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## Appendix 2

# Lakeshore Regional Entity (LRE) Interviews and Meetings

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Lakeshore Regional Entity (LRE) Interviews and Meetings  
September 30–October 22, 2015

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## Overview

Through September and October of 2015, Beacon Health Options (Beacon) conducted initial interviews with CEOs of the Lakeshore Regional Entity (LRE) Prepaid Inpatient Health Plan (PIHP) and each Community Mental Health Services Program (CMHSP), LRE Board members, and providers and consumers in the Region.

The goals of these meetings included making introductions, learning about existing operations within each CMHSP, the PIHP, the LRE Board and identifying areas for improvement. In addition, learning about the Region from the provider and consumer prospective, below are notes summarizing each discussion.

# CEO of Lakeshore Regional Entity

## PIHP Structure and Background

- In Michigan, there were 18 PIHPs that were reorganized to 10 effective January 1, 2014 with minimal input from CMHSPs. Lakeshore Regional Entity was formed from five entities with different experience, only Kent County had experience as a stand-alone PIHP.
- The five CMHSPs in LRE represent five unique communities.

## What are some of the needs and opportunities of this PIHP?

- The Region experienced funding issues, including enrollment in TANF decreasing and the elimination of use of Healthy Michigan funds.
- There are no standardized rates for providers that work with multiple CMHSPs.
- There are duplicative administration processes in place because providers have not adjusted to a centralized PIHP structure.
- There are minimal Board governance policies (except for conflict of interest). There is a need for a Board governance structure that is committed to the PIHP structure.
- There is no overlap between committees and existing Board members and there is a lack of consumer involvement.

## What is the committee structure in the PIHP?

There are several committees:

- Citizens Advisory Committee – made up of stakeholders and advocates.
- Provider Network Committee – a newly-formed group of providers.
- Operations Committee – made up of CMHSP CEOs and the PIHP CEO.

## Describe the makeup of the Board and how often the Board meets.

- The LRE Board meets monthly and is made up of two representatives from each of the five CMHSP Boards. No CEOs are on the LRE Board, but they are on the Operations Committee.
- The CMHSPs have an equal number of votes and equal representation.

### **Is the PIHP CEO giving basic reports at the Board meetings?**

The CEO provides “bucket reports” outlining funding that goes into each of the five regions and enrollment. Currently there are reporting challenges, which include timeliness of information and consolidation of the reports. The PIHP is about two to three months behind on reporting and each CMHSP submits individual reports.

### **What are ISF Funds?**

- The Internal Service Fund (ISF) started at \$14M and is currently at \$7M. ISF funding is used to offset unfunded administrative expenses of Lakeshore. There is no ongoing funding for ISF.
- There is no cap on administrative payments. CMHSP administrative spending is difficult to measure and compare because in some instances administrative expenses have been pushed back to the service line for reporting purposes.

### **What is the total utilization of the PIHP?**

Total utilization is approximately \$150M in service dollars with an administration rate of 6.8 percent. Lakeshore retains only about 1.3 percent of the administrative funding.

### **Initially we heard there was a \$17M deficit and the latest number has dropped to a \$3M deficit. Please clarify.**

Assumptions about FY15 financing came through initially at a \$17M deficit. Some of what has led to the \$3M estimate has been the cuts made by individual CMHSPs. Each entity has addressed their budget challenges by making cuts in different areas. The centralized role of the PIHP was limited to budget planning for the entity as a whole.

### **Does the CEO or Board have any ability to sanction a provider who does not improve identified shortfalls in performance?**

There are no performance withholds, performance guarantees, or administrative caps. The PIHP does have the ability to introduce a Corrective Action Plan (CAP).

### **What is the staffing structure of the PIHP?**

There are currently 15 full-time equivalent (FTE) staff, including:

- A CEO, two assistants, utilization management (UM) staff, substance abuse staff, contracting staff, provider relations staff, quality management (QM), and data analytics staff. There are additional staff for compliance who are contracted or shared between the PIHP and CMHSPs.

### **What is the legal structure of Lakeshore?**

Provider partners are member-owners of Lakeshore.

### **What is the process for maintaining risk reserves?**

A required risk reserve balance is maintained. LRE has not had an operating margin to date to determine how this dividend process would be applied in practice.

