LAKESHORE REGIONAL ENTITY

Meeting Agenda
Board of Directors Work Session
November 20, 2024, 11:00 AM
GVSU Muskegon Innovation Hub
200 Viridian Dr, Muskegon, MI 49440

1. Welcome and Opening Comments – Ms. Gardner
2. Public Comment
3. LRE Quality Assessment and Performance Improvement Program (QAPIP*) (Attachment 1)*
4. LRE Risk Management Strategy (RMS) *(Attachment 2)*
5. Public Comment
6. Adjourn

5000 Hakes Drive, Norton Shores MI 49441
Phone: 231-769-2050
Fax: 231-269-2071

LAKESHORE
REGIONAL ENTITY

FY25 QAPIP Review

Wendi M. Price - Chief Managed Care Officer

November 20, 2024

QAPIP

Quality
Assessment
Performance
Improvement
Programs

DATA

Collecting
Analyzing
Monitoring
Reporting
Auditing
Remediating
Validating

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QAPIP Components

- Oversite of Provider Network
- PIPs
- MMBPIS
- Utilization Management
- Clinical Practice Guidelines
- MEV
- Critical Incidents
- Risk Events
- Unexpected Deaths
- Behavior Treatment Review
- External Quality Reviews
- Credentialing
- Customer Satisfaction Survey
- Sentinel Events
- Long Term Services and Supports

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QAPIP

Regulatory & Contractual Obligations

- 42 CFR § 438.330[1]
- MDHHS-PIHP Contract[2]
- MDHHS QAPIP Policy[3]

[1] eCFR 42 CFR 438.330
[2] FY24 MDHHS-PIHP Contract, Section K, pp. 55-56; FY25 MDHHS-PIHP Contract, Section L, pp. 58-59
[3] MDHHS QAPIP Policy, December 2022

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QAPIP

LRE Board of Director QAPIP Responsibilities

- Formally Approve the QAPIP
- Submit the QAPIP to MDHHS by February 28th
- Receive “Routinely Written” QAPIP Reports
- “Formally Review” the QAPIP Annual Effectiveness Report
- Submit the QAPIP Annual Effectiveness Report to MDHHS by February 28th

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FY25 Substantive QAPIP Changes

- 12/29/2024: Reporting Requirement Changes:
  - Critical Incidents,
  - Risk Events,
  - Immediately Reportable Events,
  - SUD Sentinel Events
- 3/31/2025: Universal Credentialing Implementation
- 9/30/2025: Sundowning of MMBPIS
- Implementation of CMS Behavioral Health Core Set Measures
  - 10/1/2025: Year 1
  - 10/1/2026: Year 2
  - 10/1/2027: Year 3
- 10/1/2025: Begin Site Reviews for Fiscal Intermediaries & Providers rendering services to Self-Determined Population

Q&A

LAKESHORE REGIONAL ENTITY

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Plan FY25

Prepared by LRE Chief Managed Care Officer: November 11, 2024
Reviewed by LRE Executive Team: November 18, 2024
Reviewed and Approved by LRE Board of Directors: November X, 2024
Submitted to MDHHS: February X, 2025

TABLE OF CONTENTS

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I. INTRODUCTION

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

LRE is comprised of five (5) Community Mental Health Service Providers ("CMHSPs"). LRE has the distinction of being the only regional entity where all of its CMHSPs are Michigan Certified Community Behavioral Health Clinic ("CCBHC") Demonstration Sites. With this distinction, LRE is tasked with integrating the CCBHC metrics with its already existing metrics, which may require LRE to archive certain quality metrics so as to not overburden the provider network with overlapping or duplicative monitoring and reporting.

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

II. PURPOSE

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

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

III. QUALITY IMPROVEMENT AUTHORITY AND ORGANIZATIONAL STRUCTURE

The LRE Board of Directors, which serves as LRE's Governing Board, reviews and approves the

QAPIP on an annual basis thereby giving authority for the implementation of this QAPIP and all the components necessary for continuous quality improvement.

A. Governing Body

1. ***Membership:*** The LRE 15-member Governing Board includes three representatives from each of the five (5) Member CMHSP Boards of Directors. Currently, the LRE Governing Board has no vacancies; however, seven of the fifteen Directors are new to the LRE Governing Board.

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

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

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

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

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

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

B. Organizational Structure

In Fiscal Year 2022, LRE reorganized its organization structure and added the role of Chief Quality

Officer thereby enhancing LRE's organization structure to support the implementation, management, and oversight of the QAPIP. In Fiscal Year 2024, LRE changed the title of Chief Quality Officer to Chief Managed Care Officer.

In Fiscal Year 2023, LRE created the Home and Community Based Services ("HCBS") Manager role enhancing Regional compliance with the HCBS Final Rule, which went into full effect on March 17, 2023.

In Fiscal Year 2024, LRE added two full-time employees to its Quality team increasing its auditing capabilities to meet the federal requirements under the HCBS Final Rule and the contractual obligations regarding HCBS annual physical assessments and tri-annual comprehensive assessments. LRE also added two full-time employees to its Information Technology ("IT") team reducing the development time for data analytics tools, such as Power BI Dashboards.

LRE's new organizational structure allows for the clear and appropriate administration and evaluation of the QAPIP. (Exhibit A).

C. Designated Senior Official

The LRE Chief Executive Officer ("CEO") has delegated to the Chief Managed Care Officer ("CMCO") the responsibility for submitting a regional QAPIP to the LRE Board of Directors for final approval. LRE CEO also provides regular QAPIP updates to the Operations Advisory Council, which includes all Member CMHSP CEOs, where applicable. In addition, if issues or barriers to operational effectiveness are identified, the CMCO escalates the issues or barriers to the LRE CEO, who may review the identified issues or barriers with the LRE Operations Advisory Council and/or the LRE Board of Directors for input, resolution, and/or awareness.

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

D. Regional Operations Advisory Teams and Quality Improvement Council

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

To facilitate the implementation and management of the QAPIP, LRE created the Quality Improvement Regional Operations Advisory Team ("QI ROAT"), which consists of representation from LRE, Member CMHSPs, and other stakeholders. The QI ROAT is responsible for regularly reviewing all activities within the QAPIP. The QI ROAT members also collaborate with one

another and between ROATs when any systemic or performance issues are identified to resolve said issues as efficiently and effectively as possible.
For Fiscal Year 2023, LRE created the LRE Quality Improvement Council ("LRE QIC"), which consists of the LRE Executive Team and LRE Staff, with the purpose being to

1. Ensure effective oversight and monitoring of the LRE's managed care functions, both internal and delegated through the application of data reports.
2. Ensure all departments are collaboratively and consistently utilizing data and key performance indicators.
3. Ensure LRE departments are collaborating to foster open communication and cross-pollination of information toward effective project completion.

When necessary, LRE QIC invites external stakeholders such as Member CMHSPs, ROAT members, providers, etc. to participate in its meetings. (Exhibit C).

IV. ACTIVE PARTICIPATION OF CONSUMERS AND PROVIDERS

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

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

LRE monitors CMHSP engagement in consumer and provider participation as part of its Member CMHSP Site Reviews.

V. QUALITY MANAGEMENT SYSTEM

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

The Quality Management System helps LRE achieve its mission, realize its vision, and live its values. It protects against adverse events, and it provides mechanisms to bring about positive

change. Continuous quality improvement efforts ensure a proactive and systematic approach that promotes innovation, adaptability across the region, and a passion for achieving best practices.

The *Quality Management System* includes:

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

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

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

VI. PERFORMANCE INDICATORS

LRE continues to measure its performance using standardized indicators based on the systemic, ongoing collection, and analysis of valid and reliable data. In Fiscal Year 2025, LRE will continue utilizing the performance measures established by MDHHS, meaning the Michigan Mission Based Performance Indicator System ("MMBPIS"), in the areas of access, efficiency, and outcomes, which LRE reports to MDHHS on a quarterly basis.

In parallel, LRE will begin preparing for MDHHS' transition from the MMBPIS performance measures to the newly announced performance measures from the CMS Behavioral Health Core Set, many of which are NCQA HEDIS® measures.[1]

A. Current State: Michigan Mission Based Performance Indicator System

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

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

On October 1, 2023, MDHHS implemented new compliance threshold for Indicators 2a, 2e, and 3. In Fiscal Year 2024, LRE focused its efforts on supporting the CMHSPs in achieving compliance rates that align with MDHHS' new compliance thresholds. In Fiscal Year 2025, LRE will continue to support the CMHSPs in achieving compliance rates that align with MDHHS' new compliance thresholds.

B. Future State: CMS Behavioral Health Core Set

In Fiscal Year 2025, LRE is preparing itself, its Member CMHSPs, and Network Providers for MDHHS' transition from MMBPIS performance measures to selected CMS Behavioral Health Core Set ("BHCS") measures, some of which must be stratified by race, ethnicity, gender, and/or geography. In the next three years, MDHHS is adding twenty-three (23) new measures across five programs and seven domains. LRE will focus its efforts on understanding the new measures, leveraging technology to develop accurate and reliable reporting processes, identifying performance gaps, and creating action plans to close any performance gaps.

[1] On September 26, 2024, MDHHS stated that "in October 2023, MDHHS Bureau of Specialty Behavioral Health Services began a comprehensive review of the existing QAPIP with the goal of developing and implementing a new program. The transformed program will be more comprehensive, better defined, with a more rigorous methodology that aligns with other state and national requirements." *See* Attachment E.

As of September 26, 2024, MDHHS' transition plan follows a three-year implementation strategy. (Attachment E):

1. **Year 1:** MDHHS will focus on aligning PIHIP reporting requirements with the CMS BHCS Reporting requirements for the following measures, which must be stratified by race and ethnicity, and establishing baseline thresholds for each measure:[2]

Measure Abbreviation	Measure Description	Program	Domain
ADD	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	BHCS	MH
AMM	Antidepressant Medication Management	BHCS	MH
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	BHCS	MH
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	BHCS	MH
CDF	Screening for Depression and Follow-up Plan	BHCS	MH
FUA	Follow-up After Emergency Department Visit for Substance Use	BHCS	Access
FUH	Follow-up After Hospitalization for Mental Illness	BHCS	Access
FUM	Follow-up After Emergency Department Visit for Mental Illness	BHCS	Access
IET	Initiation and Engagement into Substance Use Disorder Treatment	BHCS	SUD
MSC	Medical Assistance with Smoking and Tobacco Use Cessation	BHCS	SUD

2. **Year 2:** MDHHS will focus on implementing stratification for Year 1 measures, along with the following supplemental measures, which must be stratified by race and ethnicity, gender, and geography:

[2] AMM, CDF, FUA, FUH, FUM, IET are currently reporting requirements for CCBHC and/or the Performance Based Incentive Program ("PBIP").

