Response to MDHHS "Lakeshore Regional Entity Contract Termination FAQs"
Completed by LRE and LRE Member CMHs and Community Mental Health Association of Michigan

Background: On June 28, 2019, MDHHS contacted the five CMH members of the Lakeshore Regional Entity (LRE) to inform them of their intent to terminate its contract with the LRE and assign management of the region to Beacon Health Options, the current private management partner of the LRE. Shortly after that contact, MDHHS released a press release and sent formal letters to the LRE and the member CMHs.

On July 10, 2019, a member of another PIHP shared a document entitled "Lakeshore Regional Entity Contract Termination FAQs" with the LRE CEO. This document was produced by MDHHS and shared with a variety of stakeholders including legislators, stakeholders, and county officials from the 7-county region. MDHHS did not share the document directly with any member of the LRE or any of the LRE CMH CEOs. After reviewing the MDHHS Frequently Asked Questions (FAQ) document and comparing with our own experience, it became clear that the FAQ presented a one-sided narrative of the situation in the LRE Region.

This document shares, side by side, the FAQ information presented by MDHHS (left side) compared to the actual data from the LRE and its member CMHs (right side).

MDHHS Statements re LRE Contract Termination FAQs		LRE Data re MDHHS Statements
BACKGROUND		
What is happening to the Lakeshore Regional Entity (LRE)? To provide quality behavioral health services on a sustainable basis for West Michigan, the Michigan Department of Health and Human Services (MDHHS) is cancelling its contract with Lakeshore Regional Entity (LRE) as of September 30, 2019. MDHHS will establish a new pre-paid inpatient health plan (PIHP) in the region, building on recent work there with Beacon Health Options. MDHHS intends to keep the region intact and will initiate temporary state management when the contract with LRE ends. The state will seek to establish a new PIHP to serve beneficiaries.		MDHHS is proposing to: • terminate the state's contract with the Lakeshore Regional Entity. LRE is the public managed care plan (a Prepaid Inpatient Health Plan (PIHP) in federal terms) that manages the Medicaid behavioral health benefit for the counties on the west side of the state; • contract directly with Beacon Health Options, a private managed care company currently managing the Medicaid behavioral health benefit in a partnership with LRE; • eliminate the Lakeshore Board of Directors and replace it with an advisory board formed by the state; • have the State hold the contract, directly with Beacon, for FY 2020, with another of the State's public managed care plans or a private behavioral healthcare plan taking on this managed care role, from the State, for FY 2021. MDHHS staff, in a discussion with the Regions 5 CMH CEOs and the Community Mental Health Association of Michigan (CMHAM) on June 28th, outlined three aims that they hope to accomplish with their proposal: 1. Greater involvement, by the State, in the management of the Medicaid benefit in the LRE region

