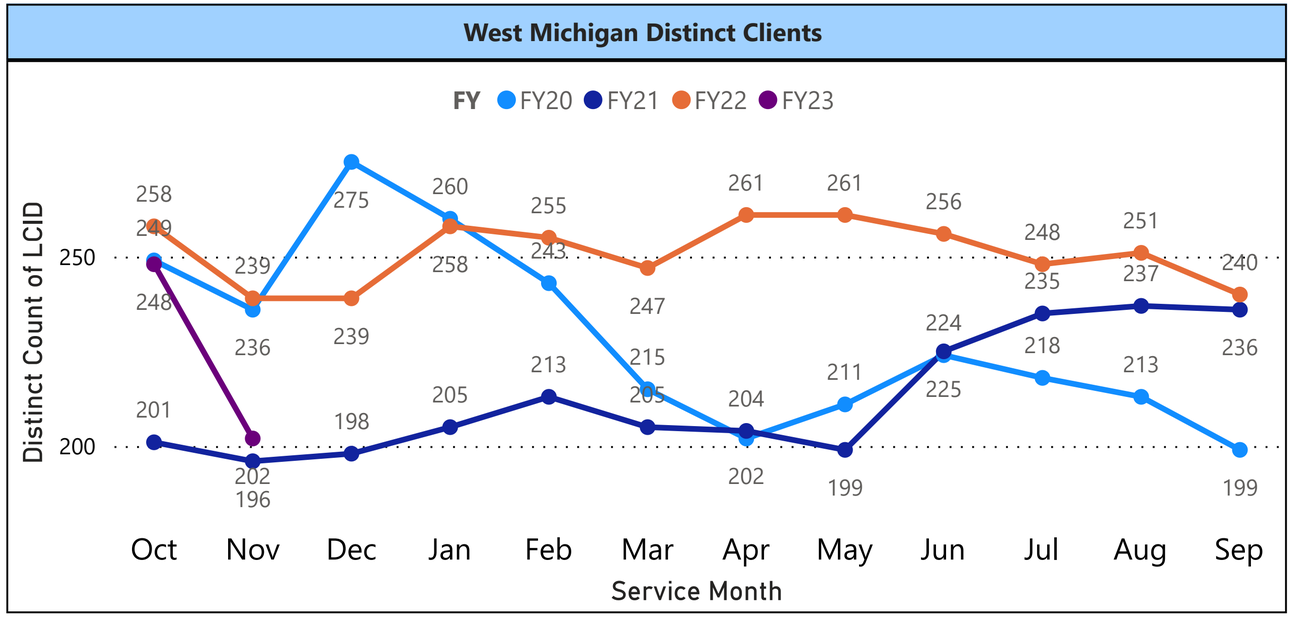
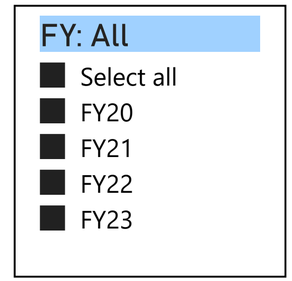
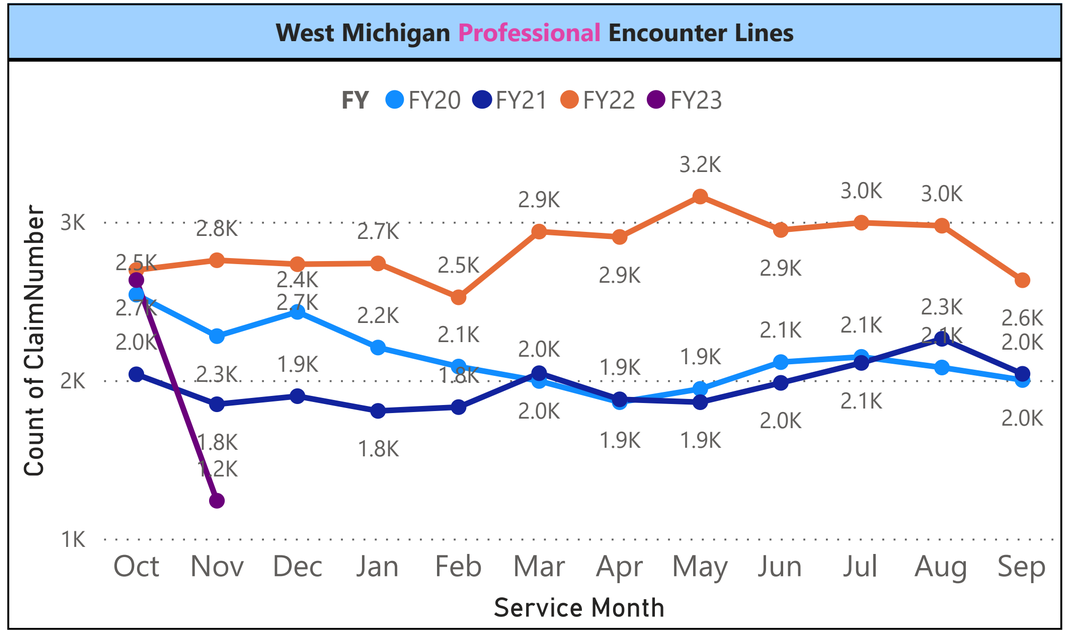
Latest ProcessDate

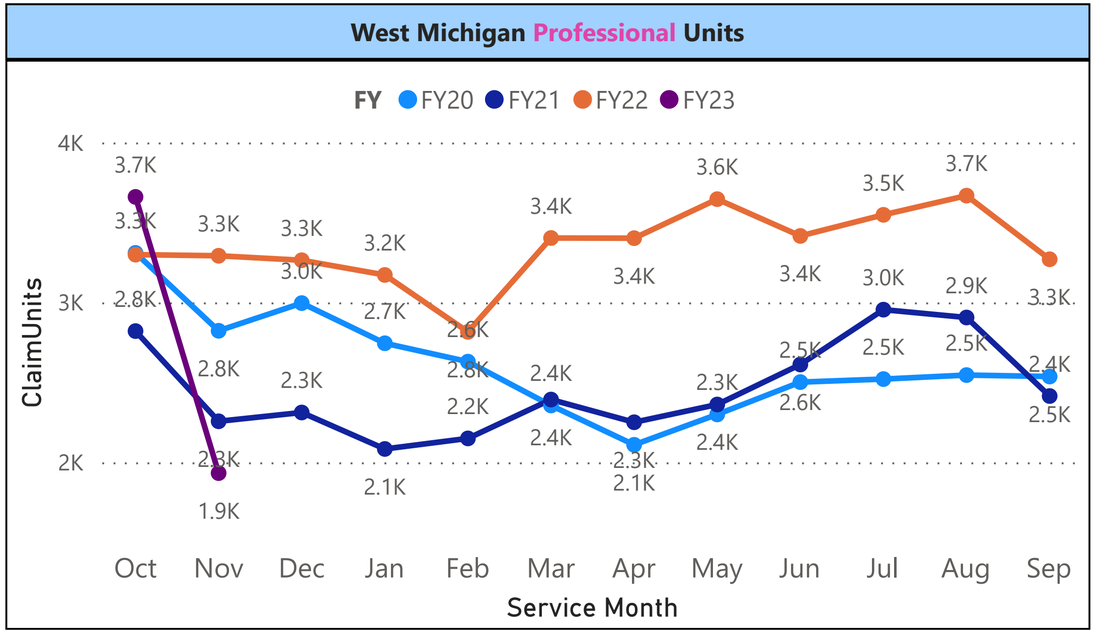
LAKESHORE REGIONAL ENTITY

West Michigan Substance Use Disorder









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Latest ProcessDate

Data Sources and Definitions

Data Source LRE_DW_CorporateInfo.LRE_Encounters

Definitions

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

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

Encounter Lines: Count of ClaimNumber

Units: Sum of ClaimUnits

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

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

Professional Lines and Units: TransactionType = Professional

Institutional Lines and Units: TransactionType = Institutional

Fiscal Year: FY

LAKESHORE REGIONAL ENTITY

EXECUTIVE COMMITTEE SUMMARY
Wednesday, December 7, 2022, 3:00 PM

Present: Mark DeYoung, Matt Fenske, Linda Garzelloni, Jack Greenfield, Jane Verduin
LRE: Mary Marlatt-Dumas, Stephanie VanDerKooi, Stacia Chick

WELCOME

i. December 7, 2022, Meeting Agenda
ii. November 9, 2022, Meeting Minutes

Motion: To approve the December 7, 2022, meeting agenda and the November 9, 2022, meeting minutes as presented

Moved: Matt Fenske Support: Jane Verduin
MOTION CARRIED

LRE/NETWORK180 MEDIATION UPDATE

There was a meeting scheduled for yesterday with a mediator that was agreed to by both parties (LRE/N180). Prior to the meeting Mr. Stek sent a request to have the mediation meeting put on hold due to the ongoing past liabilities issue making it difficult to focus on mediation process. Ms. Marlatt-Dumas agreed although her recommendation was to move forward as there is still communication issues with N180. Mr. Stek then communicated that the mediation is voluntary and as such N180 would like to delay the date. LRE communicated to the mediator that we will contact them when another date is settled on.

Ms. Marlatt-Dumas had spoken with Mr. Stek prior to this request regarding N180 filing a claim at the Kent County circuit court to garnish LRE for the past liabilities. A meeting is scheduled to discuss the implications this action may have, negative or positive, with LRE legal on Friday. If legal advises against this suit and N180 moves forward at our objection, then LRE will formally object to the suit.

MDHHS REQUEST FOR EVALUATION UPDATE

LRE has pulled the data required and we will begin analyzing CMH to CMH how rates are developed. The information that has been asked for is the policy and procedure for how rate increases are determined for providers. Ms. Chick updates that the policy analysis will be submitted on time to the State but there is additional financial information that is needed therefore LRE will ask for an extension until January 15.

Ms. Marlatt-Dumas reports that LRE has been working with Wakely on the LRE's rates. They are finding that the DABs risk factor is decreasing and may be linked to BHTEDs reporting. A couple of CMHs have been struggling with this and LRE received another update from the State

that we are under the required submission percentage. LRE continues to work on this and will update the Board when more information is available.

The Executive Committee would like Wakely to attend a Board meeting in the future to give a presentation.

DEC ACTION UPDATE

LRE filed a response last Friday in rebuttal to the States cross filing. The state will have another 14 days to respond and then the first discovery hearing is January 23. The action states that our PIHP contract allows for the use of ISF to pay down the past liabilities and the State's counter claim is that the contract language makes this unallowable. The Dec action is asking the judge to make a ruling on this. The LRE is standing on the fact that the contract states that we must follow Gatsby 10 which is what we are doing. The state believes we can only use for future expenses, but the word "future" is not in the contract.

Ms. Marlatt-Dumas comments that LRE still has not reconciled with N180 as this would hurt their cash flow if we were to take any funds back. If the judge rules against us, we will be unable to pay the past liabilities and then we will have to have more conversations with N180 about the reconciliation process. If the judge rules in our favor LRE is unsure there will be enough funds left over to completely pay off the liabilities. There continues to be a large swing in projections from the CMHs regarding their expenditures which decreases the amount of excess funds left to pay these down. LRE will have to have a conversation with all the CMHs on how the past liabilities would be paid if the ruling is in our favor, but we do not have the full amount to address the past liabilities.

Executive Committee would like recommendations from LRE CEO and CFO regarding the ISF. Wakely will complete an ISF analysis that will help to guide that process. This analysis is a contract requirement and has to be complete prior to making a recommendation to the Board.

OMA/ADA ACCOMODATION

Mr. Greenfield comments that the CMHs would most likely have some best practices in place and LRE should reach out for those policies/procedures to help inform LRE's policy/procedure. Mr. Fenske recalls that the LRE Board chair would make the final decision. Mr. DeYoung would like a policy wrote to help the Board Chair in the decision-making process and to include language from the ADA as to what qualifies for an accommodation and keeps LRE in compliance with the ADA requirements. Ms. Garzelloni comments that she agrees that it should be the Board Chairs final decision on a case-by-case basis, but she does not necessarily agree with the interpretation that COVID should be allowable for an ADA accommodation.

LRE will evaluate other organizations (CMHs, PIHPs) policies/procedures along with pulling language from the ADA and write a policy and procedure and bring back to the January Executive Committee. Mr. Greenfield suggest evaluating if COVID needs an accommodation after the policy/procedure is written.

2023 EXECUTIVE COMMITTEE MEETING SCHEDULE

The Executive Committee meetings will change to the 3rd Wednesday of the month at the same time.

LRE CEO EVALUATION –

The process will begin with some updates to the template. Ms. Marlatt-Dumas' contract ends in the beginning of March. The evaluation should be completed 30 days prior to the end of the contract which will be February 3. The survey will go to the Board, CEOs and LRE Executive Team. We will prompt the Board during the next Board meeting to look for the evaluation.

BOARD MEETING AGENDA ITEMS

- New Board Member – Richard Kanten (Ottawa CMH)
- 2023 Risk Management Strategy – there has been concern about some language about CMH risk. LRE will be reviewing other PIHPs language and will review with legal.

BOARD WORK SESSION AGENDA

No work session.

OTHER

- STRATEGIC PLANNING UPDATE
  LRE is wrapping up meetings with the ROATs and any feedback they might have. LRE will provide the final Mission and Values next week Board to approve. This is the document that the Board has been working on and is not the full strategic plan. The goal is to have the final draft by March.

- WEBSITE UPDATE
  The website has not launched due to some last-minute changes but will be live by the December Board meeting.

UPCOMING MEETINGS

- December 8, 2022 – Consumer Advisory Panel, 1:00 PM
- December 15, 2022 – LRE Executive Board Meeting, 1:00 PM
  GVSU, Muskegon Innovation Hub, 200 Viridian Dr, Muskegon, MI 49440
- TBD, 2023 – LRE Executive Committee, 3:00 PM

- January 25, 2023 – LRE Executive Board Meeting, 1:00 PM
  GVSU, Muskegon Innovation Hub, 200 Viridian Dr, Muskegon, MI 49440

ADJOURN

Policy 1.3

POLICY TITLE:	POLICY PROMULGATION	POLICY #1.3		
Topic Area:	GENERAL MANAGEMENT	Page 1 of 4	REVIEW DATES	
Applies to:	All CMHSP Programs	ISSUED BY: Chief Executive Officer	9/18/14	2/12/20
Review Cycle:	Annually		12/16/21	
Developed and Maintained by:	LRE Chief Executive Officer	APPROVED BY: Board of Directors		
Supersedes:	N/A	Effective Date: 9/18/14	Revised Date:	

I. PURPOSE

To provide standards and guidelines for the development, review, approval, and publishing of Lakeshore Regional Entity (LRE) policies. LRE develops and maintains policies and procedures to support achievement of the organization's Mission, Vision, and Values; to meet the changing needs of LRE; to achieve compliance with applicable laws, rules, and funding requirements and to assure responsiveness to customer/stakeholder needs.

