Community Mental Health Association of Michigan

Concerns and recommendations: MDHHS-proposed Conflict-Free Access and Planning approach

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Summary

MDHHS has proposed options, in pursuit of compliance with Centers for Medicare and Medicaid Services (CMS) rules, that call for organizations that carry out the access, person centered planning, and case management/supports coordination functions of Michigan's public mental health system be separate organizations from those that provide other mental health services. These requirements, in Michigan, are referred to as Conflict Free Access and Planning (CFAP).

While CMHA and its members strongly support the aim of the CMS rule, the Community Mental Health Association of Michigan (CMHA), its members, and the persons served who participated in the MDHHS Listening Sessions, have concerns regarding the options proposed by MDHHS to achieve this aim. These concerns center around the **threat that these options hold for persons served and to the integrity of Michigan's public mental health system**.

CMHA has proposed, in accordance with federal and state law and Michigan's Medicaid waivers, a comprehensive alternative to the MDHHS approach – an alternative that provides for conflict mitigation while also ensuring ease of access for Michiganders to mental health services.

Approach proposed by MDHHS

The Conflict Free Access and Planning (CFAP) approach, proposed by MDHHS, would require that a person seeking mental health services from the state's public mental health system obtain their assessment, individual plan of service (clinical treatment plan), and case management from one organization and receive the services outlined in that plan from another organization.

Support for the intent of CMS rule and for freedom of choice for persons served

CMHA and its members strongly support the aim of the CMS rule - to ensure that conflicts of interest in the provision and financing of services are mitigated.

Additionally, **CMHA and its members strongly support the foundational principle that persons served be empowered by exercising their rights to make choices regarding the services and supports** that they receive. These rights include:

- the right to select an independent facilitator of their person-centered planning (PCP) (not employed by or affiliated with the CMHSP/PIHP) to facilitate the PCP process.
- the right to lead the person-centered planning (PCP) process with the involvement of allies chosen by the person served.
- the right to be provided with full information regarding the array of services and supports available, the choice of providers, and access to self-determination arrangements.

- The right to choose their case manager/supports coordinator – from those employed by the CMHSP, the CMHSP contractor, or to choose an independent supports coordinator ((not employed directly by a CMHSP or by a current CMH contracted provider)
- The right to use the CMHSP Recipient Rights System and Grievance/Appeal process. These processes are independent of the clinical reporting line from PCP development, service authorization, and HCBS services and are subject to MDHHS oversight.

Concerns around options proposed by MDHHS

1. This structural separation of access, planning, and case management from service delivery, proposed by MDHHS, **makes an already complex system more complex for persons** served and creates an artificial access barrier to persons seeking services and weakens continuity and coordination/integration of care.

In fact, same day service (what is often termed "treat first") would be impossible under the separation of functions that MDHHS is proposing.

Additionally, outreach to persons in need of services would be seriously hindered by prohibiting the services provider from assessing and building a treatment/services plan with the person in need.

The comments of persons served, obtained during the MDHHS listening sessions underscore the concerns of persons served around the complexity, loss of access, and continuity of care that will occur as a result of the Department's proposed system restructuring. These comments are provided below:

- "I think [Separating access/planning from direct service] could be problematic due to a person having to repeat providing their info…"
- "Having to go from here, to here, to here to do it when being in a place where I need help would be a lot. It's a lot to ask one person to go through."
- "The concern is the challenge is managing [different organizations] that need to be in alignment with one another. The management now is already a concern. Does this make it worse.
- "…if no communication or miscommunication this will be hard because it will be left to person with disabilities to relay info."
- "[I have] mixed feelings. [It is] Protecting people getting these services, but I can get frantic going places to places."
- "Between the point of access and referral, things get dropped and lost."
- "It feels like the game it goes through several people and it is not the same in the end after it has moved through all the steps."