Measure Abbreviation	Measure Description	Program	Domain
ACC	Access to Care—Appointment within 10 Days of Request	Final Rule	Access
HPCMI	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	BHCS	Comorbid Conditions
OUD	Use of Pharmacotherapy for Opioid Use Disorder	BHCS	SUD
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	BHCS	Comorbid Conditions

3. **Year 3:** MDHHS will focus on implementing patient experience and Home and Community Based Services ("HCBS") measures as part of a Consumer Assessment of Healthcare Providers and Systems ("CAHPS"), which is included in the CMS Quality Rating System ("QRS") that LRE must make publicly available by 2027:

Measure Abbreviation	Measure Description	Program	Domain
CAHPS	How People Rated Their Health Plan	QRS	Patient Experience
	Getting Care Quickly		
	Getting Needed Care		
	How Well Doctors Communicate		
	Health Plan Customer Service		
HCBS CAHPS	Choosing the Services that Matter to You	HCBS	Patient Experience and Home & Community Based Services
	Community Inclusion and Empowerment		
	Transportation to Medical Appointments		
	Physical Safety		
	Personal Safety and Respect		
	Staff are Reliable and Helpful		

	Staff Listen and Communicate Well Unmet Needs Composite Measure		
MLTSS-1	Medicaid Managed Long-Term Services and Supports Comprehensive Assessment and Update	MLTSS	
MLTSS-2	Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update	MLTSS	
	Social Needs Screening- Tool TBD	CCBHC	Social Needs

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

VII. PERFORMANCE IMPROVEMENT PROJECTS

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

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

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

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

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

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

For Fiscal Year 2025, LRE continues conducting its two PIPs centered on improving the HEDIS® Follow-up After Hospitalization. LRE's research suggests that an increase in the FUH metric can improve outcomes, decrease suicides, decrease recidivism, and increase satisfaction.

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

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

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

In Fiscal Year 2025, LRE will improve the FUH performance across Region 3 with targeted interventions related to the lagging FUH performance of some CMHSPs and MHPs.

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

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

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

In Fiscal Year 2024, which is the PIP's first measurement year, HSAG did not validate LRE's PIP performance as LRE did not statistically significantly reduce the disparity between blacks and whites.

In Fiscal Year 2025, LRE will collaborate with its Member CMHSPs and MHPs to implement targeted interventions across Region 3 to improve LRE's PIP performance.

VIII. EVENT REPORTING AND NOTIFICATIONS

LRE requires each Member CMHSP with direct services as well as contracted, external providers to record, assess, and report critical incidents, risk events, sentinel events, unexpected deaths, and immediately reportable events (a/k/a immediate event notification) according to contractual obligations and MDHHS reporting requirements.[3] LRE reports critical incidents, risk events, sentinel events, unexpected deaths, and immediately reportable events in accordance with MDHHS contractual requirements.

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

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

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

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

[3] Critical Incident Reporting And Event Notification Requirements, updated August 30, 2024.

from October 1, 2024, to December 29, 2024. CMS granted MDHHS' waiver.

MDHHS' new event reporting and notifications requirements include the following:

1. Add 1915 iSPA population to Non-Suicide Death reporting requirements,
2. Add 1915 iSPA population to the Emergency Medical Treatment due to an Injury or Medication Error reporting requirements,
3. Add 1915 iSPA population to the Hospitalization due to an Injury or Medication Error reporting requirements,
4. Add 1915 iSPA population to the Risk Events reporting requirements
    a. Harm to Self
    b. Harm to Others
    c. Two or More Unscheduled Admissions to a Hospital within a 12-month Period.
5. Add "Injury due to a fall" Event Sub-Type Qualifier to the Emergency Medical Treatment or Hospitalization due to an Injury or Medication Error reporting requirements, which must be remediated 100% of the time when it occurs.
6. Add "Crisis Stabilization Unity Only" Event Type with the following Event Sub-Types and Event Sub-Type Qualifiers:
    a. Physical Management without Injury
    b. Emergency Response
        i. Law Enforcement
        ii. Security
    c. Use of Restraint,
7. Add Immediately Reportable Event – Critical Incident Media Event,
8. Add SUD Sentinel Event Sub-Types:
    a. Conviction
    b. Serious illness requiring admission to a hospital
    c. Alleged cause of abuse or neglect
    d. Accident resulting in injury to recipient requiring emergency room visit or hospital admission
9. Remove the CCI living situation from the Emergency Medical Treatment due to an Injury or Medication Error reporting requirements,
10. Remove the CCI living situation from the Hospitalization due to an Injury or Medication Error reporting requirements, and
11. Remove the CCI living situation from the Arrest reporting requirement.

LRE is implementing MDHHS' new reporting requirements for event reporting and notifications, which include critical incidents, risk events, sentinel events, and unexpected deaths. LRE will provide training materials and technical specifications to the CMHSPs to facilitate a smooth implementation. If MDHHS revises its event reporting and notification requirements, LRE will adjust accordingly.

A. Critical Incidents

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

1. Suicide
2. Non-Suicide Death
3. Emergency Medical Treatment due to Injury or Medication Error ("EMT")
   a. Injury
      i. Injury was not during physical management
      ii. Injury was during physical management
      iii. Unknown whether injury was during physical management
      iv. Injury due to a fall
4. Hospitalization due to Injury or Medication Error ("Hospital"),
   a. Injury
      i. Injury was not during physical management
      ii. Injury was during physical management
      iii. Unknown whether injury was during physical management
      iv. Injury due to a fall
5. Arrest of Consumer,
6. Death of Unknown Cause, and
7. Crisis Stabilization Unit
   a. Physical Management without Injury
   b. Emergency Response
      i. Law Enforcement
      ii. Security
   c. Use of Restraint.

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

Service	Suicide (01)	Death (02)	EMT (03)	Hospital (04)	Arrest (05)	Death of Unknown Cause (06)	PM without Injury	Emergency Response	Use of Restraint
CLS	●	●				●			
Support Coordination	●	●				●			
Case Management	●	●				●			
ACT	●	●				●			
Homebased	●	●				●			
Wraparound	●	●				●			
Hab Waiver	●	●	●	●	●	●			

SED Waiver	●	●	●	●	●	●			
Child Waiver	●	●	●	●	●	●			
1915 iSPA	●	●	●	●		●			
Any Other Service	●	●				●			
Living Situation									
Specialized Residential	●	●	●	●	●	●			
Child Caring Institution	●	●				●			
Crisis Stabilization Unit	●	●				●	●	●	●

Upon notification by MDHHS, LRE requires each Member CMHSP to remediate critical incidents within 30 days of the reported date to CRM, or the date requested by MDHHS that are:

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

B. Risk Events

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

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

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

Service	Harm to Self (106)	Harm to Others (107)	Police Calls (108)	Physical Management (109)	Hospitalization 2+ within 12 months (110)
Supports Coordination	●	●	●	●	●
Case Management	●	●	●	●	●
ACT	●	●	●	●	●
Home-Based	●	●	●	●	●
CLS	●	●	●	●	●

Wraparound	•	•	•	•	•
Hab Waiver	•	•	•	•	•
SED Waiver	•	•	•	•	•
Child Waiver	•	•	•	•	•
1915 iSPA	•	•	•	•	•
Living Situation					
Specialized Residential	•	•	•	•	•
Child Caring Institution	•	•	•	•	•
Crisis Stabilization Unit	•	•	•	•	•

C. Sentinel Events and Unexpected Deaths

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

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

D. Immediately Reportable Events

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

1. Any death that occurs because of suspected staff member action or inaction or any death that is the subject of a recipient rights, licensing, or police investigation is reported to MDHHS within 48 hours of either the death, the PIHPs receipt of notification of the death, or the PIHPs receipt of notification that a rights, licensing, and/or police investigation has commenced to QMPMeasures@michigan.gov and include the following information:
   a. Name of Beneficiary,
   b. Beneficiary ID Number ,
   c. Consumer ID (CONID) if there is no Beneficiary ID Number,
   d. Date, Time, and Place of Death (if a licensed foster care facility, include the

license number),
   e. Preliminary Cause of Death, and
   f. Contact Person's Name and Email Address.
2. Relocation of a consumer's placement due to licensing suspension or revocation within five (5) business days of relocation.
3. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours within five (5) business days of relocation.
4. The conviction of a PIHP or provider panel staff members for any offense related to the performance of their job duties or responsibilities which results in exclusion from participation in federal reimbursement within five (5) business days of knowledge.
5. Any changes to the composition of the provider network organizations that negatively affect access to care within seven (7) days of any change.
6. Critical incidents which may be newsworthy or represent a community crisis must be reported to MDHHS immediately.

E. SUD Sentinel Events

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

Service	MAT Med Error (07)	SUD Med Error (08)	Serious Challenging Behaviors (09)	Conviction	Serious Illness Requiring Hospitalization	Accident EMT or Hospital	Alleged Cause of Abuse or Neglect
SUD 24-Hr Specialized Residential	•	•	•	•	•	•	•

IX. BEHAVIOR TREATMENT REVIEW

Member CMHSPs collect, review, and analyze Behavior Treatment data quarterly and submit an attestation to LRE demonstrating compliance with the MDHHS Technical Requirement for Behavior Treatment Plans.[4] The regional Behavior Treatment Plan Review Committee ("BTPRC"), with representation from each Member CMHSP and LRE, convenes quarterly to review and analyze the regional data, including but not limited to 911 calls and use of physical management. The committee ensures submitted data is correct and complete and reviews the data for any trends or areas of concern. Where intrusive or restrictive techniques have been approved for use and/or where physical management or 911 calls to law enforcement in an emergency have occurred, the BTPRC conducts quarterly analysis of the data submitted by Member CMHSPs to

[4] MDHHS Technical Requirement for Behavior Treatment Plans-September 13, 2024, Section III(2)(g), pp. 5-6.

identify trends and subsequent actions that may need to be taken to reduce the potential for future events. The LRE Physical Management Episode Tracking Report is reviewed quarterly by both the LRE Behavior Treatment Plan Review Committee and the QI ROAT. This report allows for the review of the physical management data including the number of interventions and length of time the interventions were used per individual. LRE adheres to the provisions outlined in the MDHHS Technical Requirements for Behavior Treatment Plans Policy and the current MDHHS-PIHP Contract.

