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Center for Healthcare Integration & Innovation

Community Mental Health Association of Michigan

Foundational components of Michigan's public mental health system design

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Aim of paper

This paper is aimed at describing the core components of the Michigan's public mental health system's structure and operations – components found in advanced provider and managed care systems - and providing references to industry and academic literature that underscores the value of these components.

Background to structure of Michigan's Medicaid behavioral health system

Michigan moved to a managed care system, in 1997, with the state's Community Mental Health Services Programs (CMHSPs) and, over time, public Prepaid Inpatient Health Plans (PIHPs), formed and governed by the CMHSPs), taking on the role of the managed care organization for the state's Medicaid behavioral health benefit.

This managed care system has the characteristics of a number of advanced managed care and risk-sharing and risk management models. Because of this mix of these innovative characteristics, drawn from a number of models, all of the parties involved in operating the state's public mental health system (MDHHS, CMHSPs, PIHPs, and the providers in the CMHSP and PIHP networks) must have a working knowledge of the Michigan-model and what it offers relative to clinical/service delivery, fiscal, risk-management, and governance advantages.

Summary of foundational components in the structure and operation of Michigan's public mental health system

The Michigan system possesses the characteristics of the following managed care models:

1. Michigan's CMHSPs are **comprehensive specialty service networks**, providing a wide range of traditional and non-traditional services with **statutorily defined safety net responsibilities** borne by **no other health care providers nor payers** in the state.

2. Michigan's CMHSPs are funded by an **advanced/alternative payment method strongly promoted by CMS and other payers - sub-capitation payments**. which require **the assumption, by the CMHSPs of a range of managed care and risk management functions.**

3. Michigan's PIHPs are, in healthcare parlance, **public Provider-Sponsored Health Plans**, with the provider organizations sponsoring, forming, and governing those plans being the **public CMHSPs** in the region served by each PIHP (whether sponsored by one or more CMSHPs)

4. These CMHSPs **directly provide** some services (akin to a **staff-model HMO**) and **purchase** other services (akin to a **network-model HMO**).

The background to each of these four foundational components is provided below. The Medicaid waivers referenced in this document can be found at:

- Current waivers: https://www.michigan.gov/mdhhs/doing-business/providers/providers/medicaid/medicaid-waivers
- Foundational system design waivers: https://cmham.org/resources/important-information/

Discussion of each of these four foundational components

1. Michigan's CMHSPs are public comprehensive specialty service networks, providing a wide range of traditional and non-traditional services with provider, payer, and safety net responsibilities borne by no other health care providers nor payers in the state.

Foundation in state law: Michigan's CMHSPs are defined, in the Michigan Mental Health Code, as a county-based comprehensive specialty service provider and payer. This role is delineated in the Michigan Mental Health Code requirement (Code language provided below) that outlines the comprehensive service array that CMHSPs must provide **whether provided directly or via contract with another provider**.

> *Michigan Mental Health Code (PA 258 of 1974)*
> *330.1206 Community mental health services program; purpose; services.*
> *Sec. 206.*
>
> *(1) The purpose of a community mental health services program **shall be to provide a comprehensive array of mental health services** appropriate to conditions of individuals who are located within its geographic service area, regardless of an individual's ability to pay. The array of mental health services shall include, at a minimum, all of the following:*
> *(a) **Crisis stabilization and response including a 24-hour, 7-day per week, crisis emergency service** that is prepared to respond to persons experiencing acute emotional, behavioral, or social dysfunctions, and the provision of inpatient or other protective environment for treatment.*
> *(b) **Identification, assessment, and diagnosis** to determine the specific needs of the recipient and to develop an individual plan of services.*
> *(c) **Planning, linking, coordinating, follow-up, and monitoring** to assist the recipient in gaining access to services.*
> *(d) **Specialized mental health recipient training, treatment, and support**, including therapeutic clinical interactions, socialization and adaptive skill and coping skill training, health and rehabilitative services, and pre-vocational and vocational services.*
> *(e) Recipient rights services.*
> *(f) Mental health advocacy.*
> *(g) **Prevention activities** that serve to inform and educate with the intent of reducing the risk of severe recipient dysfunction.*
> *(h) **Any other service approved by the department**.*

Foundations in Michigan's Medicaid waivers: Since the 1998 implementation of the Michigan Medicaid Managed Specialty Supports and Services Program and subsequent federal waiver authorities, CMHSPs were designated as Comprehensive Specialty Services Networks (CSSNs) and are expected to create and maintain Provider Specialty Services Networks (PSSNs). This has been the state's expectations for all CMHSPs and is the very foundation for Michigan's unique managed care "carve-out" sole source contractual arrangement with the public community mental health system.