Policies that require approval are those that, if not followed, represent a risk to LRE. The Board has authorized the Chief Executive Officer (CEO) to recommend policies necessary to carry out the Mission of the organization and to accomplish the objectives established by the Board. Policies require Board approval and shall be reviewed annually. Policy shall be easy to understand, communicated broadly, and enforceable.

Procedures are established by LRE staff/designees to assure effective and efficient implementation of Board approved policies and business practices. Procedures may be developed in consultation with Community Mental Health Service Programs (CMHSP) Participants as necessary.

II. POLICY

It shall be the policy of the Lakeshore Regional Entity (LRE) that all policies will be developed, reviewed, and revised in accordance with the policy procedures listed.

A. The CEO shall manage the annual review of policy and procedures and shall provide for maintenance of an electronic policy and procedure manual. The policy and procedure approval process shall be a collaborative effort inclusive of CMHSP Participants as appropriate. Policy review shall be led by a designated author with review and input being facilitated through appropriate councils and committees. A compliance and/or legal review shall be conducted as necessary.

B. Policies shall be developed, maintained, organized, and approved in a consistent, easily accessible format.
    1. Policy Header includes:

a. LRE Approved Logo
b. Policy Chapter
c. Policy/Procedure Title
d. Page
e. Review Cycle
f. Developed and Maintained By
g. Review Date
h. Revision Effective Date

2. Policy Body includes:
   a. Policy- The governing principle and/or senior leadership expectations, plan or understanding that guides the action. It states what we do, but not how.
   b. Purpose- The rationale for the policy.
   c. Applicability and Responsibility- Defines who the policy or procedure applies to.
   d. Monitoring and Review- Defines who will monitor the policy/procedure and how often it will be reviewed.
   e. Definitions- Explanation of key terms/phrases not obvious or otherwise self-explanatory.
   f. Related Policies and Procedure- Other source documents that provide context of support the need for the policy.
   g. Reference(s)/Legal Authority- Provide a summary of related laws, regulations, and other institutional policies.
   h. Change Log: Provides a history of the policy/procedure, including evidence or regular review and rationale for related changes.
      i. Date of Change
      ii. Description of Change
      iii. Responsible Party

3. Procedure Body includes:
   a. Purpose- The rationale for the procedure.
   b. Procedure- The governing principle and/or senior leadership expectations, plan or understanding that guides the action. It states what we do, but not how.
   c. Applicability and Responsibility- Defines who the policy or procedure applies to.
   d. Monitoring and Review- Defines who will monitor the policy/procedure and how often it will be reviewed.
   e. Definitions- Explanation of key terms/phrases not obvious or otherwise self-explanatory.
   f. Related Policies and Procedure- Other source documents that provide context of support the need for the policy/procedure.

g. Reference(s)/Legal Authority- Provide a summary of related laws, regulations, and other institutional policies.
h. Change Log- Provides a history of the procedure, including evidence or regular review and rationale for related changes.
    i. Date of Change
    ii. Description of Change
    iii. Responsible Party

4. Formatting:
    a. Calibri (Body), 12 pt. font; bold for headings
    b. One-inch margins on all sides
    c. Paragraphs are left justified (i.e., left aligned with a ragged right edge)
    d. Single spacing for paragraphs
    e. Use position titles (e.g., Chief Executive Officer/CEO) rather than names
    f. Acronyms should be used only after the full compound terms have been written out
    g. Policies submitted for approval of revisions shall be submitted in Microsoft Word, 'Track Changes' format

5. Policy Development and Approval:
    a. Policies shall be developed by the responsible LRE employee and subject matter expert.(s) ;
    b. Policies are reviewed by appropriate councils, committees and/or ROATS within the LRE organizational structure;
        i. Operational Policies are approved by the Chief Executive Officer (or designee).
        ii. Board Policies and all revisions to Board Policies are approved by the Board of Directors.
    c. After approval and posting to the official website, LRE policies are in effect unless a specific date on which they become effective is noted.

6. Procedures: LRE personnel shall maintain operating procedures for all important organizational processes. Procedures shall be reviewed annually and approved by CEO or designee. Procedures shall be accessible and shall be communicated to involved personnel and LRE's provider network as part of the regular professional development/training and contract management practices. Any changes in procedures shall be consistent with and supportive of associated LRE policy.

7. Annual Policy Review: Annually, within 30 days prior to the required review date, the Functional Area Lead will review the current policy and will seek input from LRE staff, workgroups, ROAT's and committees, as applicable. The Functional

Area Lead will make changes, if necessary and follow the "Revision of Policies" process listed above.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to all LRE staff and operations.

IV. MONITORING AND REVIEW

This policy will be reviewed by the Executive Operations Team, with input from the Operations Committee and Functional Area Leads, on an annual basis.

V. DEFINITIONS

N/A

VI. RELATED POLICIES AND PROCEDURES

A. Policy Promulgation Operational Procedure

VII. REFERENCES/LEGAL AUTHORITY

N/A

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
9/18/2014	New Policy	Chief Executive Officer
2/12/2020	Annual Review	Chief Executive Officer
2021	Language additions/changes	Chief Executive Officer
2022	Updated Policy Approval Process and Organizational Procedure	Chief Operating Officer

POLICY TITLE:	**CREDENTIALING AND RECREDENTIALING**	**POLICY # 4.4**	
Topic Area:	**PROVIDER NETWORK MANAGEMENT**		**REVIEW DATES**
Applies to:	Entity Operations/Staff, Member CMHSPs and the Provider Network	**ISSUED BY:** Chief Executive Officer	8/21/2017 / 12/16/21
Review Cycle:	Annually		
Developed and Maintained by:	CEO and Designee	**APPROVED BY:** Board of Directors	
Supersedes:	**N/A**	**Effective Date:** 1/1/2014	**Revised Date:**

I. PURPOSE

In accordance with statutory and funding requirements, the Entity is responsible to assure that providers (practitioners and organizations) within the region are appropriately qualified and competent to provide covered and authorized services. All professionals who provide clinical services within the network must be properly credentialed and re-credentialed. (These services can either be by direct contract with the Entity or by the Entity affiliated CMHSPs/regional providers if employed by that entity.)

II. POLICY

Lakeshore Regional Entity (Entity) seeks to ensure the competency and qualifications of the service delivery network in the provision of Medicaid specialty services and supports covered services and programs. To achieve that goal, it is the policy of the Entity that specific credentialing and recredentialing activities shall occur and be documented to ensure that staff, regional network providers, and their subcontractors are operating within assigned roles and scope of authority in service delivery or business functions. The Entity shall adopt procedures that assure credentialing and recredentialing practices require providers and sub-contractors obtain and maintain proper credentials for their job position and responsibilities as required by statute, policies, and/or job description qualifications.

The policy, and related procedures, applies to Community Mental Health Service Participants (CMHSPs) and their network of providers including substance use disorder (SUD) providers. The Entity delegates credentialing of CMHSP-affiliated Licensed Individual Practitioners to the CMHSPs and provides oversight of these credentialing activities at the annual site review of the CMHSP. The Entity credentials all organizational providers in the region, according to the requirements outlined by Michigan Department of Health and Human Services (MDHHS). The Entity also credentials Entity-affiliated Licensed Individual Practitioners when needed.

Licensed Individual Practitioners

All credentialing/recredentialing practices shall be conducted in accordance with the MDHHS Credentialing and Recredentialing Process and the Entity Organizational Procedure Credentialing and Recredentialing-Individual Practitioners, and at a minimum, require:

- Initial credentialing upon hire or contracting,
- Re-credentialing at least every two years, and
- A process for ongoing monitoring and primary source verification of expired licenses, certifications, and other credentials.

Credentialing and recredentialing processes shall not discriminate against: (a) a health care professional solely on the basis of license, registration, or certification; or (b) a health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

Credentialing and recredentialing processes must ensure that network providers residing and providing services in bordering states meet all applicable licensing and certification requirements within their state.

Organizational Providers

For organizational providers included in its network, and in accordance with Organizational Procedure Credentialing and Recredentialing Organizational Providers, the Entity and CMHSPs must:

- Validate, and re-validate at least every two years, that the organizational provider is licensed or certified as necessary to operate in the State and has not been excluded from Medicaid or Medicare participation and is approved by an accredited body, or an on-site quality assessment is completed if the provider is not accredited. For solely community-based providers (e.g. ABA or CLS in private residences) an on-site review is not required, an alternative quality assessment is acceptable.
- Ensure that the contract with any organizational provider requires the organizational provider to credential and re-credential their directly employed and subcontract direct service providers in accordance with the Entity credentialing/re-credentialing policies and procedures (which must conform to MDHHS's credentialing process).

Monitoring and Oversight of Credentialing and Recredentialing Activities

The Entity is responsible to ensure all CMHSPs providing Medicaid Services shall have policies and procedures for credentialing and recredentialing that are updated as needed, to meet MDHHS credentialing guidelines, Entity policy, and any other pertinent regulatory requirements.

The Entity is responsible for the oversight of any delegated credentialing or recredentialing decisions within its service delivery network and shall review these practices in accordance with the Entity delegated functions monitoring and oversight policy, procedure, and protocols. Compliance shall be assessed based on the Entity policies and standards in effect at the time of the credentialing or recredentialing decision.

The Entity retains the right to approve the credentialing decisions of a CMHSP or require discontinuation of service by organization providers and/or licensed individual practitioners without the proper credentialing status. Improper or insufficient credentialing practices by CMHSP may be cause for contractual sanction(s) by the Entity, requiring a corrective action plan, and could be cause for contract suspension or termination. In accordance with the Medicaid Event Verification Policy and Procedure, the Entity may recoup funds for any fee-for-service provider for any claims/encounters that are found to be invalid as a result of improper credentialing. Any invalid claims/encounters will require correction either by resubmission or voiding.

Administration of credentialing/recredentialing activities and oversight is the responsibility of the Entity Credentialing Specialist, under the direction of the Entity Credentialing Committee. The Credentialing Committee charter details the membership and roles/responsibilities for credentialing activities.

Deemed Status

Organizational Providers or Licensed Individual Practitioners may deliver healthcare services to more than one agency. The Entity may recognize and accept credentialing activities conducted by any other agency in lieu of completing their own credentialing activities. In those instances where the Entity chooses to accept the credentialing decision of another agency, they must maintain copies of the credentialing PIHP's credentialing decisions in their administrative records.

Notification Requirements and Appeal of Adverse Credentialing Decision

Organizational Providers and Licensed Individual Practitioners shall be notified, in writing, of all credentialing decisions, including credentialing status, effective date, and recredentialing due date. An organizational provider or licensed individual practitioner that is denied credentialing or recredentialing shall be informed of the reasons for the adverse credentialing decision in writing and shall have an appeal process that is available when credentialing or recredentialing is denied, suspended, or terminated for any reason other than lack of need. In instances of a conflict of interest, subcontracted providers responsible for credentialing and recredentialing LIPs may utilize the Entity provider appeal process to ensure a neutral and fair appeal process is available.

If the reason for denial, suspension, or termination is egregious (serious threat to health safety of consumers or staff, represents a substantiated criminal activity, etc.) action shall be taken immediately. In the event of immediate suspension or termination the Entity, CMHSPs, shall address coordination of care so as to prevent disruption of services.

Record Retention

All credentialing and recredentialing documentation must be retained for each credentialed provider and include:

- Initial credentialing and all subsequent recredentialing applications;
- Information gained through primary source verification; and
- Any other pertinent information used in determining whether or not the provider met credentialing and recredentialing standards.
- Records shall be retained in accordance with the Entity Record Retention Policy.

Reporting Requirements

Member CMHSPs are responsible to report suspected fraud, abuse, and licensing violations to the Entity as soon as it is suspected. If a matter is expected to lead to suspension or revocation, is known to be related to fraud, abuse, and/or a licensing violation, reporting shall be conducted in coordination with the Chief Operating Officer and Chief Compliance Officer and any regulatory/investigative agency involved. The Entity and the responsible CMHSP shall coordinate immediate verbal (phone) reporting to the Office of the Inspector General (OIG), Licensing and Regulatory Affairs (LARA) and the Division of Program Development, Consultation and Contracts, Behavioral Health and Developmental Disabilities Administration in MDHHS accordingly. Verbal notice shall be followed by written notice of the matter including any relevant supporting documentation. Information shall be submitted via e-mail in an encrypted format and by regular mail if requested. Once a matter has been turned over to the OIG further investigation should be suspended unless approval is granted by the OIG.

The Chief Compliance Officer shall maintain records of all credentialing activities reported to MDHHS or the OIG in accordance with the Entity compliance monitoring policies and procedures. Additionally, the Entity and its provider network shall maintain written procedures to address:

- Standards and responsible parties for credentialing functions;
- Initial credentialing and recredentialing (including primary source verification and evidence that minimum training requirements are met);
- Temporary and provisional credentialing;
- Suspension and revocation;
- Use of Quality Assessment and Performance Improvement Program information and findings as part of the recredentialing process;
- Background checks.
- Monitoring of credentialing/recredentialing practices including the practices of organizational providers.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to Entity Staff, member CMSHPs and the Provider Network.

IV. MONITORING AND REVIEW

This policy is reviewed by LRE CEO and/or designee on an annual basis.