X. CUSTOMER SATISFACTION ASSESSMENT

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

In Fiscal Year 2024, LRE deployed a new survey that incorporates the Mental Health Statistics Improvement Program ("MHSIP") Adult Consumer Experience of Care Survey for Adult consumers and the Youth/Family Services Survey for Families ("YSS-F") Experience of Care Survey for Youth consumers and their families as required by MDHHS for CCBHC Demonstration Sites.

LRE reviews the results of the Customer Satisfaction Survey, and solicits feedback, in the LRE QIC, Customer Satisfaction ROAT, QI ROAT, Consumer Advisory Panel, Customer Satisfaction Workgroup, and LRE Governing Board.

In April 2025, LRE will determine if the MHSIP and YSS-F are effective customer satisfaction surveys for the populations served in Region 3. Additionally, LRE is evaluating how to incorporate the new patient experience and HCBS measures that are part of MDHHS' CMS Behavioral Health Core Set implementation in Year 3. (*See* Section VI(B)(3) above).

LRE monitors CMHSPs Survey deployment as part of its Member CMHSP Site Reviews. Where appropriate, LRE issues a corrective action plan when non-compliance is identified.

XI. CLINICAL PRACTICE GUIDELINES

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

LRE, in collaboration with its Member CMHSPs, developed and approved an Inter-Rater Reliability

Process ensuring that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. LRE reviews all Audit Summary results in the LRE QIC, Clinical ROAT, and Utilization Management ROAT.

LRE monitors the use of established guidelines as part of its Member CMHSP Site Reviews. Where appropriate, LRE issues a corrective action plan when non-compliance is identified.

XII. CREDENTIALING

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

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

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

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

In Fiscal Year 2024, LRE incorporated quality measures into its recredentialing process by considering the extent an organization or a practitioner has been grieved, has received a less

than desired Survey score, has fallen below performance indicator thresholds, which could include CMHSP Site Review results for clinical and credentialing audits, or has experienced a rise in critical incident or sentinel events. In Fiscal year 2025, LRE will continue to examine if additional quality measures should be added to the recredentialing process.

In Fiscal Year 2025, LRE continues to prepare for MDHHS' implementation of the Universal Credentialing Module in the CRM. LRE and its Member CMHSPs have been diligently working to prepare for this implementation as MDHHS placed the project on hold in Fiscal Year 2024. During the first two weeks of December 2024, LRE will complete its Universal Credentialing training. LRE anticipates full implementation by March 31, 2025, barring any unforeseen delays.

XIII. STAFF TRAINING AND DEVELOPMENT

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

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

During CMHSP and Substance Use Disorder ("SUD") Site Reviews, LRE audits each Member CMHSP and SUD Treatment provider ensuring staff possess the appropriate qualifications as outlined in their job descriptions and required by contract, policy, or regulations, including the qualifications such as:

1. Educational Background,
2. Relevant Work Experience,
3. Certification, Registration, and Licensure as Required by Law,
4. Criminal Background, Convictions, and SOR Checks,
5. Sanctions Checks,
6. Population Specific Qualifications,
7. General and Specific Trainings,
8. Training of New Personnel Regarding their Responsibilities, Program Policy and Staff Development Activities.

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

In addition, LRE Policy 4.2 Provider Network and Contract Management describes the mechanism

for monitoring and assessing compliance with contract, state, and federal requirements of service providers.

XIV. MEDICAID SERVICES VERIFICATION

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

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

LRE follows its written policy and procedure for monitoring and evaluating the claims/encounters submitted by its Member CMHSPs ensuring compliance with federal and state regulations as well as the MDHHS Medicaid Verification Process technical requirements.[5]

LRE's policy and procedure consider conflicts of interest, validation of claims/encounters data, sampling methodology, audit criteria, review and reporting standards, recoupment procedures, corrective action plan procedures, and documentation standards, as required by the MDHHS Medicaid Verification Process technical requirements.

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

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

XV. UTILIZATION MANAGEMENT

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

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

reported to the LRE QIC, Clinical ROAT, IT ROAT, and other ROATs, as appropriate.

In Fiscal Year 2025, LRE will continue to conduct UM reviews for Continued Stay Reviews and Pre-Admission Screenings while leveraging PowerBI Dashboards to analyze data and report findings to the LRE QIC and ROATs, as appropriate.

XVI. OVERSIGHT OF PROVIDER NETWORK

A. CMHSP Site Reviews

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

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

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

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

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

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

B. MDHHS Waiver Site Reviews

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

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

C. External Quality Reviews

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

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

D. Facility Reviews

LRE conducts annual Facilities Reviews for all contracted, external providers within LRE's catchment area to ensure compliance with the following requirements:

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

E. Miscellany Site Reviews

LRE conducts annual Site Reviews for the following provider types:

1. Crisis Residential Providers,
2. In-Patient Provider, and
3. SUD Treatment Providers.

In Fiscal Year 2025, LRE is developing Site Review tools to more efficiently and effectively audit Fiscal Intermediaries and agencies serving the Self-Determined population.

During the Site Review Process, LRE evaluates these providers' compliance is the areas of

1. Federal Regulations, State Requirements, and Regional Policies.
2. Contractual Obligations.
3. Clinical Documentation Standards.

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

XVII. LONG TERM SERVICES AND SUPPORTS

During the CMHSP Site Reviews, LRE ensures its sampling methodology used to select consumers for clinical chart audits is a representative cross-section of the overall distribution of service types provided in Region 3 by distinct consumer. For example, for FY24, LRE served almost 70% of its distinct consumer count with services defined by 1115 Pathway to Integration Waiver as Long-Term Services and Supports ("LTSS").[6] Hence, when LRE selects its random sample for its clinical chart audits, most of the samples selected tether to individuals receiving LTSS. LRE's sampling methodology is the first step ensuring that LRE is able to assess the quality and appropriateness of care furnished to individuals receiving LTSS.

Secondly, LRE's Clinical Chart Audit Tool, which is used during CMSHP Site Reviews, is the mechanism used to assess the quality and appropriateness of care furnished to individuals

[6] 1115 Pathway to Integration defines Long-Term Services and Supports as Community Living Supports, Enhanced Medical Equipment and Supplies, Enhanced Pharmacy, Environmental Modification, Family and Support Training, Fiscal Intermediary, Goods and Services, Non-Family Training, Out-of-Home Non-Vocational Habilitation, Personal Emergency Response System, Prevocational Services, Skill Building Assistance, Specialty Services/Therapies (Music Therapy, Recreation Therapy, Art Therapy, and Massage Therapy), Supports and Service Coordination, Respite, Private Duty Nursing, Supported/Integrated Employment Services, Child Therapeutic Foster Care, Therapeutic Overnight Camping, Transitional Services.

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

LRE also ensures all individuals, including those receiving LTSS, receive a LOCUS/CAFAS upon admission, annually, and when there has been a significant change in consumer's presentation. In an effort to improve visibility of LOCUS utilization, LRE has developed PowerBI Dashboards.

Finally, LRE conduct Facility Review and HCBS Physical Assessments annually for all Specialized Residential (licensed and non-licensed), Autism, Supported Employment, and Skill Building providers as well as other providers, as appropriate or requested. During its Facility Review and HCBS Physical Assessments, LRE conducts a comprehensive HCBS review of the setting and , if a modification or restriction is found, LRE conduct a comprehensive audit of all Region 3 consumers' IPOSs to ensure compliance with the HCBS Final Rule and MDHHS' HCBS Monitoring Requirements Technical Advisory and PCP Policy.[7]

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

XVIII. FISCAL YEAR 2025 QAPIP WORKPLAN

QAPIP Component	Goal / Opportunity	Objectives (Specific Actions to be taken)	Responsible Party	Barrier Analysis	Deadline
Performance Measures	LRE will meet and maintain the performance standards as set by the MDHHS / PIHP Contract for Indicators 1, 4a, 4b, and 10	1. CMHSPs will consistently meet all MDHHS MMPBIS 95% Standards for Indicator 1, 4a, & 4b, and the less than 15% Standard for Indicator 10. 2. LRE will require Plans of Correction from each CMHSP for each Indicators not meeting MDHHS Standards.	CMCO Monitored By: 1. MMBPIS Workgroup 2. QI ROAT	Staffing Shortage	Ongoing
Performance Measures	LRE will meet and maintain the performance standards as set by the MDHHS / PIHP Contract for Indicators 2a, 2e, and 3	1. CMHSPs will consistently meet all MDHHS MMPBIS 62% Standards for Indicator 2a and 72.9% for Indicator 3. 2. LRE will require Plans of Correction from each CMHSP for each Indicators not meeting MDHHS Standards.	CMCO Monitored By: 1. MMBPIS Workgroup 2. QI ROAT	Staffing Shortage	Ongoing
Performance Measures	LRE will implement MDHHS' requirements for Year 1 of its CMS BHCS 3-year implementation strategy	1. Develop training and crosswalk 2. Build PowerBI Dashboards from CC360 and ZTS data 3. Determine correlation between CC360 and ZTS data 4. Conduct Gap Analysis by CMHSP 5. Collaborate with	CMCO Monitored By: 1. QI ROAT	Timely Availability of Data from CC360 Correlation between CC360 and ZTS data	10/1/2025 10/1/2026 10/1/2027

		CMHSPs to develop action plan to meet and maintain 50th and 75th percentile for Year 1 measures			
Performance Improvement Projects	LRE will implement two PIP projects that meet MDHHS Standards. <u>Formal PIP</u>: FUH Metric: Decrease in Racial Disparity between Whites and African American/ Blacks Baseline Data for FY2022: submitted to HSAG July 2022 FUH_ Adults and Children who identify as African American/Black: 60.2% FUH_Adults and Children who identify as While: 70.9%	1. The objective for the PIP is that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African-Americans/ Blacks) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (Whites). 2. LRE will develop improvement strategies and interventions to impact this performance indicator outcomes and achieve significant improvement. 3. LRE will work with the five CMHSPs and MHPs within Region 3 to implement agreed upon interventions	CMCO Monitored By: 1. PIP Workgroup 2 . QI ROAT	Data Integrity Lag in Data Availability	Ongoing