These roles are outlined in a number of foundational documents of Michigan's behavioral health Medicaid program, excerpts of which are provided below:

Michigan Department of Community Health; Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans; Final Version; September 2000

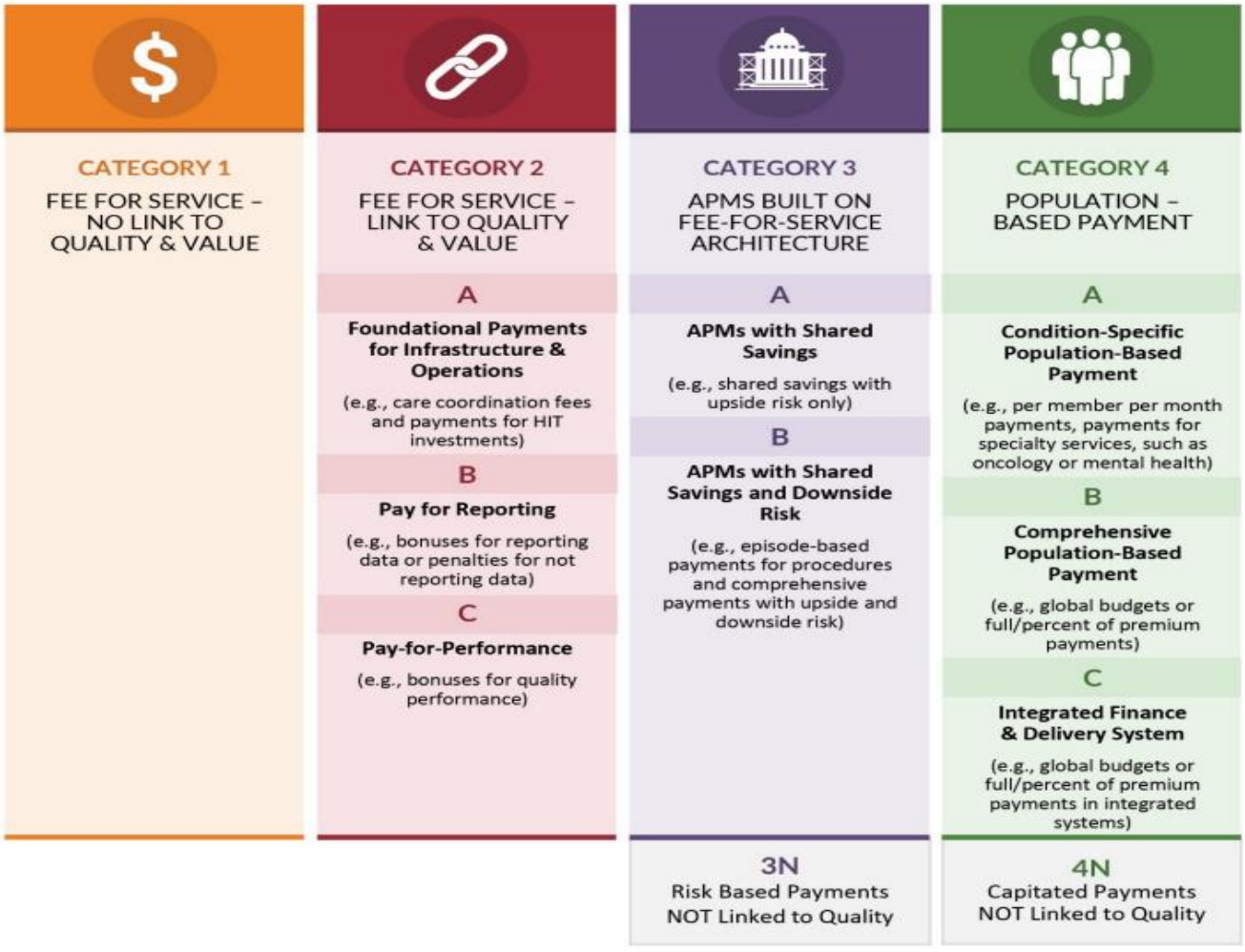
> *… CMHSPs in the affiliation would be eligible for a special provider designation – that of **"Comprehensive Specialty Service Network" (CSSN)** – that affords them special consideration in the provider network and qualifies them to receive a sub-capitation from the PIHP or hub-CMHSP.*

2. Michigan's CMHSPs are funded by an advanced/alternative payment method strongly promoted by CMS and other payers - sub-capitation payments. which require the assumption, by the CMHSPs of a range of managed care and risk management functions.

