Program Audit of Lakeshore Regional Entity PIHP

Final Written Report with Recommendations for PIHP Improvement on:

1. Managed Care Functions
2. Risk Management Strategy
3. Review of Conflict of Interest Policy

November 6, 2015

beacon health options

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EXECUTIVE SUMMARY

Beacon Health Options (Beacon), at the direction of the State of Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration (BHDDA), has completed a focused program review of Lakeshore Regional Entity (LRE) Prepaid Inpatient Health Plan (PIHP) over an eight-week period. Beacon's focus was to review three main components of this regional PIHP:

1. Managed Care Functions
2. Risk Management Strategy
3. Conflict of Interest Policy

To review current operations, we collected data and information on the LRE, attended public meetings, and conducted interviews. LRE and Community Mental Health Services Program (CMHSP) Administrators and Board members were welcoming to and cooperative with Beacon and the program review. Consumers, family members, providers, advocates, and other stakeholders were generous with their time and open with their feedback to Beacon. All clearly had the same goal, namely to improve the operations of the LRE and ensure appropriate services and positive outcomes for individuals served.

As the largest specialty behavioral health management organization in the nation, Beacon manages mental health and substance use disorder services for more than 48 million individuals, including over 13 million Medicaid beneficiaries, in partnership with 28 state Medicaid programs. This experience across statewide, regional, and/or county-based behavioral health systems has resulted in valuable insights on the models of care that deliver greatest value to government agencies, stakeholders, and most important, the individuals that require behavioral health treatment. Further, with more than 30 years of combined experience in implementation and program operations, Beacon offers MDHHS, LRE, and stakeholders a variety of best practices to consider when evaluating how best to focus the activities of the LRE in the future, assuring optimum clinical outcomes and programmatic efficiency.

The review findings and recommendations included in this report are drawn from the information that we garnered from our review, along with our deep experience in managed care operations.

As an overview of Beacon's findings, *Figure 1* to the right depicts the functions currently performed by the PIHP and the CMHSPs, as well as functions performed exclusively by the CMHSPs. Each individual function is detailed in *Section 1, Managed Care Functions,* of the report.

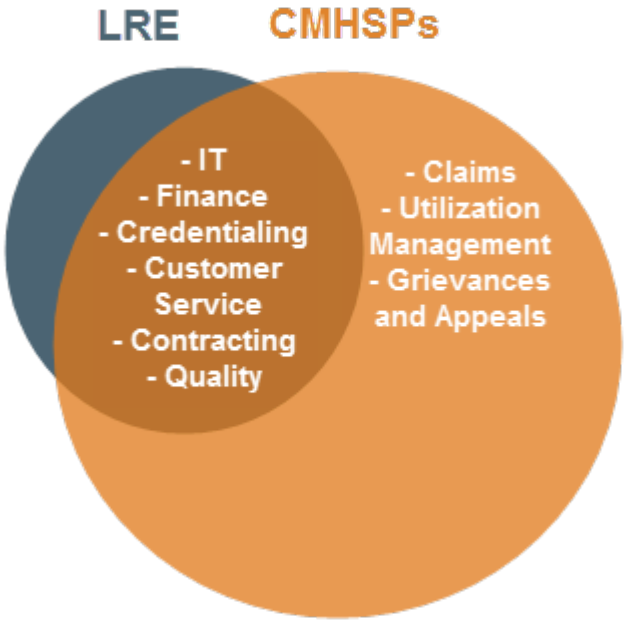


Figure 1. Current State of LRE PIHP Managed Care Functions

Beacon's overall findings and recommendations are offered by report section and are summarized in *Table 1* below:

Table 1. Summary of Findings and Recommendations

Functional Area	Findings	Recommendations
Managed Care Functions	• Duplicative functions are managed by the PIHP and the CMHSPs • Some managed care functions are provided exclusively by the CMHSPs • There is a lack of service uniformity across the CMHSPs • There is a lack of managed care expertise • There is no centralized Management Information System; therefore, data systems are not integrated or coordinated • There is a lack of shared vision, values, and goals • The LRE's historical funding formula is flawed • Services to consumers have been affected • Providers feel significant administrative burden • Supports Coordinators are providing authorizations	1. Centralize all managed care functions of the PIHP at the Regional Level 2. Provide needed technical assistance to the LRE Administration and Board 3. Improve communication and stakeholder involvement 4. Audits of CMHSP processes and services should occur
Risk Management	• The LRE has a flawed business model • There are LRE historical funding formula problems • There is a lack of ability to project expenses • There is a lack of standardized UM to manage medical losses • There are no LRE policies on funding and disbursement of risk reserves • The MDHHS contract with the PIHPs and CMS waivers limit the manner in which PIHPs can reinvest system savings	1. Centralize PIHP functions at LRE and implement a managed care MIS to track and trend authorizations and claims payments across the Region 2. Work with the State to establish reserve balance target commensurate with risk and claims payments across the Region 3. The State should consider revising the MDHHS contract with the PHIPs and CMS waivers so PIHPs are incentivized to create efficiencies within the system and allowed to reinvest regional savings with greater flexibility 4. Provide needed technical assistance to the LRE Administration and Board

Functional Area	Findings	Recommendations
Conflict of Interest	• Governance and conflict of interest policies are insufficient • Current Board composition creates conflicts of interest • Stakeholder input is severely limited	1. Complete a comprehensive review of existing conflict of interest policies 2. Update the Operating Agreement and Bylaws 3. Clearly define CEO authority versus what decisions/actions require Board input

Major recommendation themes include:

1. Centralizing managed care functions at the PIHP
2. Implementing a managed care management information system (MIS) at the PIHP
3. Providing needed technical assistance and training to LRE Administration and Board
4. Improving governance structures

Additional recommendations specifically for MDHHS consideration include:

1. Providing more specific guidance, focus, and direction to the PIHP in areas such as Department priorities, system transformation goals, and concrete steps to assist the PIHP in attaining these goals
2. Amending the MDHHS contract with the PHIPs and CMS waivers so PIHPs are incentivized to create efficiencies within the system and allowed to reinvest regional savings with greater flexibility

OVERVIEW

Effective January 1, 2014, the Michigan Department of Health and Human Services (MDHHS) reorganized 18 Prepaid Inpatient Health Plans (PIHPs) across the State of Michigan into 10 regional PIHPs. Each entity is under contract with MDHHS and is defined as an organization that manages Medicaid specialty services under the State's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR Part 438. A Regional Entity is defined as an entity established by a combination of CMHSPs under section 204b of the Michigan Mental Health Code, Act 258 of 1974, as amended.

Lakeshore Regional Entity (LRE) was the PIHP created in the Western Region (Region Three in *Figure 2* below) to manage specialty carved out Medicaid mental health, developmental disability, and substance use disorder services (Behavioral Health services) for Medicaid and Healthy Michigan enrollees in Lake, Mason, Oceana, Muskegon, Ottawa, Kent, and Allegan counties (i.e., the Western Region). The new Western Region is made up of diverse providers ranging from two of three statewide county Community Mental Health agencies, one former stand-alone PIHP, and two additional Community Mental Health Service Providers (CMHSPs). The LRE contains five diverse CMHSPs, including Allegan County Community Mental Health, HealthWest (formerly Muskegon County Community Mental Health), Network180, Ottawa Community Mental Health, and West Michigan Community Mental Health.

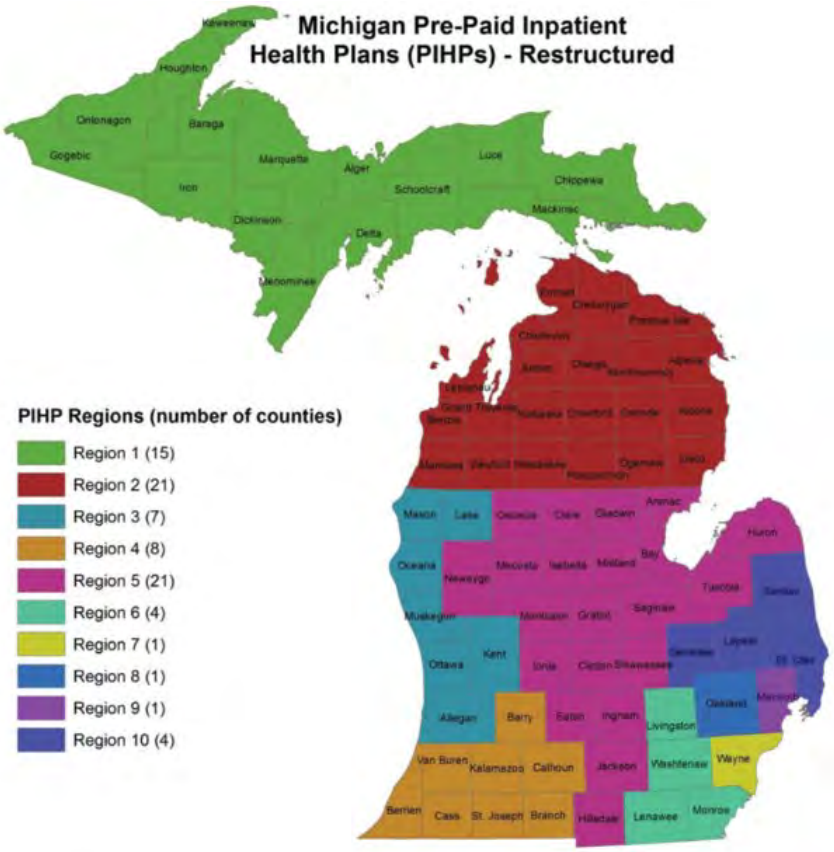


Figure 2. Michigan PIHP Regions

In July 2015, the LRE notified the State that it estimated overspending by $13.9 million for fiscal year 2014–15. This was of particular concern, as Medicaid funding was not decreased from the prior fiscal year. In addition to this financial risk, MDHHS was concerned about the quality of clinical services being provided. MDHHS has received complaints from consumers, family members, and advocates regarding utilization management (UM) and authorization practices that have recently changed, resulting in many reductions of services. The concern articulated is that these actions are in response to budget problems, versus changes in consumer needs and person-centered planning. Further, concerns were communicated regarding the lack of centralization and consistency of the managed care functions within the Region. This leads to significant duplication of and variation in processes and services across the CMHSPs, negatively affecting the experience of consumers, family members and providers.