2. The CMS rules were intended to prevent inappropriate financial gain/inappropriate profit taking by providers. CMHSPs are governmental bodies, prohibited from profit-taking. Additionally, because Michigan's CMHSPs, unlike nearly every other state in the country, are financed via a shared-risk prepaid capitated basis, the state's CMHSPs have no financial interest in self-providing services, as would be true in a private or fee-for-service financing model. The funds retain their public identity subject to reporting, accounting, and government oversight.

3.The MDHHS options dismantle and are in conflict with:

- The **statutorily required core functions of Michigan's CMHSPs** – access and assessment, clinical plan development, and provision of services directly or through a directly managed provider network.

- The **federally required core functions of Michigan's Certified Community Behavioral Health Clinics (CCBHC) and Behavioral Health Homes (BHH)** – the functions of access and assessment, clinical plan (individual plan of service) development, and provision of services directly and through a directly managed provider network.

4. MDHHS already has the approval of CMS of the innovative set of sound conflict-mitigation design elements and <u>can apply the CMS-outlined exception to the CMS rule</u>. These approaches reflect the unique nature of Michigan's system and are included in Michigan's HCBS plan amendment. These conflict mitigation approaches include:

- The person facilitating the Person Centered Planning process are not providers of any Home and Community Based Services (HCBS) for that individual and are not the same persons responsible for the independent HCBS needs assessment.
- The person facilitating the PCP process does not authorize the services contained in the plan
- The development of the IPOS through the person-centered planning (PCP) process is led by the person served with the involvement of allies chosen by the person served to ensure that the service plan development is conducted in the best interests of the beneficiary.
- The person served can choose an independent facilitator (not employed by or affiliated with the CMHSP/PIHP) to facilitate the PCP process.
- The CMHSPs are required to provide full information regarding the array of services and supports available, the choice of providers, and access to self-determination arrangements.
- The person served can choose their case manager/supports coordinator employed by a CMHSP or PIHP contractor or can choose an independent supports coordinator (not employed directly by or affiliated with the PIHP except through the provider network)
- The persons served has the right to use the CMHSP Recipient Rights System and Grievance/Appeal process. These processes are independent of the clinical reporting line from PCP development, service authorization, and HCBS services and are subject to MDHHS oversight.

The public structure of and the state statutes that guide Michigan's CMH system **provides Michigan with the ability to apply the exception to the CMS rule which would allow the use of these conflict mitigation approaches**. The basis for such an exception is contained on page 6 of the legal opinion of the firm of Feldesman Tucker (one of the nation's leading Medicaid managed care law firms).

5. Rather than harm access and cause unnecessary system complexity,– what is needed are efforts to ensure that these conflict mitigation approaches are widely known and used by persons served. If these options are not often requested by persons served, what is needed is a strengthened effort to ensure that all persons served are informed of and supported in pursuing these options with the vigor that is found in the system's work to ensure that persons served are aware of their Recipient Rights.

Recommendation: Comprehensive alternative conflict mitigation approach to Home and Community Based Services in Michigan

As Michigan works to ensure compliance with the CMS rule, the intent of which is strongly supported by the Community Mental Health Association of Michigan (CMHA), **CMHA and its members have proposed, below, an alternative conflict mitigation approach to those proposed by MDHHS.**

This alternative approach:

- Is founded on state and federal law and Medicaid waivers
- Provides strong safeguards against conflict of interest
- Prevents the addition of unnecessary and access-hindering complexity to the service access and delivery system
- Ensures the comprehensive organized system of care provided by Michigan's public mental health system and its ability to fulfill its statutory obligations.
- Can obtain CMS approval based on the points contained in this paper

Proposed approach to HCBS conflict mitigation

The alternative approach, outlined below, builds upon and strengthens the wide range of conflict mitigation processes and tools currently existing in Michigan's system and described in Michigan's HCBS plan amendment .

The efforts proposed below need to be **designed and implemented with the vigor, breadth, and depth found in the state's mental health Recipient Rights system**. This effort would significantly bolster the state's work in ensuring HCBS conflicts are mitigated and that all persons served are informed of and supported in the exercise of the rights outlined in state's HCBS plan and the Michigan Mental Health Code.