Michigan's CMHSPs receive their Medicaid funding via the most advanced payment methodology – capitation payments, whether they are CMHSPs who also serve as PIHPs or are CMHSPs who have formed Regional PIHPs. This payment method is outlined in one of an early Michigan Medicaid waiver and forms the foundation of the system's advanced payment system:

> *Michigan Department of Community Health; Specialty Pre-Paid Health Plan 2002 application for participation; January 2002*
>
> > *Sub-capitation: An applicant (PIHP)* ***may sub-capitate for shared risk with affiliates*** *or established risk-sharing entities.*

Capitated payments (population-based payments) to comprehensive provider organizations, such as Michigan's CMHSPs, is strongly encouraged by CMS and other payers, using the **well-recognized APM framework**, below, to underscore the dimensions of this payment approach. In this framework, Michigan's CMHSPs receive funding using the most advanced payment method, Category 4 (Population Based Payment) with quality incentive payments.



All of the work of the CMHSP in fulfilling this role, including staff credentialling, contract management, quality improvement, claims payment, customer services and recipient rights, is **related to the CMHSP role as a comprehensive services provider as it has been for decades long prior to the advent of managed care in Michigan's Medicaid program.**

Providers in these advance alternative payment methods (APMs), take on a number of clinical and fiscal functions that are core to their work as advanced APM providers. These functions include:

- Utilization management (including eligibility determination, level of care determination, authorization, Utilization review)
- Network management (including staff/provider credentialing, network development, contract management)
- Quality Improvement (including standard setting, performance assessment, corporate and regulatory compliance, evaluation, and provider training)
- Financial management (including claims payment, fiscal risk management, and organizational fiscal management)
- Customer services (including complaints, grievances and appeals)
- Information services (including data aggregation and reporting)

As with all MCO-to- provider relations, the **PIHP retains the responsibility for ensuring that these functions are carried out by the comprehensive service provider** – by the receipt of reports from the comprehensive advanced ABP provider, reviews of samples of work products and processes, audits, and the implementation of corrective action plans as needed.

These functions are those of a comprehensive APM-financed provider and not those of a managed care subcontractor. One of the clearest descriptions of the roles that sub-capitated comprehensive provider networks is provided by the United Hospital Fund in its report, "Capitation and the Evolving Roles of Providers and Payers in New York". The most relevant segments of the roles that provider organizations take on to fulfill their obligations under a sub-capitated payment arrangement are included in Appendix A.

3. Michigan's PIHPs are, in healthcare parlance, public Provider-Sponsored Health Plans, with the providers sponsoring, forming, and governing those plans being the public CMHSPs in the region served by each PIHP (whether sponsored by one or more CMSHPs)

In contrast to the traditional fee-for-service health insurance model, currently used to manage Michigan's Medicaid physical health care benefit, Michigan's Medicaid behavioral health care system is structured around provider sponsored plans. These plans, in federal terms, are public Prepaid Inpatient Health Plans (PIHPs) and the providers sponsoring them are the state's public Community Mental Health Services Programs.

In the traditional fee-for-service health insurance model, the private insurance company payer determines the kind of care and how much of that care providers are allowed to provide and the latter simply provides the care within the bounds set by this insurance payer. In this model, the private payer is incentivized to not approve/authorize care (allowing them to retain the savings as revenue) and the private provider is incentivized to provide high volumes of expensive care (allowing them to generate revenue). This model causes friction between payer and provider, often leaving the person served caught in the middle.