These concerns prompted MDHHS to contract with Beacon to perform a focused program review of LRE, to identify inefficiencies and make recommendations to improve LRE's performance, and ultimately the experience of all affected stakeholders. The goal of this report is to provide actionable steps that LRE can take to improve clinical and financial outcomes while ensuring operational efficiencies.

Due to the disparate structures and policies of each of the five CMHSPs, LRE is currently operating more like a partnership than a managing entity, with each CMHSP acting independently to provide managed care and clinical services to the beneficiaries they represent. In the past few months, under the leadership of a new Interim Chief Executive Officer (CEO), the LRE has begun evaluating the need to centralize services. Many of the recommendations included in this report speak to the need to move toward a more centralized management of managed care functions as well as streamlining and making more consistent, processes across all CMHSPs in the Region.

Methodologies

Beginning September 11, 2015, Beacon conducted a comprehensive review of LRE's governance and operations, focusing on three main areas:

1. Managed care functions
2. Risk management strategy
3. Conflict of interest policies

The review was completed through analysis of supplied data and documentation and interviews with a range of stakeholders, including State officials, LRE leadership, CMHSP leadership, LRE Board members, providers, consumers, family members, advocates, and other stakeholders. The findings and recommendations included in this report are based on a comparison of Beacon's knowledge of national best practices and what the reviewers could glean about the LRE organization and operations. Upon review of each PIHP function, Beacon identified specific recommendations for improvement.

PROJECT MANAGEMENT

Beacon completed an audit of LRE's current processes and operations over an eight-week period. All data collection, review and reporting was completed within this timeline. The LRE audit initiative was broken into five distinct project steps, as depicted in *Figure 3*:

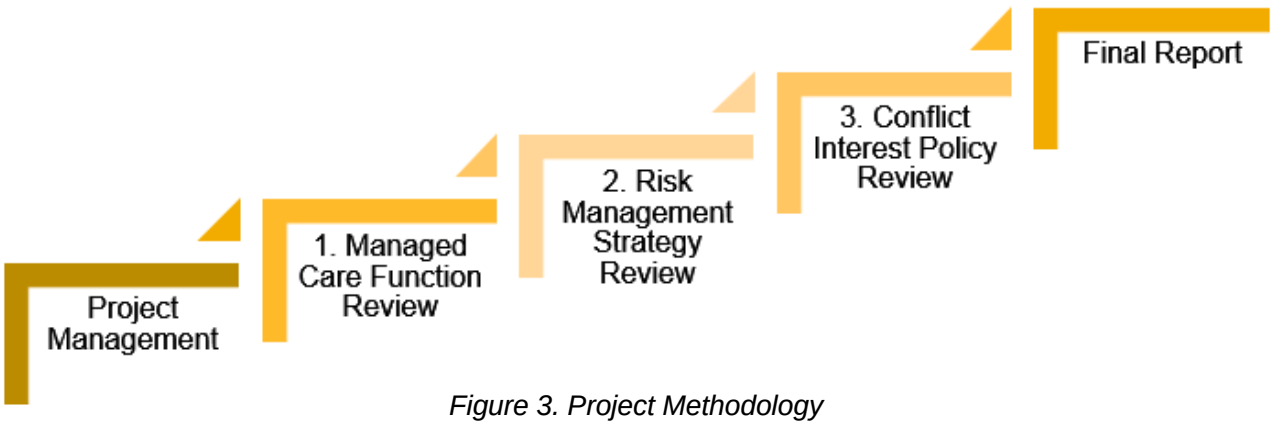


Figure 3. Project Methodology

Project Management: Initial project kickoff meeting and planning began in early September. This included creating a comprehensive list of all relevant data to be analyzed and creating a project work plan. Throughout the project, interview questions were also developed for LRE, CMHSPs, consumers, and providers. In addition, bi-weekly status reports were provided to MDHHS on the progress of the findings.

1. Managed Care Functions Review: Reviewing the functions of the PIHP was an ongoing process throughout the program audit. First, initial data was collected and analyzed. Second, a thorough review of the PIHP's functions and processes occurred. Beacon also conducted multiple trips to Michigan to conduct interviews and attend meetings. Lastly, subsequent data was requested and reviewed after initial analysis and interviews occurred.

2. Risk Management Strategy Review: A review of LRE's risk management strategy was conducted to assess the risk reserve, LRE's financial estimation process, and review operational efficiencies. This included a comprehensive review of financial reports.

3. Review of Conflict of Interest Policies: A review of LRE's conflict of interest policies was conducted to understand current policies of the PIHP and review PIHP Board and executive functions. This included an in-depth analysis of existing PIHP Board functions and governance structures.

Reporting: Throughout the review of LRE operations, Beacon provided bi-weekly status reports to MDHHS. In addition, Beacon compiled this final written report documenting findings and recommendations, providing an in-depth overview of Beacon's review of LRE with regard to managed care functions, risk management strategy, and conflict of interest policy.

DATA ANALYSIS

A comprehensive list of relevant data needed for analysis was submitted to MDHHS and LRE. Data requested included existing policies, contracts, financial information, encounter data, and regulations.

Following the data request, MDHHS, LRE, and the five CMHSPs provided the information requested to the project team. Other relevant data was also collected through research and review of publicly-available information and media.

Appendix 1 lists all documents requested, collected, and reviewed.

INTERVIEWS

In-person meetings and interviews formed the foundation of the fact-finding initiative completed by Beacon's project team. Critical information was collected by conducting interviews and meetings with LRE leadership, CMHSP leadership, the LRE Board, providers, consumers, family members, advocates, and other stakeholders.

Multiple meetings were attended by Beacon, including:

- Board of Directors meeting (via telephone): September 17, 2015
- PIHP CEO and Board Chair Interviews: September 30, 2015 and October 1, 2015
- Interviews with all five CMHSP CEOs: September 30, 2015 and October 1, 2015
- Consumer Advisory Committee meeting (via telephone): October 8, 2015
- Board of Directors meeting: October 15, 2015
- PIHP CFO and COO interview: October 15, 2015
- Consumer Stakeholder Forum: October 19, 2015
- Provider Forums: October 19th and 20th, 2015
- Members of the LRE Board: October 20, 2015 and October, 22, 2015

Additional information relating to interviews and meetings is included in *Appendix 2*.

1. MANAGED CARE FUNCTIONS

Overall, Beacon found that the LRE does not consistently administer core managed care functions, and duplication of efforts between the PIHP and its CMHSPs create inefficiencies and inconsistencies across the Region. Beacon believes concerted efforts need to be focused on two primary areas: centralization of core managed care services and technical assistance to help guide the LRE's Board and the development of effective managed care practices.

This section outlines Beacon's review, findings, and recommendations relating to PIHP-required functions in 42 CFR Part 438, Sub Part D (Access, Structure and Operation, and Measurement and Improvement Standards) for efficiency and effectiveness. This report section is broken out into the following categories adapted from State of Michigan contract 391B5500009:

1.1 Direct-operated PIHP functions and functions delegated to CMHSPs (including review for efficient, effective, and consistent processes across the Region, between CMHSPs, and between CMHSPs and the PIHP)
1.2 Feedback from consumers, family members, providers, advocates, and other stakeholders, including views provided to the LRE through Board meeting public comments and other sources
1.3 Managed care function findings and recommendations

1.1 Direct-operated PIHP Functions and Functions Delegated to CMHSPs

REVIEW SUMMARY

Upon initial formation of the LRE, the shared goal of the partner CMHSPs was to limit the impact of the shift in regional composition by creating a small PIHP, referred to anecdotally by the CMHSPs as "skinny." This goal was realized through the PIHP managed care functions outlined in the narrative below.

Currently, there are no managed care functions provided exclusively by the PIHP. Each function performed by the PIHP is duplicated or supported at the individual CMHSP level. Additionally, no managed care function is completely standardized across all CMHSPs.

In our meetings with LRE and CMHSP leaders, there was recognition that centralization and standardization of managed care functions needed to occur; however, interviewees greatly differed in their opinions on which managed care functions should be provided by the PIHP and which should be maintained by the CMHSPs.

It is clear from the review of existing processes and discussions with PIHP and CMHSP leadership that there is a need to shift administrative functions from the individual CMHSPs to the PIHP to provide central managed care services on behalf of the Region as a whole. In practice, there are many parallel managed care functions operated by the legacy entities with no demonstrated effort to standardize approaches or increase efficiency. To effectively centralize managed care responsibilities and experience the benefits of a coordinated managed care program, a commitment will have to be made in growing the shared services capabilities of the PIHP with a focus on key functions such as complaints and grievances, claims payment, credentialing, provider contracting, UM, and data and quality management (QM). It is recommended that a single technology platform be implemented by the PIHP to manage the regional system of care efficiently, support managed care activities, and create a standardized reporting program, increasing transparency and improving monitoring of health systems impact/outcomes.

Managed Care Functions Duplicated by the PIHP and CMHSPs

Current managed care functions performed by the PIHP include Information Technology (IT), Finance, Customer Service, and Quality Analysis. Across the board, these functions are limited in scope and do not alleviate the need for each CMHSP to establish their own supplemental managed care functions, leading to a lack of uniformity across the CMHSPs/Region.

Information Technology (IT): The PIHP maintains a centralized database and employs one database administrator but currently has a vacant position for the Chief Information Officer (CIO). By failing to employ a CIO, LRE is out of compliance with their proposed organizational chart embedded within the Region Three 2013 Application for Participation. The PIHP has an IT coordinator and two IT support staff, all of whom support the LRE under a service agreement with a CMHSP.

Moreover, the PIHP does not have a Management Information System (MIS) able to perform managed care functions for the Region. Further challenging the program, the IT systems currently used across the CMHSPs are varied in their functionality, as they are mainly designed to be electronic medical records. Due to limited IT infrastructure, the Region does not have access to the data needed to complete managed care activities such as managing services appropriately, improving quality, projecting spending trends, or producing reports for stakeholders. Currently, State requirements do not mandate the usage of a centralized IT system; however, the State does have the ability to mandate how the information goes to the PIHP by setting requirements around timing, reporting, and formatting. The State could expand its mandates to ensure greater consistency and content, short of a centralized MIS, to improve reporting and ultimately outcomes.