Performance Improvement Projects	LRE will implement two PIP projects that meet MDHHS Standards. 2nd PIP: FUH HEDIS Measure: The percentage of discharges for patients 6 years of age or older who were hospitalized for treatment of selected mental illness or intentional self harm diagnoses and who had follow-up visit with a mental health provider within 30 days of discharge.	1. Develop standard reports for lagging PIP performance by CMHSP and MHP. Distribute report and hold meetings to discuss how to improve outcomes. 2. LRE will develop improvement strategies and interventions to impact this performance indicator outcomes and achieve significant improvement. 3. LRE will work with the five CMHSPs within Region 3 to implement agreed upon interventions.	CMCO Monitored By: 1. QI ROAT 2. FUH Workgroup 3. UM/Clinical ROAT	Data Integrity Lag in Data Availability	Ongoing
Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Management	LRE will implement MDHHS' new reporting requirements for Critical Incidents, Risk Events, IREs, Sentinel Events, SUD Sentinel Events, CSU	1. Clarify ambiguity in MDHHS guidance. 2. Develop technical specification for CMHSP LIDS Submission 3. Develop training for CMHSPs and Network Providers	CMCO Monitored By: 1. CIRE Workgroup 2. QI ROAT	Imple-mentation deadline is 12/29/2024, but need further clarification from MDHHS	12/29/2024
Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Management	LRE will review and monitor CIRE events by type of incident and facility incident occurred.	MDHHS implemented a new CIRE process using MiCAL/CRM for FY23. 1. LRE will monitor CIRE data using the Power BI report looking for trends with incident types and /or facilities. 2. LRE will use the Specialized Residential	CMCO Monitored By: 1. CIRE Workgroup 2. QI ROAT	Extracting Data out of CRM for Analysis and Trending Data Integrity	Ongoing

		filter to analyze trends among consumers receiving LTSS.			
Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Management	LRE will monitor mortality data over time.	MDHHS implemented a new UD|SE process using MiCAL/CRM for FY23. 1. LRE QI Staff will review mortality data looking for trends in the causes of natural deaths and unexpected deaths. (suicide, accidental, homicide) 2. Mortality data report trends and issues will be discussed quarterly at the CIRE Workgroup and semi annually at the QI ROAT.	CMCO Monitored By: 1. CIRE Workgroup 2. QI ROAT	Extracting Data out of CRM for Analysis and Trending Data Integrity	Ongoing
Behavior Treatment Review	LRE will review and analyze behavior treatment review committee physical management data by individual and length of time for each instance of physical management used in an emergency behavioral crisis.	1. CMHSPs will submit physical management data for every instance of physical management used in an emergency behavioral health crisis to the LRE at least quarterly. This data will be reported by: • individual (separately for each instance), • include demographics of population, • Hab Waiver: Yes/No, • Behavior Plan: Yes/No, and • Time per instance will be reported in minutes and seconds. 2. LRE QI Staff will aggregate physical management data quarterly. • quarterly data will be	CMCO (#1-#2) IT Staff (#3) Monitored By: 1. LRE Behavior Treatment Workgroup 2. QI ROAT	LRE IT Project Priority	Ongoing

		reviewed for trends, issues, and performance improvement opportunities. • quarterly reports and analysis will be reviewed and discussed by Behavior Treatment Workgroup and QI ROAT. 3. LRE QI Staff will work with IT staff to have the Physical management data in Power Bi by 9/30/2025			
Member Experience with Services	LRE will determine if the new MHSIP and YSS-F are effective customer satisfaction surveys for LRE's populations.	1. Customer Satisfaction workgroup will review current power bi data and provide feedback to the LRE 1/2025 2. Consumer Advisory Panels will review data and provide feedback 1/2025-3/2025 3. Assessment will be created to analyze information provided 4/2025.	Customer Services Staff Monitored By: 1. CMCO 2. QIC 3. CS Workgroup 4. QI ROAT	Length of time to complete MHSIP & YSS-F Possible conflict with CMS/MDHHS 3rd year patient experience & HCBS patient experience measures	1/31/2025 3/31/2025 4/30/2025
Grievance and Appeals	Provider grievances, appeals and NABD's will be compliant with MDHHS Standards and Policy.	1. Conduct quarterly grievance, appeals, and NABDs audit at the CMHSP level to ensure compliance with Federal regulations and State requirements. 2. Issue CAPs, as required. 3. Approval CAPs and validate CAP remediation	Customer Services Staff Monitored By: 1. CMCO 2. QIC 3. Customer Services Workgroup 4. QI ROAT		9/30/2023

Practice Guidelines	Ensure continued education and monitoring of Clinical Practice Guidelines while improving dissemination and education to the LRE Provider network. Adopt new/alternate practice guidelines as necessary.	1. CPGs will be reviewed and updated two times a year by the LRE Medical Director and the Clinical / UM Department staff. 2. CPG information will be disseminated to the provider network through various educational opportunities as well as links to the LRE CPGs via CMHSP and LRE Websites. 3. Disseminate the Clinical Practice Guidelines to its Regional Provider Network via LRE newsletter at least annually.	UM Staff Monitored By: 1. CMCO 2. QIC 3. Clinical ROAT 4. QI ROAT		Ongoing

Credentialing and Re-Credentialing	Enhance the credentialing/ recredentialing process through successful implementation of the MDHHS CRM Universal Credentialing Module.	QAPIP Standards require that credentialing data be regularly reviewed 1. A credentialing data report will be developed by January 2023. 2. QI with LRE Credentialing Staff will review and monitor the credentialing data report monthly to identify trends and areas of concern. 3. Credentialing data report will be presented to the QI ROAT quarterly to discuss trends and areas of concerns. 4. Identified trends and areas of concern will be discussed with Provider Network Managers and a improvement plan to address and work on these with the Providers and CMHSPs will be developed as needed.	Credentialing Staff Monitored By: 1. QIC 2. QI ROAT	MDHHS delay in Universal Credentialing module deployment MDHHS not including all individual provider types in Universal Credentialing module	3/31/2025
Credentialing and Re-Credentialing	Develop specifications for developing a credentialing/ recredentialing module within LIDS and reports with the assistance of PCE Systems that complies with MDHHS Provider Credentialing Policy.	1. Work with Stakeholder to identify unmet needs related to Master Provider Database. 2. Interface with PCE to ensure transfer of technical requirements to functional module.	IT Staff CMCO Monitored By: 1. Credentialing Staff 2. QI ROAT	LRE IT Project Prioritization PCE Project Bandwidth balance with MDHHS CRM work	Ongoing

Credentialing and Re-Credentialing	Develop a process for integrating grievances, appeals, performance indicators, critical incidents, etc. into the recredentialing process.	1. Establish procedures to integrating grievances, appeals, performance indicators, critical incidents, etc. into the recredentialing process.	CMCO Monitored By: 1. QIC 2. Credentialing Staff 3. QI ROAT	LRE IT Project Prioritization PCE Project Bandwidth balance with MDHHS CRM work	Ongoing
Verification of Services	The LRE will complete Medicaid Verification of services reimbursed by Medicaid as required by MDHHS Contract.	LRE will: 1. Complete quarterly Medicaid Verification Reviews based on a sample of Medicaid paid claims from each of the five regional CMHSPs and their larger providers. 2. Complete quarterly Medicaid Verifications reports with analysis of findings. (reviewed by the QI ROAT). 3. Prepare and submit an annual Medicaid Verification report to MDHHS that includes claim verification methodology, findings, and actions taken in response to findings.	CMCO Monitored by 1. MEV Staff 2. QI ROAT	MDHHS change to MEV policy Impact of EDV on MEV processes	Ongoing
Utilization Management	LRE continue to audit over and under utilization for HLOC/IP/CR	1. Continue UM Auditing as is 2. Utilize UM audit data to identify opportunities for improved authorization and utilization opportunities	UM Staff Monitored by: 1. UM/Clinical ROAT 2. CMCO		Ongoing
Utilization Management	Implement MichiCANs successfully	Implement MichiCANs successfully	UM Staff Monitored by: 1. UM/Clinical ROAT 2. CMCO	MDHH Delays	Ongoing

Oversight of Provider Network	LRE will ensure CMHSP Site Review Tools comply with Federal regulations and State requirement.	1. Review 42 CFR 438 monthly to ensure Federal regulations have not changed and if they do, document such changes so as to incorporate in the CMHSP Site Review Tools for the following audit year.	CMCO		Ongoing
Oversight of Provider Network	LRE develop Site Review tools for FI & SD consumers.	1. Develop tools with feedback from key stakeholders 2. Work with MDHHS to facilitate publication of SD rules/requirements.	CMCO	MDHHS Delays in SD guidance	Ongoing

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

		annual facility reviews of specialized residential facilities. Specialized Residential facilities will be reviewed and monitored for HCBS required Standards. 5. Incorporate LTSS into UM Plan.			

XIX. MDHHS GOVERNING BODY FORM

Governing Body Form

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

Name of PIHP		
Lakeshore Regional Entity		
Update: October 11, 2024		
Description of Change: none		
List of members of the Governing Body (add additional rows as needed)		
Name	**Credentials**	**Organization** (if applicable)
1. Jim Storey	LRE Board Co-Chair, Allegan County Commissioner, Allegan CMH Board, LRE OPB	OnPoint CMH (f/k/a Allegan CMH)
2. Alice Kelsey	LRE Board Member	OnPoint CMH (f/k/a Allegan CMH)
3. Pastor Craig Van Beek	LRE Board Member, Pastor	OnPoint CMH (f/k/a Allegan CMH)
4. Janet Thomas	LRE Board Member, Lawyer, HW Board Chair	HealthWest
5. Linda Dunmore	LRE Board Member, Registered Nurse	HealthWest
6. Janice Hilleary	LRE Board Member, HealthWest Board	HealthWest
7. Patricia Gardner	LRE Board member, Kent County Judge	Network180
8. Stan Stek	LRE Board Chair, Kent County Commissioner, N180 Board Member	Network180
9. Jon Campbell	LRE Board member, State Division Administrator LARA	Network180