		2. Changing the make-up of the LRE Board of Directors 3. Re-examining the role of LRE staff in their partnership with Beacon, in the management of Medicaid behavioral healthcare benefit
Why did MDHHS cancel the contract with Lakeshore? MDHHS decided to terminate the contract based on many factors. Some were related to finances: five years of financial deficits, failure to address the deficits, the lack of a current risk management strategy and the lack of a plan to cover their portion of a projected $16 million deficit. The termination also reflects performance issues despite multiple years of corrective action plans and weaker member outcomes relative to other regions on key metrics like inpatient hospitalization. For example, with respect to the Healthy Michigan Plan population for which data is readily available, Lakeshore serves a significantly smaller share of eligible members than the state average, has a higher inpatient hospitalization rate than the state average, and has the highest per member costs of any region statewide.		The LRE was able to address its deficit for FY 2014, FY 2015 and FY 2016. The first year that MDHHS was required to contribute to the LRE's deficit was FY 2017. **Healthy Michigan Plan (HMP) Numbers Served:** MDHHS states that the LRE served a smaller share of Healthy Michigan members in FY 2018 when compared to the state average (1.92% of eligible members vs. state average of 2.64**%).** LRE and Beacon staff were not able replicate this data point. Using LRE enrollment and capitation details along with FY 2018 HMP utilization as reported to MDHHS in the encounter data and on the Medicaid Utilization Net Cost (MUNC) Report, LRE data shows that **there were 96,983 eligible Healthy Michigan members in the region during the fiscal year, and that 7637 members received services. This is an annual penetration rate of 7.87%.** **Healthy Michigan Member Cost Per Month:** In addition, MDHHS states that LRE's per recipient per month costs are the highest in the state ($1,701) compared to the state average of $1,122. LRE and Beacon staff were also not able to replicate this data point. Utilizing LRE MUNC Report, for FY 2018, LRE data shows a **monthly average cost of $360 per Healthy Michigan consumer served during the fiscal year.** Annually this equates to an average of $4,321 for each consumer served. The annual average cost per consumer has decreased over the past three fiscal years from $5,033 cost per consumer to $4,321. **Inpatient Utilization:** MDHHS raises the issue of higher utilization of inpatient services for FY 2018 for persons eligible for the Healthy Michigan program. The contract that LRE has in place with Beacon Health Options is already conducting continued stay reviews for all high level of care services, including community inpatient. This was initiated in February 2019 and was implemented for all CMHs in May 2019. Nearly all admissions are being reviewed/audited for appropriateness (over 95%). The findings show that 94.7% of admissions have been considered to meet medical necessity and 5.3% either Beacon disagrees with a decision or believes that insufficient information was available. Efforts to assure most appropriate high level of care services has resulted in a decrease in length of stay by 1 day for inpatient, and half a day for crisis residential. Enhanced UM and Clinical Care are showing benefits for best practice. We have also started to see a decreasing trend in the number of admissions into inpatient services**. In summary, concerns regarding inpatient utilization have been addressed through significant system development in the region through the LRE/Beacon/CMHSP collaboration.**

Lakeshore has taken some actions (like bringing in Beacon to help) to address ongoing issues. Given this progress, why did DHHS decide to terminate Lakeshore's contract and eliminate the current board? While the current board's recent decision to involve Beacon was a positive step, it was not enough to address our deep concerns arising from that board's record over many years, as detailed above. Given that record, the best path forward for West Michigan residents is for MDHHS to oversee the region directly. We value public input and oversight, and therefore are establishing a new board to assist us in overseeing Beacon's contract. This board will include membership from the CMHs, but also other representatives. Many of the issues in LRE have stemmed from the PIHP not being able to hold its member CMHs accountable and not taking actions like centralizing managed care functions and adopting consistent utilization management procedures. Diversifying the board membership to include a broader group of behavioral health stakeholders will allow it to better hold the CMHs accountable and manage services in the region. By July 26, DHHS will provide more guidance on our plans for selecting the board.		The LRE revised its governance structure and submitted to MDHHS in FY 2017. It was subsequently approved by MDHHS in April 2017. The roster of Board members offers more diversity than what MDHHS requires of other PIHPs across the state. The Board membership includes CMH Board Members, regional providers, recipients of services and/or family members of recipients, individuals working in the court system, individuals working in the healthcare system broadly, corrections officials, and business owners. The Board roster is available upon request. The revised "board" structure that MDHHS is proposing is ***advisory*** in nature, reporting to the State rather than serving as a Public Oversight Board accountable to the communities served for the operations of the region. It is not locally appointed and does not serve in the capacity of a public governance Board. LRE and member CMHSPs have proposed making any changes MDHHS recommends to its Board structure and membership to address their specific concerns related to governance and accountability. MDHHS' remaining concerns could be addressed while retaining publicly appointed governance and without threatening the foundational public nature of the PIHP in Michigan. For example, this could be a continuation of the current, locally appointed Board with an expansion of two or three additional members, all appointed by the State.
Why is LRE being singled out when other PIHPs have had financial problems? The ongoing significant overspending and poor performance in Lakeshore Regional Entity is an outlier compared to the rest of the state. The Department has requested additional funding for the PIHPs in 2019, and it is reviewing options and consulting with stakeholders		Data regarding LRE performance on the issues identified by MDHHS is presented above. **Revenue Factors Impacting LRE financial situation:** LRE's financial situation is not unique. LRE was the first of the PIHPs to experience the impact of systemic underfunding due to a variety of factors. These revenue factors are described below: • **Home and Community Based Waiver (HCBW) Slots:** This Medicaid program is designed for IDD individuals with higher levels of support needs. LRE has 602 slots available (2.2 slots per