Finance: As required by the current contractual arrangement between the MDHHS and LRE, the PIHP provides a centralized financial management function. The PIHP is currently meeting minimum financial management requirements, while all five CMHSPs maintain their own financial management operation. The lack of a central MIS inhibits LRE from tracking, analyzing, and trending service utilization to manage appropriately the regional service system.

Credentialing: Currently, credentialing is a primary function of the individual CMHSPs. There is some credentialing done at the PIHP level, such as background and license checks; however, credentialing services provided by the PIHP have not replaced ongoing credentialing operations within each CMHSP.

Customer Service: Minimal customer service functions are conducted at the PIHP level, and these functions do not alleviate the need for customer service at the CMHSPs. Each CMHSP conducts their own call center functions and Medicaid fair hearings, and there is little uniformity across the CMHSPs. The PIHP employs one half-time Customer Service staff member under a service agreement with a CMHSP.

Contracting: LRE contracts with each of the five CMHSPs, but CMHSPs are responsible for contracting their own service providers. As a result, many larger providers, such as HOPE Network and MOKA, hold contracts with multiple CMHSPs within the Region that pay different rates for the same level of service.

Quality Analysis: The PIHP is the lead entity performing quality analysis; however, the lack of a managed care MIS prevents LRE from collecting the data necessary to perform this function well. The PIHP has the ability to develop a corrective action plan if quality standards are not met by the CMHSPs. In addition to PIHP quality analysis functions, each CMHSP has their own quality metrics. LRE employs three QI full-time equivalent (FTE) staff members.

Managed Care Functions Provided by the CMHSPs

Claims Payment: Each CMHSP pays their own claims. Each quarter, the PIHP visits each CMHSP to validate the claims, using a Medicaid eligibility verification system. Due to the lack of a regional managed care MIS, there is no current way to track and analyze claims trends or compare them to service authorizations across the Region.

UM: Each CMHSP has its own internal mechanisms to determine service need and authorization. There are no universal screenings, assessments, level of care criteria, or inter-rater reliability audits in use currently.

Grievance and Appeals: Grievances and appeals are handled case by case by each CMHSP. This structure is of significant concern, because there is potential for a conflict of interest, whether perceived or actual, in instances where the CMHSP provides the service and is also accountable to ensure the grievance and appeals process is communicated and policies and procedures are followed for the affected consumers and family members.

Lack of Uniformity and Centralization

Within the Region, there is little uniformity in the services provided across the different CMHSPs. For example, the lack of a regional UM Plan and Practice Guidelines means that each CMHSP conducts their own UM process and the array of available services varies by CMHSP. Additionally, there is not a consistent assessment of need process for consumers or service level criteria. Moreover, there are no standardized provider contracts or rates.

These issues were apparent in conversations with providers held on October 19–20, 2015. Many described issues with accurately addressing consumer needs as service availability varies by county. This leads to interruptions and adjustments in services for consumers and adds to the administrative burden placed on providers. It also creates confusion for consumers who should be able to access services seamlessly across the Region.

This lack of uniformity and centralization of services largely stems from the absence of buy-in to the regional model by the CMHSPs and the current structure of the Board.

Lack of Data to Drive Health Systems Improvement

Currently, each CMHSP has their own electronic medical record (EMR) system with the exception of West Michigan and HealthWest, which share a single integrated system. Per State reporting requirements, each CMHSP has common data sets that are sent to the PIHP, aggregated by the PIHP, and passed on to the State.

The PIHP maintains a minimal centralized database and employs a database administrator, but does not currently have a Chief Operating Officer (COO). One FTE from West Michigan was shifted to LRE to aid in data systems management. LRE also contracts with TBD Solutions to provide data analysis services, including the completion of a 2015 comparative analysis of LRE's performance in comparison with other PIHPs in the State of Michigan.

The PIHP provides the Board of Directors with monthly "Bucket Reports," which show actual costs incurred compared to full year projections, which are broken out by CMHSP and funding source. Currently, there is a two- to three-month lag in reported data. For example, the October 2015 Board of Directors Meeting referenced a bucket report that was current through August 2015. Although the Fiscal Year 2014–15 budget for the period from October 2014 to September 2015 has been updated three times, full-year predictions do not appear to be updated throughout the year and spending does not appear to be capped at projected

costs. In some cases, mid-year bucket reports show cost categories with spending that already exceeds full-year projected costs. Bucket reports also show the current total reserve balance including Internal Service Fund (ISF) and Medicaid Savings as well as the projected remaining ISF at the end of the year.

There is no additional PIHP-level analysis of actual service utilization and eligibility data, both of which are essential components of cost prediction and critical to ensuring that appropriate services are provided as required by 42 CFR 438.206. Currently, the PIHP does not have timely access to critical information regarding CMHSP function, claiming, and spending.

Going forward, we recommend placing an emphasis on maintaining and sharing comprehensive real-time data to ensure that the PIHP has the information needed to manage the service system and ensure that services are appropriately provided to consumers.

There are many advantages to establishing more dynamic, all-inclusive data systems at the PIHP level, including an enhanced ability to understand trends and predict expenses. Historically, LRE has had difficulty predicting cost and revenue streams. To implement better budgeting processes going forward, there will need to be a uniform process for tracking and reporting data and sharing information from each CMHSP with the PIHP.

ADVANTAGES OF ENHANCED INTEGRATED DATA SYSTEMS

- ✓ Improved budgeting and predictability of expenses
- ✓ Ability to compare performance across CMHSPs
- ✓ Ability to identify relevant shifts in service array, eligible consumers, and expenses

1.2 Feedback from Consumers, Family Members, Providers, Advocates, and Other Stakeholders

REVIEW SUMMARY

Beacon participated in a number of sessions where feedback was collected from consumers, family members, providers, advocates, and other stakeholders. Below are the major themes from these meetings:

Feedback Provided at September 17, 2015 Board of Directors Meeting

Beacon had an opportunity to participate by phone in the Board of Directors meeting held in Grand Rapids, Michigan on September 17, 2015. During this meeting, the Board of Directors welcomed public comment and five individuals shared their experiences with LRE and the affiliated CMHSPs. Overall, the public comment period was brief.

Stakeholders who provided testimony at the Board meeting included four dissatisfied parents who were eager to share their experiences in hopes of improving the overall PIHP function. Their concerns related to recent shifts in services, the cumbersome appeals process, and limitations on the duration of care plans.

In addition, a representative from the Hope Network expressed an array of concerns and topics including availability of services, PIHP funding, appropriate application of the person-centered planning process, and the Board's financial plan.

Feedback Provided at October 8, 2015 Consumer Advisory Committee Meeting

Beacon was invited to join in the second meeting of the newly formed Consumer Advisory Committee (CAC) held on October 8, 2015. The committee comprises consumers and advocates from each of the five CMHSPs. Beacon's Project Manager had an opportunity to raise some questions to the CAC members. Responses were inconsistent across CMHSPs, with few questions and concerns affecting stakeholders from all five CMHSPs. Below is a summary of responses provided:

- Consumers are often not provided access to services because they do not meet the minimum level of need required.
- Access centers that are required to provide follow-up information to consumers who are not determined to be eligible are not always effective.
- For some income levels, CMHSPs use general funds to cover required spend down on behalf of consumers until they become eligible for Medicaid each month. In some instances, general fund limitations are resulting in the denial of services to some medically-eligible individuals.
- There are some instances where services outlined in a person-centered plan are not received because there is a shortage in available funding.
- Many consumers do not understand their rights and are not familiar with all services available to them.
- Currently, there is no process for sharing CAC concerns and information with the PIHP Board of Directors.

Feedback Provided at October 15, 2015 Board of Directors Meeting

Beacon had the opportunity to attend in person the Board of Directors meeting held in Muskegon, Michigan on October 15, 2015. During this meeting, a CEO report was given by the Interim CEO, Jeff Brown. The report included updates on the LRE moving forward with Board development, including Board member self-assessment, education, and role definition. In addition, the report included updates on starting to move some management functions to the LRE, including grievance and appeals, customer service, and autism authorizations.

The report also included updates regarding the LRE Board governance policies. LRE is working to develop Board governance policies and procedures using the Commission on Accreditation of Rehabilitation Facilities (CARF) framework, and a workgroup has been formed to review the LRE Bylaw and Operating Agreement to resolve any inconsistencies and ensure the operational integrity of the PIHP. Each CMHSP will have an opportunity to approve any revisions.

Feedback Provided at October 19, 2015 Consumer Stakeholder Forum

Beacon hosted a Consumer Stakeholder Forum on October 19, 2015. Beacon's Project Manager had an opportunity to raise some questions relating to access, wait time, satisfaction, and engagement in treatment. Below is a summary of concerns expressed by consumers, family members, and advocates from each of the five CMHSPs:

- Across all CMHSPs, access to developmental disability services including vocational services, community living services (CLS), and life skills, were significantly decreased with minimal explanation and notice during the last six months.
- Assessments that take place are not holistic and do not take into account all of the individual's needs.
- The grievance and appeals process is time consuming, expensive, and often unsuccessful for consumers. There appears to be a lack of clear information given to consumers to aid in this

process (e.g., Notices of Action are vague and/or missing information). Stakeholders believe that they are at a disadvantage, especially when CMHSPs bring legal representation.

- Budgeting takes place prior to the development of person-centered planning, which results in service allocation based on funding instead of need. There appears to be a clear conflict of interest with the Supports Coordinators placed in the role of authorizing these services while they are aware of, and need to manage budgetary shortfalls.
- There are minimal opportunities for consumers to share their testimony with LRE representatives. Public comment periods during Board meetings are capped at two minutes of information relevant to agenda items. Stakeholders feel that there is a lack of transparency within the system.
- Many consumers do not understand their rights and are not familiar with all services available to them, which was emphasized at both the CAC meeting and the stakeholder forum.
- Budget cuts have affected consumer services despite the Impact Study results shared at the October LRE Board meeting.
- Service level thresholds have been modified based on adjustments to the "medical need" scoring level. Stakeholders feel that needs have not changed, but now family members are being assessed as having lower needs based on changes in the scoring process embedded within the assessment. Changes to the scoring system are not communicated, and the process is not transparent.
- There is a lack of benefit consistency across CMHSPs.