### **Are utilization statistics tracked at the PIHP level such as Claims per FTE and productivity?**

No. Review of claims and UM happens within the CMHSPs. A 90-day claims lag is defined in the contract/operating agreement. Duplicate analysis is being done but the overall claims analysis efforts are minimal.

### **What are functions of the CMHSPs vs. the PIHP?**

- CMHSPs do credentialing, claims, contracting, utilization management, Medicaid fair hearings, call center functions, and grievance and appeals.
- Customer service is led by the PIHP. There is one person at the PIHP level, but five different entities that do Medicaid fair hearings and five different call center functions.
- Quality is led by the PIHP, but providers have their own quality metrics.
- There is a centralized database and database administrator for IT and reporting, but no CIO. The five CMHSPs are not using the same system because the State said that that cannot be dictated, but can dictate how the information goes to the PIHP (e.g., timing, formatting).

# CEOs of CMHSPs

## General Observations of the PIHP and Other CMHSPs

- There are issues with the current Board structure.
- They believe the Board should have basic guidance of best practices.
- The establishment of the Regional Operations Advisory Teams (ROATs) for Quality Improvement (QI), UM, IT, and compliance for the PIHP is a step in the right direction.
- The PIHP does have levels of care and service criteria packages defined.
- There is no standardized assessment tool at the CMHSP level. There is confusion around roles and responsibilities at the PIHP and CMHSP level and the variability across CMHSPs is extensive.
- CMHSP Boards are appointed by their County Commissioners.
- Each CMHSP has UM criteria, which should have been submitted with their initial application.
- There was little direction on how to structure the PIHP. The PIHP was put together more like a partnership and the structure was left “skinny.”
- In the first year, there was a low administrative budget at the PIHP level; however, they maintained a robust administration structure within each CMHSP.
- CMHSPs each have two members on the Board. In order to have any material change to the operation or bylaws, each member has to go back to their Board and get full approval.
- Substance use disorder programs were integrated into the CMHSPs.
- They believe there is a good group of people in the Region that care about the community and are interested in finding ways to be more effective.
- They believe the situation is salvageable and already have plans in place to be more effective.

## Board Observations

- There needs to be a definition of the role of the PIHP Board and an understanding that their primary role is not consumer advocacy.
- Education around managed care is also important to the Board.
- There historically has been, and continues to be, a lack of leadership and expertise at the Board level.
- The bylaws can change and a restructure is needed.
- There needs to be clear direction on the Board and strong LRE leadership that will delegate to the CMHSPs.
- An appointed Substance Use Advisory Board is working well.
- Things need to be implemented much more quickly.

### Who appoints Board members?

- The CMHSP Board is appointed by their respective County Commissioners. CMHSP Board chairs appoint LRE Board representation.

### Are there distinct roles for the Board?

- No, the operating agreement is not specific enough.
- There was an intention to change the operating agreement and it never happened.
- There need to be clearly-defined Board member roles.
- In order for change to happen, it will take a lot of education of the Board and a willingness of the Board members to want to change.

### Funding Concerns

- CMHSPs expected that they would be able to use excess Healthy Michigan funds, which they are not currently allowed to use.
- The five CMHSPs had to develop a funding formula. Their funding formula was based on the previous three years of funding and did not predict correctly because of Healthy Michigan funding and the ramping up of services. The goal was to make everyone financially stable and work towards a common benefit.
- The PIHP informed the CMHSPs that they would make adjustments as needed, presumably using the Internal Service Fund reserves.
- The State sent out a memo relating to Healthy Michigan clarifying that CMHSPs cannot use Healthy Michigan dollars.
- Some other PIHP regions have done a similar historic rolling average methodology.
- LRE did not take immediate corrective action when they should have, because of the Healthy Michigan dollars.
- There is a lack of sophistication in setting the rates.
- They believe the tracking of funding between the CMHSPs is not clear.
- They believe we need to increase expertise on the financial side.
- They are concerned with next year's budget.

### General Observation of State of Michigan's Current System

- Community Living Services (CLS) are not specific enough, so rates are varied.
- The CMHSP pays the contractor whatever the negotiated rate is.
- Michigan is missing service definitions and program definitions. They have fewer service codes, but a wide variety of service codes.
- They request additional guidance from the State relating to PIHP expectations.

### How are you contracted with the PIHP?

The funding formula is in an initial one-time payment from the PIHP. There is no administration cap on funding allocation.