on further steps to improve stability and performance within the PIHPs. However, these steps would not be sufficient to address Lakeshore's longstanding problems.		1000 Medicaid enrollees). The state average is 3.23 slots per 1000 Medicaid enrollees**. If LRE were at the state average there would be an additional 273 slots for the region, bringing in an estimated $14.3 million annually.** Regional coordinators report that there are many who would meet criteria and need for this program, and additional slots would be filled in short order if there was more equality in how this benefit had been rolled out historically. • **Traditional Medicaid vs Healthy Michigan:** There are several factors with traditional Medicaid that led to lower revenues for the region. Primarily, LRE is paid per enrollee for two types of Medicaid beneficiaries: DAB (Disabled Aged and Blind) and TANF (Temporary Assistance for Needy Families). The State and their actuary determine the amount of funding each region will receive for the year and then allocates those dollars over the DAB and TANF enrollees. The actuary determined the rates per DAB and TANF based on prior years' enrollments. In FY 2017 the primary concern for LRE was that the regional DAB enrollments dropped by more than 1,140 enrollees per month compared to FY2016 as individuals with higher need signed up for Healthy Michigan (an easier process for enrollees). DAB funding is paid on average of $257 per person per month, which equates to more than **$3.5 million** in lost revenue annually. • **Internal Service Fund**: When Lakeshore Regional Entity was formed in January 2014, the Member CMHs contributed $11.2M in Risk Reserves from prior years. Region 3 (LRE) is the third largest PIHP region in terms of Medicaid Enrollments, but Risk Reserves were the 9th lowest out of the 10 PIHPs. This gave LRE less room to be able to fund deficits that occurred within our region. It is also true that there was no funding in the rates to finance the reserve system as is paid to the Medicaid Health Plans. • **Healthy Michigan:** In 2015, the LRE's revenue for Healthy Michigan was $28M (net of taxes). Expenses were much lower as many enrollees were not involved with the Mental Health system before Healthy Michigan was created. LRE could build some reserves in FY 2014 and FY 2015. In FY2016, MDHHS reduced HMP revenue to $18.4M (Net of taxes) to enable LRE to spend some of those reserves. The region had expenses of $26.2M and used up a significant portion of those reserves, with the understanding that funding would be increased to cover future expenses. This has not occurred. There is a common belief among PIHPs, CMHSPs, and providers that the system is underfunded and 6 of 10 PIHPs ran Healthy Michigan deficits for FY 2018.

		It is important to note: **LRE was able to address its deficit for FY 2014, FY 2015 and FY 2016. The first year that MDHHS was required to contribute to LRE's deficit was FY 2017.** On July 24, 2019 MDHHS and its actuarial firm, Milliman, presented the new actuarially sound methodology for FY2020 based on updated FY 2018 data. This model is based on risk variables and was developed in a collaborative manner with the PIHPs and CMHSPs. Preliminary data presented by Milliman suggests that LRE will receive the highest level of increase from FY 2019 to FY 2020 (7.6% if the model is fully implemented) that it has received since its inception. This increase in revenue in conjunction with LRE's collaboration with Beacon Health Options would place the Lakeshore Regional Entity in a very strong position. MDHHS' contract action against LRE is unnecessary given the more equitable funding formula.
NEXT STEPS		
What will happen next in the region? DHHS intends to keep the region intact and will seek to establish a contract with Beacon that will allow its current work to continue. The contract would include all public policy requirements currently in place for PIHPs, including consumer protections. For legal reasons, DHHS will hold the contract with Beacon and will be ultimately accountable for ensuring Beacon's compliance and performance. However, DHHS will rely on a public board to advise the Department in reviewing budgets, monitoring service delivery, and ensuring compliance with legal requirements. DHHS will act quickly on issues identified by the Board.		On July 10th, PIHPs from around the state issued a statement to MDHHS denouncing its decision and actions regarding LRE. On July 11th, the five LRE Member CMHs sent a letter to MDHHS expressing deep concern regarding MDHHS' action, siting examples of our regional success and requesting an opportunity to continue reaping the benefits of the public-private partnership between LRE and Beacon. The CMHs received a letter back from MDHHS on July 19th, stating it would be moving forward with its proposed action regarding LRE and further justifying its intention to disassemble LRE Board and the region's public governance. On July 11th, Greg Moore, Attorney from Dickinson and Wright, sent a letter to MDHHS demanding MDHHS retract its cancellation of the LRE contract and meet with LRE and regional CMH CEOs to discuss alternative courses of action. In the absence of requested action from MDHHS within 5 days, the letter indicates that LRE will pursue its right to an official hearing. MDHHS responded to that letter on July 19th indicating they have no intention of retracting their decision and refusing a meeting with the LRE and/or CMH CEOs. On July 26th the LRE submitted a "Notice of Hearing Pursuant to MCL 24.271 and 330. 1232b" to MDHHS and specifically Director Gordon of the Michigan Department of Health and Human Services.