Feedback Provided at Provider Meetings held on October 19 and October 20, 2015

Beacon met with a range of providers under contract with one or more CMHSPs within the Lakeshore Region. First, Beacon met with Hope Network to gain the unique perspective of a large provider with experience collaborating with many CMHSPs across the State. Next, Beacon hosted two provider forums that were attended by 23 representatives of provider agencies. Providers in attendance represented wide-ranging entities spanning the entire Lakeshore Region. The team heard from providers of skill building, community living supports, substance use and mental health services, day and residential services, psychiatric hospital facilities, home-based services, and outpatient treatment. The following bullets summarize some of the comments shared by the providers in attendance:

- There are limited opportunities for provider input. Providers have requested to be more formally involved at the Board level of the LRE and with strategic planning for the Region. They hope that the Board committee structure will expand to enable providers and consumers to share their experiences and suggestions through a formalized process.
- There is limited guidance provided to providers in a timely fashion. Providers request that advance notice be given to them on changes that affect their services and consumers. Currently, changes seems to be made unilaterally and implemented without any notification to providers. Recently, these changes have significantly affected services to consumers in some counties.
- Providers are looking to the LRE for more support. Specifically, attendees at each provider forum expressed an interest in a unified education and training plan. Clinicians who fulfil separate training requirements across the Region would benefit from consolidated training requirements and training opportunities organized by the PIHP.
- Managed care processes are not centralized within the Region. Most providers reported having multiple contracts and rates as well as sending separate bills to each CMHSP. Providers indicated that they have not seen any efficiencies following the formation of the LRE. The inconsistency in UM and eligibility processes places a burden on providers to ensure continuity of services.

- Service availability varies from one county to the next within the Region. Upon receiving a call from a potential consumer, providers that span multiple counties must first determine the county of residence of the caller before they can make determinations relating to service provision.
- Recently services have been reduced as a result of fiscal problems. Budget cuts have resulted in a disruptive process for consumers and providers. In some cases, providers are funding services out of pocket to alleviate the impact on consumers. There is still a trend toward consumers receiving a reduction in services, despite having no other changes in need. In many instances, the scale on the assessment form has been shifted to make consumers appear "more well." Providers believe that there is a lack of understanding of the value of community living supports (CLS) services and vocational services.
- Providers specifically mentioned the CLS worksheet that was implemented across the LRE (prior to the cease and desist issued by the State) as an instrument used to cut services and minimize cost. Providers described the tool as "a thinly veiled way to reduce services." They also reported instances where low-, medium-, and high-need consumers were adjusted down because of the formulas within the tool.

1.3 Managed Care Functions Findings and Recommendations

FINDINGS

Findings of Beacon's managed care functions review are as follows:

1. Lack of Managed Care Expertise

There is a lack of managed care experience at the Board and leadership levels of the LRE. This lack of knowledge translates into issues with governance structures and policies, operating procedures, administrative structure, and staffing. Many interviewees admitted to needing education on managed care practices and stated that training and technical assistance would be welcome.

Examples of this finding include:

- **The Absence of Management Reports:** There are no reports on routine managed-care functions, such as call statistics, authorizations, productivity, and claims. Thus, systems operations cannot be viewed as a whole and potential need for change is not data informed.
- **Lack of Consistent Policies and Procedures:** One clear example is the absence of a clear UM Plan, which would include UM guidelines, medical necessity criteria, clinical practice guidelines/level of care criteria, and staffing.
- **The Budget Shortfall Driving Change:** Implementation of the skill-building worksheet was seen largely as a way to decrease services in an effort to save money. This reactionary measure appears to be an overcorrection based on the lack of information needed to manage the service system within the allocated budget along with the lack of uniform policies and procedures.

2. No Centralization of Managed Care Functions or Management Information System

By not centralizing key managed care functions and information technology at the regional level, there is no uniformity across the Region, and duplication of functions is leading to budgetary issues as well as creating provider and consumer frustration. Moreover, this decentralization means that there are no regional policies and procedures, creating inconsistency across the service system, an inability to manage the system, and a lack of accountability and transparency.

3. Lack of Shared Vision, Values, and Goals

There is an observed lack of buy-in of the regional model from CMHSPs. At the governance level and throughout the PIHP operations, there are apparent conflicts of interest and competing priorities amongst the LRE and CMHSPs.

4. Flawed Historical Funding Formula

By implementing the PIHP using the historical funding formulas paid to the CMHSPs, the ability of consumers to receive the right service, in the right amount, at the right time, has been greatly affected. This further enhances the disparate nature of the service system, compounded by the lack of centralized management.

5. Services to Consumers have been Affected

Administrative strain on the system has led to cuts in consumer services instead of a re-evaluation of management practices and re-investment in needed services. Consumers are confused about their benefit packages and frustrated with grievance and appeal processes.

6. Providers Feel Significant Administrative Burden

With no uniform processes such as contracting, rate development, and UM, providers are using significant staff time to complete administrative tasks. Providers communicate that administrative inconsistency and inefficiency could be reinvested into providing services to consumers.

7. Supports Coordinators Providing Authorizations

There appears to be a clear conflict of interest with the Supports Coordinators placed in the role of authorizing services and managing budgetary shortfalls within this process. This does not adhere to the policy of conflict-free case management.

RECOMMENDATIONS

1. Centralize all managed care functions of the PIHP at the Regional Level

The LRE must centralize core managed care functions to achieve efficiencies and ensure the effectiveness of the PIHP. By centralizing managed care functions, as opposed to allowing each CMHSP to provide individual administrative services, the PIHP will gain consistency across the Region, significantly improve operational efficiencies, decrease consumer and stakeholder dissatisfaction and improve transparency and outcomes. There will need to be an up-front investment in the PIHP to develop and support a team with appropriate training, institutional knowledge, and experience to take on additional managed care functions assigned to the PIHP. It may also be beneficial to introduce outside support and technical assistance to help with the transition period. The initial objectives of the PIHP should be:

- Education on managed care principles to CMHSP partners, Board members and stakeholders
- Adopting a new governance structure, including advisory committees that include consumer, family members, community stakeholders, and providers
- Developing shared vision, values, and goals

- Developing and disseminating regional policies and procedures across all managed care functions (i.e., UM, QM, provider credentialing, contracting and training)
- Purchasing or creating a managed care technology platform to support and inform PIHP functions

Efficiencies can be created and economies of scale can be realized through the strengthening of PIHP operations. By integrating managed care operations across the Region, LRE can minimize the need to train staff on multiple unique processes, ensure Region-wide uniformity and reduce administrative spending. For example, developing policies and procedures that provide clear medical necessity, level of care guidelines, and a UM program would create uniformity within the Region.

Throughout the centralization process, it is expected that administrative funding will need to shift from the CMHSPs to the PIHP. Expanding PIHP operations and developing technology infrastructure will require an up-front investment, and the PIHP will need to recruit and train additional staff to support the enhanced managed care functions that are shifted to LRE. Additionally, as functions provided by the PIHP increase, there should be a corresponding reduction in the administrative cost incurred by each individual provider partner.

The end result of a shift to regional managed care oversight will include increased transparency and accountability, improved clarity on PIHP, CMHSP, and provider roles and responsibilities, better consumer access and outcomes, increased stakeholder satisfaction, effective management of regional resources, and ultimately, a reduction and/or appropriate reallocation of service costs based on consumer needs.

2. Provide needed technical assistance to the LRE Administration and Board

The LRE's administration and Board of Directors is in need of technical assistance and training in core managed care functions, implementing a managed service system, and creating a more effective governance structure. Providing assistance would lead to better organization and communication within the PIHP and greater understanding of managed care principles and operations, as well as creating transparency throughout the Region.

3. Improve Communication and Stakeholder Involvement

Stakeholder buy-in, in the form of meaningful input and feedback, is crucial for the LRE. Managed care is a partnership between the managing entity and its consumers, providers, family members, and other stakeholders. Regular communication and feedback loops allows a dialogue to ensure that high quality care is provided to consumers. This communication also creates a partnership that is necessary for change to take place within the LRE. Communication would create transparency within the system, which would lead to better accountability between the LRE, the CMHSPs, providers, consumers, family members, and other stakeholders. Please also see recommendations related to formal governance structures in *Section 3, Conflict of Interest Policy.*

4. Audits of CMHSP Processes and Services Should Occur

Due to consumer and family member complaints about CMHSP assessment and authorization processes, we are concerned that some consumers are not receiving the right services, at the right time, in the right duration. Based on feedback, it appears in some instances that service decisions are being driven by budgetary factors instead of consumer need. Modifications to processes were made without notification to consumers and their families, which affected their services. When auditing, LRE should focus on modifications made to assessment scales, delivery of conflict-free case management, and any information that indicates services were based on budgetary concerns.

2. RISK MANAGEMENT STRATEGY

The report sections below outline Beacon's review, findings and recommendations on PIHP financial management and risk management strategies broken out into the following categories adapted from State of Michigan, Contract 391B5500009:

2.1 Risk Reserves Balance and Operational Issues
2.2 Risk Management Strategy Findings and Recommendations
2.3 Examples from a Proven Behavioral Health Care Risk Management Strategy

2.1 Risk Reserves Balance and Operational Issues

REVIEW SUMMARY

Based on a review of LRE financial documentation and meetings with LRE administrators and Board members, it is evident that LRE has no established policies governing the funding or disbursement of the risk reserve balance. It also has no system in place to accurately project expenditures and routinely monitor trends. Without a centralized managed care management information system (MIS), LRE currently relies on fiscal reporting from each CMHSP. Through interviews with CMHSP CEOs, it is also noted that the level of financial accounting sophistication varies by CMHSP partner. Service budgets are largely tracked by paid claims; however, there is no method to review authorizations trends, authorization to claims ratios, or other claims related lags at the regional level.