V. DEFINITIONS

Credentialing: Confirmation system of the qualification of healthcare providers. The act of verifying a health care practitioner's "credentials" such as licensure, education, and training.
CMHSP: Community Mental Health Services Program.
Individual Practitioner: includes Licensed Individual Practitioners who are permitted by law and the organization to provide care and services without direction or supervision, within the scope of the individual's license OR other Licensed or Certified Health Care Practitioners who are licensed, certified, or registered but who are not permitted by law to provide care and services without direction or supervision.
MDHHS: Michigan Department of Health and Human Services
Organizational Providers: Entities that directly employ and/or contract with independent contractors to provide behavioral health/health care services. Examples of organizational providers include but are not limited to: Community Mental Health Services Programs; hospitals; nursing homes; homes for the aged; psychiatric hospitals, units, and partial hospitalization programs; substance abuse programs; and home health agencies.
Recredentialing: Process of updating and re-verifying credential information
SUD Provider: Substance Use Disorder (Treatment, Prevention, and Recovery) provider

VI. RELATED POLICIES AND PROCEDURES

A. Credentialing and Recredentialing Licensed Individual Practitioners Procedure
B. Credentialing and Recredentialing Organizational Providers Procedure

VII. REFERENCES/LEGAL AUTHORITY

A. MDHHS Medicaid Specialty Supports and Services Contract
B. Michigan Medicaid Provider Manual
C. MDHHS Provider Credentialing and Re-Credentialing Processes
D. 42 CFR 438.214
E. 42 CFR 438.12

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
12/16/2021	Added general requirements, updated language	COO and Designee
12/15/2022	Updated delegation language	CEO and Designee

POLICY TITLE:	NETWORK PROVIDER APPEALS AND GRIEVANCES	POLICY # 4.7	
Topic Area:	Provider Network Management		REVIEW DATES
Applies to:	Entity Staff, CMHSPs, and LRE Network Providers	ISSUED BY: Chief Executive Officer	12/16/2021
Review Cycle:	Annually		
Developed and Maintained by:	CEO and Designee	APPROVED BY: Board of Directors	
Supersedes:	N/A	Effective Date: 12/15/2016	Revised Date:

I. PURPOSE

To outline a process by which provider complaints and requests for reconsideration of non-clinical decisions are resolved.

II. POLICY

It is the policy of the Lakeshore Regional Entity (LRE) to provide for a fair and efficient process for resolving disputes between network providers and LRE or Region 3 Community Mental Health Services Program (CMHSP) that complies with State, Federal, and contractual requirements.

LRE and CMHSPs will develop, maintain, and convey policy and procedures whereby network providers may request review of non-clinical disputes related to the provider contract requirements. CMHSP policy and procedure will adhere to the standards and timeliness set forth in this policy and any referenced LRE procedures, and include, minimally, two levels of dispute resolution (i.e. an initial request and a request to review adverse disposition of a dispute request).

Disputes may be filed by a network provider when it is perceived the LRE or the CMHSP have not acted fairly in decisions related but not limited to issues involving:

- Results reported through provider monitoring reviews.
- Compliance issues resulting in a sanction or decision to place the provider on a provisional status.
- Actions related to a suspension or termination of a provider.
- Instances where there is a breach of contract or where there is potential cause for termination of the contract, with or without cause.
- Actions related to a provider's non-compliance, professional competency, or conduct.
- Overall professional conduct related to contract management and oversight.
- Credentialing, recredentialing, or paneling decisions.
- Reduction, suspension, or adjustments of payments, including non-payment of

Medicaid claims.
- Material breach of contract.
- Alterations or amendments to the regional common contract boilerplate language.
- Other non-clinical issues.

This policy does NOT apply to the following:

- Medicaid Fair Hearing Appeals and Grievances.
- Medical Necessity Appeals.
- Conditions that result in immediate termination.
- Contracts the LRE holds with CMHSPs.
- Consumer rights regarding appeals and grievances, as defined by Michigan Department of Health and Human Services (MDHHS) Appeal and Grievance Resolution Processes Technical Requirement.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to the LRE, CMHSPs, and Network Providers.

IV. MONOTORING AND REVIEW

This policy will be maintained by the LRE Chief Executive Officer or designee and reviewed on an annual basis.

V. DEFINITIONS

Dispute: An expression of dissatisfaction by a provider regarding a perceived inequitable issue, aspect of interpersonal relation, or other issue as defined above.

Dispute Resolution: A formal process by which provider concerns and request for reconsideration of non-clinical decisions are resolved.

VI. RELATED POLICIES AND PROCEDURES

A. Provider Appeal and Grievance Procedure
B. 4.2 Contract Management
C. 4.4 Credentialing and Privileging

VII. REFERENCES/LEGAL AUTHORITY

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
12/9/22	Title change. Clarified what policy applies to.	Don Avery

Policy 10.2

POLICY TITLE: COMMITTEES STRUCTURE	POLICY # 10.2	
Topic Area: Board of Directors		**REVIEW DATES**
Applies to: Board of Directors	**Issued By and Approved By**	11/18/21
Review Cycle: Annually	Board of Directors	
Developed and Maintained by: CEO		
Supersedes: N/A	**Effective Date:** 9/17/16	**Revised Date:** 11/18/21

I. PURPOSE

To define the roles and functions of the Entity Board of Directors and Committees.

II. POLICY

A Committee is established as a Lakeshore Regional Entity (the "Entity") Board of Directors Committee only if its existence and charge is directed by the Entity Board of Directors, regardless of whether the Entity Board of Director's members sit on the committee. Unless otherwise stated, a committee ceases to exist as soon as its work is complete.

Committee Structure

A. The Entity Board of Directors will create Committees, as needed to address specific areas of concern.
B. A written charge for each Committee will be developed. The charge will include a written statement of the scope, purpose, and obligation of the Committee as well as details regarding committee makeup, member terms, and defined time frames for completion of the Committee's charge.

Committee Principles

Committees shall:

1. Assist the Entity Board of Directors by preparing policy alternatives and implications for the Entity Board of Directors deliberation. In keeping with the broader focus, the Entity Board of Directors committees will normally not have direct dealings with current staff operations.
2. Not speak or act for the Entity Board of Directors except when formally given such authority for specific and time-limited purposes.
3. Not exercise authority over the Entity staff.
4. Be developed sparingly and ordinarily in an ad hoc capacity.
5. The Member CEOs will assign staff resources necessary for committee support

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to any group that is formed by the Entity Board of Directors action, whether or not it is called a committee and regardless of whether the group includes the Entity Board of Directors members. It does not apply to committees formed under the authority of the Entity CEO.

IV. MONITORING AND REVIEW

This policy is reviewed by the CEO on an annual basis.

V. DEFINITIONS

N/A

VI. RELATED POLICIES AND PROCEDURES

A. Board of Directors By-laws
B. Operating Agreement

VII. REFERENCE/LEGAL AUTHORITY

N/A

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
11/18/21	Merged 10.2 and 10.3, formatted. Renamed policy	CEO

POLICY TITLE BOARD GOVERNANCE	POLICY # 10.4	
Topic Area: Board of Directors		**REVIEW DATES**
Applies to: Board of Directors	**Issued By and Approved By:** Board of Directors	
Review Cycle: Annually		
Developed and Maintained by: CEO and Designees		
Supersedes: N/A	**Effective Date:** 9/17/16	**Revised Date:** 11/18/21

I. PURPOSE

The Entity Board of Directors will engage in continual refinement of its values and vision, guaranteeing the accountability of the Entity Board of Directors through monitoring of performance.

II. POLICY

The Lakeshore Regional Entity (the "Entity") Board of Directors will govern lawfully, observing the principles of the Policy Governance model, with an emphasis on

(a) outward vision rather than an internal preoccupation,
(b) encouragement of diversity in viewpoints,
(c) strategic leadership more than administrative detail,
(d) clear distinction of the Entity Board of Directors and chief executive roles,
(e) collective rather than individual decisions,
(f) future, rather than past or present, and
(g) proactive rather than reactive.

Entity Board of Directors Commitment

1. Cultivate a sense of group responsibility. The Entity Board of Directors, not the Entity staff, will be responsible for excellence in governing. The Entity Board of Directors can be the initiator of policy, not merely a reactor to the Entity staff initiatives. The Entity Board of Directors will not use the expertise of individual members to substitute for the judgment of the Entity Board of Directors, although the expertise of individual members may be used to enhance the understanding of the Entity Board of Directors as a body.
2. Direct, control, and inspire the organization through the careful establishment of broad written policies reflecting the Entity Board of Directors values and perspectives. The Entity Board of Directors major policy focus will be on the intended long-term impacts, not on administrative or programmatic means of attaining those efforts.
3. Enforce upon itself whatever discipline is needed to govern with excellence. Discipline will apply to matters such as attendance, preparation for meetings, policy-making principles, respect of roles, and ensuring the continuance of governance capability.

Although the Entity Board of Directors can change its governance process policies at any time, it will observe those currently in force.

4. Continuing development of the Entity Board of Directors development will include orientation of new Board of Director members in the Entity Board of Directors governance process and an annual self-assessment of the Entity Board of Directors functioning for process improvement.
5. Allow no officer, individual, or committee of the Entity Board of Directors to hinder or be an excuse for not fulfilling group obligations.
6. The Entity Board of Directors will monitor and discuss its process and performance periodically. Self-monitoring will include comparison of the Entity Board of Directors activity and discipline to policies in the Governance Process and Board of Directors-Management Delegation categories.

To accomplish its job, the Entity Board of Directors will adopt an annual calendar which

a) completes a re-exploration of Accomplishments/Goals annually;
b) continually improves its performance through attention to board education, and deliberation.
c) formally reviews all the Entity Board of Director Policies; and
d) sets primary strategic imperatives for a following 12-18-month period.

<u>Board Outcomes and Accomplishments</u>

The Entity Board of Directors will provide clear direction by determining specific outcomes, approving interpretations, and adopting Specific Outcome Metrics.

The Entity Board of Directors shall:

1. Identify areas of focus (Outcomes) for strategic monitoring.
2. Approve Interpretations of Outcome. The Entity CEO shall propose Interpretations.
3. Adopt Outcome Metrics which are clear, succinct, results-oriented, achievable, realistic, and objective. The Entity CEO shall propose specific outcome measurements.
4. Regularly review data related to focus (Outcomes) Metrics as planned in the Entity Board of Directors-approved calendar, upon request of the Entity Board of Directors, or at the initiation of the Entity CEO.
5. Revisit Outcomes, Interpretations and Metrics as it sees fit. The Entity CEO may propose to the Entity Board of Directors additions or revisions to Outcomes, Interpretations and Metrics as the Entity CEO sees fit. No changes to these are permitted absent the Entity Board of Directors approval.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to the Entity Board of Directors.

IV. MONITORING AND REVIEW

The CEO and designees will review this policy on an annual basis.

V. DEFINITIONS

N/A

VI. RELATED POLICIES AND PROCEDURES

A. Board Policies and Procedures
B. Board of Directors By-Laws
C. Operating Agreement

VII. REFERENCES/LEGAL AUTHORITY

N/A

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
11/18/21	Language from 10.1 Annual Planning Cycle, Updated title, added language from policy 10.9	CEO and Designees

POLICY TITLE: CODE OF CONDUCT	POLICY # 10.5	
Topic Area: Board of Directors		**REVIEW DATES**
Applies to: Board of Directors	**Issued By and Approved By:** Board of Directors	11/18/21
Review Cycle: Annually		
Developed and Maintained by: CEO and Designees		
Supersedes: N/A	**Effective Date:** 9/17/16	**Revised Date:** 11/18/21

I. PURPOSE

The Entity Board of Directors commits itself to ethical, lawful, and businesslike conduct including proper use of authority and appropriate decorum when acting as an Entity Board Director.

II. POLICY

It is the policy that each Lakeshore Regional Entity (the "Entity") Board of Directors member represent the interests of the Entity. This accountability supersedes any potential conflicts of loyalty to other interests including advocacy or interest groups, membership on other boards, relationships with other's or personal interests of any Board Director.

1. Each of the Entity Board of Directors will follow the Entity Conflict of Interest Policy
2. Each of the Entity Board of Directors may not attempt to exercise individual authority over the organization except as explicitly set forth in the Entity Board of Directors policies.
    a. Each of the Entity Board of Directors interaction with the Entity Chief Executive Officer (CEO) or with the Entity staff must recognize the lack of authority vested in individuals except when explicitly the Entity Board of Directors-authorized.
    b. Each Entity Board Director's interaction with public, press or other entities must recognize the same limitation and the inability of any Entity Board of Director to speak for the Entity Board of Directors.
    c. Each Entity Board Director commenting on the agency and the Entity CEO performance must be done collectively and as regards to explicit Entity Board of Directors policies. Any comments regarding the Entity and/or the Entity CEO performance must be done collectively as related to the policies.
3. Each Entity Board Director will respect the confidentiality appropriate to issues of a sensitive nature including, but not limited, to those related to business or strategy.
4. Confidentiality: Each Entity Board Director shall comply with the Michigan Mental Health Code, Section, 330.1748, & 42 CFR Part 2 relative to substance abuse services,

and any other applicable privacy laws (Materials can be found by contacting the Entity Compliance Department)

5. Each Entity Board Director will be properly prepared for the Entity Board of Directors deliberation.
6. Each Entity Board Director will support the legitimacy and authority of the final determination of the Entity Board of Directors on any matter, without regard to the Entity Board Director's personal position on the issue.
7. Delegation of Authority: The Entity Board of Directors will use due care not to delegate substantial discretionary authority to individuals whom they know, or should have known through due diligence, have a propensity to engage in illegal activities.
8. Excluded Individuals: Persons who have been excluded from participation in Federal Health Care Programs may not serve as an Entity Board Director. Each Entity Board Director becomes responsible for notifying the Entity Corporate Compliance Department if they believe they will become an excluded individual. Each Entity Board Director is responsible for providing information necessary to monitor possible exclusions. The Entity shall periodically review the Entity Board Director's names against the excluded list per regulatory and contractual obligations.
9. Each Entity Board Director will read and seek to understand the Entity Compliance Plan and Code of Conduct.
    a. The Entity Board of Directors have a duty to report to the Entity Chief Compliance Officer any alleged or suspected violation of the Entity Board of Directors Code of Conduct or related laws and regulations by themselves or another Entity Board Director.
    b. The Entity Board of Directors may seek advice from the Entity Board of Directors Chairperson or the Entity Chief Compliance Officer concerning appropriate actions that may need to be taken to comply with the Code of Conduct or Compliance Plan.
    c. Reporting Suspected Fraud: The Entity Board of Directors must report any suspected "fraud, abuse or waste" (consistent with the definitions as set forth in the Compliance Program Plan) of any Entity funding streams.
    d. Failure to comply with the Entity Compliance Plan and the Entity Board of Directors Code of Conduct may result in the recommendation to a participant CMHSP Board the member's removal from the Entity Board of Directors.
    e. The Entity Board Directors will participate in required Entity Board of Directors compliance trainings.
    f. The Entity Board of Directors will establish and encourage throughout its region, cultures that promote prevention, detection, and resolution of instances of misconduct in order to conform to applicable laws and regulations.
    g. The Entity Board of Directors shall cooperate fully in any internal or external Medicaid or other LRE funding stream compliance investigation.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to the Entity Board of Directors.