How will individuals be protected during and after the transition to the new PIHP? Individuals receiving services from community mental health service providers in this region will continue to receive the medically necessary services authorized in their person-centered plans of care and retain access to their existing providers. MDHHS hopes that improved governance and oversight in the Lakeshore region will result in enhanced quality of services for beneficiaries, and that improved financial management will make more funds available to reinvest in services and ensure the long-term financial sustainability of the region. The process for the closeout of a PIHP after termination is outlined in MDHHS's contract with Lakeshore Regional Entity. This process, which will run through December 31, 2019, will ensure a smooth handoff of responsibilities and closeout of the new PIHP entity. Lakeshore is contractually bound to assure continuity of care during the closeout process. DHHS is committed to ensuring that people and providers do not experience disruptions, and will be actively overseeing the process.		The LRE Board, LRE CEO, CMH Boards, CMH CEOs and Beacon remain 100% committed to no disruption in services to consumers in the region during this period of disagreement with MDHHS. Although the region will take all necessary and appropriate action to maintain the public system, this distraction will not disrupt our delivery medically necessary, therapeutically appropriate services to Medicaid consumers. Furthermore, we remain collectively committed to maintaining and strengthening our public-private partnership as a vehicle to achieve the best possible outcomes to the people we serve. Allegations of "mismanagement" are addressed in other places in this document.
How will SUD payments be handled, if not through LRE? Will Beacon serve as the CMHE? Under the Mental Health Code, Beacon cannot currently serve as the CMHE. We have several options we're looking at for how the SUD benefits will be managed.		The complexities created by MDHHS' proposed solution for LRE are exemplified in the issue of CMHE. Reassigning or alternate management of the CMHE status for LRE would disrupt the following: existing provider relationships, well-functioning SUD management, the SUD Advisory Board, and the relationships of the LRE/CMHE with the 7 counties within the region. The alternate proposal of the LRE CEO, CMH CEOs, and Beacon regarding a shared 3-party contract between the LRE, Beacon, and MDHHS does not disrupt the CMHE status of LRE, the existing functionality of the SUD management and delivery system, or the relationships between the 7 counties and LRE SUD Advisory Board.
THE NEW BOARD		