Internal Service Fund (ISF)

Under current processes in FY2015, the Internal Service Fund (ISF) was used to supplement overspending of budgeted funds. Upon formation of the PIHP, the ISF included contributions from all five provider partners. Although the PIHP operated at a deficit in both FY2014 and FY2015, LRE was able to apply surplus funds from FY2013 to avoid the use of ISF funds for FY2014. Going into FY2015, there were no prior year surplus funds to offset spending and ISF dollars were applied to neutralize overspending in FY2015.

The total entity ISF started at approximately $14 million and has decreased to approximately $7 million. This is a critical component of the risk reserve, which is necessary to ensure the financial sustainability of the PIHP. In the past, depletion of ISF has been approved by the PIHP to plug deficits. Consequently, the ISF balance at the beginning of FY2016 has decreased significantly from FY2014 and FY2015 levels.

If the PIHP continues to spend down their ISF funding, the PIHP will no longer have an adequate reserve balance with which to manage risk, prepare for unexpected circumstances, and ensure the financial continuation of the entity. Identifying operational efficiencies is crucial to enable the PIHP to sustain ISF dollars and continue to support CMHSPs in the provision of critical mental health services.

CMHSP Funding Formula

For two years following the formation of the LRE, the allocation of funding to each CMHSP was based on a three-year rolling average of historical spending. Effective October 1, 2015, a new methodology was introduced based on the State's per-member per-month (PMPM) payment. The updated methodology will be phased in over a period of several years. Ottawa and West Michigan CMHSPs each stand to lose more than $1 million in funding under the updated methodology.

By adopting a funding model based on historical cost, LRE's costs were skewed toward CMHSPs that spent more per member historically and had a negative impact on those that were more fiscally conservative. Moving to a service-based payment methodology will reward financial responsibility and encourage additional operational efficiencies. This will be particularly true for Ottawa and West Michigan CMHSPs, each of which are expected to experience the largest decreases in funding under the updated funding formula.

We have identified multiple PIHPs with a structure of CMHSPs that is comparable to Lakeshore. These include Midstate and Northern Michigan. Similar to LRE, Midstate was created through the consolidation of many CMHSPs and PIHPs. Additionally, Midstate initially offered limited centralized managed care functions and has built administrative capacity slowly over time. Northern Michigan consolidated a handful of CMHSPs and has struggled with centralizing services and reducing local control.

In spite of these challenges, Midstate and Northern Michigan PIHPs have not faced the same financial difficulties that LRE has encountered. One possible explanation is the difference in funding structure upon initial formation. Unlike LRE, Midstate and Northern Michigan chose not to factor historical funding into the formula for allocating funds to provider partners. Consequently, provider partners that had been higher spenders in the past were forced to tighten their belts and operate within new financial constraints.

No Centralization of Managed Care Functions

As discussed above in *Section 1, Managed Care Functions,* there is currently no centralization of managed care functions at the LRE, leading to a lack of standardization of policies, procedures, and service delivery across the Region. Efforts are duplicated by the CMHSPs, and providers feel burdened by all of the variances and administrative waste. In addition, the lack of a centralized managed care MIS inhibits the LRE from gathering and analyzing needed data to ensure appropriate spending and efficiency. Building centralized functionality and data collection will allow LRE to track and trend service utilization and expenditures; measure the impact of operational efficiencies; and make adjustments in real time to maximize the impact of services to consumers.

No Process to Share Savings

Even after the LRE is expanded to provide more centralized services, some of the responsibility for prudent fiscal management will remain with the CMHSPs. One barrier to moving the existing system of care forward is a lack of a formalized process for sharing savings among all CMHSPs. By creating a standard methodology for ensuring that the savings of the PIHP are realized by the CMHSPs, LRE would be taking an important step toward aligning the interests of the PIHP and its provider partners. Furthermore, the development of a way in which PIHP savings can be reallocated back to the CMHSPs may help to incentivize CMHSPs to identify new operational efficiencies.

2.2 Risk Management Strategy Findings and Recommendations

FINDINGS

Findings of Beacon's Risk Management Strategy review are as follows:

1. LRE has a Flawed Business Model

LRE's risk management strategy should be focused on ensuring:

- There are effective ways to predict administrative and service expenses
- LRE has adequate capital available to deploy against those expenses
- There is a fair and equitable way of funding the capital reserves

Our review uncovered several deficiencies in the LRE's current business model related to these three focus points, which hinder its ability to effectively manage financial risk as a PIHP.

2. There are Historical Funding Formula Problems

Funding by historical allocation or conversion to a PMPM does not allow focus on traditional managed care principles of having the right services at the right time in the right duration.

3. Lack of Ability to Project Expenses

While reporting on authorizations and expenditures does occur at varied levels at the CMHSPs, the frequency and depth of the reporting is not standardized across the LRE. As a result, there is no comprehensive report at the LRE level that can track and predict service expenses to inform management decision-making and capital allocation. The absence of regular reporting that contemplates the entire LRE's business hampers the organization's ability to forecast upcoming expenses and take the necessary actions to ensure adequate funding is available.

Examples of management reports may include:

- **Paid claims triangles**: A report that details the date of service of a claim versus the date paid to measure claims lag
- **High utilizer reports:** Paid claims reports for the top tier of consumers (e.g., 10 percent) to track expenditures over time and review the impact of targeted care plans
- **Incurred but Not Reported (IBNR) estimates:** IBNR is an estimate of the liability for claim-generating events that have taken place but have not yet been reported to an insurer.[1] Insurers track IBNR by period and use it to determine levels of risk reserve funding. The characteristics of IBNR make it look more like a reserve or provision for the particular types of losses not reported; hence, it gives a better estimation of profits for the insurer's current business period.

[1] Glossary of Insurance and Risk Management Terms, International Risk Management Institute, Inc. Accessed at https://www.irmi.com/online/insurance-glossary/terms/i/incurred-but-not-reported-ibnr-losses.aspx

4. Lack of Standardized UM to Manage Medical Losses

The LRE's risk management strategy is lacking a comprehensive policy on UM that ensures that the right services are provided at the right time and for the right duration. Reporting on authorizations and expenditures allows visibility into potential losses; however, once a shortfall is identified, LRE management must have a way to understand and limit payments for care that is not medically necessary.

While each of the member organizations has clinicians that engage in UM, there is no standardized set of protocols to ensure that identical clinical criteria is applied in the same way across the LRE. Differences in UM policies and procedures make it difficult for LRE to understand and manage the drivers of medical costs.

5. No LRE Policies on Funding and Disbursement of Risk Reserves

As mentioned above, the initial funding of the ISF included contributions from all five provider partners. Since then, the ISF has been able to use surplus funds from prior years to cover deficits. That will likely not always be the case and LRE is not adequately prepared for that eventuality.

LRE's Board does not have a written procedure in place that governs:

- When member organizations will be required to contribute capital to the ISF
- What circumstances are required to draw down funds
- How to manage excess funds when applicable

In addition, the incentives for the member organizations are not necessarily aligned with those of the LRE. Member organizations that run a deficit and contribute disproportionally to any shortfall are not currently required to commit any more capital to the fund to cover their share of the losses. This creates a "free-rider" problem where there is no financial penalty to the member organization for failing to manage expenses well.

6. The MDHHS Contract with the PIHPs and CMS Waivers Limit the Manner in which PIHPs can Reinvest System Savings

There are currently no incentives for CMHSPs who perform well while realizing savings for the system.

RECOMMENDATIONS

1. Centralize PIHP functions at LRE and implement a managed care MIS to track and trend authorizations and claims payments across the Region

To support the centralization of PIHP functions as described in the previous section and to address reporting deficiencies detailed in this one, we recommend implementing a managed care management information system (MIS). This system would:

- **Create efficiency and allow administrative savings:** The LRE will be able to identify strengths and weaknesses due to the presence of claims and authorization reports, UM statistics, consumer services data, and other health systems information. Specifically, the tool will allow the:
    - Monthly projection of claims triangles at LRE level
    - Monthly projection of service expenses
    - Identification of outlier providers/consumers

- **Act as a communication and planning tool:** The availability of claims and authorization data can help the LRE to align its business processes according to the needs of its consumers and providers. The effective management of this data can help the LRE to plan ahead to mitigate financial risk due to medical losses.

Identifying these aspects will help the LRE improve its business processes and operations.

2. Work with the State to establish reserve balance target commensurate with risk and claims payments across the Region.

To provide guidelines to govern the funding of the risk reserves, we recommend working with the State and other stakeholders to establish a minimum reserve balance in line with industry standards to cover likely claims payments. Beacon suggests reserving a minimum of one month of medical expenses.

In addition, Beacon recommends implementing a defined process to fund reserve balance within 15 days in the event the balance falls below the target. This process will clearly delineate responsibilities for funding from each of the CMHSPs and codify the conditions for which it is allowable to use risk reserve funds. The process should be put before the Board of Directors for a vote and reviewed every 12 months to ensure continued relevance.

3. The State should consider revising the MDHHS contract with the PHIPs and CMS waivers so PIHPs are incentivized to create efficiencies within the system and allowed to reinvest regional savings with greater flexibility.

To align the incentives of all of the CMHSPs, the State should allow the PIHPs to reinvest savings from exceptional management of medical risk. The possibility of greater flexibility in the LRE's use of any revenues over expenditures will focus the organization on the effective management of claims and operating expenses. The State can implement protections to ensure financial fidelity and quality of care such as maintenance of effort requirements, risk corridors, as well as provisions for guaranteed access and services.

If the State were to consider this change, productive competition among the CMHSPs and PIHPs may result, which fosters innovation in care delivery and operational efficiency.

4. Provide needed technical assistance to the LRE Administration and Board.

The LRE's administration and Board of Directors would benefit from technical assistance and training related to their risk management strategy. By bringing in an expert in this area, LRE will gain knowledge and insight that can be implemented in a timely manner to improve the regional service system.

2.3 Example(s) from Proven Behavioral Health Care Risk Management Strategies

The challenges facing LRE can be surmounted with the commitment of time and resources to address the capability deficit at the core of its operational issues. However, this effort will not solve LRE's problems in the near term. In the list below, Beacon has described several models used across the country to implement effective, sustainable managed care structures that have been successful in similar circumstances:

1. **Carve-in to Physical Health Managed Care Organizations (MCOs):** The state hires the Medicaid MCO(s) currently managing physical health benefits to "carve-in" the behavioral health benefits for management through a capitated or an Administrative Services Only (ASO) funding arrangement. The benefits of this structure include simplification of administration at the state level by allowing the MCOs to handle the roles of building a network, paying providers, managing financial risk, and overseeing quality of care.