IV. MONITORING AND REVIEW

This policy is reviewed by the CEO and designees on an annual basis.

V. DEFINITIONS

Conflict of Interest: Any actual or proposed direct or indirect financial relationship or ownership interest between each individual director and any entity with which the Entity has or proposes to have a contract, affiliation, arrangement, or other transaction.

VI. RELATED POLICIES AND PROCEDURES

A. Conflict of Interest Policy
B. Compliance Plan
C. Board By-Laws

VII. REFERENCES/LEGAL AUTHORITY

A. MDHHS Medicaid Specialty Supports and Services Contract
B. 42 CFR Part 2
C. Michigan Mental Health Code

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
11/18/21	Add references	CEO and Designees

Policy 10.12

POLICY TITLE: BUDGET		**POLICY #: 10.12**	
Topic Area: Board of Directors			**REVIEW DATES**
Applies to: Chief Executive Officer, Board of Directors		**Issued By and Approved By:** Board of Directors	11/18/21
Review Cycle: Annually			
Developed and Maintained by: CEO and Designees			
Supersedes: N/A		**Effective Date:** 9/16/17	**Revised Date:** 11/18/21

I. PURPOSE

To ensure the Board of Directors, in its governance role, is provided accurate information to ensure fiscal accountability and oversight.

II. POLICY

Budgeting any fiscal year or the remaining part of any fiscal year shall not deviate from Lakeshore Regional Entity (the "Entity") Board of Directors accomplishments/results/outcomes priorities, risk fiscal jeopardy, or fail to be derived from multi-year plan.

Accordingly, the Entity CEO will provide appropriate budgeting which:

1. Contains adequate information and includes information which enables credible projection of revenues and expenses, separation of capital and operational items, cash flow, and disclosure of planning assumptions.
2. Plans for the expenditures in any fiscal year of funds that are conservatively projected to be available for that period.
3. Provides detail that is sufficient for the Entity Board of Directors prerogatives, such as costs of fiscal audit, the Entity Board of Directors development, the Entity Board of Directors and committee meetings, and the Entity Board of Directors legal fees.
4. Ensures the fiscal soundness of future years and builds organizational capability sufficient to achieve future ends.
5. Can be shared with the Entity Board of Directors on a monthly basis.
6. Adheres to generally accepted accounting practices and standards.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to the Entity Chief Executive Officer (CEO).

IV. MONITORING AND REVIEW

This policy is reviewed by the CEO and designees on an annual basis.

V. DEFINITIONS

N/A

VI. RELATED POLICIES AND PROCEDURES

A. Financial Policies and Procedures
B. Board Policies and Procedures

VII. REFERENCES/LEGAL AUTHORITY

N/A

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
11/18/21	Added Purpose	CEO and Designees

POLICY TITLE: COMMUNICATION AND COUNSEL TO THE BOARD OF DIRECTORS	POLICY #: 10.13	
		REVIEW DATES
Topic Area: Executive Responsibility	**Issued By and Approved By:** Board of Directors	11/18/21
Applies to: Chief Executive Officer, Chief Compliance Officer, Chief Financial Officer		
Developed and Maintained by: CEO and Designees	**Effective Date:** 9/17/16	**Revised Date:** 11/18/21
Supersedes: N/A		

I. PURPOSE

To make appropriate decisions, the Entity Board of Directors must be informed of relevant information by the Entity Executive staff.

II. POLICY

Chief Executive Officer

The Lakeshore Regional Entity (the "Entity") Chief Executive Officer (CEO) shall ensure that the Entity Board of Directors is informed and supported in its work.

The Entity CEO must:

1. Submit monitoring data required by the Entity Board of Directors in in a timely, accurate, and understandable fashion, directly addressing provisions of Entity Board of Directors policies being monitored and including the Entity CEO interpretations as well as relevant data.
2. Ensure that the Entity Board of Directors is aware of any noncompliance actual or anticipated of Entity Board of Directors policies regardless of monitoring policy schedule.
3. Ensure that the Entity Board of Directors has adequate information to be aware of relevant trends, regardless of monitoring policy schedule.
4. Inform the Entity Board of Directors of any significant information on impending media coverage, threatened or pending lawsuits, and material internal and external changes.
5. Ensure that the Entity Board of Directors is aware that, in the Entity CEO's opinion, the Entity Board of Directors is not in compliance with its own policies, particularly in the case of the Entity Board of Directors behavior that is detrimental to the work relationship between the Entity Board of Directors and the Entity CEO.
6. Refrain from presenting information in unnecessarily complex or lengthy form or in a form that fails to differentiate among information of three types: monitoring, decision preparation, and other.

7. Ensure that the Entity Board of Directors will have a workable mechanism for official Entity Board of Directors, officers, or committee's communications.
8. Not deal with individual Entity Board of Directors in a way that favors or privileges certain the Entity Board of Directors members over others, except when fulfilling individual requests for information or responding to officers or committees duly charged by the Entity Board of Directors.
9. Submit to the Entity Board of Directors a consent agenda containing items delegated to the Entity CEO required by law, regulation, or contract to be approved by the Entity Board of Directors, along with applicable monitoring information.

Chief Financial Officer and Chief Compliance Officer

The Financial Officer and Chief Compliance Officer shall have direct access to the Entity Board of Directors.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to the Entity Board of Directors, Entity CEO, Entity Chief Compliance Officer, and the Entity Chief Financial Officer.

IV. MONITORING AND REVIEW

The CEO and designees will review this policy on an annual basis.

V. DEFINITIONS

N/A

VI. RELATED POLICIES AND PROCEDURES

A. Compliance Policies and Procedures
B. Board Policies and Procedures
C. Board By-Laws

VII. REFERENCE/LEGAL AUTHORITY

N/A

CHANGE LOG Date of Change	**Description of Change**	**Responsible Party**
11/18/21	Moved procedure to policy section. Added language from 10.17	CEO and Designees

Policy 10.17

POLICY TITLE: MANAGEMENT DELEGATION AND EXECUTIVE LIMITATIONS	POLICY #: 10.17	
		REVIEW DATES
Topic Area: Board of Directors	**Issued By and Approved By:** Board of Directors	11/18/21
Applies to: CEO, CFO, Compliance Officer		
Review Cycle: Annually		
Developed and Maintained by: CEO and Designees		
Supersedes: N/A	**Effective Date:** 9/17/16	**Revised Date:** 11/18/21

I. PURPOSE

All Entity Board authority delegated to staff is delegated to the CEO. The CEO shall execute the delegated authority of the Entity Board within defined executive limitations.

II. POLICY

The Lakeshore Regional Entity (the "Entity") Board of Directors sole official connection to the operational organization, its achievements and conduct will be through its chief executive, titled Chief Executive Officer (CEO).

The Entity CEO shall have the authority delegated to that position from time to time by the Entity Board of Directors. The Entity CEO may not simultaneously hold another position (employee, board member or contractor) with any Member.

Delegation of Authority

Contracts

A. For funds included in the Entity Board's approved budget, the CEO is authorized to enter into purchase-of-service agreements such as maintenance contracts, printing contracts, television advertising, clinical service contracts, and other contracts that implement functions of the Entity system administration. This also includes entering into contracts with consultants and contracts for professional services.
B. For items not included in the Entity Board's approved budget, the CEO is authorized to enter into purchase-of-service agreements and contracts whose total cost does not exceed $50,000. Such contracts will be reported to the Entity Board in a timely manner as specified by Policy 2.2 – Cash Management- Disbursements.

Executive Limitations

A. Decisions or instructions of individual Entity Board of Directors officers, or committees are not binding on the CEO except in instances when the Entity Board of Directors has specifically authorized such exercise of authority.

B. In the case of individual Entity Board of Directors or committees requesting information or assistance without the Entity Board of Directors authorization, the Entity CEO can refuse such requests that require, if in the Entity CEO's opinion, a material amount of staff time or funds are required or are disruptive.
C. The CEO shall not cause or allow any practice, activity, decision, or organizational circumstance, which is either illegal, imprudent or in violation of commonly accepted business and professional ethics or in violation of contractual obligations.
D. With respect to the actual, ongoing condition of the Entity's financial health, the Entity Chief Executive Officer (CEO) may not cause or allow the development of fiscal jeopardy or the material deviation of actual expenditures from board priorities established in policies.

   The Entity CEO may not:

   1. Expend more funds than have been received in the fiscal year to date (including carry forward funds from prior year) unless the Entity Board of Directors debt guideline is met as defined in the LRE Operating Agreement under Section 4.8 Debt-Thresholds.
   2. Incur debt in an amount greater than can be repaid by certain and otherwise unencumbered revenues in accordance with the LRE Entity Board of Directors approved schedule.
   3. Use any designated reserves other than for established purposes.
   4. Conduct inter-fund shifting in amounts greater than can be restored to a condition of discrete fund balances by certain and otherwise unencumbered revenues within ninety days.
   5. Fail to settle payroll and debts in a timely manner.
   6. Allow tax payments or other government-ordered payments of filings to be overdue or inaccurately filed.
   7. Fail to adhere to applicable generally acceptable accounting standards.
   8. Make a single purchase or commitment of greater than $ 50,000.00 in a fiscal year, except for participant CMHSP and direct-contracted prevention or treatment provider contracts. Splitting orders to avoid this limit is not acceptable.
   9. Purchase or sell real estate in any amount absent the Entity Board of Directors authorization.
   10. Fail to aggressively pursue receivables after a reasonable grace period.

E. Treatment of Staff

   The Entity CEO may not:

   1. Operate without written personnel rules that:
      i. Articulate federal and state work rules
      ii. Clarify these rules for staff
      iii. Provide effective handling of grievances
      iv. Protect against wrongful conditions such as nepotism and grossly preferential treatment for personal reasons.

2. Retaliate against any staff member for expression of dissent.
3. Fail to acquaint staff with the Entity CEO interpretation of their protections under this policy.
4. Allow staff to be unprepared to deal with emergency situations.

F. Treatment of Plan Members

The Entity CEO may not:

1. Use forms or procedures that elicit information for which there is no clear necessity.
2. Use methods of collecting, reviewing, or storing plan member information that fail to protect against improper access to the information elicited.
3. Fail to inform the Entity Board of Directors of the status of uniform benefits across the region or fail to assist Participant CMHSPs towards compliance.
4. Fail to provide procedural safeguards for the secure transmission of Plan members' protected health information.
5. Fail to establish with people served by the Entity a clear contract of what may be expected from the Entity including but not limited to their rights and protections.
6. Fail to inform people served by the Entity of this policy or to provide a grievance process to those plan members who believe that they have not been accorded a reasonable interpretation of their rights under this policy.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to the Entity CEO and the Entity Board of Directors.

IV. MONITORING AND REVIEW

The CEO and designees will review this policy on an annual basis.

V. DEFINITIONS

N/A

VI. RELATED POLICIES AND PROCEDURES

A. Board By-Laws
B. Financial Policies and Procedures
C. Board Policies and Procedures
D. Compliance Plan

VII. REFERENCES/LEGAL AUTHORITY

N/A

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party

11/18/21	Added language from 2.1, 10.11, 10.15, 10.16, 10.20 10.21	CEO and Designees

Policy 10.19

POLICY TITLE:	**MONITORING CHIEF EXECUTIVE OFFICER PERFORMANCE**	**POLICY #: 10.19**	
Topic Area:	Board of Directors		**REVIEW DATES**
Applies to:	Board of Directors, Chief Executive Officer	**Issued By and Approved By:** Board of Directors	11/18/21
Review Cycle:	Annually		
Developed and Maintained by:	CEO and Designees		
Supersedes:	N/A	**Effective Date:** 9/17/16	**Revised Date:** 11/18/21

I. PURPOSE

To ensure executive performance is monitored and evaluated.

II. POLICY

Monitoring executive performance is synonymous with monitoring organizational performance against Lakeshore Regional Entity (the "Entity") Board of Directors policies and approved outcomes. Any evaluation of the Entity Chief Executive Officer (CEO) performance, formal or informal, may be derived from these monitoring data.

1. The purpose of monitoring is to determine the degree to which the Entity Board of Directors policies are being fulfilled. Information that does not do this will not be considered to be monitoring
2. A given policy may be monitored in one or more of three ways; with a balance of using all the three types of monitoring:
   a. Internal report: Disclosure of compliance information to the Entity Board of Directors from the Entity CEO.
   b. External report: Discovery of compliance information by a disinterested, external auditor, inspector or judge who is selected by and reports directly to the Entity Board of Directors. Such reports must assess executive performance only against policies of the Entity Board of Directors, not those of the external party unless the Entity Board of Directors has previously indicated that party's opinion to be the standard.
   c. Direct Entity Board of Directors inspection: Discovery of compliance information by an Entity Board Director, a committee, or the Entity Board of Directors as a whole. This is an Entity Board of Directors inspection of documents, activities or circumstances directed by the Entity Board of Directors which allows a "prudent person" test of policy compliance.
3. Upon the choice of the Entity Board of Directors, any policy can be monitored by any method at any time. For regular monitoring, however, each Outcome and Executive Limitations policy will be classified by the Entity Board of Directors according to frequency and method.

a. Internal
b. External
c. Direct Inspection

4. Annually the Entity Board of Directors will have a formal evaluation of the Entity CEO. This evaluation will consider monitoring data as defined here, and as it has appeared over the calendar year.
5. The Executive Committee of the Entity Board of Directors (Chairperson, Vice Chairperson, and Secretary) will take data and information from the bulleted documents below upon which the annual performance of the Entity CEO will be evaluated. The overall evaluation consists of compliance with Executive Limitations Policies; Outcomes interpretation and Outcomes monitoring reports and supporting documentation (as per the Entity Board of Directors developed schedule) and follow through on the Entity Board of Directors requests (what we ask for in subsequent meetings; what we want to see on the agendas). For the performance review the following should be documents given to the Executive Committee of the Entity Board of Directors at least one-month prior to the Entity Board of Directors Entity CEO evaluation.
    - Minutes of all meetings
    - Outcomes monitoring reports for the past year along with the Outcomes Interpretation for each Outcomes monitoring report
    - Any supporting Outcomes documentation
    - Outcomes Monitoring Calendar
    - Other policies monitoring calendar

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to the Entity Board of Directors and the Entity CEO.