Provider-sponsored plans, in contrast, especially public/governmental provider-sponsored plans and their provider organization sponsors (again, in Michigan' bring together the obligation to and clinical knowledge needed for providing high quality care with the obligation for paying for it and for ensuring that the full

population for which the payer is funded has access to needed care. **The advantages of this model are even greater when the provider-sponsored plan and the providers who sponsor the plan are governmental bodies, such as in Michigan's Medicaid behavioral health system.**

The views of some of the leaders and observers of provider sponsored plans are helpful in obtaining a sense of the value of such plans:

J.P. Holland, President and CEO, Johns Hopkins Health Plan:

> *The provider-sponsored plan model encompasses the entirety of the continuum of care, from funding to health care delivery, connecting the patient, provider, and payer. This mutual interest enhances collaboration between clinical and management objectives and enables full accountability for patient-centric and effective managed care—across quality performance, patient experience, health outcomes, and cost. Aligned in this manner, PSPs possess greater insights over health outcomes and patient engagement. There are three distinct benefits of the provider-sponsored plan model:*
>
> ***1. Enhanced Patient Relationships:***
> *Members of a PSP are the same patients that health system clinicians see every day in their offices. This relationship facilitates trust and patient-centric care plan collaboration with members. Through affiliation with a local health system or provider organization, the PSP benefits from established familiarity and trust, which enhances members' adherence with care plans, improves self-care, and ultimately leads to better health outcomes. Additionally, patients are supported by a health care team, across provider and health plan resources.*
>
> ***2. More Integrated Approach:*** *PSPs are uniquely positioned with direct access to affiliated providers and improved access to unaffiliated providers. Using care coordination and care management strategies, PSPs are able to more nimbly assist with communication between primary care providers and specialists, to improve information sharing. Additionally, PSPs have access to claims and clinical data, allowing more sophisticated analytics and improved medical management, which is especially beneficial with high-risk, complex patients. This enhanced integration can* ***improve the quality of care*** *and reduce costs, while providing an optimal experience to members, providers, and care team members.*
>
> *With easy and reliable access to data, PSPs can innovate quickly. This approach derives strategic and operational insights from more sources than traditional insurers, including patient behaviors, patient preferences, and better clinical data. Leveraging these insights, plus the world-class research and discovery at Johns Hopkins Medicine, JHHC deploys improved interventions and new product designs with greater ease.*
>
> *Some of the most challenging patient populations to serve, including the elderly and low-income, can have their health care coordinated more successfully and efficiently by a PSP.*
>
> ***3. Inherent Value-Based Care:*** *he PSP model creates accountability that is better aligned to invest in preventive care and quality improvement for the patients being served. Bringing together payer and provider uncovers the* ***shared objectives within health care utilization****, striving to achieve the Triple Aim of improved population health, improved patient experience, and reduced cost. PSPs can overcome the sometimes divergent objectives of providers and payers, ensuring the right services are provided at the right time, right cost, and in the right setting.*

Health systems recognize that operating their own health plans gives more flexibility over health care management and coordination. This can catalyze innovation for population health-based care models and ensure effective resourcing and execution. (Drawn from The Value of Provider- Sponsored Health Plans)

Robert Gluckman, MD, Chief Medical Officers, Providence Health:

As a provider-sponsored plan, one of the key differentiators is that we are able to have a perspective that is aligned with the physicians (clinicians) who actually care for people on the front lines. It is just part of our DNA and how we think about how we care for people and how we think about how we partner with providers because that is a good chunk of who we are." To Gluckman, the dynamic between health system and health plan in a provider-sponsored health plan is particularly influential in the market segments where care management is so crucial to patient outcomes. He points out that persons who have challenges around maintaining activities of daily living or have a number of health issues greatly benefit from being enrolled in provider sponsored plans. (Drawn from The Role of Provider-Sponsored Health Plans in Value-Based Care .)

Joyjit Saha Choudhury and Ryan Gish with Kaufman Hall (Nationally recognized health care consultants)

"A core strength of provider-sponsored health plans (PSHP) is the alignment of financial incentives between plan and provider; that much is well understood.

Network design, member experience, and care management: Because many PSHPs mingle with the broader provider community, they have nuanced insights into other providers' care practices and their approaches to patient experience. PSHPs can use these insights to supplement standard provider performance profiles, inform their network design, and enhance their knowledge of referral patterns.

PSHP's member experience advantages extend to care management as well. As experienced PSHP leaders know, everyone benefits when care management is embedded in a physician's practice, not delivered by a disembodied voice on the phone.