Case study – Iowa

- In summer of 2015, The Iowa Department of Human Services (DHS) announced the winning bidders for its Medicaid Modernization initiative, ending a 20-year relationship with the incumbent statewide behavioral health vendor.
- The RFP, titled the Iowa High Quality Health Care Initiative, requested bids from potential vendors as the State moves toward a risk-based managed care approach for Iowa's Medicaid program and eventually selected four winners for different regions throughout the State.
- Goals of the initiative are to:
    - Improve quality and access
    - Promote accountability for outcomes
    - Create a more predictable and sustainable Medicaid budget

2. **Regional Managed Behavioral Health Care Partnership:** In this structure, specialty Managed Behavioral Health Organization (MBHOs) and consortia of community mental health agencies form partnerships, with each organization having equity in the entity. Having equity gives parties a powerful incentive to work together clinically and operationally to manage the population in the most effective way. An integral part to the success of this model is to have a defined operating agreement that details decision-making authority at the CEO and Board of Directors level. This structure gives the MBHO the responsibility and authority to influence the legacy organization and make organizational changes, leveraging its expertise.

Case study – Colorado

- The community behavioral health services program provides comprehensive statewide mental health and substance use disorder services to all Colorado Medicaid members.
- Colorado Medicaid members are assigned to a Behavioral Health Organization (BHO) based on residence. BHOs arrange for medically necessary behavioral health services, like therapy or medications.
- BHOs are partnerships between the county entities and Behavioral Health Organizations (BHOs).
- There are five BHOs throughout the State:
    - Colorado Access – Northeast
    - Behavioral Healthcare, Inc.
    - Colorado Health Partnership
    - Foothills Behavioral Health Partners
    - Colorado Access – Denver

3. **County-based Managed Care[2]:** In this structure, counties within the state band together to form organizations that contract with MBHOs to bring management principles and expertise to bear. The MBHOs help bridge conflicting situations among counties, such as standardizing rates paid to providers, implementing standardized UM, credentialing, and network programs. The counties retain direct administration of social services beyond behavioral health and oversee the MBHOs' management of behavioral health benefits.

Case study – Pennsylvania

- Pennsylvania introduced HealthChoices in 1997, a risk-based managed care program.
- The goals of the HealthChoices program are to:
  - Improve access to health care services for recipients
  - Improve the quality of care available to recipients
  - Stabilize Pennsylvania's spending
- The State's Office of Mental Health and Substance Abuse Services oversees the behavioral health (BH) component of the HealthChoices program, and services are provided by behavioral health plans under contract with each county or group of counties.
- Five MBHOs were chosen including Community Care Behavioral Health (38 counties), Community Behavioral Health (one county), Magellan Behavioral Health (13 counties), PerformCare (nine counties) and Value Behavioral Health of Pennsylvania (13 counties).

[2] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/pennsylvania-mcp.pdf

4. **Interim Managed Care:** In this structure, the MCO is hired by the state and assumes active management of the organization, filling leadership positions as well as seats on the Board of Directors. The MCO is sometimes hired for a specific focus, such as setting rates, implementing core managed care principles, or alternative payment structures. In other instances, the MCO is hired to stabilize the organization after financial difficulties or a vacancy in leadership, assuming day-to-day responsibilities while permanent managers are hired.

Case study – Managed care plan based in New Jersey

- A physical health plan hired an MBHO to assume a risk relationship to manage the majority of its behavioral health benefits in 2012.
- The MBHO implemented behavioral health services within the core health plan IT environment and other systems.
- The MBHO negotiated all provider contracts with the health plan as primary contractor.
- Behavioral health management services are co-located with the physical health operations.
- Under terms of the contract, once the behavioral health services are stabilized, the health plan has the option at various points to bring components of behavioral health management back under its direct management.

5. **Long-term Technical Assistance Contract:** The MBHO is hired as a contractor to work alongside state employees to provide expertise to address clinical and operational issues. MBHO staff provide training to build capabilities, then disengage when the entity is capable of running managed care operations without assistance.

Case study – Kansas Health Solutions

- In 2010, at the direction of the State, a consortium of risk-bearing community mental health centers (CMHCs) administering the Kansas Health Solutions program contracted with an MBHO to provide interim leadership services
- On behalf of Kansas Health Solutions, the MBHO developed and executed an action plan with the division of insurance to allow the company to stabilize and come into compliance with equity reserve requirements as promulgated by the Division of Insurance.
- In addition, the MBHO:
    - Appointed a CEO and CFO to provide Board leadership and stabilization
    - Renegotiated with the provider network using alternative payment method and value-based purchasing principles
    - Developed and implemented a financial control system to address instances of fraud within the program

6. **Carve-out to Specialty MBHO[3]:** In this model, the state hires a specialty MBHO to manage BH claims through a capitated or ASO funding arrangement. The carve-out simplifies administration at the state level and allows an MBHO with specific expertise to manage risk and authorize care for high-need populations. Contracting across the state, or for a sizeable portion of it, captures economies of scale and fosters standardization by allowing the MBHO to leverage its employees' capacity. In addition, this structure allows the state to organize around behavioral health, centralizing management of BH benefits that are often fragmented across many state agencies.

Case study – Louisiana Behavioral Health Partnership

- The Louisiana Behavioral Health Partnership (LBHP) is the system of care for Medicaid and non-Medicaid adults and children who require specialized behavioral health services
- The LBHP includes participation of a private MBHO, OBH, Medicaid, Office of Juvenile Justice (OJJ), Department of Children and Family Services (DCFS), and Department of Education (DOE), who together form the Partnership.
- The LBHP is designed to serve the needs of individuals who comprise one of the following target populations:
  - Children with extensive behavioral health needs either in or at-risk of out-of-home placement
  - Medicaid-eligible children with medically necessary behavioral health needs who need coordinated care
  - Adults with severe mental illness and/or addictive disorders who are Medicaid eligible
  - Non-Medicaid children and adults who have severe mental illness and/or addictive disorders
- Through better coordination of services, the Louisiana Behavioral Health Partnership was designed with the following goals in mind:
  - Enhance the consumer experience
  - Increase access to a more complete and effective array of behavioral health services and supports
  - Improve quality of care and outcomes
  - Reduce repeat ER visits, hospitalizations, out-of-home placements and institutionalizations
- In 2015, Louisiana decided to transfer the BH benefits into Bayou Health, the State's physical health managed care program.

[3] http://www.magellanoflouisiana.com/about-magellan-of-louisiana-la-en/louisiana-behavioral-health-partnership.aspx

7. **MBHO as Clinical Care Expert:** In this structure, the State or a physical health MCO engages an MBHO to address specific access and quality of care issues. The MBHO focuses on developing new programs, bringing rigor and standardization to foster medically necessary care and improve outcomes.

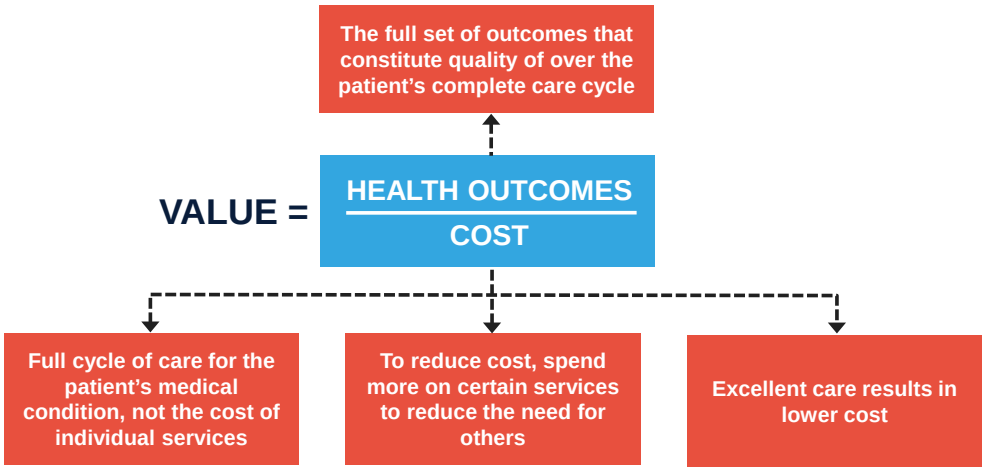
Case study – Minnesota MCO

- An MCO in Minnesota lost a sizeable portion of its membership and requested a re-evaluation of its partnership with its MBHO to form a new structure that aligns with its growth plan
- The new partnership structure was designed to:
  - Improve the clinical delivery model
  - Put capital against growth
  - Brings on another entity to offset risk.

Implementing Value-based Purchasing (VBP) with Key Providers

An important component of risk management in today's health care marketplace is value-based purchasing. Ensuring that individuals receive high-quality care at the right place, at the right time, is the goal of managed care. Below, Beacon provides a few examples of how the LRE can move towards these goals.

Value is defined as outcomes relative to the real costs it takes to deliver those outcomes. Outcome improvement without understanding the true cost of care is unsustainable and does not help effective allocation of limited resources. Cost reduction without regard to the outcomes achieved is dangerous and self-defeating. As illustrated in *Figure 4*, health care value is defined as a ratio of health outcomes to cost.



Source: Michael Porter & Elizabeth Teisberg, Redefining Health Care (2006)

Figure 4. Value-based Purchasing

There are currently no alternative payment plans, such as case rates, sub-capitation, or risk reward systems in place. The use of these payment systems can:

- Create expense certainty
- Align provider and medical expectations
- Allow providers to have more active participation in management of care
- Create better outcomes, as focus is on consumer need, not program volume
- Allow LRE to focus on identifying and instituting best practices across the CMHSPs

Medicaid managed care companies throughout the country are looking to move contracts with providers into value-based arrangements to address some of the inherent conflicts present in a fee-for service model, as depicted in *Table 2* below.