IV. MONITORING AND REVIEW

This policy is reviewed by the CEO and designees on an annual basis.

V. DEFINITIONS

N/A

VI. RELATED POLICIES AND PROCEDURES

N/A

VII. REFERENCES/LEGAL AUTHORITY

N/A

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
11/18/2021		CEO and Designees

Attachment 10

Strategic Pl nn ng Ove view

LAKESHORE REGIONAL ENTITY

What?

Engage stakeholders to ID strategic priorities and related actions for a 3-year strategic plan.
Will address operations of the LRE, including management and oversight* of funded services.

*Will *not* address programmatic aspects of service delivery.*

Who?

- LRE Board of Directors (BOD)
- CMHSP Members
- ROAT workgroups
- LRE staff

Why?

Empower the LRE to effectively direct their efforts to address priorities.

rocess

We are here.

DISCOVERY

Survey stakeholders re: perceptions, priorities, strategic direction, and employee needs

Environmental scan for state and national issues

GUIDING FRAMEWORK

Board of Directors establish:

Mission
Purpose & Intention

Values
Moral compass

Strategic Priorities
Focus for Planning

STRATEGIC PRIORITIES

Compile relevant data/ information for each priority

↓

ROAT groups & key staff will ID potential action areas for each

↓

Survey BOD & stakeholders to inform prioritization of action areas

TACTICS & METRICS

ROAT groups & key staff determine tactics for each action area

Metrics for priorities & action areas (goals & objectives)

Structures to monitor

STRATEGIC PLAN

Strategic lan Draft developed

Operations Committee review & feedback

Present to BOD for review/revisions/ approval

MONITOR PROGRESS

Additional discovery & planning (as necessary)

Monitor implementation & outcomes

Refresh plan (as necessary)

Timeline

- Fall 2022
- Fall 2022
- Winter 2022/23
- Spring 2023
- Early Summer 2023
- Ongoing

Regional Leadership. Local Excellence.

LAKESHORE REGIONAL ENTITY

Our Mission: Through regional support and leadership for collaboration and innovation, we work to strengthen the public behavioral health system and ensure excellence in services.

Our Values:

LOCAL SOLUTIONS

VALUE LOCAL DIFFERENCES

We value locally unique service systems that are responsive to local needs, partnerships, & available resources.

FISCAL RESPONSIBILITY

ACCOUNTABLE & RESPONSIBLE WITH FUNDS

Transparent & accountable use of public funds.

Maximize available resources.

COLLABORATIVE RELATIONSHIPS

FOSTER EFFECTIVE PARTNERSHIPS

Nurture collaboration based on mutual trust & shared commitment to quality.

Approach all interactions with respect, openness, & a commitment to proactively resolve conflict.

INNOVATION

BOLDLY PURSUE EXCELLENCE

Pursue audacious goals by challenging the status quo & trying new things.

Actively work to identify & support opportunities for innovation.

The LRE serves as one of ten Prepaid Inpatient Health Plans (PIHP) in Michigan, as the public behavioral health plan for people with mental illness, developmental disability, and substance use disorders in Allegan, Kent, Lake, Mason, Muskegon, Oceana, and Ottawa counties.

CORPORATE COMPLIANCE PLAN
December 2022 (Fiscal Year 2023)

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ORGANIZATIONAL STRUCTURE

The Lakeshore Regional Entity (LRE) serves as the Medicaid Prepaid Inpatient Health Plan (PIHP) for the following seven county region:

Allegan County:	OnPoint (Allegan County Community Mental Health Services)
Kent County:	Network 180 (Kent County Mental Health Authority)
Lake County:	West Michigan Community Mental Health System
Mason County:	West Michigan Community Mental Health System
Muskegon County:	Health West
Oceana County:	West Michigan Community Mental Health System
Ottawa County:	Community Mental Health of Ottawa County

The Member Community Mental Health Service Programs have elected to configure LRE under the Michigan Mental Health Code Section 3301.1204b.

LRE as the PIHP

LRE serves as the Medicaid Prepaid Inpatient Health Plan (PIHP) for the region with authority and accountability for operations and fulfillment of applicable federal and state statutory, regulatory, and contractual obligations related to the applicable waiver(s) and MDHHS contract(s). The role of LRE as the PIHP is defined in federal statute, specifically 42CFR 438 and the MDHHS/PIHP Contract.

LRE contracts with MDHHS for The Medicaid Managed Specialty Supports and Services 1115 Demonstration Waiver, 1915 (c)/(i) Waiver Program(s), the Healthy Michigan Program, the Flint 1115 Waiver and Substance Use Disorder Community Grant Programs

LRE: MISSION, VISION, and VALUES

MISSION:

Through regional support and leadership for collaboration and innovation, we work to strengthen the public behavioral health system and ensure excellence in services.

VISION:

The vision of the Lakeshore Regional Entity is to promote the efficiency and effectiveness of the Members by jointly serving as the PIHP for Medicaid Specialty Behavioral Health Services for the region. Behavioral Health Services include services for persons with developmental disabilities, adults with mental illness, children with emotional disturbance and persons with substance use disorders. The Lakeshore Regional Entity seeks to build upon and maximize the unique strengths of the individual Member Boards serving Allegan, Kent, Lake, Mason, Muskegon, Oceana, and Ottawa Counties, while establishing a regional organization and identity that supports an essential standard for services. The Lakeshore Regional Entity will promote performance that supports and advocates for and is informed by the needs of the individuals the Entity serves across the region.

VALUES:

- **Local Solutions – Value Local Differences:** We value locally unique service systems that are responsive to local needs, partnerships, and available resources.

- **Fiscal Responsibility – Accountable and Responsible with funds:** Transparent and accountable use of public funds. Maximize available resources.

- **Collaborative Relationships – Foster Effective Partnerships:** Nurture collaboration based on mutual trust and shared commitment to quality. Approach all interactions with respect, openness, and a commitment to proactively resolve conflict.

- **Innovation – Boldly Pursue Excellence:** Pursue audacious goals by challenging the status quo and trying new things. Actively work to identify and support opportunities for innovation.

- **Integrity:** Commitment to achieving performance, ethically, effectively, and professionally.

OVERVIEW

This Corporate Compliance Plan documents LRE's approach to assuring that federal and state regulatory and contractual obligations related to compliance of the Prepaid Inpatient Health Plan (PIHP) are fulfilled.

The LRE Corporate Compliance Plan addresses the LRE's regulatory compliance obligations as a Prepaid Inpatient Health Plan (PIHP) and how, where it has obligations, it will oversee the PIHP functions it delegates to the Member Community Mental Health Service Providers (CMHSP).
The LRE's Corporate Compliance Program is designed to further LRE's commitment to comply with applicable laws, promote quality performance throughout the LRE region, and maintain a working environment for all LRE personnel that promotes honesty, integrity, and high ethical standards.
The LRE's Corporate Compliance Program is an integral part of the LRE's vision, and all LRE personnel, Member CMSHPs and contracted and sub-contracted Providers are expected to support the corporate compliance program.
The LRE's compliance plan is a high-level compliance program comprised of the following eight principal elements as outlined in the Federal Sentencing Guidelines:

1. Standards, Policies, and Procedures – The development and distribution of written standards of conduct, policies, and procedures that promote the LRE's commitment to full compliance with Federal and State laws that are accessible and applicable to all company employees. These policies and procedures will incorporate the culture of compliance into our day-to-day operations and will address specific areas of potential fraud, waste, and abuse.

2. Compliance Program Administration – The designation of a Chief Compliance Officer and a Compliance Oversight Committee that is charged with the responsibility and authority of operating and monitoring the compliance program to make sure that it is implemented, reviewed, and revised, as appropriate in an effective manner.

3. Screening and Evaluation of Employees, Physicians, Vendors, and other Agents – The application of risk-based due diligence to third party relationships and the demonstration that processes are in place to identify and disclose conflicts of interest, assure inclusion of compliance obligations, verify background checks are conducted in accordance with applicable rules and laws, monitor government sanction list for excluded individuals, and assure corrective action is taken based on all findings.

4. Communication, Education, and Training on Compliance Issues – The development and implementation of appropriately tailored training programs, education, and communication programs for all employees. Effectuate lines of communication between the Chief Compliance Officer, all employees, and all members in the region.

5. Monitoring, Auditing, and Internal Reporting Systems – The use of audits or other risk evaluation techniques to monitor compliance and assist in the reduction of identified problem areas within delivered services, claims processing, and managed care functions. The use of efficient and trusted mechanisms where employees can contact the Chief Compliance Officer through a hotline to receive complaints, the adoption of procedures to protect the anonymity of complainants, and to protect callers from retaliation.

6. Discipline for Non-Compliance – The development of disciplinary mechanisms to consistently enforce standards across the organization and the development of policies addressing dealings with sanctioned and other specified individuals.

7. Investigations and Remedial Measures – The development of policies to respond to detected offenses, to initiate corrective action to prevent similar offenses, and to report to Government authorities when appropriate.

8. Risk Assessment – The development of a Risk Assessment plan that will be used to identify, analyze, and address the risks the organization faces and how well the current systems in place are able to prevent those risks.

The LRE's Corporate Compliance Program is committed to the following goals:

- Minimize organizational risk and improve compliance with the service provision, documentation, and billing requirements of Medicaid;
- Maintain adequate internal controls throughout the region and provider network;
- Encourage the highest level of ethical and legal behavior from all employees and providers;
- Educate employees, contract providers, board members, and stakeholders on their responsibilities and obligations to comply with applicable local, state, and federal laws; and
- Provide oversight and monitor functions.

LEGAL AND REGULATORY STANDARDS

There are numerous laws that affect the regulatory compliance of the LRE and its provider network; however, in formalizing the PIHP's compliance program, the legal basis of the LRE compliance program centers around four key laws and statutes:

- **The Affordable Care Act (2010)**
  This Act requires the PIHP to have a written and operable compliance program capable of preventing, identifying, reporting, and ameliorating fraud, waste and abuse across the PIHP's provider network. All programs funded by the PIHP including CMHSPs, sub-contract provider organizations and practitioners, board members and others involved in rendering PIHP covered services fall under the purview and scope of LRE's compliance program.

- **The Federal False Claims Act**
  This Act applies when a company or person knowingly presents (or causes to be presented) to the Federal government (or any entity on its behalf) a false or fraudulent claim for payment; knowingly uses (or causes to be used) a false record or statement to get a claim paid; conspires with others to get a false or fraudulent claim paid; or knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Federal government (or its designated entity).

- **The Michigan False Claims Act**
  This Act prohibits fraud in the obtaining of benefits or payments in conjunction with the MI Medical assistance program; to prohibit kickbacks or bribes in connection with the program to prohibit conspiracies in obtaining benefits or payments; and to authorize the MI Attorney General to investigate alleged violations of this Act.

- **The Anti-Kickback Statute**
  This Act prohibits the offer, solicitation, payment or receipt of remuneration, in cash or in kind, in return for or to induce a referral for any service paid for or supported by the Federal government or for any good or service paid for in connection with consumer service delivery.

There are numerous Federal and State regulations that affect the LRE compliance program. Some of these laws not referenced above include but are not limited to:

Federal and State Laws and Rules

- Michigan Mental Health Code, Public Health Code and Administrative Rules
- Requirements as identified in the MDHHS contract
- Requirements as identified by the Office of Inspector General
- Technical Assistance Advisories, as required
- Medicaid State Plan
- Waiver Applications
- Medical Services Administration (MSA) Policy Bulletins
- Michigan Whistleblowers Act, Act 469 of 1980
- Home and Community Based Final Rules

Federal Medicaid Law, Regulations, and Related Items

- Social Security Act of 1964 (Medicare and Medicaid)
- Balanced Budget Act of 1997
- Deficit Reduction Act/Medicaid Integrity Program of 2005
- Anti-kickback Statute
- Code of Federal Regulations
- 42 CFR Part 2 Confidentiality of Alcohol and Drug Use Patient Records
- State Operations Manual
- Letters to State Medicaid Directors

- Technical Assistance Tools
- Quality Improvement Systems for Managed Care (QISMC)
- Guide to Encounter Data Systems
- Office of Management and Budget (OMB) Circulars
- Government Accounting Standards Board (GASB)
- The Balanced Budget Act of 1997

Other Relevant Legislation

- Privacy and Security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- False Claim Act (Federal and Michigan)
- Provisions from Public Act 368 of 1978 – revised – Article 6 Substance Abuse
- Office of Inspector General Annual Work Plan
- Stark Law
- Health Information Technology for Economic and Clinical Health Act (HITECH) Act
- American with Disabilities Act of 1990
- State of Michigan MDHHS/PIHP contract provisions
- Michigan State Licensing requirements
- Michigan Medical Records Act
- Civil Monetary Penalty Law of 1981

The LRE Compliance Plan is subject to the following conditions:

A. LRE's Chief Compliance Officer (CCO) may recommend modifications, amendments, or alterations to the written Corporate Compliance Plan as necessary and will communicate any changes promptly to all personnel and to the Board of Directors.

B. This document is not intended to, nor should be construed as, a contract or agreement, and does not grant any individual or entity employment or contract rights.

DEFINITIONS AND TERMS

These terms have the following meaning throughout this Compliance Plan.

1. **Compliance investigation:** the observation or study of suspected fraud, abuse, waste, or reported violations of applicable laws and regulations for all Medicaid covered services by close examination and systematic inquiry.
2. **Abuse:** Practices that are inconsistent with sound fiscal, business, or clinical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. (42 CFR § 455.2)

3. **Fraud (Federal False Claims Act):** Is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law including but not limited to the Federal False Claims Act and the Michigan False Claims Act. (42 CFR § 455.2)
4. **Fraud (MI Medicaid False Claims Act):** Michigan law permits a finding of Medicaid fraud based upon "constructive knowledge." This means that if the course of conduct reflects a systematic or persistent tendency to cause inaccuracies" then it may be fraud, rather than simply a good faith error or mistake. (Public Act 421 of 2008, effective 1/6/2009)
5. **Waste:** Overutilization of services, or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions but rather the misuse of resources.
6. **Member CMSHPs:** Member CMSHPs hold a subcontract with LRE to provide supports and services to adults and children with mental illness, developmental disabilities, and co-occurring mental health and substance abuse disorders to Plan Members and to perform various delegated managed care functions consistent with LRE policy. "Member CMSHPs" includes the agency itself as well as those acting on its behalf, regardless of the employment or contractual relationship.
7. **Contracted Providers:** substance abuse, hospital, and other Providers throughout the LRE region with which the LRE directly holds a contract to provide Medicaid covered mental health and substance abuse services.
8. **Subcontracted Providers:** various Providers throughout the LRE region that contract directly with one or more of the Member CMSHPs to provide covered mental health and substance abuse services.

