LAKESHORE REGIONAL ENTITY

Questions for the Pre-Paid Inpatient Health Plan (PIHP)
RFP Proposal No. 250000002670:

Submitted by Stephanie VanDerKooi, Chief Operating Officer
Email: stephaniev@lsre.org

1. **Definitions:**
    a. What is the definition of a provider? Is a CMHSP considered a provider?
    b. What is the definition of a beneficiary?
2. **Board of Directors (BOD) (Page 25-26 of Schedule A, G):**
    a. How will a region comprised of 44 counties be adequately represented with a 15-member (maximum) BOD? Is the state willing to offer T.A. on this or consider increasing that number? This creates a perception among counties that their voices are not being heard, or that only those of the more heavily populated counties are prioritized.
    b. How does having providers constitute 1/3 of the BOD, as prescribed in the RFP, not present a conflict of interest?
    c. What is the definition of the Governing Body Chair?
    d. How will the BOD operationalize "overseeing daily operations" and "managing consumer complaints", especially if they choose to meet quarterly (per G.4)?
3. **Oversight Policy Board (OPB) (Page 25 of Schedule A, G):**
    a. Per 330.1287 of pa 258 of 1974, as amended in the mental health code the Substance Use Disorder Oversight Policy Board shall include the members called for in the establishing agreement, but shall have at least 1 board member appointed by the county board of commissioners for each county served by the department-designated community mental health entity. How does the state propose structuring the OPB to adequately represent all 44 counties?
    b. Is there leverage to break up the counties by current regions?
    c. OPB is subject to the Open Meetings Act and Roberts Rules, what is the recommendation for the feasibility of these meetings within such a large geographic area (s)?
4. **Medicaid Beneficiaries (Schedule A Section H.1.d.iii.)**

a. Does this apply to all new Medicaid beneficiaries? Does this mean an initial screening will have to be conducted for every new person who becomes Medicaid eligible in the region?

5. Where is the **Gambling** grant/funding in all of this, is it to be assumed its under SUD?
6. **Sanctions (Page 8-Schedule A):**
    a. Needs clarification on the sanctions. There appears to be a lack of clarity around the conditions under which funds may be withheld, which leads to concerns about appropriateness and transparency.
    b. (Schedule A-D.1.9)-Sanctions seem extreme. What is the goal here?
7. **Health Homes:**
    a. Is a BHH required as it is not referenced in the RFP?
    b. SUDHH in Schedule J appears to be a requirement and in Schedule A it appears to be optional, please clarify if this is a requirement or not.
8. **NCQA (Schedule J):**
    a. What are the consequences if an organization is not NCQA certified by October 1 of 2027? How will this impact the consumers?
9. **Timeline:**
    a. This is a significant overhaul of the system. Why is the RFP timeline so short to develop and operationalize a program of this size and complexity?
    b. It appears that it is at the sole discretion of MDHHS. In the event that the organization decides to withdraw from participation, is there a succession plan to ensure continuity?
10. **Health Disparities (Page 22 of Schedule J):**
    a. The RFP outlines significant details regarding health disparities, yet the Federal Government has indicated that we are restricted from addressing these issues or using certain terms in our projects. How is the state going to provide guidance on this and or reassurance that there will not be retaliation from the Feds (via grant cuts, etc.)?
11. **Michigan Department of Corrections (MDOC):**
    a. MDHHS have been very hands-off in helping the current system succeed with this department. How will the winning bid(s) be communicated with MDOC?
    b. Is MDOC leadership going to be involved in the bidder's approach to system design and implementation?
12. **SUD Recipient Rights:**

a. The RFP is silent on this, where and how does this fit with the RFP?

13. HCBS:

a. The RFP is silent on this, where and how does this fit with the RFP?

14. Program Integrity :

a. **(Page 70 of Schedule A, Statement of Work)** Indicates that Program Integrity functions including random and scheduled audits, investigating complaints, and data mining activities must be performed on a monthly basis. Page 77 of the same document indicates that data mining must be performed at least annually. Please explain the difference in timelines.
b. Network Provider Medicaid Enrollment (section stating, "all network providers of the Contractor must enroll with the Michigan Medicaid program".
    i. **ALL** providers, does this mean that they have to be enrolled in CHAMPS? and or does it mean that they have to be credentialed in the CRM?

15. Claims Management (Page 53 of Schedule A, Claims Management, Post-Payment Review (7.d.i)):

a. How would a PIHP verify that services were provided, beyond the annual EOB process, which sends statements to 5% of the persons served annually and the Medicaid Event Verification process? What more will be required to verify? Please provide more context.

16. Capital Reserve Requirements (Page 93 of Schedule A, Section T)

a. Provide an example of the minimum capital reserve calculation(s) to be used.
b. When will the risk-based capital principles and financial risk assumptions be communicated by MDHHS?
c. Will the risk-based capital principles and financial risk assumptions be the same for all Contractors?
d. How will the differential treatment between Contractors (private nonprofit corporation/public university versus public body/governmental entity) factor into the scoring?