10. Sara Hogan	LRE Board Member, Director of Administration (Benjamin's Hope) Provider Network,	Ottawa CMH
11. Richard Kanten	LRE Board Member, LRE OPB	Ottawa CMH
12. Dave Parnin	LRE Board Member, LRE OPB	Ottawa CMH
13. Ron Bacon	LRE Board Member, WM CMH Board Member	West Michigan CMH
14. O'Nealya Gronstal	LRE Board Member	West Michigan CMH
15. Andrew Sebolt	LRE Board Member, LRE OPB, WM CMH Board, MDHHS County Board, Veteran	West Michigan CMH
Changes to membership during the past year: **Directors no longer on LRE Board:** Ron Sanders, **New Board Members in the past year:** O'Nealya Gronstal, Dave Parnin		
Date the Governing Body approved the annual QAPIP (prior SFY QAPIP evaluation, current SFY QAPIP description, and current SFY QAPIP work plan)*		
Date: November 20, 2024.		
Dates the Governing Body received routine written reports from the QAPIP (during the prior SFY; add additional rows as needed)*		
October 25, 2023		
November 15, 2023		
February 28, 2024		
May 21, 2024		
September 25, 2024		
MDHHS Feedback		

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

XX. ACRONYMS

BBA – Balanced Budget Act

BTC – Behavior Treatment Committee

BTP – Behavior Treatment Plan

CAP – Corrective Action Plan

CAFAS – Child and Adolescent Functional Assessment Scale

CEO – Chief Executive Officer

CIRE – Critical Incidents & Risk Events

CMCO – Chief Managed Care Officer

CMHSP – Community Mental Health Service Provider

CMS – Centers for Medicare and Medicaid Services

COO – Chief Operations Officer

CPG – Clinical Practice Guideline

CRM – Customer Relationship Management

CS – Customer Satisfaction

EQR – External Quality Review / External Quality Review Organization

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

HCBS – Home and Community-Based Services

HIPAA – Health Insurance Portability and Accountability Act

HMP – Healthy Michigan Plan

ICO – Integrated Care Organization

I/DD – Intellectual/Developmental Disability

IPOS – Individual Plan of Service

KPI – Key Performance Indicator

LOCUS – Level of Care Utilization System

LTSS – Long-Term Services and Supports

LRE – Lakeshore Regional Entity

MDHHS – Michigan Department of Health and Human Services

MHL – MI Health Link Demonstration Program

MHP – Medicaid Health Plan

MI – Mental Illness

MHSIP – Mental Health Statistics Improvement Program Adult Consumer Experience of Care Survey

MMBPIS – Michigan Mission Based Performance Indicator System

PCP – Person-Centered Planning

PIHP – Prepaid Inpatient Health Plan

PIP – Performance Improvement Project

QAPIP – Quality Assessment and Performance Improvement Plan

QIC – Quality Improvement Council

QI – Quality Improvement

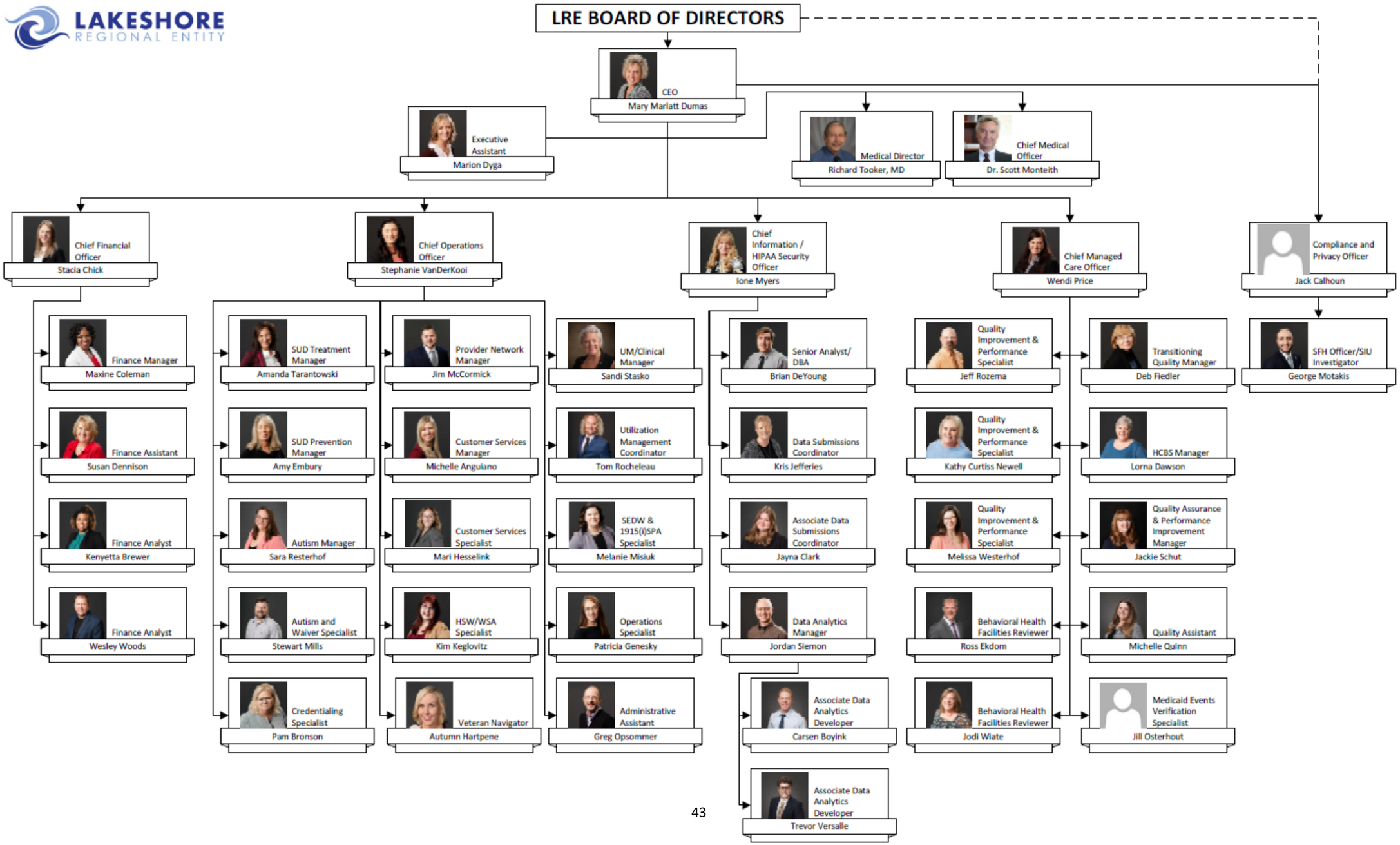
ROAT – Regional Operations Advisory Team

Survey – Customer Satisfaction Survey

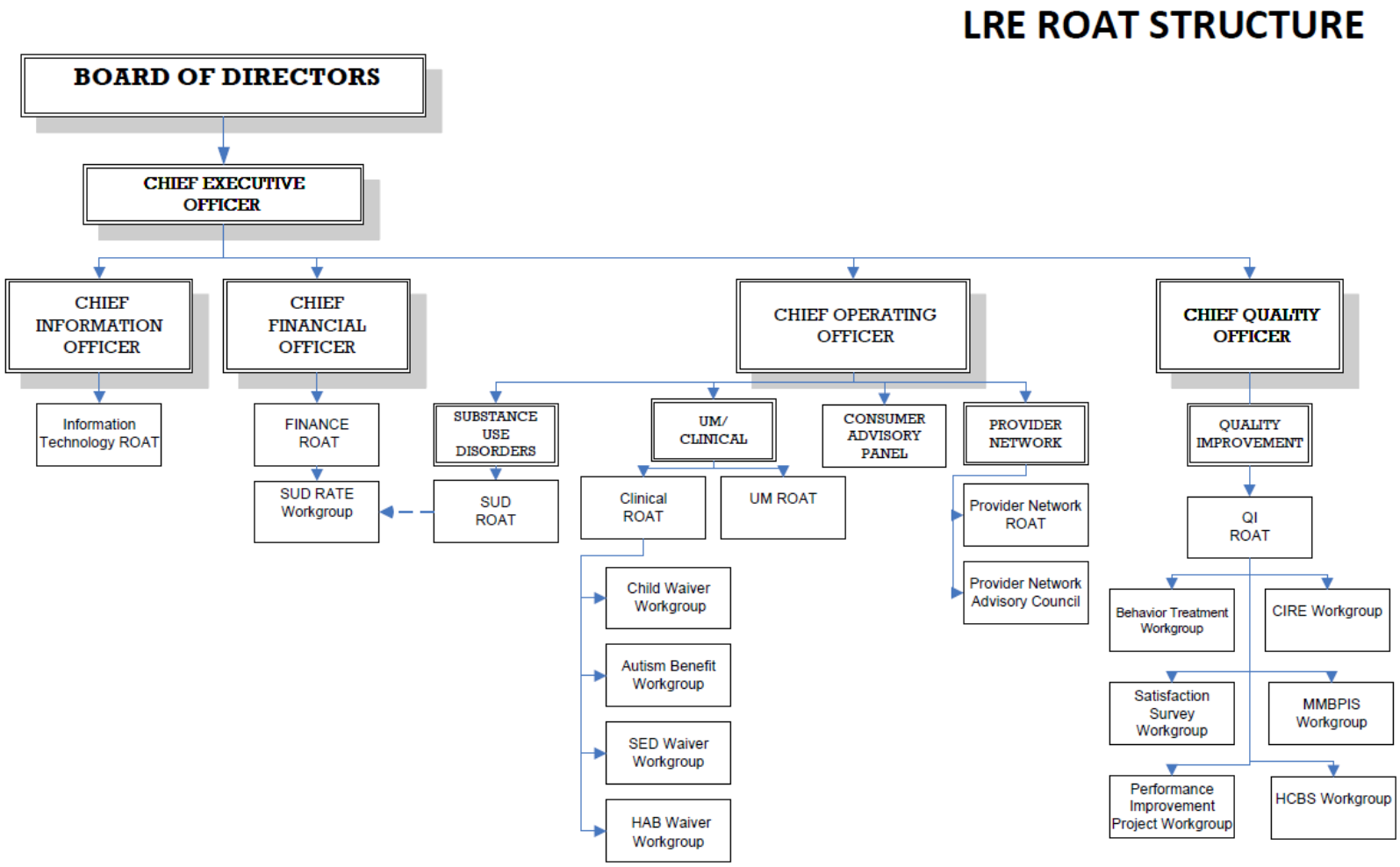
UM – Utilization Management

YSS-F – Youth/Family Services Survey for Families Experience of Care Survey

XXI. Exhibit A



XXII. Exhibit B



Quality Improvement Committee CHARTER

COMMITTEE LEAD: LRE CMCO and LRE

COO

ADOPTED: 8/4/2023

REVIEWED: 8/3/2024

This charter shall constitute the structure, operation, membership, and responsibilities of the Lakeshore Regional Entity (LRE) Quality Improvement Committee (QIC).