### What functions fit better with the CMHSPs than the PIHPs?

- Authorization, credentialing, reporting, claims systems, and managing of contracts should be done at the PIHP level to ensure conflict-free case management.
- Most of the UM and QM functions are defined by DHHS.
- Medicaid fair hearings should never have been delegated to the members. It should be the responsibility of the PIHP.
- Customer service is currently delegated to the CMHSPs and should instead be integrated into the PIHP.
- Corporate compliance is contracted out for the PIHP.
- Investigations and setting policy for the Region is the PIHP's responsibility.
- PIHP should set the standard for the members and that is not happening.
- Accountability for all CMHSPs is lacking. The PIHP needs to act as a leader to manage the CMHSP leads.
- There should be a defined role between the PIHP and the leadership of the Operations Committee.
- LRE Board does not have a lot of power because Board members have to return to the CMHSPs for approval of all votes.
- Site visits are completed individually by all CMHSPs for quality and credentialing purposes.
- Training curricula and staff for group home and other services are already being centralized.
- Provider relations needs to stay with the CMHSPs.
- CCBHC functions should be at the PIHP level.

- Criminal background checks and credentialing could be centralized.
- CMHSPs still have to complete site visits under general fund contract, but would like the responsibility to be redistributed.

#### **What is working well?**

- There have been many great partnerships that have formed out of the LRE PIHP, but there are issues with the Board and policies were not implemented quickly enough when the Region was formed, which has resulted in a lack of structure and accountability.
- There is a training repository workgroup to ensure that everyone is receiving consistent training and it should be rolled out shortly.
- The PIHP is currently working on common contract language.

#### **Are partners prepared to move funding to the PIHP in order to ramp up PIHP functions?**

- There are things that need to be centralized.
- CMHSPs expressed willingness to allow the PIHP to manage UM as long as the system is strong.
- To make a change, there needs to be more investment in the organizational change, which will require a shift of funds from the CMHSPs.

#### **What are the roles of Support Coordinators and case managers?**

There are not clear definitions between Support Coordinators and case managers. Case managers are direct service providers that complete Person-centered Plans (PCPs), determine medical need assessment, and ultimately influence what the service package looks like.

#### **How often do denials occur because of Person-centered Plans (PCPs)?**

Almost never.

#### **What is the common worksheet?**

Previously, each CMHSP had an internal process for PCPs. As an effort to move toward common benefits, an LRE worksheet was implemented in July 1, 2015. Soon after, the CMHSPs, which had started implementing the worksheet, received a cease and desist letter from DHHS. This was due to advocates' opposition to the worksheet, which resulted in a decrease in services.

### Is there any data sharing that is going on?

- There is data that the LRE PIHP has to send up to the State, which is done well.
- Each CMHSP has their own electronic medical record (EMR) system.
- Each CMHSP has common data sets that are sent to the PIHP and then the PIHP sends the data to the State to meet reporting requirements.
- The PIHP is not taking full advantage of the data software. The PIHP should be doing more to take advantage of the software to apply data analytics.
- There has been many financial data sharing.
- There are performance dashboards on the statewide performance monitoring system.
- Most sharing of services and program information is from CMHSP to CMHSP, but it has not been done at the PIHP level.

### How would you prioritize the opportunities for improvement?

- Enact two functions of PIHP: distribute dollars in accordance with the rules and manage funds.
- Improve governance structure, increase expertise and capacity in terms of managed care strategies and development of program, and get the budget in line.

### On a monthly basis, what tools are used to measure the budget?

- Monthly “bucket reports”
- CMHSPs have difficulty knowing what revenue will be available for budgeting purposes.
- There was no CFO at the LRE level until July 1, 2014.

### Are there standardized tools in place?

- State has mandated SIS use for evaluations of all persons with developmental disabilities.
- All leaders believe in person-centered planning.
- There is no standardized “skill building” tool.

### How does your claims system work?

- Each CMHSP has their own claiming system.
- There is a Medicaid verification system and someone from the PIHP visits each CMHSP quarterly for claims verification.

### **What metrics do the PIHP staff measure when they do a site visit?**

They review policy and procedures and CMHSP data, provide consultation and recommendations, and create corrective action plans that they then monitor to make sure required corrective actions are taken.

### **Are providers paid at the same rate in the Region?**

- Rates are consistent for inpatient services, but for all other services, it depends on the service being requested and provided as well as the provider.
- How services are delivered throughout the state varies.