STRUCTURE OF THE COMPLIANCE PROGRAM

A. General Structure

- The LRE Board of Directors: The Board of Directors is responsible for the review and approval of the Compliance Plan and Policies, and review of matters related to the Compliance Program.

- The LRE Compliance Oversight Committee: The Compliance Oversight Committee (COC) provides guidance, supervision, and coordination for compliance efforts at the LRE. The COC is comprised of the LRE Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Quality Officer, Chief Compliance Officer, and Chief Information Officer. Legal Counsel will be an ad-hoc member of the COC. In addition, other members of the LRE not mentioned above may be asked to participate in the COC on a case-by-case basis to provide consultation on specific areas of expertise. The COC will meet quarterly and when otherwise needed to address specific impromptu matters.

- The LRE Chief Compliance Officer: The Chief Compliance Officer has primary responsibility for ensuring that the LRE maintains a successful Compliance Program. In particular, the Chief Compliance Officer oversees the implementation and effectiveness of the Compliance Plan and Compliance Policies, serves as the Chair of the Compliance Regional Operations Advisory Team (ROAT) and the LRE COC, provides consultative support to the provider network and has the responsibility for the day-to-day operations of the compliance program.

- The Compliance Regional Operations Advisory Team: The Compliance ROAT advises on matters involving compliance with contractual requirements and all related Federal and State laws and regulations, inclusive of the Office of Inspector General guidelines and the 42 CFR 438.608. The committee is comprised of the LRE Chief Compliance Officer and the compliance officers of each CMHSP Participant.

- Operations Council: The Operations Council reviews reports concerning compliance matters as identified by the Compliance ROAT and reported by the LRE Chief Executive Officer. The Operations Council shall be comprised of the Chief Executive Officers or Executive Directors of each CMHSP Participant and the LRE Chief Executive Officer.

B. The LRE Chief Compliance Officer

The LRE designates the Chief Compliance Officer who will be given sufficient authority and control to oversee and monitor the Compliance Program related Policies and Procedures, including but not limited to the following:

- Oversight of internal (PIHP Audits) and external provider network audits (MDHHS Audit) and monitoring activities outlined in the compliance plan.
- Directs and is accountable for the implementation and enforcement of the Compliance Plan.
- Serves as chair of the LRE's COC and the Compliance ROAT.
- Provides leadership to the LRE compliance activity and consultative support to CMHSP Participants/SUD Providers.
- Responsible for oversight of the LRE's efforts to maintain compliance with Federal and State regulations and contractual obligations.

C. The Compliance Regional Operations Advisory Team (ROAT)

The Compliance ROAT will consist of the LRE Chief Compliance, and the CMHSP Participants' Compliance Officers appointed by the CMHSP Participant's. The Compliance ROAT will meet on the first Wednesday of each month and shall be responsible for the following:

- Advising the LRE Compliance Officer and assisting with the development, implementation, operation, and distribution of the Compliance Plan and supporting LRE policies and procedures.
- Reviewing and recommending changes or revisions to the Compliance Plan and related policies and procedures and developing new policies and procedures as needed.
- Evaluating the effectiveness of the Compliance Plan.
- Determining the appropriate strategy to promote compliance with the Compliance Plan and detect potential violations and areas of risk as well as areas of focus.
- Recommending and monitoring the development of internal systems and controls to carry out the Compliance Plan and supporting policies as part of daily operations.

D. The LRE Compliance Oversight Committee (COC)

The LRE COC will meet at minimum quarterly and whenever unique situations arise that require such a meeting. The duties and responsibilities of the COC are as follows:

- Review the Compliance Plan and related policies to ensure they adequately address legal requirements and identified risk areas;
- Analyze the regulatory environment and the legal requirements with which it must comply and specific risk areas;
- Analyze the effectiveness of the compliance program and make recommendations;
- Assist the Chief Compliance Officer with developing policies and procedures to promote compliance with the Compliance Plan;
- Assess existing policies and procedures that address these areas for possible incorporation into the compliance program;
- Assist the Chief Compliance Officer with identifying potential risk areas and violations;
- Advise and assist the Chief Compliance Officer with compliance initiatives;
- Work with appropriate departments, as well as affiliated providers, to develop standards of conduct and policies and procedures that promote compliance to legal and ethical standards;
- Recommend and monitor, in conjunction with the relevant functional area leaders, the development of internal and external systems and controls to carry out LRE's standards, policies and procedures as part of its daily operations;
- Determine the appropriate strategy and approach to promote compliance with the LRE compliance program and detection of any potential violations, such as through hotlines and other fraud reporting mechanisms;
- Develop a system to solicit, evaluate, and respond to complaints and problems;
- Monitor internal and external audits and investigations for the purpose of identifying risk areas and implement corrective and preventative action;
- Assist in the development of program measurements to evaluate the compliance program effectiveness;

- Ensure compliance issues are appropriately communicated to the departments, CEO, Executive Leadership committee, Board of Directors, and affiliated Providers, as needed; and
- Address other functions as requested by the CEO, CCO, and Board of Directors.

APPLICATION OF COMPLIANCE PLAN

As a regional PIHP, this Compliance Plan is intended to provide the framework for the LRE to comply with all applicable laws, regulations, and program requirements. It is the LRE's intent that all its compliance policies and procedures should promote integrity, support objectivity, and foster trust throughout the service region. This Plan applies to all LRE operational activities, administrative actions, and includes those activities that come within Federal and State oversight of PIHPs.

LRE personnel are subject to the requirements of this plan as a condition of employment. All LRE personnel are required to fulfill their duties in accordance with LRE's Compliance Plan, human resource and operational policies, and to promote and protect the integrity of LRE. Failure to do so will result in discipline, up to and including termination of employment depending on the egregiousness of the offense. Disciplinary action may also be taken against a supervisory employee who directs or approves an employee's improper conduct, is aware of the improper conduct and does not act appropriately to correct it, or who fails to properly exercise appropriate supervision over an employee.

LRE directly and indirectly, through its Member CMSHPs, contracts services for adults and children with mental illness, developmental disabilities, and co-occurring mental health and substance abuse disorders within its seven counties (Allegan, Kent, Lake, Mason, Muskegon, Oceana, and Ottawa counties).

The LRE Corporate Compliance Plan applies to all contracted and subcontracted providers receiving payment through LRE and/or through the PIHP managed care functions. All Member CMSHPs and contracted and subcontracted providers, including their officers, employees, servants, and agents, are subject to the requirements of this Plan as applicable to them and as stated within the applicable contracts. Failure to follow the LRE Compliance Plan and cooperate with the compliance program will result in remediation effort attempts and contract action, if needed.

The LRE Corporate Compliance Plan, standards, and policies included or referenced herein are not exhaustive or all inclusive. All LRE personnel, Member CMSHPs and providers are required to comply with all applicable laws, rules and regulations including those that are not specifically addressed in the Corporate Compliance Plan.

SECTION I – STANDARDS OF CONDUCT

LRE Personnel and Board of Directors Standards of Conduct

To safeguard the ethical and legal standards of conduct, LRE will enforce policies and procedures that address behaviors and activities within the work setting, including but not limited to the following:

1. Confidentiality: LRE is committed to protecting the privacy of its consumers. Board members and LRE personnel are to comply with the Michigan Mental Health Code, Section, 330.1748, 42 CFR Part 2 relative to substance abuse services, and all other privacy laws as specified under the Confidentiality section of this document.

2. Harassment: LRE is committed to an environment free of harassment for Board members and LRE personnel. LRE will not tolerate harassment based on sex, race, color, religion, national origin, citizenship, chronological age, sexual orientation, or any other condition, which adversely affects their work environment. LRE has a strict non-retaliation policy prohibiting retaliation against anyone reporting suspected or known compliance violations.

3. Conflict of Interest: LRE Board members and personnel will avoid any action that conflicts with the interest of the organization. All Board members and personnel must disclose any potential conflict of interest situations that may arise or exist. LRE will maintain standards establishing a clear separation of any supplemental employment in terms of private practice and outside employment from activities performed for LRE.

4. Reporting Suspected Fraud: LRE Board members and personnel must report any suspected or actual “fraud, abuse or waste” (consistent with the definitions as set forth in this Plan) of any LRE funds to the organization.

5. Culture: LRE Board members, Executive Officer and management personnel will establish at LRE, and encourage throughout its region, cultures that promote prevention, detection, and resolution of instances of misconduct in order to conform to applicable laws and regulations. LRE will assist Member CMSHPs, contracted and subcontracted providers in adopting practices that promote compliance with Medicaid fraud, abuse, and waste program requirements. The LRE Compliance Plan and program will be enforced consistently.

6. Delegation of Authority: LRE Board members, Executive Officer and management personnel will use due care not to delegate substantial discretionary authority to individuals whom they know, or should have known through due diligence, have a propensity to engage in illegal activities.

7. Excluded Individuals: LRE will perform or cause to be performed criminal records checks and sanctions screenings on potential LRE personnel and shall avoid placing untrustworthy or unreliable employees in key positions.

8. LRE Board members and LRE personnel are expected to participate in compliance training and education programs.

9. LRE Board members and LRE personnel are expected to cooperate fully in any investigation.

10. Reporting: All LRE Board members and LRE personnel have the responsibility of ensuring the effectiveness of the organization's Compliance Program efforts by actively participating in the reporting of suspected violations of the Compliance Plan or policies and the standards stated in this Code of Conduct and Ethics.

11. Gifts from Consumers/Members: LRE personnel are prohibited from soliciting tips, personal gratuities or gifts from members or member families. Additionally, LRE personnel are prohibited from accepting gifts or gratuities of more than nominal value. LRE generally defines "nominal" value as $25.00 per gift or less. If a member or other individual wishes to present a monetary gift of more than nominal value, he or she should be referred to the Executive Officer.

12. Gifts Influencing Decision-Making: LRE personnel will not accept from anyone gifts, favors, services, entertainment, or other things of value to the extent that decision-making or actions affecting LRE might be influenced. Similarly, the offer or giving of money, services, or other things of value with the expectation of influencing the judgment or decision- making process of any purchaser, supplier, customer, member, government official, or other person by any LRE personnel, or the LRE is absolutely prohibited. Any such conduct should be reported immediately to the CO, or through the LRE Compliance Hotline at 1-800-420- 3592.

13. Gifts from Existing Vendors: LRE personnel may accept gifts from vendors, suppliers, contractors, or other persons that have nominal values as defined in LRE financial and compliance policies. LRE expects LRE personnel to exercise good judgment and discretion in accepting gifts. If any LRE personnel have any concerns regarding whether a gift should be accepted, the person should consult with his or her supervisor. LRE personnel will not accept excessive gifts, meals, expensive entertainment or other offers of goods or services, which has a more than a nominal value as defined in LRE financial and compliance policies.

14. Vendor Sponsored Entertainment: At a vendor's invitation, LRE personnel may accept meals or refreshments of nominal value at the vendor's expense. Occasional attendance at local theater or sporting events, or similar activity at a vendor's expense may also be accepted provided that, a business representative of the vendor attends with LRE

personnel. Such activities are to be reported to the Compliance Officer by LRE personnel.

15. Purchasing and Supplies: It is the policy of LRE to ensure that all rental, lease, and purchasing agreements are structured in accordance with applicable federal and state self-referral and anti-kickback regulations as well as federal guidelines regarding tax-exempt organizations. All agreements must be commensurate with the fair market value for equipment or space.

16. All subcontractor and supplier arrangements will be managed in a fair and reasonable manner, consistent with all applicable laws and good business practices. Subcontractors, suppliers, and vendors will be selected based on objective criteria including quality, technical excellence, price, delivery, and adherence to schedules, services, and maintenance of adequate sources of supply. Purchasing decisions will be made on the supplier's ability to meet needs and not on personal relationships or friendships. LRE will always employ the highest ethical standards in business practices in source selection, negotiation, determination of contract awards, and the administration of purchasing activities.

17. Marketing: Marketing and advertising practices are defined as those activities used by LRE to educate the public, provide information to the community, increase awareness of services, and recruit employees or contractual providers. LRE will present only truthful, fully informative, and non-deceptive information in any materials or announcements. All marketing materials will reflect available services.

    The federal Anti-kickback Statute (section 1128B[b] of the Social Security Act) makes it a felony, punishable by criminal penalties, to offer, pay, solicit, or receive "remuneration" as an inducement to generate business compensated by Medicaid programs. Therefore, all direct-to-consumer marketing activities require advance review by the Compliance Oversight Committee or designee if the activity involves giving anything of value directly to a consumer.

18. Financial Reporting: LRE shall ensure integrity of all financial transactions. Transactions shall be executed in accordance with established policies and procedures and with federal and state law and recorded in conformity with generally accepted accounting principles or any other applicable criteria.

    All financial reports, accounting records, research reports, expense accounts, time sheets and other documents will accurately and clearly represent the relevant facts or the true nature of a transaction. No undisclosed or unrecorded funds or assets will be established for any purpose.

    LRE will not tolerate improper or fraudulent accounting, documentation, or financial reporting. LRE personnel have a duty to make reasonable inquiry into the validity of

financial information reporting. In addition to employee discipline and termination, LRE may terminate the contractual arrangement involving any contracted provider due to fraudulent accounting, documentation, or financial reporting.

LRE shall develop internal controls and obtain an annual independent audit of financial records; shall ensure that reimbursement for services billed is accurate, appropriate, and based on complete documentation; and shall maintain accountability of assets.

19. Third Party Billing and Governmental Payers: LRE is committed to truthful billing that is supported by complete and accurate documentation. LRE personnel may not misrepresent charges to, or on behalf of, a consumer or payer.