Table 2. Fee-for-Service Payment System vs. Value-based Purchasing Models, and the Value for LRE

	Fee for Service	Value-based Purchasing (VBP)	Value for LRE
Provider Incentive	• Number of procedures performed • Quantity over quality • Care delivered in silos	• Performing the right procedures • Quality over quantity • Incentives to collaborate	• Members will receive integrated care focused on improving their outcomes • Reduced waste as unnecessary care is avoided
Flexibility	• Payments only allowed for predetermined procedures	• Provider flexibility for how their time is spent and how funding is allocated (e.g., transportation as a covered service)	• No pre-authorization needed from clinicians
Financial Risk	• 100% of financial risk on payor	• Up to 100% risk sharing	• Predictable financial risk • Reduced volatility in medical expenses
Operational Costs	• Individual claims processing • Large clinical teams to manage utilization	• Simpler payment scheme • Reduced resources needed to support initial and concurrent reviews	• Reinvest cost savings from reduced administrative costs to improve care

3. CONFLICT OF INTEREST POLICY

Based on Beacon's review of PIHP governance and conflict of interest policies and practices, this report section is broken out into the following categories adapted from State of Michigan contract 391B5500009:

3.1 Review of PIHP Conflict of Interest Policy

3.2 PIHP Board and Executive Functions (Governance)

3.3 LRE Conflict Balance

3.4 LRE Governance Structure Findings and Recommendations

3.5 Examples from Proven Governance Structures

3.1 Review of PIHP Conflict of Interest Policy

REVIEW SUMMARY

Beacon completed a comprehensive review of LRE's current Conflict of Interest Policy to identify both appropriateness and areas of potential non-compliance. This review expanded beyond the formal Conflict of Interest policy to other relevant documentation including the Operating Agreement, Bylaws, and Mental Health Code.

Conflict of Interest Policy

The current conflict of interest policy of the LRE provides direction for any individual, voting or non-voting, to identify and report any direct or indirect financial interest or potential or actual conflict of interest. The policy allows the LRE to review all potential or actual conflict of interest and take action when necessary. The policy identifies who is applicable including:

- Members of the LRE's Board
- LRE officers
- Members of committees of the Board with delegated authority from the Board
- LRE employees, independent contractors, or agents who are responsible for the expenditure of Federal or State government funds in excess of $100 on behalf of the LRE

LRE's 2015 Conflict of Interest policy also includes a detailed list of duties that are applicable to all individuals listed above. This includes acting in a reasonable and informed manner, performing his or her duties for the LRE in good faith, and acting in the best interest of the LRE.

In addition, the policy includes a set of procedures and records of proceedings to which the Board must adhere. The Board requires that all individuals submit a disclosure of financial interests, and all forms submitted may be up for Board discussion. The Board may also appoint a disinterested individual to conduct an external investigation on a conflict of interest, if deemed necessary. The Board will then take a vote to determine if the financial interest is substantial enough to affect the integrity of the services that the individual would be providing.

The LRE's current conflict of interest policy allows the Board to grant conflict of interest waivers. The State of Michigan has developed the following waivers already supported by law:

- A CMHSP Board member may be a party to a contract with a CMHSP, administer, or financially benefit from that contract, if the contract is between the CMHSP and the LRE.
- A CMHSP Board member may also be a member of the LRE Board, even if the LRE has a contract with the CMHSP.
- A CMHSP Board may approve a contract with the LRE, if a CMHSP Board member is also an employee or independent contractor of the LRE.
- CMHSP public officers (e.g., Board members, officers, executives and employees) may also be Board members, officers, executives and employees of the LRE, even if the LRE contracts with the CMHSP.

However, as LRE's Board comprises two Board members from each CMHSP, there is an inherent conflict of interest on the LRE Board. Board members struggle to understand their role on the LRE Board, and many wear their CMHSP "hat" during meetings. It appears to be hard for Board members to make decisions based on what is good for the LRE, instead of choosing what is good for each of their representative CMHSPs.

In addition, during the beginning of each Board meeting, members are asked to declare if they have a conflict of interest with anything on the agenda. Beacon was informed that no one ever declares a conflict, and during the meetings, there are no further discussions on perceived conflicts or member recusals from conflictual topics.

LRE's Conflict of Interest policy does not address the above issues in a clear manner, so there is a need to revisit the policy to make improvements to ensure the success of the LRE.

Operating Agreement of LRE

LRE's operating agreement sets forth the Region's vision and values, financial structure, governance, management, and operations. The operating agreement emphasizes that the formation of the LRE would create benefits to consumers served within the Region. This includes a "No Wrong Door" policy, which states that a person can be evaluated for eligibility and receive services anywhere within the Region, regardless of local county differences in member structure. In addition, other benefits include having a uniform benefit with consistent eligibility criteria, regional implementation of person centered planning processes, increased choice of services and providers anywhere within the Region, increased advocacy, integrated behavioral health services, and an emphasis on prevention, wellness, and overall health.

The operating agreement also describes how the LRE will adopt one equitable funding methodology across the Region based upon the needs of the individuals living in the Region. It also emphasizes that members of the Region (the CMHSPs) should share their strengths with the Region as a whole.

Based on feedback Beacon has received from consumers, family members, providers, advocates, and other stakeholders, LRE is not adhering to the terms within its Operating Agreement. Examples include, but are not limited to the following:

- Benefits are not uniform across CMHSPs
- Eligibility criteria differs across CMHSPs
- Choice of services is being severely limited by recent budget cuts

Bylaws of the LRE

The bylaws set forth detailed policies on the purposes and the powers of the LRE and its member CMHSPs. The bylaws include a conflict of interest clause that states that the LRE Board must adopt a conflict of interest policy and must require the disclosure of the Executive Board Chair and any committee chairperson's actual or possible conflict of interests. In addition, the Executive Board Directors must ensure that disclosures are written into the minutes of the LRE Board meeting or committee meeting so that adequate reporting and discussion occurs.

The bylaws also detail information on members, the Executive Board, voting rights, Board term, and Board subcommittee structure. In Beacon's review, there are many issues noted within the current LRE Bylaws, such as the limited composition of the Executive Board, lack of term limits, and inadequate subcommittee structure. More information on this topic is detailed below.

3.2 PIHP Board and Executive Functions (Governance)

REVIEW SUMMARY

Board Structure

The LRE Operating Agreement states that each CMHSP will appoint an equal number of individuals to the LRE Board, which results in an equal share of the LRE. The structure was organized this way to balance the needs of each CMHSP within the Region. The LRE CEO is not part of the Board structure.

According to the LRE Bylaws, each CMHSP appoints two designees who are members of their respective CMHSP Boards. At any time, CMHSPs may appoint, remove, or replace an appointee to the LRE Board, but there is no term limit. The bylaws briefly mention that each Director of the LRE Board will hold office until the Director's death, resignation, removal by the CMHSP that appointed him or her, completion of the appointed term, or withdrawal of the appointing CMHSP. In addition, the LRE Board has additional requirements including:

- If the Entity is a Department-designated community mental health entity, as defined in Section 100a(22) of 2012 PA 500, the Executive Board shall also consist of representatives of mental health, developmental, or intellectual disabilities and substance use disorder services as required under 2012 PA 500.
- The Executive Board shall also include consumer representation.
- Directors may not hold staff positions with any of the CMHSPs.

The powers of LRE are provided in MCL 330.1204b(2) and include, but are not limited to:

- Entering into contracts with the State and CMHSPs
- Accepting funds, grants, gifts, or services from the Federal government, the State, and private or civic sources
- Creating a risk pool and taking actions necessary to reduce the risk

Within the LRE, there is an established Operations Committee and newly-formed regional operational advisory teams and Consumer Advisory Committee. The purpose of these groups is to serve as an advisory capacity to the CEO of the LRE. The Operations Committee is composed of the CEO of LRE and the CEOs/Executive Directors of the CMHSPs. Other staff from LRE or the CMHSPs may attend as requested, but only in a support capacity. The regional operational advisory teams consist of staff that already exist

within the CMHSPs. In addition, a Consumer Advisory Committee has recently been formed, but this committee does not have a formalized way to interact with the LRE Board.

The current composition of the LRE Board, Operations Committee, and regional operational advisory teams are not inclusive of anyone outside of the CMHSPs. Independent representation does not exist in any of these structures, despite stated interest by providers, consumers, and other stakeholders. In addition, within the current policies, the role of the LRE Board is not clearly defined.

Beacon has found that the LRE Board functions differently from common board structures seen elsewhere. Typically, boards will constitute committees that focus on specific areas of expertise, such as finance, operations, clinical guidelines, and other areas. Operating in smaller committees allows board members to accomplish more as committees report to the board with their findings and recommendations. This is not occurring at the LRE. The committee structure is not well organized, participation is unclear, and there are no clear reporting requirements back to the Board.

Voting Structure

According to the bylaws, the CMHSPs have specific voting rights when it comes to matters that require a vote. CMHSPs have one vote on the following matters and votes must be unanimous for a change to be made:

- The operating agreement, any amendments, and its termination
- Fix compensation of the Executive Board, if any
- A plan of merger or consolidation
- The termination of the LRE and distribution of assets and liabilities, if any
- The issuance of debt, which exceeds certain threshold amounts established by the members set forth in the Operating Agreement
- Secured borrowings and unsecured borrowings in excess of amounts established by the members, as set forth in the Operating Agreement
- The sale, transfer, or other disposition of substantially all the assets of the LRE
- The dissolution of the LRE

Other matters also require a two-thirds majority vote, including the removal of a CMHSP and participation of a new CMHSP.

The LRE Board also has its own specific voting rights. A majority of the LRE Board members constitutes a quorum for the transaction of any business at any meeting of the LRE Board. Actions voted on by a majority of the LRE Board, where a quorum is present, will constitute authorized actions.

After conducting interviews, the CEOs of the CMHSPs all had different accounts of what the voting requirements are, when a unanimous or two-thirds vote is needed, and where the voting policy is located. It should be noted that there are no voting policies in the operating agreement, only in the Bylaws.

3.3 LRE Conflict Balance

REVIEW SUMMARY

One of the challenges faced by the LRE is balancing conflicts that arise from CMHSP provider systems uniting to form a PIHP regional entity. More specifically, it is challenging to align the interests of the Board with the interests of the PIHP when every Board member represents a CMHSP. The operating agreement requires that each CMHSP appoint an equal number of representatives to the Board of Directors of the LRE, with the goal of ensuring that each CMHSP has an equal voice within the LRE. Currently, the Board is made up of two representatives from the Board of Directors of each CMHSP.

