LAKESHORE REGIONAL ENTITY

Lakeshore Regional Entity Board
Financial Officer Report for May 2020

- A motion is requested to approve the April 2020 disbursements. A summary of those disbursements is included as an attachment.

- A Statement of Activities report through March 2020 is also included as an attachment.

- **Regional Projections** - A Bucket Report for March 2020 is included as an attachment for today's meeting. When compared to February's report, which showed a projected deficit of $6,572,142, the region is now expecting a surplus of $1,315,005 for Medicaid and Healthy Michigan Plan (HMP). A significant change this month is due to another projected increase in revenue of $7.7 million. Our revenue assumptions were adjusted to reflect the new rates received in April for the rate setting issue Milliman discovered and to also account for a noticeable increase in Medicaid enrollment. The amounts projected for our regional ISF, regional withholds for performance and reporting standards, as well as the MDHHS performance bonus incentive revenue anticipated are also included again this month. If these additional sources of revenue can be realized by the LRE and its members, the projected surplus will be approximately $6.9 million.

- **FY2019 Audit Report** – an extensive amount of time and effort has been spent working with our auditors and CMHSPs to finalize our financial audits for FY2019. The Department of Treasury granted the LRE an extension to submit its financial audit report by June 1, 2020. The LRE's financial audit, single audit, and compliance exam reports for FY19 are also due to MDHHS no later than June 30. Our auditor is currently scheduled to present the LRE's audits during next month's board meeting.

- **PIHP FY20 Rate Setting** – As noted above, new rates were issued in April to correct rate setting assumptions previously made by the state's actuary, Milliman. LRE realized an increase of close to $3 million for April's rate adjustment. We have also been informed of another FY20 rate adjustment that will occur in June. This rate adjustment is in response to COVID-19 and will cover a temporary $2 per hour wage increase for direct care workers providing certain face-to-face, in-home services during the period of April 1, 2020 to June 30, 2020. Click here for more information on this increase: https://www.michigan.gov/documents/mdhhs/L_20-28_690340_7.pdf

- **FY20 HRA Payment Schedule Changes** – PIHPs were notified last month that MDHHS is making changes to issue its Hospital Reimbursement Adjustment (HRA) payments more frequently during the next few months. Instead of quarterly, payments will be issued monthly during the 3rd quarter. HRA payments are intended to sustain capacity at psychiatric hospitals so that Medicaid beneficiaries have access to quality inpatient psychiatric care. These payments are an add-on to locally negotiated rates. MDHHS will reevaluate the frequency for the 4th quarter payments in June.

- **NEW Regional Revenue Allocation Model** – As reported last month, there is interest among the CMHs to have the risk-based revenue allocation model run in parallel with the existing revenue methodology to allow CMHs a chance to better understand revenue on a monthly basis and build confidence and comfort with the way data submissions are used. The LRE and Beacon will also work to find solutions that address different service areas within the region (i.e. rural verses urban, competitive provider areas verses non-competitive provider areas) and to determine how those factors

could be taken into consideration during the revenue allocation process. Weekly meetings with Beacon and the LRE will be occurring to vet and discuss these issues. We will report as progress is made.

- **COVID-19** – The LRE, Beacon and CMHSP finance officers continue to meet regularly to discuss challenges, share solutions, and explore opportunities to establish consistencies in responding to various COVID-19 issues. Recent focuses and discussions have been about methodologies, assumptions, and provider impact relating to distributing the $2 per hour premium pay for direct care workers. The initial directive regarding this increase was received in Letter 20-27, dated May 1, 2020. On May 12 a new letter was issued (L 20-28) which expanded the list of services to be included for the $2 premium pay. Then again on May 18 a letter from MDHHS was distributed informing PIHPs of an increased capitation payment to be expected in June that will cover the cost of the premium pay, confirming services provided via tele-health or in clinic-based settings do not qualify for the increase, and also stating their expectations in regards to encounter submissions. There are still additional requests for clarification regarding the roll out of this pay increase. It is also unknown how the Senate's recent approval for a $3 per hour increase to direct care workers may tie in.

  On April 30, 2020 MDHHS provided PIHPs and CMHSPs with a memo outlining several funding changes and proposals discussed to provide financial assistance for the provider network and to limit the risk exposure for PIHPs. Their proposals included changes limiting the PIHP risk corridor, limiting the amount PIHPs can retain in Medicaid savings, instituting sub-capitated contracts with providers at historical costs, and increasing inpatient psych per diem rates. The LRE, along with other PIHPs across the state, provided feedback to the state's proposal. Our response is attached to this report.

  Lastly, CMHSPs were notified and have since received a portion of the $5 million general fund monies appropriated for COVID-19 CMHSP emergency services. This funding was distributed to bolster the COVID-19 related response due to projected increases in the need for behavioral health services. Funding can be used to support essential services to address behavioral health needs or for any supports or resources necessary to provide such services (i.e. personal protection equipment, transportation needs, etc.).

- **Funding and Grant Updates –** The LRE's State Targeted Response (STR) grant ended on April 30, 2020. This was a 3-year grant used to support initiatives in Michigan that address the state's opioid crisis. Funding was used for prevention, treatment, and recovery interventions that increased access to treatment, reduced unmet treatment needs, and focused on reducing opioid overdose deaths. Our region was able to use close to $2 million of the additional funding it received over the past 3 years. Fortunately, similar efforts and programming continue through Michigan's State Opioid Response (SOR) grant. The LRE's current FY20 SOR budget is approximately $2.4 million.