## LRE Board Interviews

### What is the current funding distribution?

In the past, funding was based on each CMHSP's historical proportion of total funding available. The LRE has recently adopted a resolution that will implement a per-member per-month funding methodology over a four-year transition period.

### Define the LRE structure upon initial formation.

- When LRE was formed, it involved the creation of two entities, which were authorities under Michigan law and under county control, two entities that were already a PIHP, and Allegan, which was under another PIHP. Not everyone was happy with the selection process that brought the CMHSPs together.
- Network 180 ran the CFO function for the first year before the CFO was hired.
- HealthWest and Ottawa were also PIHPs. An attempt was made to recruit a CEO who would have contacts with everyone and establish best practices to maximize access and establish a common good irrespective of the CMHSP and county. Currently, progress is being made in spite of the circumstances.
- Staff from all of the CMHSPs were working in this LRE to fill spots until positions were filled.
- The Board members are interested in participating in training and some relationship building.

### What is working well and/or not working well?

- There are issues with how to change the delivery of services, but the changes that need to be made are in the right direction. The Board needs to learn how to work together.
- Some programs have closed and people are struggling with the change in delivery. The Board needs to focus on the new delivery system and not look at to the past.
- The LRE needs to have a specific role. The role and function of the LRE needs to be defined. What are the policy and procedures? What is the Board's purpose? We should be focusing on the population being served.
- The Board as a whole knows the direction they need to go in, but each individual Board member has different ideas of how that can be done. Services were reduced using assessment tools (SIS and CLS/Skill Building tool) as a direct result of budget deficit.
- There is now a growing conversation to build trust and commitment to the population being served. There are financial challenges at the LRE level (external and self-imposed). There needs to be restructuring of the Board to manage the LRE effectively. Restructuring needs to happen at the CMHSP level.

### What is the focus and role of the Board?

- Everyone who sits on the Board aims to serve the public and the consumer, but they all bring a different perspective on how that service should be rendered. Some have been unable to put that aside for purposes of establishing a policy.
- The state has to share some of the responsibility (Healthy Michigan dollars were promised and then drawn back). There is some cooperation, which will allow the governance to function better in the future.
- The perception is that the Board is not working as well as it should have been. There was no roadmap.
- Initially the group chose to use a senatorial model for representation. There was a lack of cooperation moving forward.

### Do you think there are transparency issues? What about accountability?

- Transparency is a huge issue. We need to be transparent going forward while we restructure.
- Transparency is a problem. The public comment period during meetings was being cut off, but that has since been resolved. We need better communication between Board and staff so that information can be collected and analyzed.
- Many people on the Board believe that they do not receive sufficient data from the CMHSP level.

### Do you think some services should be centralized to the LRE?

- There was hope that there would be centralization of some services, but LRE has not gotten there yet.
- There were LRE members that were protective of the way things were before LRE was formed. We need local perspective because we serve different types of populations. There is a willingness to change, but we are not there yet.
- Five separate organizations function five different ways, and it is difficult to move from individual ideas to one common goal.
- There can be standards established at the Region level that should be applicable across the Board.
- It is duplicative to have five CMHSPSPs paying claims in five different ways. These things need to be defined at the LRE level. We need someone to come in and identify differences and areas that need to change.

### **Do you think additional representation on the Board would be helpful?**

- There would need to be more information regarding who (e.g., accountant, lawyer) first before we add people to the Board. Adding more people would just complicate things. We are moving in the right direction.
- It would be helpful to have consumer representation on the Board, because services are being provided in each CMHSP.
- There is a lack of input and advice from the State.

### **Has there been any Board turnover?**

No Board members have “termed out.” One representative from West Michigan and Allegan and two from Network 180 resigned and in all cases, substitutes have been appointed.

### **How can an organization with no managed care experience come together? Were there missed opportunities with local leadership early on?**

- One thing that should be reflected is the expression of the passion that all LRE members have for the provision of services.
- We tried to balance the budget to make sure consumers are served. The prior Board CEO was not at fault, but he was in over his head. There was no transparency.

### **Is there a lack of transparency for consumers?**

- We thought we were working toward ensuring that they get the same services in other counties.
- Back in the day, we talked about some satellite offices that would be instituted. One county provides services, the next county over can access them as well. This ultimately was eliminated due to a lack of funding. The general funding was cut. Spend down is challenging for people to afford.