With the health plan and the provider under the same ownership, PSHPs are equipped to design a highly streamlined approach to utilization management that focuses exclusively on select high-value areas, thereby expediting processing time. This approach can reduce operating costs and improve the experience during a potentially stressful time for members. **(Drawn from** The Next Act for Provider Sponsored Plans)

4. These CMHSPs directly provide some services (akin to a staff-model HMO) and purchase other services (akin to a network-model HMO).

The mix of provided and purchased services, to serve the behavioral health needs of Michiganders provides the state's CMHSPs with a comprehensive, diverse, yet highly organized care network. Michigan's CMHSPs use a mixed Health Maintenance Organization (HMO) model, applying both network and staff model HMO structures:

- *Network model HMO—An HMO that contracts with multiple provider organizations to provide services to HMO members.*
- *Staff model HMO—A closed-panel HMO – made up of a providers who are employees of the HMOs*

(Drawn from Centers For Disease Control and Prevention; National Center for Health Statistics; Health Maintenance Organizations)

Appendix A

Excerpts from:

United Hospital Fund report: Capitation and the Evolving Roles of Providers and Payers in New York [1]

Through our interviews with the outside experts, we developed a framework that identifies some of functions provided by payers under traditional payment schemes. In Table 1, we grouped those functions into four broad categories. **The experts whom we interviewed suggested that a (comprehensive provider) operating under a capitation contract would likely want to control or strongly influence those functions that have the greatest impact on the measures of the (comprehensive provider's) success: whether it improves quality, provider experience, and member experience, and whether it controls costs. They suggested that (comprehensive providers) themselves might want to assume responsibility for these functions, indicated by the areas (boxed) in the table.**

Table 1. Migrating (Comprehensive Provider) Administrative Functions from Payers
Boxed areas indicate functions for which (Comprehensive Providers) might assume responsibility.

Product design, sales, and regulatory compliance

Product Design
Actuarial soundness
Network design
Co-insurance and deductibles
Premium rate-setting

Marketing
Specify population covered
Purchaser relations
Advertising and sales

[1] Capitation and Evolving Roles of Providers and Payers in New York
United Hospital Fund
May 2016
"Capitation and the Evolving Roles of Providers and Payers in New York

Provider-facing functions

Compliance & Risk Management
Insurance rules, regulations
Policies and procedures
Risk management

Provider Relations
Network management
Credentialing
Provider contracting
Provider communications

Medical Management
Quality reporting and improvement
Utilization management
Disease management
Care management
Care coordination

Member-facing functions
Customer Service
Member communications
Call center and member services
Health education
Track and report on member experience
Appeals and grievances

Finance, Planning, and Analysis
Finance
Pricing services
Receive, adjudicate, pay claims
Tracking expenditures
Monthly, regular reports to providers
Monitor and report to plan / purchaser
Reinsurance and stop-loss

Planning and Analytics
Planning
Claims data and analytics
Monitor, report on quality
Monitor utilization, expenses, costs
Track provider and network performance

(Underlined bold-faced text, in the following excerpts, is provided for emphasis)

Provider-Facing Functions. (Comprehensive providers) are responsible for the performance of an entire provider network in caring for their attributed population. To do so effectively, they must be prepared to assume or oversee a series of new functions that affect their relationships with participating providers, including credentialing, contracting, communications, and network management. **Most important, they will need to control processes for medical management,** including care management, quality improvement (identifying and spreading best practices and reducing variation), and **sensitive functions like pre-authorization and utilization management, which can greatly influence both costs of care and provider satisfaction.**

Finance, Planning, and Analytics. Perhaps the greatest challenge facing (comprehensive providers) **under capitation is in the broad category of finance, planning, and analytics.** Under shared savings and shared risk arrangements, (comprehensive providers) need to develop basic capabilities in some of these areas; but since most of their provider payments are still tied to fee-for-service billing (and only a small portion to the year-end bonuses based on the shared savings they may generate), their performance in these areas may not be perceived as critical.

Under capitation, however, (comprehensive providers) need robust health information and planning capacities, including the ability to assess and adjust for risk, to promptly produce clinical and claims data analytics needed to support quality improvement, to track performance against budget, and to mitigate the potential impact of the increased risk they are assuming. (Comprehensive providers) will also need to develop or acquire new financial, actuarial, and accounting systems, including the capacity to negotiate payment rates, and pay bills received from providers.