    LRE must comply with all payment requirements for government- sponsored programs. All LRE personnel must exercise care in any written or oral statement made to any government agency. LRE will not tolerate false statements by LRE personnel to a governmental agency. Deliberate misstatements to governmental agencies or to other payers will expose the individual to potential criminal penalties and termination.

20. Responding to Government Investigations: LRE will fully comply with the law and cooperate with any reasonable demand made in a governmental investigation. LRE personnel may not conceal, destroy, or alter any documents, lie, or make misleading statements to governmental representatives. LRE personnel may not aid in any attempt to provide inaccurate or misleading information or obstruct, mislead, or delay the communication of information or records relating to a possible violation of the law.

    It is crucial that the legal rights of LRE personnel and LRE are protected. If any LRE personnel receives an inquiry, a subpoena, or other legal documents requiring information about LRE business or operation, whether at home or in the workplace, from any government agency, LRE requests that the person notify LRE's Executive Officer or the Compliance Officer immediately.

    LRE will distribute the Code of Conduct and Ethics to all LRE personnel upon hire who shall certify in writing that they have received, read, and will abide by the organization's Code. In addition to the Code, all LRE personnel will be familiar with and agree to abide by all LRE operational and human resources policies and procedures. All operational and human resources policies and procedures are available to LRE personnel through the LRE intranet and the shared drive.

Member CMSHP and Contracted and Subcontracted Provider Relationships

It is the policy of the LRE to ensure that all direct and subcontracted provider contractual arrangements are structured in accordance with Federal and State laws and regulations and are in the best interest of the organization and the consumers we serve. To meet all standards ethically and legally, the LRE will strictly adhere to the following:

1. LRE does not receive or provide any inducement for referrals. Consumer referrals and intakes will be accepted based on the consumer's needs, eligibility, and our ability to provide the services needed.

2. No employee, Member CMSHP, or contracted or subcontracted provider, or any other person acting on behalf of the organization is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of consumers.

3. LRE does not enter into financial arrangements with physicians that are designed to provide inappropriate remuneration to the organization in return for the physician's ability to provide services to state and federal health care program beneficiaries.

4. LRE does not enter into contractual relationships with individuals, agents, or agencies that have been convicted of a criminal offense related to health care or that are listed by a Federal agency as debarred, excluded, or otherwise ineligible for participation in Federal health care programs. Reasonable and prudent background investigations will be completed prior to entering a contractual relationship with all individuals, agents, or agencies.

5. All Member CMSHP, contracted and subcontracted provider personnel have the responsibility of ensuring the effectiveness of LRE's Compliance Program efforts by actively participating in the reporting of suspected violations.

Member CMSHPs and contracted and subcontracted providers will be required to have written standards of legal and ethical conduct of their own. Member CMSHPs and contracted or subcontracted providers having developed their own standards of conduct will be required to provide evidence of such for inclusion in the contractor file.

Member CMSHPs and contracted and subcontracted providers will be familiar with and agree to abide by the LRE Compliance Plan and all applicable policies and procedures as incorporated into relevant contracts. All policies and procedures relevant to the Member CMSHPs and Providers are available via the LRE Internet Website at www.lsre.org. Member CMSHPs and contracted and subcontracted providers are responsible for monitoring and staying informed of regulatory developments independent of LRE Compliance Program efforts.

All LRE personnel, Member CMSHPs, contracted and subcontracted providers will refrain from conduct that may violate the Medicaid anti-kickback, false claims or physician self-referral laws and regulations. A false claim includes the following: billing for services not rendered; misrepresenting services actually rendered; falsely certifying that certain services were medically necessary; or submitting a claim for payment that is inconsistent with or contrary to Medicaid payment requirements. In general, these laws prohibit:

- Submission of false, fraudulent, or misleading claims for payment, the knowing use of a false record or statement to obtain payment on false or fraudulent claims paid by the

United States government, or the conspiracy to defraud the United States government by getting a false or fraudulent claim allowed or paid. If the claims submitted are knowingly false or fraudulent then the False Claims Act has been violated;
- Knowingly and willfully making false representation to any person or entity in order to gain or retain participation in the Medicaid program or to obtain payment for any service from the United States government;
- A physician (or immediate family member of the physician) who has a financial relationship with an entity from referring a Medicaid patient to the entity for the provision of certain "designated health services" unless an exception applies, or an entity from billing an individual, third-party payer; or other entity for any designated health services provided pursuant to a prohibited referral; and
- Knowingly and willfully making or causing to be made any false statement or representation of a material fact in any application (claim) for benefits or payments under a Federal health care program.

SECTION II - COMPLIANCE OFFICER AND COMPLIANCE OVERSIGHT COMMITTEE

The LRE CEO will designate a Chief Compliance Officer (CCO), who will be given sufficient authority to oversee and monitor the Compliance Plan, including but not limited to the following:

- Recommending revisions/updates to the Compliance Plan, policies, and procedures to reflect organizational, regulatory, contractual, and statutory changes.
- Reporting on a regular basis the status of the implementation of the Compliance Plan and related compliance activities.
- Assuring and/or coordinating compliance training and education efforts for LRE personnel, Member CMSHPs and contracted and subcontracted providers.
- Assuring continuing analysis, technical expertise and knowledge transmission of corporate compliance requirements and prepaid health plan performance in keeping with evolving federal requirements and MDHHS contractual obligations and standards.
- Coordinating and oversight of audits and monitoring activities
- Performing or causing to be performed risk assessments, verification audits, and on-site monitoring consistent with the approved annual PIHP compliance work plan(s) intended to reduce the risk of criminal conduct at LRE, Member CMSHPs, contracted and subcontracted providers.
- Ensure coordinating efforts with human resources, Provider Network Manager and other relevant departments regarding employee certifications/licensures, background checks, sanctions screenings, and privileging and credentialing.
- Developing and modifying policy and programs that encourage the reporting of suspected fraud and other potential problems without fear of retaliation.
- Independently investigating and acting on matters related to compliance.
- Drafting and maintaining LRE Board and executive reports including annual Compliance Program Evaluation.

The authority given the CCO will include the ability to review all LRE, Member CMSHP, contracted and subcontracted provider Medicaid and Healthy Michigan documents and other information relevant to compliance activities, including, but not limited to, consumer records, billing records, employee records and contracts and obligations of LRE consistent with Section XVIII of the Medicaid Subcontracting Agreement.

LRE maintains and charters a Compliance Oversight Committee (COC) that oversees the implementation and operation of the LRE Compliance Program. The COC reviews reports and recommendations made by the LRE CO regarding compliance activities. This includes data regarding compliance generated through audits, monitoring, and individual reporting. Based on these reports, the CCO will make recommendations to the Executive Leadership regarding the efficiency of the LRE Compliance Plan and program.

SECTION III - COMPLIANCE TRAINING AND EDUCATION

Proper and continuous training and education of LRE personnel at all levels is a significant element of an effective compliance program. Therefore, LRE will establish a regular training program consistent with applicable compliance policies that covers the provisions of the Code of Conduct and Ethics, as well as the processes for obtaining advice and reporting misconduct. Training is provided upon hire for new employees; annual and periodic retraining is provided to existing LRE personnel and, as applicable, independent contractors.

LRE Board members and personnel will be scheduled to receive LRE's compliance program training on the Compliance Plan and Code at orientation or within thirty (30) days of employment. Tailored training may be required for employees involved in specific areas of risk and the CO will coordinate and schedule this as needed and will supplement with training and/or newsletters, e-mails and in-services. Records will be maintained on all formal training and educational activities. Training is considered a condition of employment and failure to comply will result in appropriate disciplinary action.

SECTION IV - COMPLIANCE REPORTING AND ONGOING COMMUNICATION

All LRE Board members and personnel must be familiar with applicable federal and state laws and regulations as well as LRE policies and procedures. Any LRE Board member and personnel that know, or has reason to believe, that an employee of, or independent professional providing services to, LRE is not acting in compliance with federal and state laws and regulations should report such matters to the CO. Reporting of suspected violations may be accomplished through a verbal, written, or anonymous report using the following mechanisms:

- LRE Telephone Hot Line – Suspected compliance violations or questions can be made to a toll-free hot line. The number is 1-800-420-3592 and includes confidential voice mail.

- LRE Electronic Mail (E-Mail) – Suspected compliance violations or questions can be sent electronically via e-mail to the Chief Compliance Officer at compliance@lsre.org.

- Mail Delivery – Suspected compliance violations or questions can be mailed to:

  Attn: George Motakis
  Chief Compliance Officer
  Lakeshore Regional Entity
  5000 Hakes Drive
  Suite 250
  Norton Shores, Michigan 49441

- In Person - Suspected compliance violations or questions can be made in person to LRE's CCO at the above address.

Whistleblower Protections for LRE Personnel

Employees who make good faith reports of violations of federal or state law are protected by state and federal whistleblower statutes, as more fully described below.

Under the Federal False Claims Act and the Michigan Medicaid False Claims Act, employees who report violations in good faith are entitled to protection from disciplinary actions taken by their employer.

The Federal False Claims Act, 31 USC §§3729 through 3731, provides for administrative remedies, encourages enactment of parallel State laws pertaining to civil and criminal penalties for false claims and statements, and provides "whistle-blower" protection for those making good faith reports of statutory violations.

Under the Michigan Medicaid False Claims Act, an employer shall not discharge, demote, suspend, threaten, harass, or otherwise discriminate against an employee in the terms and conditions of employment because the employee initiates, assists in, or participates in a proceeding or court action under this act or because the employee cooperates with or assists in an investigation under this act. This prohibition does not apply to an employment action against an employee who the court finds: (i) brought a frivolous claim, as defined in section 2591 of the revised judicature act of 1961, 1961 PA236, MCL §600.2591; or (ii) planned, initiated, or participated in the conduct upon which the action is brought; or (iii) is convicted of criminal conduct arising from a violation of that act.

An employer who acts against an employee in violation of the Michigan Medicaid False Claims Act is liable to the employee for all of the following:

1. Reinstatement to the employee's position without loss of seniority;
2. Two times the amount of lost back pay;
3. Interest on the back pay;
4. Compensation for any special damages; and,
5. Any other relief necessary to make the employee whole.

Under the Federal False Claims Act, any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained because of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate district court of the United States for the relief provided in this subsection.

Partly because of their status as primary contracted agents performing delegated managed care functions and to minimize regional risk and harm, Member CMSHPs will report suspected compliance issues within three business days or less to the LRE Compliance Officer when one or more of the following criteria are met:

1. During an inquiry by the Member CMSHP compliance officer there is determined to be (reasonable person standard) Medicaid fraud, abuse, or waste as defined by federal statute, CMS, HHS OIG and applicable Michigan statute or regulation; or
2. Prior to any self-disclosure to any federal, state or Medicaid authority. In no way is this intended to nor should it be interpreted as a requirement or request to violate the letter or spirit of federal or Michigan reporting and whistleblower statutes or related regulations; or
3. When a Member CMSHP knows or (reasonable person standard) suspects that an action or failure to act in the organization or its contractors would result in the improper application or improper retention of Medicaid funds.

Participant CMHPSs shall undertake fraud, waste and abuse prevention, detection, and surveillance measures per contractual obligations and industry standards.

A. Reporting of Suspected Violations or Misconduct

The LRE shall maintain a reporting system that provides a clear process and guidelines for reporting potential offenses or issues.

The LRE board members, employees, contractual providers, consumers, and others are to report suspected violations or misconduct to the LRE Chief Compliance Officer or the appropriate CMHSP Participant/SUD Provider Compliance Officer and/or designee as outlined below. Suspected violations or misconduct may be reported by phone/voicemail, email, in person, or in writing (mail delivery).

LRE employees, consumers, contractual providers, and CMHSP Participant/SUD Provider staff who make good faith reports of violations of federal or state law are protected by state and federal whistleblower statutes, which includes protections from disciplinary actions such as demotions, suspension, threats, harassment, or other discriminatory actions against the employee by the employer.

Violations Involving Suspected Fraud, Waste, or Abuse:

- LRE board members, employees, contractual providers, and the provider network will report all suspected fraud and abuse to the Chief Compliance Officer. The report will be submitted in writing utilizing the Office of Inspector General (OIG) Fraud Referral Form.
- The LRE Chief Compliance Officer will complete a preliminary investigation, as needed, to determine if a suspicion of fraud exists.
- If there is suspicion of fraud, the LRE Chief Compliance Officer will report the suspected fraud and abuse to the MDHHS Office of Inspector General using the OIG Fraud Referral Form.
- The LRE Chief Compliance Officer will inform the appropriate provider network member when a report is made to the MDHHS Office of Inspector General.
- The LRE will follow the guidance/direction provided by the MDHHS Office of Inspector General regarding investigation and/or other required follow up.
- The LRE and the provider network will cooperate fully with investigations involving the MDHHS Office of Inspector General and/or the Department of Attorney General and adhere to any subsequent legal action that may result from such investigation.

Suspected Violations (NOT Involving Fraud, Waste, or Abuse) and/or Misconduct:

- LRE employees will report all suspected violations or misconduct (not involving suspected fraud or abuse) directly to the LRE Chief Compliance Officer for investigation. If the suspected violation involves the Chief Compliance Officer, the report will be made to the LRE Chief Executive Officer. Information provided shall at a minimum include the following:

    - Provider Information, if applicable (Name, Address, Phone Number, NPI Number, Email)
    - Complainant Information (Name, Address, Phone Number, NPI number [if applicable], Medicaid ID # [if applicable], Email)
    - Consumer Information, if applicable (Name, Address, Phone Number, Email)
    - Summary of the violation and/or misconduct
    - Date(s) of the violation and/or misconduct
    - Supporting documentation, if any (i.e. claims data, audit findings, etc.)
    - Action, if any, taken prior to submitting the violation

- Any suspected violations regarding the LRE Chief Executive Officer will be reported to the LRE Chief Compliance Officer and/or the LRE Board Chairperson/Executive Committee for investigation.
- CMHSP Participant/SUD Provider staff with firsthand knowledge of activities or omissions that may violate applicable laws and regulations (not involving suspected fraud or abuse) are required to report such wrongdoing to the LRE Chief Compliance Officer or to the CMHSP Participant/SUD Provider Compliance Officer. The CMHSP Participant/SUD Provider Compliance Officer will review reported violations to determine the need to report to the LRE Chief Compliance Officer. The review will be based on but not limited to: external party involvement, Medicaid recipient services, practices and/or system-wide process applicability.
- The Provider Network (CEO)/Executive Director(ED) and/or designee, shall inform, in writing, the LRE Chief Executive Officer (CEO) of any material notice to, inquiry from, or investigation by any Federal, State, or local human services, fiscal, regulatory, investigatory (excluding Recipient Rights related to non-PIHP activities), prosecutory, judicial, or law enforcement agency or protection and/or advocacy organization regarding the rights, safety, or care of a recipient of Medicaid services. The Provider Network CEO/ED shall inform, in writing, the LRE CEO immediately of any subsequent findings, recommendations, and results of such notices, inquiries, or investigations.
- Reports of suspected violations or misconduct may be made on a confidential basis to the extent possible.