### **Diversity breeds accountability but needs to be harnessed behind a shared mission, vision, and goal to be productive, what are your thoughts?**

- There was hope that there would be more leadership and coaching for the Board. I think that would be a great concept.
- We have made a lot of progress over the last few months. The Board should approve all CEO positions and there should be a pay scale for what employees receive.

- The Boards have the ability to approve a budget. We are neither a governance Board nor a policy Board and we attempt to do both.
- There was only one person making all spending decisions. If they misuse those funds, the responsibility falls back on the Board.

#### **Do you have the data today to understand what that information will look like six months from now?**

- When we found out the total cost for consultants, there was a lot of trying to determine what needed to change. Services are being cut, and we are facing a deficit.
- Unfortunately, we could not maintain a CIO (left about five or six months ago). We were making progress until that occurred.

#### **What would you want to add?**

- We need to have more general funds. The Legislators are not aware of our need. If we could continue to pay spend-downs, we could enhance our services.
- We need to be educated in managed care. If we got there, I do not think we would need a Board coach.
- If we had our current Interim Director from the get-go, we would be in a different spot.

## Provider Meetings

### General Observations?

- The CMHSP systems have become more bureaucratic.
- Efficiencies gained in technology are critical to health care. The many IT systems that are not integrated are a “great disappointment.”
- There was a dual CMHSP/PIHP role within the 18 PIHPs. The goal of the regional systems was to provide support and consistency across the PIHP. Now, there is a lack of uniform benefit, rates and standardized methodology to determine medical necessity. The goal for the Region always included a robust and comprehensive provider network.
- The Medicaid provider manual can be vague, but it is specific enough to have uniformity over program design. Historically, services have been provided differently. The State has never taken a position on methods of delivery. There was a lack of definition from the State along with a lack of uniformity in services.
- The CMHSP system was designed years ago to move dollars to the community. Each CMHSP is looking out for their own community.
- Budget deficit reduction strategies have negatively affected consumers. There needs to be an independent Board with consumers.
- The technical issues for the Region include procurement. Some partners went from directly-operated services to contracted services. Not all procurement policies were followed, and there was not always a formal RFP process.
- The Region is responsible for grievance and appeals. There is not a uniform process in place.
- There is a need to create an IT infrastructure that allows the care plan to be coordinated.
- The fundamental issue is role confusion. Who has the authority to do what?

### What is it like to intersect with Lakeshore?

- We contract with several counties in the LRE. Staffing is the biggest challenge and there is a limited amount of training available. Expanding training capacity has been slow. Training and efficiencies for quality management vary. Each county has slightly different training. There is a provider network meeting, but no opportunities for representation. Strategic planning is difficult with the suddenness of information that is shared.
- Reporting out is argumentative in general. Provider meetings seem like a waste of time. Many of the providers could inform the people who are speaking. Some providers have challenged the LRE Board to move forward.

### Do you work with other PIHPs as well?

- Yes, there has been a learning curve for all of them; however, there is more unity and collaboration in the other PIHPs. There is better communication of what to expect.
- If someone calls for services, providers have to find out what county they are from, because there is a discrepancy between services, inconsistency on the rates and the number of units that will be authorized. Access to services is “a little grey” for them. Clients get frustrated because they cannot always be authorized for certain levels of care.

### Level of care requirements are broad and there is variation of care and rates:

- Authorization is not always occurring at the supports coordination level.
- In some counties, Supports Coordinators tells the client that they are authorized for service and often there is no service. It seems like the LRE made the county lines more definitive. There was not a lot of guidance at the State level.
- Consistency is important, but there is the reality that it does not cost the same to provide services to someone located in a rural community versus a downtown area.
- There needs to be a behind-the-scenes training process and opportunities for all providers to get together.
- Inclusive strategic planning would be extremely helpful. There is an opportunity for the State to provide clarity.
- There needs to be an openness to looking at what is going well and preserving that.

### Data analysis:

- Data has been a big frustration. The LRE should have one IT system for authorization and credentialing. Local systems can manage demographics. Providers are facing the prospect of having to do duplicate data entry.
- We do not have the money to invest in electronic records. We are increasing our cost just to bill. We follow up on codes and then match up based on a 3,000-line data dump.

### Claims adjudication timeline:

- Varies by CMHSP.
- Some providers still have claims from last year and only one FTE working on claims adjudication.