Purpose:
The LRE QIC:

- Ensures effective oversight and monitoring of the Lakeshore Regional Entity's managed care functions, both internal and delegated through the application of data reports.
- Ensures all departments are collaboratively and consistently utilizing data and key performance indicators.
- Ensures LRE departments are collaborating to foster open communication and cross-pollination of information toward effective project completion.

Responsibilities and Duties: The responsibilities and duties of the LRE QIC shall include the following:

- Ensure managed care functions are being appropriately monitored and in compliance with MDHHS and HSAG standards.
- Ensure coordination and information sharing between LRE departments.
- Recommend improvement strategies where adverse trends are identified by the Data Analytics Steering Committee

Membership: LRE QIC membership is determined by the LRE Chief Operating Officer and Chief Managed Care Officer, including but not limited to department managers responsible for Managed Care Functions (Utilization Management, Customer Services, Provider Network, Finance, Quality, Information Technology).

Reporting Expectations: At a minimum, subject matter experts (SMEs) are expected to present the performance metrics as follows:

1. Overview of metric by region and by CMHSP
2. Identification of any outliers and reason for data anomaly
3. Comparison of quarter over quarter metric performance by region and by CMHSP
4. Comparison of year over year metric performance by region and by CMHSP
5. Trend analysis by metric by region and by CMHSP
6. Identify reason why the metric is trending up or down by region and by CMHSP
7. Present recommendations if metric is trending downward
8. Present recommendation if a CAP is necessary
9. Present recommendation if a training opportunity exists

Reporting Schedule:

REPORTING AREA	SME	JAN	FEB	MAR	APRIL	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
iSPA	Melanie			X			X			X			X
Waiver	Kim			X			X			X			X
Credentialing	Pam			X			X			X			X
Autism	Sara/Stewart	X			X			X			X		
Customer Services - Grievance/NABDs	Michelle	X			X			X			X		
Customer Services - CS Survey	Mari	X			X			X			X		
Clinical/UM	Tom		X			X						X	
PNM - Network Adequacy	Jim					X			X			X	
PNM - CAP Completion	Jim		X			X			X			X	
PNM - Timeliness Standards	Jim		X			X			X			X	
Quality - MMBPIS	Wendi	X			X			X			X		
Quality - CIRE	Wendi	X			X			X			X		
Quality - UD/SE	Wendi	X			X			X			X		
Quality - CMHSP Site Reviews	Wendi					X						X	
Quality - SUD/InPatient Site Reviews	Wendi					X						X	
Quality - Facility and HCBS Reviews	Wendi			X			X			X			X
Quality - HCBS	Wendi			X			X			X			X
Quality – BTPRC & Physical Mgmt	Wendi			X			X			X			X
IT	Ione												
Finance	Stacia	X			X			X			X		
Compliance	George												
SUD	Amanda/Amy		X										
Veterans Navigator	Autumn		X										
Quality - HSAG (PIP, CR, PMV)	Wendi		X			X			X			X	
		7	6	6	7	7	6	7	4	6	7	7	6

LAKESHORE REGIONAL ENTITY

Change Log:

Description of Change	Reason for Change	Date of Change	Change made By
Moved BTP and PM out 1 month	BTP and PM data not ready for initial reporting cadence	11/02/2023	Wendi Price - CMCO

XXIV. Exhibit D

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

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

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

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

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

Behavioral Health Quality Overhaul – 3YR Rollout Strategy

Q&A Document

Last Updated: 9/26/24

In October 2023, the Bureau of Specialty Behavioral Health Services began a comprehensive review of the existing quality assessment and performance improvement program toward the goal of developing and implementing a new program. The transformed program will be more comprehensive, better defined, with a more rigorous methodology that aligns with other state and national requirements. The rollout of the updated program is as follows:

Year 1

The first year will focus on aligning reporting requirements for PIHPs with CMS Core Set Reporting. By the end of YR1 measure roll-out, all required CMS Core Set measures will be available by PIHP. It is recommended that all measures in this table are stratified by race/ethnicity.

	Measure	**Program**	**Domain**
ADD	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	BHCS	MH
CDF	Screening for Depression and Follow-up Plan*	BHCS	MH
FUH	Follow-up After Hospitalization for Mental Illness*	BHCS	Access
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	BHCS	MH
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	BHCS	MH
FUA	Follow-up After Emergency Department Visit for Substance Use*	BHCS	Access
FUM	Follow-up After Emergency Department Visit for Mental Illness*	BHCS	Access
IET	Initiation and Engagement into Substance Use Disorder Treatment	BHCS	SUD
MSC	Medical Assistance with Smoking and Tobacco Use Cessation	BHCS	SUD
AMM	Antidepressant Medication Management	BHCS	MH

Year 2

The second year will focus on rolling out stratification of measures, along with adding several key measures. In alignment with 2025 CMS Core Set Reporting requirements, the following measures will be rolled out stratified by race and ethnicity, gender, and geography.

	Measure	Program	Domain
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	BHCS	Comorbid Conditions
HPCMI	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	BHCS	
OUD	Use of Pharmacotherapy for Opioid Use Disorder	BHCS	SUD
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	BHCS	MH
ACC	Access to Care—appointment within 10 days of request	Final Rule	Access

Year 3

The third year will focus on implementing patient experience and Home and Community Based Services (HCBS) measures. Both standard CAHPS (included in the required CMS Quality Rating System) and HCBS CAHPS measures are included. All plans (MCOs, PIHPs, and PAHPs) are required to have a QRS publicly available by 2027.

	Measure	Program	Domain
CAHPS	How people rated their health plan	QRS	Patient Experience
CAHPS	Getting care quickly	QRS	
CAHPS	Getting needed care	QRS	
CAHPS	How well doctors communicate	QRS	
CAHPS	Health plan customer service	QRS	
HCBS CAHPS	Choosing the Services that Matter to You	HCBS	Patient Experience and Home and Community Based Services
	Community Inclusion and Empowerment		
	Transportation to Medical Appointments		
	Physical Safety		
	Personal Safety and Respect		
	Staff are Reliable and Helpful		

	Staff Listen and Communicate Well		
	Unmet Needs Composite Measure		
MLTSS-1	Medicaid Managed Long-Term Services and Supports Comprehensive Assessment and Update	MLTSS	
MLTSS-2	Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update	MLTSS	
	Social Needs Screening- Tool TBD.	CCBHC	Social Needs

MEASURES

1. ***Question: Are the new measures being introduced HEDIS Measures?***

   Answer: Most measures will come from the Behavioral Health CMS Core Set, many of which are HEDIS measures.

2. ***Question: Will Year 1 data be used to establish a baseline?***

   Answer: Some measures already have benchmarks due to current inclusion in a quality program, for example, the performance bonus incentive program. After a rigorous vetting process, Year 1 data will be used to establish baseline rates. For measures not previously included in a MDHHS quality program.

3. ***Question: Is it expected that CMS will provide the specifications, or will each state be developing these?***

   Answer: National specifications will be provided for all measures where available. The Access to Care measure will have a state developed specification.

4. ***Question: When you add a new measure, do you look to see if there is anything similar that can be removed?***

   Answer: Yes. MMBIS measures will be retired after FY25. Every effort is being made to reduce duplication and redundancy with the implementation of new measures.

5. ***Question: Regarding the NCQA/CMS on the initial list – have we already looked to see if there are surveys being done at the CMHSP/PIHP level so there is no duplication?***

   Answer: Yes, we are looking at the National Core Indicators (NCI-IDD survey). As part of the Habilitation Supports Waiver, the department is required to be in contact with a third party to implement the NCI-IDD to a small population receiving services each year. Historically, CMHSPs have used a survey that has focused on ACT programs, and our children's services programs. However, those surveys are not consistently being implemented.

6. ***Question: When speaking about Medicaid core measures, there is a lot of emphasis on initiation and engagement with alcohol use treatment, but with the PIHP measures, there is more about substance use. Will substance use measures be included?***

   Answer: Yes. IET (Initiation and Engagement of Substance Use Disorder Treatment (IET-AD and IET-HH) represents multiple sub-measures included in the CMS core list.

7. ***Does MDHHS intend to include all the sub measures in FUH, FUM, IET?***

   Answer: Yes.

8. ***Question: Regarding Access to Care measures on the Access Assessment, is it measured at intake or at first service post Access intake?***

   Answer: This will be aligned with what is required in the CMS rule change that just came out April 20, 2024. (Ensuring Access to Medicaid Services (CMS-2442-F)). Federal requirements establish a 10-business day window for routine mental health and substance use appointments.

9. ***Question: Some of us don't have the ability to monitor all HEDIS measures (e.g., FUA). How are other PIHPs doing that?***

   Answer: To monitor performance, PIHPs can access measures using CC360. For reporting purposes BPHASA will be pulling these rates.

10. ***Question: For the publicly available quality rating system, will MDHHS create a required template for this system? For example, similar to how MDHHS established the Customer Service Manual template.***

    Answer: The state will generate the quality rating system for the PIHPs and develop and implement the methodology. The methodology will be made available for review prior to implementation.

11. ***Question: This is going to change the PMV audit. What will that look like, especially with overlap with MMBPIS Indicators across the measure years?***

    Answer: BPHASA will collaborate with HSAG to determine what this will look like in coming years. HSAG's Summer 2025 review will audit MMBPIS measures from 2024 and Q1 FY25.

12. ***Question: Does any entity conduct PMV (or a similar type of review) of the measures in CC360?***

    Answer: CC360 results are based on a HEDIS-certified product called Symmetry. Any measure where NCQA is the measure steward can be considered certified. CC360 user documentation includes a listing of the CC360 measures and the measure steward for each.

13. ***Question: Would all MMBPIS indicators be discontinued, including those that are State calculated?***

    Answer: The intent is discontinuation of all MMBPIS indicators after FY25, including those that are State calculated.

TIMEFRAMES & ALIGNMENT

14. ***Question: How will the Access indicator align with the upcoming 42CFR e.1 change, effective January 1, 2026?***

    Answer: We anticipate that the Access indicator will align with federal requirements.