B. Process for Investigation

All reports involving suspected fraud, waste, and abuse will follow the guidance/direction of the MDHHS Office of Inspector General for any required investigation.

Expectations on fraud referrals:
If the CMHSP participant identifies a credible allegation of fraud with an overpayment of $5,000 or more, the CMHSP must use the OIG Fraud Referral Form to refer the case to MDHHS-OIG. The allegation must be an intentional deception, misrepresentation, or action made by an individual, provider, or other entity with knowledge that the action could result in some sort of benefit.

- Opinions/feelings are not enough to demonstrate a credible allegation of fraud.
- Fraud referrals must not be sent until there is enough documentation to support the allegation.
- Failure to produce records or documentation in records not sufficient to support claims is not an automatic conclusion of fraud. The intent component is critical and must be present.

The CMHSP participant should not be initiating claim adjustments or recovery when there is a credible allegation of fraud until MDHHS-OIG advises the CMHSP participant to proceed.

- Cases with findings indicating waste, error, and abuse are reported on a quarterly basis and authorization to proceed with recovery and correction of encounter claims is not required.

All reports of suspected wrongdoing, not involving fraud or abuse, shall be investigated promptly following the process outlined in the LRE Compliance Investigation Procedure.

"Prompt response" is defined as action taken within 15 business days of receipt by the PIHP of the information regarding a potential compliance problem.
The investigation process and outcome will be documented and will include at a minimum the following (as identified on the required OIG report template):

- Date of Complaint
- Consumer Name (if applicable)
- Provider Name (if applicable)
- Source of the Complaint/Activity (Identify how the report was received such as phone, hotline, anonymous, etc)
- Activity Type (audit, complaint, referral, etc.)
- Medicaid ID# (if applicable)
- Target of Activity (indicate whether the report involves a provider, consumer, etc.)
- Provider Type (Group home, Facility, etc.)
- Time Period Covered (enter a date range that the activity occurred)
- Summary of the Complaint/Activity
- Codes Involved in Complaint/Activity (If Applicable)
- Total Amount Paid Relating to Activity (If Applicable)
- Overpayment Identified (If Applicable)
- Date the Initial Review was Completed (for determining if further action is needed such as reporting to OIG)
- Was Potential Fraud Identified (Yes or No)
- Date Referred to MDHHS OIG (If Applicable)
- Date Final Notice sent to Provider (If Applicable for matters of overpayment, etc.)
- Total Overpayment Amount Identified (If Applicable)
- Total Number of Paid Claims Related to Overpayment (If Applicable)
- Total Collection Amount (If Applicable)
- Date the Complaint was Resolved
- Summary of the Findings

In conducting the investigation, judgment shall be exercised, and consideration shall be given to the scope and materiality consistent with the nature of the concern. Each investigation must be carefully documented to include a report describing the disclosures, the investigative process, the conclusions reached and the recommended corrective action, when such is necessary. No one involved in the process of receiving and investigating reports shall communicate any information about a report or investigation, including the fact that a report has been received or an investigation is ongoing, to anyone within the LRE who is not involved in the investigation process or to anyone outside of the LRE without the prior approval of the LRE Chief Compliance Officer. All LRE employees, Provider Network staff, and subcontractors are expected to cooperate fully with investigation efforts.

The LRE Chief Compliance Officer and the CMHSP Participant/SUD Provider Compliance Officers must report any conflict of interest that may exist when investigating a report of suspected wrongdoing or misconduct. If a conflict of interest does exist, the LRE Chief Compliance Officer will be responsible for securing an appropriate source to complete the investigation, which may

include utilizing the Chief Compliance Officer, one of the Provider Network Compliance Officers or an external source if necessary.

SECTION V - COMPLIANCE AUDITING, MONITORING, AND RISK EVALUATION

The LRE CCO is responsible for monitoring compliance activities and operations within LRE. The CCO must then report any determinations of noncompliance to the CEO, the COC, and the CCO will identify, interpret, and determine standards of compliance through internal and external audits, and other monitoring functions. The CCO shall prepare an Auditing and Monitoring Plan addressing identified risk areas.

Monitoring and Auditing: The LRE believes that a thorough and ongoing evaluation of the various aspects of LRE's Compliance Plan is crucial to its success. To evaluate the effectiveness of the Plan, the LRE will employ a variety of monitoring and auditing techniques, including but not limited to, the following:

- Periodic interviews with personnel within LRE, Member CMSHPs, and contracted and subcontracted providers regarding their perceived levels of compliance within their departments or areas of responsibilities;
- Questionnaires developed to poll personnel within LRE, Member CMSHPs, contracted and subcontracted providers regarding compliance matters including the effectiveness of training/education;
- Information gained from written reports from LRE compliance staff utilizing audit and assessment tools developed to track all areas of compliance;
- Audits designed and performed by internal and/or external auditors utilizing specific compliance guidelines;
- Incidents of alleged noncompliance reports are investigated.
- Member CMSHPs, contracted and subcontracted providers are encouraged to perform auditing and monitoring functions involving Medicaid covered services through their own compliance program efforts.

The LRE CCO, legal counsel, COC, and as appropriate, other LRE personnel will take actions to ensure the following:

- Access to and familiarity with the latest HHS OIG compliance guidelines and current enforcement priorities; and
- Assessment of the baseline risk of any significant issues regarding non- compliance with laws or regulations in accordance with LRE's Compliance Plan.

The CCO is also responsible to ensure a risk assessment is performed annually with the results integrated into the daily operations of the organization.

SECTION VI - ENFORCEMENT OF COMPLIANCE POLICIES AND STANDARDS

Corrective Actions and Prevention:

If an internal investigation substantiates a reported violation, corrective action will be initiated as identified within the LRE policies and procedures and the LRE subcontracts with the CMHSP Participant/SUD Providers including, as appropriate, making prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, the provision of a corrective action plan from the designated Provider Network member (as necessary) including follow-up monitoring of adequate implementation, and implementing system changes to prevent a similar violation from recurring in the future.

Basis for Member CMSHP, Contracted, or Subcontracted Provider Corrective Action: Monitoring and auditing, and reports of questionable practices may form the basis for imposing corrective action.

Elements of a Member CMSHP, Contracted or Subcontracted Provider a Corrective Action Plan: As appropriate given the nature of the noncompliance, a corrective action plan submitted to LRE for approval shall include:

- A description of how the issue(s) identified was immediately corrected OR the reason the issue(s) cannot be immediately corrected (i.e. the consumer has been discharged).
- A description of the steps put to be put into place to prevent the issue(s), or a similar issue(s), from occurring again (i.e. staff training, process redesign, etc.)
- A description of the quality assurance program put into place for monitoring purposes to ensure the corrective action plan is effective and/or similar issues do not occur.

Depending on the seriousness of the offense, the resulting action for LRE staff could include additional training, written reprimand, suspension, or termination of employment. The resulting action for the provider network would also depend on the seriousness of the offense and could include additional training, written reprimand, suspension, letter of contract non-compliance, and termination of contract.

SECTION VII - CONFIDENTIALITY AND PRIVACY

All LRE Board members, LRE personnel, Member CMSHPs, and contracted and subcontracted providers must conduct themselves in accord with the principle of maintaining the confidentiality of consumers' information in accordance with all applicable laws and regulations, including but not limited to the Michigan Mental Health Code and the Privacy and Security Regulations issued pursuant to HIPAA and recent updated HITECH revisions, and 42 CFR Part 2 as it relates to substance abuse records. All will refrain from disclosing any personal or confidential information concerning members unless authorized by laws relating to confidentiality of records and protected health information. If specific questions arise regarding the obligation to maintain the confidentiality of information or the appropriateness of releasing

information, LRE Board members, LRE personnel, and Member CMSHPs should seek guidance from the Compliance Officer/ Privacy Officer, or anonymously through the LRE corporate compliance hotline at 1-800-420-3592.

References, Legal Authority, and Supporting Documents

1. Managing Compliance Program Effectiveness: A Resource Guide
   https://oig.hhs.gov/documents/toolkits/928/HCCA-OIG-Resource-Guide.pdf

2. Federal Sentencing Guidelines Section 8
   https://www.ussc.gov/guidelines/2021-guidelines-manual-annotated

3. DOJ Compliance Guidance
   https://www.justice.gov/criminal-fraud/page/file/937501/download

4. United States Department of Justice, Criminal Division, Evaluation of Corporate Compliance Program
   https://www.justice.gov/criminal-fraud/page/file/937501/download

5. United States Attorney Manual (USAM)
   https://www.justice.gov/jm/jm-9-28000-principles-federal-prosecution-business-organizations#9-28.800

6. Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans, Medicaid Alliance for Program Safeguards, May 2002
   https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf

7. Anti-kickback Statute (section 1128B[b] of the Social Security Act)
   http://www.ssa.gov/OP_Home/ssact/title11/1128B.htm
   https://oig.hhs.gov/compliance/safe-harbor-regulations

8. False Claims Act
   https://oig.hhs.gov/fraud
   http://www.legislature.mi.gov

9. 42 USC 139a(a); Section 1902(a) of the Social Security Act (AKA the Deficit Reduction Act of 2005)
   http://www.cms.hhs.gov/deficitreductionact

10. Michigan Mental Health Code
    http://www.legislature.mi.gov/(S(ea1olrem4pvgdzylgs0hay4e))/mileg.aspx?page=GetObject&objectname=mcl-Act-258-of-1974

11. Department of Health and Human Services, Office of Inspector General
    https://oig.hhs.gov

12. Michigan Public Health Code
    http://www.legislature.mi.gov/documents/mcl/pdf/mcl-act-368-of-1978.pdf

13. Code of Federal Regulations (Title 42, Part 2 and Title 45, Part 160 & 164) http://www.ecfr.gov/cgi-bin/ECFR?page=browse

THE LAKESHORE REGIONAL ENTITY

COMPLIANCE OFFICER CONTACT INFORMATION

George V. Motakis
Chief Compliance Officer
Lakeshore Regional Entity
5000 Hakes Drive
Suite 250
Norton Shores, Michigan 49441
Compliance Hotline: 1-800-420-3592
Compliance Fax: 231-769-2075
Compliance Officer: 231-769-2079
E-mail: georgem@lsre.org

CMHSP Compliance Officer

Allegan County:	OnPoint (Allegan County Community Mental Health Services)	Mandy Padget Director of Quality Improvement and Compliance Tel: 269-673-6617, Ext.2718 Fax: 269-686-5201 E-mail: mpadget@onpointallegan.org
Kent County:	Network 180 (Kent County Mental Health Authority)	Stacey O'Toole Director of Quality, Data Analytics, and Compliance Tel: 616-825-5400 E-mail: stacey.otoole@network180.org
Lake County: Mason County: Oceana County:	West Michigan Community Mental Health System	Devon Hernandez Director of Corporate Compliance and Risk Management Tel: 231-843-7298 Fax: 231-845-7095 E-mail: devonh@WMCMHS.org
Muskegon County:	Health West	Linda Closz CCBHC Project Manager and Corporate Compliance Officer Tel: 231-724-3631 Fax: 231-724-3659 E-mail: linda.closz@healthwest.net
Ottawa County:	Community Mental Health of Ottawa County	Kristen Henninges Compliance Program Coordinator Tel: 616-393-5685 Fax: 616-393-5687 E-mail: khenninges@miottawa.org

MDHHS Medicaid Fraud Hotline:	1-855-MI-FRAUD (1-855-643-7283)
HHS/OIG Hotline:	1-800-HHS-TIPS (1-800-447-8477)

LRE PERSONNEL COMPLIANCE CERTIFICATION FORM

1. I have received, read, and understand the LRE Compliance Plan, Code of Conduct and Ethics, and related policies and procedures.

2. I pledge to act in compliance with and abide by the Code of Conduct and Ethics and LRE Compliance Plan during the entire term of my employment and/or contract.

3. I acknowledge that I have a duty to report to the Chief Compliance Officer any alleged or suspected violation of the Code of Conduct and Ethics, agency policy, or applicable laws and regulations.

4. I will seek advice from my supervisor or the Chief Compliance Officer concerning appropriate actions that I may need to take in order to comply with the Code of Conduct and Ethics or Compliance Plan.

5. I understand that failure to comply with this certification or failure to report any alleged or suspected violation of the Code of Conduct and Ethics or Compliance Plan may result in disciplinary action up to and including termination of employment or contract.

6. I agree to participate in any future compliance trainings as required and acknowledge my attendance at such trainings as a condition of my continued employment/contract.

7. I agree to disclose the existence and nature of any actual or potential conflict of interest to the Chief Compliance Officer. Further, I certify that I am not aware of any current conflicts of interest.

_____ _____

Board/Employee/Provider/Contractor Signature Date

LRE BOARD OF DIRECTORS COMPLIANCE CERTIFICATION FORM

1. I have received, read, and understand the LRE Compliance Plan and Code of Conduct and Ethics.

2. I pledge to act in compliance with and abide by the Code of Conduct and Ethics and LRE Compliance Plan during the entire term of my Board service.

3. I acknowledge that I have a duty to report to the LRE Chief Compliance Officer any alleged or suspected violation of the Code of Conduct and Ethics or related laws and regulations by myself, another Board Member, or any other person.

4. I will seek advice from the LRE Board Chairman or the LRE Chief Compliance Officer concerning appropriate actions that I may need to take to comply with the Code of Conduct and Ethics or Compliance Plan.

5. I understand that failure to comply with any part of this certification may result in my removal from the Board of Directors.

6. I agree to participate in future Board compliance trainings as required.

7. I agree to disclose the existence and nature of any actual or potential conflict of interest to the Board Chairman and Chief Compliance Officer. Further, I certify that I have disclosed all current conflicts of interest.

_____ _____

Board Member Signature Date