Although the current structure is successful in ensuring that all CMHSPs are represented, there are no assurances in place to guarantee that each Board member is able to evaluate the needs of the PIHP without maintaining any bias toward the CMHSP they also represent. Impartial representation does not currently exist on the Board from outside the CMHSP system, such as consumers, providers, and other stakeholders.

Although the current interim CEO has made progress toward moving the regional agenda forward, there is an opportunity for additional Board development and training to ensure a shared vision, value, and goals within the PIHP. There appears to be uncertainty about the responsibilities Board members share in assuring the success of the regional entity.

Given the widespread impact of shifts in PIHP function on CMHSPs, consumers, and contracted providers, it is critical that all stakeholders are able to share their concerns with the Board of Directors. To that end, a committee structure inclusive of clear reporting guidelines and advisory functions would improve transparency of Board functions, while minimizing conflicts of interest.

3.4 LRE Governance Structure Findings and Recommendations

FINDINGS

1. Governance and Conflict of Interest Policies are Insufficient

Written policies and procedures related to Governance and Conflict of Interest do not sufficiently define the roles and responsibilities of Board members, operating processes of the Board, and committee structures.

2. Current Board Composition Creates a Conflict of Interest

The current composition of the LRE Board creates an inherent conflict of interest. LRE Board members identify themselves as their representative CMHSP, and self-interest appears to trump the needs of the PIHP. Furthermore, no impartial representation currently exists on the Board.

3. Stakeholder Input is Severely Limited

There is no impartial representation on the LRE Board including consumers, family members, providers, advocates, or other stakeholders (who are not also a Board member of one of the CMHSPs). Consumers, family members, providers, advocates, and other stakeholders do not feel that the LRE Board is transparent in its operations and have not felt heard within the current Board operating process.

RECOMMENDATIONS

1. Complete a comprehensive review of existing Conflict of Interest Policies

The LRE should conduct a comprehensive legal review of the existing conflict of interest policies to identify gaps and areas of concern for amendment and increased transparency.

2. Update the Operating Agreement and Bylaws

The Operating Agreement and Bylaws should be updated to dictate a clear mission, vision, values, and goals of the PIHP. They should also be updated to increase transparency by:

- Reducing areas of noncompliance and contradictory language
- Including independent representation on the Board and committees
- Updating the Committee Structure to enhance their advisory role – each should be chaired by a Board member and have formal reporting back to the Board to inform decision making
- Detailing roles and responsibilities of Board members and establish and enforce term limits for Board membership

3. Clearly define CEO authority versus what decisions/actions require Board input

Beacon recommends that decision-making authority of the CEO be increased to streamline functioning of the PIHP, with Board input required only for decisions of significance. *Table 3* below details cases and examples of when to involve the Board:

Table 3. LRE Decision-making Authority Recommendations

Decision Authority	Uses	Examples
CEO only, no vote required	Everyday functioning of the LRE	• Hiring staff • Purchasing office supplies • Execute provider contracts • Contract negotiations with the State
Simple majority	Use for significant decisions	• Arrange for such personnel as may be necessary or convenient to carry out the business and affairs of the LRE, except the Chief Executive Officer • Establish such reasonable cash reserves to provide for anticipated expenses of the LRE as the Board determines to be necessary for timely payment of such expenses • Direct any other duly appointed officer of the LRE to make, execute, assign, acknowledge, and file on behalf of the LRE

Decision Authority	Uses	Examples
		any and all documents or instruments of any kind which the Board may deem necessary or appropriate in carrying out the business and affairs of the LRE, including, without limitation, powers of attorney, agreements of indemnification, documents, or instruments of any kind or character, and amendments thereto (and no person, firm or corporation dealing with the Board shall be required to determine or inquire into the authority or power of the Board to bind the LRE) • Approve any contract or revisions to any contracts between the LRE and the State • Establish committees and appoint members, as necessary, appoint representatives to other Boards and commissions and to implement required policies • Review and approve any required financial statements, except for audits • Review and approve clinical policies and procedures, committee minutes, clinical care guidelines, and similar policies • Review performance data and recommend appropriate corrective action, including recommending possible sanctions for review and approval
Unanimous vote	Use for major financial and operational decisions	• Approval of the annual operating budget • Incurrence of indebtedness, including granting of Guarantees in excess of $100,000) • Review and approval of any required audits • Approval of any sanctions against a member in accordance with the Performance Standards and Sanctions approved by the Board • Approval of expenditures of over $100,000 • Hiring or termination of the Chief Executive Officer and approval of performance reviews and compensation, as such may be recommended by the Board • Any reduction in the number of members in the LRE • Changes to the basis for distribution to member of any revenues • The addition of any new members • Changes to the voting rights, voting requirements or other ability to vote of any member or of the Board members • Amendments to the Performance Standards and Sanctions for non-performance policies adopted by the LRE • Changes to the procedures for appointing Board members • Entering into any business other than provision of mental health services pursuant to contracts with the State of Michigan

Decision Authority	Uses	Examples
		• Mergers, consolidations, sale of all or substantially all of the assets, conversions, liquidation (partial or complete) or dissolution of the LRE, or acquisition by another business (either by asset or stock or partnerships interest purchase) or any equity of another entity • Purchasing the interests of a member • Execution, termination, amendment or adoption of any material change to any delegated service agreement, provider agreement, subcapitation agreement, management agreement or administrative services agreement between the LRE and any member • Adoption of amendments to the Operating Agreement

4. Provide needed technical assistance to the LRE Administration and Board

The LRE's administration and Board of Directors is in need of technical assistance to create a more effective governance structure for the PIHP. As this will be the first step in transforming the regional system, it may be prudent to bring in outside impartial counsel (e.g., a consultant) in an effort to make changes in a timely manner.

3.5 Examples from Proven Governance Structures

Based on Beacon's experience, we offer the following proven governance structures, provided in *Table 4* below.

Table 4. Effective Governance Structures in Other State Medicaid Programs

State	Governance Structure
Connecticut	Managed behavioral health system overseen by a legislatively mandated "oversight" council consisting of legislators, consumers, providers, family members, advocates, and other stakeholders. Multiple committees chaired by Board members inform council decisions. The managed care entity and multiple State agencies participate on the council without voting rights.
Colorado	Managed care entity holds an equity position in the larger combined entity (inclusive of provider partners) that oversees provision of BH services. There is a defined operating agreement that details decision-making authority at the CEO and Board levels.
Pennsylvania	The counties entered into a partnership to participate in Health Choices, Pennsylvania's Medicaid program. Counties in turn hired managed care entities to bring management principles and expertise to bear. This entity helps bridge variances and other situations that arise between counties, such as provider rates and network participation.

State	Governance Structure
Kansas	Community Mental Health Centers (CMHCs) had significant Board conflicts. A managed care entity was hired to staff leadership positions on Board. Specific focus was on setting rates, implementing core managed care principles, and alternative payment structures. This moved the system into the black within three to six months. The managed care entity was given the authority and autonomy to make decisions on behalf of the CMHC system.

In *Figure 5* below, we also offer a recommended committee structure and reporting relationship that may benefit the PIHP.

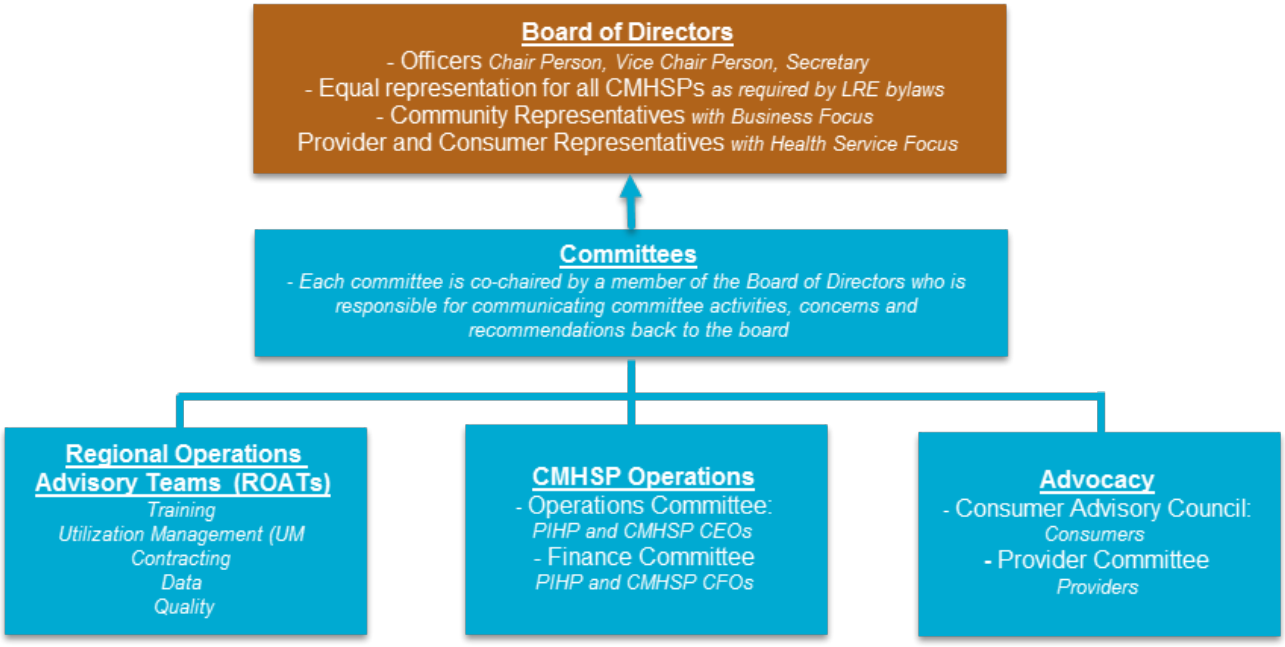


Figure 5. Recommended LRE PIHP Committee Structure

APPENDICES

Appendix 1: Chart of documents reviewed
Appendix 2: Comprehensive list of meetings attended and interviews conducted