15. ***Question: How soon shall we expect a new code book with these new standards, and will it give us enough time to implement changes to collect data?***

    Answer: MDHHS will work with the PIHPs/CMHSPs on developing the new Access to Care measure specification. The codebook is expected to be completed in June 2025. PIHPs will no longer be required to generate measure data except for the Access to Care measure. All other data will be pulled from the data warehouse or from consumer surveys.

16. ***Question: Will we be able to download the measures? We will need to communicate out to CMHs and make dashboards; having the measures before June would be a huge advantage to start visibility.***

    Answer: Specs are available for CMS core set measures and are updated annually (links below). You should be able to access all these measures (except Access to Care) in CC360 to see how you are performing. The measures that the department needs to report to CMS were recently added to CC360, so you should be able to use that tool to monitor performance.

    - Adult Core Set
    - Adult Core Set Reporting Resources
    - Child Core Set
    - Child Core Set Reporting Resources

17. ***Question: LRE's standard is 14 calendar days. In the Final Rule, Access to Care is 10 business days, but not for every service. Is there clarification on 10 business days vs. 14 calendar days, and which services the Final Rule applies to?***

    Answer: The goal is to align directly with the new rule. The rule indicates a 10-business day standard for routine mental health and substance use appointments.

18. **Question: We have the Final Rule Access to Care 10 Day requirement, and also have the CFR change (440.230 - 7-day pre-authorization requirement) coming up January 1. How will these be aligned?**

    Answer: The state will follow federal guidance for these upcoming rules.

19. ***Question: Will measurement year align with fiscal year?***

    Answer: The measurement year will align with the calendar year.

INCLUSION/EXCLUSION CRITERIA

20. ***Question: The measure in Year 3 refers to a CCBHC measure. If we are not a CCBHC site, does this apply to us?***

    Answer: The social needs screening measure is going to be required for everyone. The reference to CCBHC indicates where the measure is derived from. MDHHS is making every effort to align with current efforts of existing programs but will be requiring this measure for all PIHPs.

21. ***Question: Are these quality metrics only applicable to Medicaid beneficiaries? What about Medicare beneficiaries?***

    Answer: These metrics will not be assessed for Medicare beneficiaries. These measures are applicable to Medicaid beneficiaries and those receiving services through a combination of funding (Medicaid, MH/SUD block grant funding, etc.).

22. ***Question: If measures are required for children and adults, do we need to stratify by race and age? A possible issue is that the number of children is too small to be stratified by age and race. How should we deal with this issue?***

    Answer: Some populations will not be big enough to report. When BPHASA pulls the data, we will follow established guidelines for population/sample size requirements.

CAHPS SURVEYS

23. Question: How is information from individuals who access Medicaid services collected?

Answer: Through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which is designed to assess patient perspectives on care. The adult and child CAHPS surveys are administered once per year and are conducted for Medicaid health plan and fee-for-service members. In the past, the surveys have been administered by Health Services Advisory Group (HSAG) using a mixed method approach including web-based surveys, mailed surveys, and telephone follow-up. HSAG contacted individuals who received services (or their caregivers) first by mail, then by telephone, to conduct the survey. The survey administration protocols employed by the adult MHPs included mail, telephone, and/or web. MDHHS provided HSAG with a list of all eligible members of the sampling frame. The MHPs sent the adult population data to HSAG for incorporation in the report. HSAG then presented statewide aggregate and plan-level results to MDHHS and compared them to national Medicaid data and prior years' results, where appropriate.

24. Question: What is the ultimate goal of the CAHPS surveys? For example, for someone with schizophrenia, is it measuring if they are adherent to their medication?

Answer: The ultimate goal of the survey is to get feedback from patients/consumers on their experience getting care. Questions cover topics such as getting services, communication with providers, case managers, choice of services, transportation, personal safety, and community inclusion and empowerment. It is not a measure of medication adherence, however, there are other measures that look at claims and encounters to measure if the client is compliant or not. The survey is trying to measure quality of care and where MDHHS/PIHPs need to improve services.

25. Question: Will CAHPS replace the NCI survey?

Answer: This is still being determined and we will notify everyone when there is a concrete answer.

26. Question: Will the State be utilizing a CAHPS vendor or will each PIHP need to obtain a certified vendor to administer the CAHPS survey?

Answer: This is still being determined and we will notify everyone when there is a concrete answer. In the past, this survey has been administered by the Health Services Advisory Group (HSAG).

GENERAL QUESTIONS

27. Question: What is the Health Services Advisory Group (HSAG)?

Answer: Federal requirements stipulate that each state must have an external quality review organization. HSAG is a vendor that functions as Michigan's External Quality Review Organization (EQRO). They work with state Medicaid agencies and perform EQR services to help improve the quality of care provided to Medicaid recipients. They also work with each state's staff to develop quality improvement plans and design initiatives that will result in measurable outcomes. (https://www.hsag.com/)

28. Question: Can you clarify what CBSA is?

Answer: Core-Based Statistical Area (CBSA) is a geographic area (defined by the Office of Management and Budget) that the Centers for Medicare and Medicaid Services uses to define the payment areas for the hospital wage index. CBSA is a collective term for metropolitan statistical areas and micropolitan statistical areas.

Chief Managed Care Officer - Report to the Board of Directors

November 20, 2024

LRE finalized its Fiscal Year 2025 Quality Assessment and Performance Improvement Program (QAPIP) for review and consideration for approval by LRE's Governing Body.

LRE submits this Fiscal Year 2025 Change Log referencing any substantive changes from Fiscal Year 2024 to 2025.

FISCAL YEAR 2025 QAPIP CHANGE LOG

Date of Change	Source of Change	Description of Change	QAPIP Section	QAPIP Page #
10/01/2024	Admin	Updated Table of Contents	Table of Contents	2
10/01/2024	Admin	Changed Chief Quality Officer to Chief Managed Care Officer	Entire Document	N/A
10/01/2024	Admin	Added Quality & IT organizational changes	III(B)	6
10/01/2024	CMS/ MDHHS	Added CMS Behavior Health Core Set measure implementation (3-year implementation strategy) in lieu of MMBPIS	VI	8-12
10/01/2024	MDHHS	Added language related to target interventions specific to CMHSPs and MHPs that are causing LRE's FUH performance to lag	VII	12-13
10/01/2024	CMS/ MDHHS	Added new Critical Incident, Risk Event, Immediately Reportable Event, and SUD Sentinel Event reporting requirements	VIII(A)	15-19
10/01/2024	CMS/ MDHHS	Added BTPRC attestations in lieu of quarterly data reporting until MDHHS determines next steps	IX	19-20
10/01/2024	CMS/ MDHHS	Added new patient experience and HCBS measures that are part of MDHHS' CMS Behavioral Health Core Set implementation in Year 3	X	20
10/01/2024	MDHHS	Added Universal Credentialing implementation and deadline of 3/31/2025	XII	21-22
10/01/2024	N/A	Added Site Review audits for Fiscal Intermediaries and providers who render services to Self-Determined population.	XVI(E)	26
10/1/2024	MDHHS	Updated FY25 QAPIP Work Plan	XVIII	28-38
10/1/2024	Admin	Updated MDHHS Governing Body Form	XIX	39-40
10/1/2024	Admin	Updated LRE Organizational Chart	XXI	43
10/1/2024	MDHHS	Added MDHHS CMS BHCS 3-year Implementation Strategy	XXV	49-56

LAKESHORE REGIONAL ENTITY

FY25 Risk Management Strategy (RMS) Plan

Stacia Chick, Chief Financial Officer
November 20, 2024

Agenda

- Regulatory & Contractual Requirements
- Responsibilities of LRE and LRE Board of Directors (BOD)
- Recap of FY24 RMS Plan
- Internal Service Fund (ISF) requirements
- Review of FY25 RMS Plans

Regulatory & Contractual Obligations

- Michigan Department of Health and Human Services (MDHHS) and Prepaid Inpatient Health Plan (PIHP) Contract:
  - Risk Management Strategy
    - Each Contractor must define the components of its risk management strategy that is consistent with general accounting principles as well as federal and State regulations.
  - Contractor Assurance of Financial Risk Protection
    - Contractor must provide, to the State, upon request, documentation that demonstrates financial risk protections sufficient to cover Contractor's determination of risk. Contractor must update this documentation any time there is a change in the information.
    - Contractor may use one or a combination of measures to assure financial risk protection, including pledged assets, reinsurance, and creation of an ISF. The use of an ISF must be consistent with the requirements of Section 4 of the State/Contractor Contract with the State.
    - Contractor must submit a specific written Risk Management Strategy to the Department. The Risk Management strategy will identify the amount of reserves, insurance and other revenues to be used by Contractor to assure that its risk commitment is met.
- 2.0 Financial Management Policy of LRE
  - FINANCIAL RISK [Risk analysis, risk modeling and underwriting] [Insurance, re-insurance and management of risk pools]
    - In keeping with MDHHS requirements, it shall be the policy of the LRE to establish an internal service fund risk reserve for the potential of future liability. This fund will contribute to the overall financial planning and stability of the LRE in the capitated risk funded environment.
    - The maximum risk exposure for the LRE under the MDHHS contract is 7.5% of applicable funding. The operating agreement shall contain details for funding and management of the ISF.
    - The Risk Management Strategy submitted to MDHHS per the contract shall detail the LRE short term strategy

Responsibilities of LRE and LRE BOD

- Formally approve the FY25 RMS Plan
- Submit the plan to MDHHS by December 3, 2024
- Update the plan any time there is a change in the information

Recap of FY24 RMS Plan

- FY24 RMS Plan was approved by LRE Board of Directors November 2023
- Projected a regional deficit of ($2,215,644)
- Actual projected regional deficit per the FY24 Combined September Financial Status Report (FSR) is ($21,426,897)
- Plan indicated that Prior Year ISF balance and/or PBIP revenues received in FY24 would be utilized to satisfy the risk obligation.