- **PIHP FY21 Rate Setting** – CMHSPs, Beacon, and the LRE have all been working to finalize, correct, and ensure the accuracy and completeness of all FY19 data. FY19 data will be used as the basis for the FY21 rate setting process. Final reports and data submissions for the FY21 rate setting process is due to the state on May 24. Draft rates are expected at our next rate setting meeting on June 18. We will keep you posted.

LAKESHORE REGIONAL ENTITY

DATE: May 8, 2020

TO: Jeffery Wieferich, M.A., LLP, Director
Bureau of Community Based Services
Behavioral Health and Development Disabilities Administration (BHDDA)

CC: Alan Jansen, Senior Deputy Director, BHDDA

FROM: Greg Hofman, Chief Executive Officer
Lakeshore Regional Entity

SUBJECT: April 30, 2020 Funding Information Memo

Thank you for sharing information discussed by your administration. We truly appreciate being informed as work progresses to help manage the current concerns and financial challenges faced during the COVID-19 pandemic. Please accept and consider the following feedback from Lakeshore Regional Entity (LRE) prior to finalizing your proposal.

MDHHS Proposal 1: Any change would be retroactive to October 1, 2019 and would be for this fiscal year only.

LRE and its provider network have been experiencing a variety of challenges since the onset and mitigation strategies surrounding the spread of COVID-19. We support retroactive changes regarding risk corridors if they are made in light of the additional feedback below. However, the LRE does not support provider retention payment strategies that are retroactive to periods earlier than the onset of executive orders relating COVID19 and the need for social distancing.

MDHHS Proposal 2-3:

- The risk corridor will be changed to allow the PIHP to retain unexpended funds between 98% and 100% - all funds up to 98% must be returned if not expended.
- The PIHP will be financially responsible for liabilities incurred between 100% and 102%.

LRE has been trying to rebuild a reserve for many years since having to use 100% of its savings and ISF to cover deficits for state mandated services and programs. The LRE does not support a 2% cap on funds PIHPs are able to retain. This does not allow us to further develop our reserve.

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The LRE expects to fully cover its liabilities this fiscal year and does not anticipate spending to the extent that risk reserve support would be required. In good faith, the LRE is also assuming the MDHHS and/or Federal mandates for premium pay to direct care workers and other provider stabilization payments beyond the allowable charges to Medicaid, will be adequately funded.

MDHHS Proposal 4: MDHHS will be responsible for liabilities above 102%.

The LRE realizes not all PIHPs are in the same financial position for FY20. We support a proposal to limit the liability of the PIHP for costs above 2 percent. If there is a change to the risk profile and arrangement between the MDHHS and the PIHP, this is a more feasible approach that does not impose unintended and negative consequences for PIHPs in following years.

MDHHS Proposal 5-6:

- ISF amounts would remain at currently approved levels.
- Medicaid savings (Section 8.6.2.1 of the contract) criteria will reflect the change for the PIHP to only be able to retain up to 2% of capitation funds.

While some PIHPs may have more ISF and Savings than others, the LRE is at a critical state of rebuilding its reserve. The LRE does not support a change to reduce the amount of savings it can retain. There are many unknowns regarding the extent and duration of the COVID-19 impact on the provider network. Reducing the Medicaid savings maximum will further limit our ability to mitigate future risks. This change is untenable for the LRE and would likely result in further destabilization of the PIHP system.

MDHHS Proposal 7: Mandated sub-capitation contracting based on 95% of historical costs over the last 2 years (primary focus to support residential service providers -MI/IDD/SUD).

The LRE is interested in ensuring a stable, available, and accessible provider network and has considered many options for doing so. In some cases, provider service production has remained about the same, necessitating no significant change to purchasing or financing methods or resources provided. In other cases, provider service production has been severely disrupted resulting in significant threats to provider fiscal stability. The LRE does not support a sub-capitated contracting approach that assumes all provider needs and experiences over the last 2 years remain the same.

The LRE supports a method that allows providers to submit requests for financial assistance at levels up to 95% of their historical costs with a means to cost settle and net against payments from other sources (i.e. grants, federal assistance, etc.) that support the same services and costs. We also strongly encourage, and support, limiting the 2 year

period to a more recent period (i.e. first quarter of the current fiscal year) that is closer to recent developments experienced by providers.

As an alternative proposal, we encourage the state to allow PIHPs and CMHSPs to address the actual costs incurred by providers through enhanced fee-for-service rates or alternative payment methodologies. We believe that a public policy and financial support to ensure the costs of providers are covered is the goal, and the methods are best left to local determination.

MDHHS Proposal 8: Mandated inpatient psych per diem increase of 25% - effective April 1-September 30 (for those taking COVID-19 patients, still considering this for all facilities due to social distancing requirements impact on hospital census).

LRE recommends use of the Hospital Rate Adjuster (HRA) payments to channel additional funds to the hospitals as a pass through from MDHHS through the PIHPs to support hospitals taking COVID-19 patients. This method seems to be the most efficient and exponential way of ensuring the state's goal here is met. We support state mandates to increase costs whenever they are accompanied by associated funding.

MDHHS Proposal 9: Direct Care Wage Increase.

The LRE understands there will be a revision to L 20-27 issued on May 1, 2020 that may include additional services provided by behavioral health direct care workers. The LRE supports this increase and expansion with assurance payments to PIHPs are adjusted to support the additional cost.

Thank you again for accepting our feedback. We appreciate the opportunity to be involved in a process that helps ensure additional perspectives and aspects of the suggested proposals are taken into consideration. We welcome the opportunity to discuss any of our concerns or suggestions in greater detail if needed.