How will the new board be structured? Who will be on it and how will members be selected? Board membership will include representation from the CMHs, the counties, advocates and individuals receiving services. In the coming weeks, DHHS will engage with stakeholders and legislators, and by July 26, DHHS will put forward our more detailed plan for the composition, selection, and powers of the new board. The Board will be fully established prior to October 1, 2019.		The revised "board" structure MDHHS is proposing is ***advisory*** in nature, reporting to the State, rather than serving as a Public Oversight Board accountable to the communities served, for the operations of the region. It is not locally appointed and does not serve in the capacity of a public governance board. The LRE and member CMHs have proposed making additional changes to its Board structure and membership to address their specific concerns related to governance and accountability. Indeed, the LRE has already modified its Board governance on three occasions refining the accountability, representation and experience of the Board. Each time MDHHS has indicated its approval of these refinements. MDHHS' new concerns could be addressed just as easily while retaining publicly appointed governance and without threatening the foundational public nature of the PIHP in Michigan. For example, this could be a continuation of the current, locally appointed Board with an expansion of two or three additional members, all appointed by the State.
What powers and level of independence will the board have? DHHS will hold the contract with Beacon and will be ultimately accountable for ensuring Beacon's compliance and performance as required by the Mental Health Code. However, DHHS will rely on the board to advise the Department to ensure that Beacon is performing well, with a smooth transition of services, where people are receiving appropriate levels of care, providers are being paid timely, and there is sound fiscal management. DHHS will act quickly on issues identified by the Board. Once appointed, Board members will be subject to removal only for just cause. The Board will be able to make inquiries, request data, ask questions, and publicly report independently of the department.		This proposal eliminates local public governance of the public behavioral health system – one of the foundations of Michigan's nationally recognized behavioral health system for the past 50 years – and replaces it with a state-appointed advisory group. Please see above.
What role will the CMHs, counties, and advocates have in the appointment process?		This proposal eliminates local public governance of the public behavioral health system – one of the foundations of Michigan's nationally recognized behavioral health system for the past 50 years – and replaces it with a state-appointed advisory group.

DHHS will work collaboratively with the counties and stakeholders to select board members. More details about the board structure and appointment process will be released on July 26.		
ADDITIONAL QUESTIONS		
Does this plan require the approval of the local county boards of commission? Or the legislature? Under the Mental Health Code, DHHS holds the contracts with regional entities serving as the Medicaid Specialty service Pre-paid Inpatient Health Plans (PIHP). The Mental Health code permits the department to terminate any PIHP contract for failure to substantively comply with regulatory requirements and therefore does not need county or legislative approval to terminate a contract or initiate a new one. We will be engaging the legislature and the counties throughout this process and look forward to working in partnership to determine the best path forward.		While the state has the authority to terminate contracts, it does not have the right to do so based on claims of failure that do not comport with the facts. LRE has not failed to substantively comply with regulatory requirements. In fact, it is in complying with Medicaid regulatory requirements, in the face of inadequate funding by MDHHS, that has led to the fiscal distress faced by LRE. The LRE will pursue its right to an official hearing. The PIHP serving the region currently served by Lakeshore, must be a regional entity, in compliance with the Michigan Mental Health Code given that the regional entity provides the legal structure for retention of the local county-based public body as the core of the state's statutorily defined public mental health system (http://legislature.mi.gov/doc.aspx?mcl-330-1204b). Additionally, the Regional Entity structure is the structure recognized by CMS, via the 1915(b) and (c) waivers and now the 1115 waiver and 1915i state plan amendment, as the entities that serve as the state's PIHPs. This structure - a local, county-based public body - will be a bedrock component of any newly emerging financing, risk management, service delivery, and governance structure.
Is the DHHS going to absorb the past and current deficits of the LRE? What will happen to those financial obligations? DHHS will continue to work with the legislature to address the state and local share of LRE's deficits.		On July 24, 2019 MDHHS and its actuarial firm, Milliman, proposed the new actuarially sound methodology for FY2020 based on updated FY 2018 data. This model is based on risk variables and was developed in a collaborative manner with the PIHPs and CMHSPs. Preliminary data presented by Milliman suggests that LRE will receive the highest level of increase from FY 2019 to FY 2020 (7.6% if the model is fully implemented) that it has received since its inception. This increase in revenue in conjunction with the collaboration with Beacon Health Options would place Lakeshore Regional Entity in a very strong position. MDHHS contract action against LRE is unnecessary given the more equitable funding formula. There have been offers made and since withdrawn to commit local funds (PA2 as well as resources loaned from foundations and other private organizations) to assist with filling the gap between the obligations and our risk reserve. Our position is that counties have contributed their required local match funds and beyond that it is not appropriate to supplant the State's fiscal