ISF Requirements

- MDHHS-PIHP Contract:
  - The establishment of an ISF is a method to secure funds as part of the overall strategy for covering the contractor's total risk exposure while assuring that the majority of Contractor's Medicaid/Healthy Michigan Plan capitated funds are directed towards consumer services rather than risk reserves.
  - Contractor must establish an ISF.
  - The defined purpose of the ISF is to allow the Contractor to reserve and use Medicaid/Healthy Michigan capitated funds to pay Contractor's liabilities in excess of 100% of risk corridor annual operating budget as described in Section 7, Risk Corridor.
  - The amount of funds paid to the ISF will be determined in compliance with reserve requirements as defined by GAAP and applicable federal and State financing provisions contained in the State/Contractor Contract.
  - Contractor must establish a policy and procedure for increasing payments to the ISF in the event that it becomes inadequate to cover future losses and related expenses.
  - Payments to the ISF must be based on either actuarial principles, actual historical cost experiences, or reasonable historical cost assumptions, pursuant to the provisions of 2 CFR 200 sub part E. If actual historical cost experiences or reasonable historical cost assumptions are utilized, they must cover, at a minimum, the most recent two years in which the books have been closed.
- 2.6 Establishing an Internal Service Fund Policy
  - LRE will establish an internal service fund (ISF) as a method for securing funds as part of the region-wide strategy for managing Medicaid risk exposure under the MDHHS/PIHP Medicaid Managed Specialty Supports and Services Contract. The funding of the ISF will be maintained at a level that sufficiently covers the projected overall risk of the Pre- Paid Inpatient Health Plan (PIHP), yet ensures maximum funds are directed to consumer services.
- 2.06A Establishing an Internal Service Fund Procedure
  - LRE shall determine at least annually the optimum ISF funding level using the following criteria:
    - The expected risk based on historical costs experience or reasonable cost assumptions.
    - The funds contributed to the ISF determined in compliance with reserve requirements as defined by GAAP and applicable federal and state provisions, as stated in the MDHHS Services and Supports Contract.
- LRE Operating Agreement
  - RISK OBLIGATIONS (INSURANCE, REINSURANCE, INTERNAL SERVICE FUND). The ENTITY will establish and maintain an Internal Service Fund (ISF) to manage its primary risk exposure under the Medicaid Contract. The Internal Service Fund will be developed, used and maintained in a manner to comply with applicable MDHHS Contract requirements. The Internal Service Fund will be sufficient to manage the Region 3 Medicaid risk and will not exceed the amount of the shared risk corridor financing in the Medicaid Contract.

Review of FY25 RMS Plan

- The FY25 RMS projected deficit is ($21,369,523)
- Initial Draft reviewed by Finance ROAT 11/13/24
- Draft reviewed by Operations Advisory Council (OAC) 11/13/24, feedback and recommendations given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Q & A

State of Michigan, Department of Health and Human Services
Risk Management Strategy Submission for State Fiscal Year 2025
Provider Attestation

FY2025 RISK MANAGEMENT STRATEGY SUBMISSION ATTESTATION

	Lakeshore Regional Entity
	Name of Entity
Name of Preparer:	Stacia Chick
Title:	Chief Financial Officer
Phone Number:	(231) 747-0904
E-mail Address:	staciac@lsre.org

I hereby attest that the information submitted in the report herein is current, complete, accurate, and in compliance with MDHHS/PIHP Contract Requirements to the best of my knowledge. I understand that failure to attest (as indicated by the completed section below) will result in non-acceptance by the Michigan Department of Health and Human Services.

Name:	Stacia Chick
Title:	Chief Financial Officer
Signature:	Stacia Chick
Date Signed:	

The FY2025 risk management strategy must be submitted to MDHHS-BDHHA-Contracts-MGMT@michigan.gov no later than 11:59pm, December 3, 2024

Michigan Department of Health and Human Services

PIHP Risk Management Strategy Submission for State Fiscal Year 2025 as defined in MDHHS / PIHP Contract; Schedule A, Statement of Work; Section 6, Contractor Risk Management Strategy

PIHP Name: Lakeshore Regional Entity

#1	For Fiscal Year ended 9.30.2024, report the following:		Amount
A.	Expected balance of the Medicaid ISF	$	16,905,183
B.	Projected Medicaid Savings	$	-
C.	Expected balance of the Healthy Michigan Plan ISF	$	12,267,027
D.	Projected Healthy Michigan Plan savings	$	-
E.	The PIHP's expected unrestricted fund balance	$	-
F.	Public Act 2 (P.A.2) fund balance	$	17,428,442
G.	Performance Bonus Incentive Program (PBIP) fund balance	$	6,999,939
	Total:	$	53,600,591
#2	**For Standalone PIHPs only, Fiscal Year ended 9.30.2024:**		
A.	Projected GF redirected for Unfunded Medicaid Costs	$	-
B.	Projected GF carryforward Earned	$	-

#3	For Fiscal Year ending 9.30.2025, report the following:		
A.	Projection of Medicaid/HMP capitation payments for PIHP and affiliates in total	$	363,203,589
B.	Projection of Medicaid/HMP waiver expenditures for PIHP and affiliates in total	$	(384,573,112)
	Surplus or (Deficit) Total:	$	(21,369,523)

#4 **Is FY24 Medicaid Revenue expected to be <u>below</u> projected expenditures?**

NO **GO TO NEXT QUESTION (#5)**

YES **ANSWER LETTERS A - D BELOW**

A. Provide a **<u>brief</u>** summary of the expected change in Medicaid revenue and costs from FY24 to FY25:

Increased inflation, higher wages, and projected increased utilization and provider rate trends result in increased expenses for FY25. Inadequate capitation rates to cover the cost of mandated services (e.g. mandated DCW increases). Increased utilization in specialized residential, community living supports (CLS), and autism services. Lack of community based CLS service providers resulting in increased rates having to be paid to attract and retain CLS providers. Closure of small specialized residential providers resulting in higher rates having to be paid to larger specialized residential providers. Higher rates for higher quality specialized residential placements in order to keep it community based. Increased rates for inpatient hospitalization.

B. Provide the amount of projected local and state risk obligations the plan covers:

None

C.	Provide a detailed description of the funds (ISF, local, etc.) that will be used to satisfy the risk obligation:

Cost Reduction/Deficit Elimination Plans are being developed and will be implemented to reduce expenditures. Any remaining risk obligation will be satisfied with funding from Prior Year ISF balance and Prior Year PBIP revenues.

D.	Provide a description of any related actions such as plans to increase efficiency or reduce costs:

Per the LRE Strategic Plan, work with the Member CMHSPs to determine where there could be increased efficiencies and reduced costs. And per the LRE's Operating Agreement, a Planned Funding Adjustment agreement may be developed between the CMHSPs if necessary. Engage in the services of an external consultant and/or auditor to evaluate efficiencies, costs, and utilization management at the Member CMHSP level. Continue to advocate to the State for additional Habilitation Supports Waivers for increased revenue. Continue working with CMHSPs to implement Substance Use Disorder Health Homes and a Behavioral Health Homes to bring additional revenue to the region. Work with an actuarial firm to review the Milliman rates to determine if the rates are appropriate and if advocacy is needed. Advocacy regarding the development of the CCBHC PPS-1 rates that impact base capitation. Develop and improve strategies regarding Medicaid disenrollment. Continue to work with actuarial firm to determine how to maximize data completeness and data integrity to positively impact revenue. The development of the Financial strategic plan, including Quality Improvement activities and increased data monitoring and interpretation in an effort to be able to more easily identify inefficiencies.

Specific CMHSP Surpluses/ (Deficits) :

A. HealthWest is projecting revenues above expenditures in the amount of $1,586,410.

B. Network180 is projecting expenditures above revenues in the amount of ($19,723,758). They plan to implement cost reductions in the following areas:

i. Reduce Specialized Residential by bringing Kent County providers back 'in network' and reducing rates.
ii. Reduce Autism due to new UM guidelines
iii. Reclassification of MCD/HMP expenses to CCBHC expenses due to DCO arrangements
iv. Reduce inpatient expenses due to diversion resulting from Crisis Services Unit and allocating costs to CCBHC.

C. OnPoint is projecting expenditures above revenues in the amount of ($267,615). No cost reductions are currently planned.

D. Community Mental Health of Ottawa County (CMHOC) is projecting expenditures above revenues in the amount of ($2,964,561). CMHOC is in the process of developing a deficit reduction plan to include:

i. Hiring freeze for all open CMHOC positions
ii. Analysis of UM Specialized Residential services, Autism Services, Community Living Supports (CLS) Services, and Self Determination (SD) Services
iii. Analysis of Budget Monitoring and forecasting
iv. Analysis of FY2025 steady state budget assumptions

E. West Michigan Community Mental Health is projecting expenditures to equal revenues.

#5	**Is FY25 Medicaid Revenue expected to <u>exceed</u> projected expenditures?**
A.	Provide how much will be allocated to Medicaid savings, ISF deposit, or lapse.

NOTE: The planned utilization of this difference must be specified below.

		Amount
	Projected Earned Medicaid Savings ending balance	$ -
	Projected Medicaid ISF ending balance	$ -
	Projected Medicaid Lapse	$ -

N/A

B.	Standalone PIHPs only: Provide any general fund allocations that are expected to exceed expenditures for FY25, for the PIHP in total, whether they will be included in carry-forward or lapsed and the expected amounts of each.

		Amount
	General Fund Carry-Forward Earned	$ -
	General Fund Lapse to MDHHS	$ -

#6	**Multi-county PIHPs: Briefly describe PIHP/CMHSP affiliate risk management relationships, including the PIHP responsible CMHSP arrangements with affiliate CMHSPs in sharing financing responsibility for the projected Medicaid risk exposure. This item does not apply to single-county PIHPs.**

CMHSP must perform utilization management functions sufficient to control costs and minimize risk while assuring that medically necessary services are provided with appropriate quality of care. The CMHSP is to ensure that their total expenditures stay at or below the revenue received through the Region 3 Revenue Distribution methodology to serve the designated population, utilizing a number of managed care tools (levers) to clinically and fiscally manage their system. Those tools include:

A. Access management (addressing penetration risk): developing and applying criteria for receiving/admission to services (the penetration rate)

B. Utilization management (addressing utilization risk): determining and applying

i. Type/modality of services provided to a given person served

ii. Frequency of the service provided to a given person served

iii. Duration/length of stay of the services to a given persons served

iv. Discharge or reduced intensity or frequency of service to a given person served

Note that the Michigan Medicaid Manual underscores the clinical and fiscal flexibility that a CMHSP has in its repeated guidance that the service provided and authorized should be the most cost effective service or support to meet the clinical needs of the person serve.

C. Cost management (addressing unit cost risk): determining and implementing an appropriate cost per unit of service:

i. If directly provided by the CMHSP, these costs are impacted by staff wages, benefits, and productivity

ii. If purchased from other provider organizations, these costs are those imbedded in the contracts with these providers

D. Access to a risk reserve (aggregate fiscal risk) The risk reserve is shared with the CMHSPs and held by the PIHP.