### How in this system is eligibility verified and tracked?

- Everyone is different.
- Thousands of clients have to be checked every month. This cannot be batched.
- There needs to be more advocacy to draw attention to the deficiencies. The results are so disappointing.
- If you look at access and authorization from a client perspective, your path to access varies depending on your county of residence. Providers are not supposed to have a waiting list, but many people are eligible and waiting.

### Board Observations

- There is a structural issue affecting Board members. The meeting where Conflict of Interest was “brushed off” was astounding.
- Board training would help them move forward.
- There is a need to review the governance structure to include a role for providers.

### Complaints, appeals, denials, grievances – what is the role of providers?

- We have to give them their rights when they enter for service. There is coaching if there is an appeal. Counties have experienced significant budget cuts and there are clear guidelines that sometimes get “a little muddy.”
- The role of the providers vary by county. In one county, we provide supports coordination, in others, we just do basic rights. We are also required to have an internal grievance policy.
- Grievance and appeals are for when the system is not working. The focus should be making sure there is no need for appeals.

### Annual budget process that occurs at the individual level prior to person centered planning:

- In some places, providers have individual service budgets and can select how money is spent on their behalf.
- Instead of “this is the services I need,” there is a lot of “this is what we can afford.”
- As a provider, we are seeing services broken down into dollars on treatment plans. People are shocked with a lack of planning and loss of day services.

### Variation, lack of consistency:

- We are taken aback with the fiscal problems of the regional partners. There was an immediate loss of programs and services. It was a hugely disruptive process.

- The fallout has been a loss of efficiency, due to some cutbacks. Financial adjustments have been challenging.
- We send out four claims and receive four bills. There have been no efficiencies.

#### Who is involved in the development of criteria and where is it published?

- A lot of it comes from the State.
- Looking to the east to Midstate, which is the largest, most diverse entity, they did not have a strong vision. They were able however, to come together and make tough decisions at the onset. They had some solutions and they did not struggle with clashing personalities. They were open to leadership.
- The governance model is flawed. The LRE never grabbed the reigns. The LRE did not know their own authority. SWMBH took staff from some of the CMHSPs and merged them to the PIHP level.
- There was no strong leader appointed to lead the LRE.

#### What would you like your place at the table to be?

- Politics has gotten in the way. There needs to be a provider network that brings providers to the table regularly.
- Mental Health Boards are dealing with crises. There is no time to talk about the regional issue.
- Currently, there is more provider representation at the CMHSP level.

#### Was there any discussion about efficiency before services were cut?

- There was never a conversation about efficiencies.
- We were hoping the contracts would be the same. We hoped for one less site evaluation. Morale is low among providers. They are worried because rates are starting to be cut.

### How should the member rights process work?

- SWMBH is having the local teams manage grievances. This is the opposite of what LRE is looking at.
- Person centered planning happens behind the scenes.
- People do not know the grace period or understand when and why cuts are happening.
- Supports coordination is “more of a circus” than a process.
- At one point, CMHSPs had good data, but there is no ability to leverage it.

### Things that need to change tomorrow:

- Education to mental health staff.
- Someone needs to “own it” and people need to fall in line with that and create a vision.

### Governance

- Committee structure needs to expand and there needs to be more voice from providers and consumers that lead into recommendations that go to the Board.
- There needs to be a plan to operate within the budget.
- In relation to supports coordination and conflict of interest, there are often times where it feels like Support Coordinators are working for the system. It has been successful in other places to introduce people who are third parties.
- Transparency and consistency around the development of rates would be enormously helpful.
- The State as a whole needs a series of proclamations with timeframes.
- Consumers and providers have to be on the Board of Directors. We need people outside of the CMHSP system to sit on the Board. We need to find business leaders to serve on the Board.
- Value-based purchasing is needed. There needs to be a move away from fee-for-service reimbursement. There needs to be shared incentives for cost savings.

# Consumer Stakeholder Forum

## Access to services

- I have no idea as a parent what the LRE is supposed to do and how success is measured. It looks like another layer of government. The current reductions are affecting consumers.
- An individual had terminated services in May of 2015. The client worked for 11 years and has lived at the same group home for 19 years. Now he has no employment and no transportation services. No other option was presented. Even if he could find another job, he has no way to get there.
- There are issues with access to day programs.
- Access to vocational services has been “arbitrarily and unilaterally decreased” this past spring.
- An individual wanted job training. He was not able to work 20 hours, so job training was denied.
- An individual receives 27 hours of CLS and life skills and uses those hours to go out into the community and volunteer. Following PCP in July, he was cut to six hours and had to choose between CLS and life skills. All of the assessment tools have to do with high medical need and behavioral need.
- The assessments that take place are not holistic and do not take into account all of the individual’s needs.