		responsibility to provide the benefits required by a federally funded entitlement program. This is especially true where benefits are unilaterally expanded by the State without a foundation of adequate expense analysis and appropriate rate development.
What is the long-term plan for the region? MDHHS will evaluate the arrangement with Beacon throughout FY20 in order to support and inform decisions about the management of the region in future fiscal years. The state will also immediately begin the formal procurement process to establish management for FY21.		The LRE has already put in place a viable collaboration through its contract with Beacon Health Options. The LRE, CMHs, and Beacon are unified in direction and plan and have built a unique model for consideration in Michigan. MDHHS should allow this unique model to develop according to projection and evaluate impact of the model at established times in the course of the implementation.
How does this decision about LRE affect the section 298 pilot programs happening in the region? Two of the CMHs in the Lakeshore region are participating in the Section 298 pilot program. That program is testing financial integration through the Medicaid Health Plans to see if it improves integration of the systems. In the pilots, the DHHS is contracting directly with the MHPs to manage the physical and behavioral health of their members, and the MHPs in turn contract directly with the CMHs for the specialty behavioral health services (bypassing the PIHPs). Therefore the change in management of the PIHP will have much less effect in those counties after the pilot launches.		The two CMH members that are part of LRE and part of section 298 are HealthWest (HW) and West Michigan Community Mental Health (WMCMH). The action proposed by MDHHS will require significant administrative burden to implement changes for all CMHs in the region. Some specific examples include administrative work will need to occur relative to establishing contracts with Beacon, changing relationships with MDHHS, and shifting administrative functions in whatever way the State's advisory board for the region requires of Beacon and the CMHs. These impacts will be especially difficult for HW and WMCMH as they are simultaneously working, with very limited resources, to alter many key administrative functions to align with the management functions and expectations of the 298 Pilot. It also creates an additional layer of confusion for providers and stakeholders within the system as, within the course of a 15-month period, these functions and mechanisms will potentially change twice.
Is there a systemic funding issue across all of the PIHPs? If so, what is DHHS doing to address it? The supplemental resources requested by the Governor would address a significant portion of current funding issues. Beyond that, the department is working closely with our actuaries and the PIHPs and CMHs to		The fiscal distress that LRE has experienced for the last several years (and those of several other Michigan public managed care plans (PIHPs)) is the result of the systemic underfunding of those PIHPs. As underscored by a recent analysis carried out by the Community Mental Health Association of Michigan, those PIHPs, like LRE, facing the direst fiscal crises, received, over the past four years, either a revenue cut or only a modest increase even when the Healthy Michigan Plan enrollment was growing.

understand the reasons for the recent deficits. We are hopeful that a better understanding of current costs and utilization will allow us to better ensure that funding meets the needs, that all entities are operating efficiently and effectively, and that PIHPs and CMHs are working with providers to improve cost-effectiveness. We are working to identify system improvements to address these issues and look forward to collaborating with stakeholders and the legislature on them in the coming months.		In the case of LRE, if Lakeshore had received the same level of rate increases as those PIHPs not suffering such fiscal distress, LRE's revenues, in FY 2018 would have been $49 million greater than received in FY 2018. This level of revenues would have prevented the fiscal distress faced by LRE. Such appropriate revenue increases would have prevented the fiscal distress experienced by the other PIHPs as well. It is key to recognize that the revenue increases received by the appropriately funded PIHPs are not the problem. The revenue increases to the state's PIHPs, even those that are appropriately funded, in fact were very small, given the dramatic growth in the HMP population over this period. The problem lies in the lack of revenue increases provided to the system as a whole and especially acute for those with the lowest revenue gains over the past four years. MDHHS' proposal does not get to the root cause of the fiscal distress of LRE nor of the other public health plans facing such distress – inadequate funding over a sustained period. Without adequate funding, as required by the Michigan Mental Health Code and Michigan's Medicaid Plan, the Lakeshore Regional Entity system and others who have been underfunded - regardless of the greater involvement of the State in the operation of the local public system - will be unable to pay providers and provide behavioral healthcare services to persons entitled to such services. For the State to propose the termination of its contract with LRE, eliminating the local publicly governed managed care body for the region's public mental health system - as a result the State's underfunding of that regional entity is fiscally, ethically, and politically ironic - an irony not lost on the stakeholders to this system.