## Have you been educated on what your rights are in terms of access to service and appeals?

- An individual asked for help filing an appeal but it was not provided within the timeframe that was required. The first person to help said they filed an appeal, but they actually only filed an amendment for another month of services.
- After services were terminated, the appeals process was explained clearly. The individual filed an appeal, had a hearing, and filed with the State. The community mental health agency was there with an attorney. Consumers are at a complete disadvantage. The only recourse left is to file in circuit court.
- There was no statement of why a denial has occurred. There was a timeframe to start the appeal, which was an inaccurate timeframe. The individual has been caught up in appeal since 2013, had to hire an attorney, and won the appeal after about a year.
- An individual had a direct employer arrangement. The individual has had CLS at the same level for the last four years. The individual received a notice of action for a 26 percent cut in CLS (7.75 hours per week) for “lack of medical necessity.” A PCP was developed at the same period as the cut. The individual signed the PCP in disagreement to ensure that he is able to continue services. There will be a hearing November 17 and an attorney was hired.

### How is parental engagement?

- Individuals and families have to probe to get the information about why the service was denied.
- Recovery is an illusion for developmentally-disabled services. The model is focused on rehabilitating someone and for some patients, there is a big difference in services between MI (rehabilitative) and DD community (habilitative).
- Services were cut due to Medicaid spend-down because in some cases, general funding does not cover the spend-down.
- A parent has a son with autism who lives at home and has not had his services cut. The son had a spend-down. When he lost his job due to behavior, he was placed on SSDI because he had been employed for two years.

### How is transparency and involvement?

- The biggest dismay is with the LRE's impact study where they state that there were zero reductions due to budget limitations. An individual filed three appeals, two of which took three years, and lost. The individual is planning to file a FOIA request to learn how much money was spent on private attorneys to fight.
- CMHSPs implemented a tool to "make the regional benefit consistent." The tool was often modified. The budget is established before a person-centered plan, so budgets are driving services.
- Training requirements for counties are all over the map. Requirements are inconsistent across the board.
- An individual works for an agency that provides care in Grand Rapids. The consumer was dropped out of medical necessity level without notice. The individual set up a meeting with the family and Support Coordinator. The individual never got answers; both the Support Coordinator and supervisor were not able to provide clarification about the score sheet. The individual lost points because he has not had a seizure in a year. His medical necessity level was dropped. The individual was informed that the sheet was an "old score sheet, so they weren't really familiar with it." He was scored on old information, not current information. He did not have a script from a physical therapist confirming services he has always received and so he missed another point. A local appeal was filed and the individual received a letter in the mail saying the appeal was reviewed and it was denied.
- Many people do not know their rights, where to go, and what to advocate for.

### Is there a centralized ombudsman?

- There used to be one at Network 180. HealthWest is working on a connection center. They hold a meeting once a month for people to meet with the Director, ask questions, and get updates.
- The ombudsman needs to be delinked from CMHSPs. Transparency should extend to the Board level. We need parents who are informed and Support Coordinators who will work for them, not

against them. The PCP process has been used as a tool to reduce or eliminate services because of budget cuts.

- Even after the cease and desist for the worksheet, services have been cut. The budget process drives the PCP.
- Many people suffer with DD and substance abuse. People are not getting the services they need. We also would like to see more Peer Support Specialists.
- Tools are used inappropriately to cut budgets, flying in the face of the PCP. Budgets are cut before the PCP is completed. Families do not have the resources to hire attorneys.
- There are cost issues. The first thing that is done is to cut services. Another issue is the reduction in rates paid to provide services. You are going to get a less skilled and motivated workforce.
- Days are cut and transportation is cut. Group homes are losing funding from the State.
- The LRE is not the only PIHP in the State with significant problems. Natural supports are not always a realistic option.
- An individual lost an appeal because “if it wasn’t documented, it didn’t happen.” There needs to be thorough staff training on how to document to focus on the intervention and not the behaviors.
- It does not matter how many goals were added to the PCP. It will not increase the budget.
- In some instances, numbers are actually changed on the PCP by the administration who approves the budgets.
- The PCP is supposed to be the method of implementing services identified for the consumer.