This HCBS conflict mitigation approach consists of the following components:

Structural conflict mitigation components:

1. Persons facilitating the Person-Centered Planning process **cannot be providers** of any Home and Community Based Services (HCBS) to those with whom they facilitate PCP processes.
2. The person facilitating the PCP process or serving as the case manager/supports coordinator for the person served **cannot authorize the services** contained in the plan for that person.
3. Neither the persons facilitating the Person-Centered Planning process nor the providers of any Home and Community Based Services (HCBS) can be the person responsible for the **independent HCBS eligibility determination**. This latter role is held by MDHHS.

Process-centered conflict mitigation components:

1. **Robust monitoring and contract compliance processes** to ensure that:

   - The person facilitating the PCP process is **not a provider** of Home and Community Based services **nor the person authorizing** the services contained in the plan,
   - The development of the IPOS through the person-centered planning (PCP) process is **led by the person served with the involvement of allies chosen by the person served** to ensure that the service plan development is conducted in the best interests of the beneficiary,

- The person served has (and is informed that they have**) the right to choose an independent facilitator** (not employed by or affiliated with the CMHSP/PIHP) to facilitate the PCP process,
- The person served can (and is informed that they can) **choose their case manager/supports coordinator** employed by a CMHSP or PIHP contractor or can choose an independent case manager/supports coordinator (not employed directly by or affiliated with the PIHP except through the provider network),
- The person served was made **aware of all of the forms of grievance and appeals** to which they have a right and supported in pursuing those grievances and appeals if they choose to do so.

Communication and information sharing components:

1. **Accessible, frequent, and readily available information** to persons served regarding the rights outlined above – through the use of:
    - A uniform set of hard-copy handouts and electronic messages
    - Notices on the websites of the state's CMHSPs, PIHPs, providers, and MDHHS
    - Social media posts
2. **Continual education, training, supervision, and coaching of CMHSP, PIHP, and provider staff** around these rights – efforts led by MDHHS, the state's major advocacy organizations, and CMHA
3. The **use of contractual powers, corrective action plans, and sanctions**, when needed, to ensure that these rights are afforded persons served – via the MDHHS/PIHP contract, the MDHHS/CMHSP contract, and the PIHP/CMHSP contract.

Rationale for the use of this approach [1]

A number of characteristics, unique to Michigan's public mental health system, underscore the importance of applying the alternative HCBS conflict mitigation approaches outlined above. That alternate approach fits the definition of conflict mitigation approaches allowed by CMS – given the unique system characteristics, outlined below.

1. Michigan's Medicaid behavioral health system has one of the broadest arrays of HCBS services provided to the broadest set of persons, far beyond the limited number of persons receiving HCBS services in other states – typically only those persons certified as eligible for a limited number of "slots" through a habilitative, SED, or similar waivers. **In contrast to other states, Michigan has wisely expanded the use of HCBS services to a large and diverse number of Medicaid beneficiaries. So much so, that an iSPA was required to comply with the federal Medicaid waiver budget neutrality requirements**.

2. The **access and person-centered planning roles** of Michigan's CMHSPs, as local units of government, **are core requirements of Michigan's CMHSP system under Michigan's Mental Health Code and Medicaid waiver, unlike CMHSPs in many other states**. Michigan's system has a 60-year history of integrating the access, assessment, PCP development, case management, and provider roles into a comprehensive organized system of care.

[1] This rationale is supported by the legal opinion of the firm of Feldesman Tucker (one of the nation's leading Medicaid managed care law firms). That legal opinion can be found here.

The approach outlined above, fits the CMS standard for an alternate conflict mitigation approach, given that, **as outlined in state law and the state's Medicaid waivers, the state's CMHSPs, as the sub-capitated Medicaid Comprehensive Specialty Services Network (CSSN)**, are the only bodies that can develop and authorize individual plans of service and will be, for some beneficiaries, also an HCBS provider, given the breadth of Michigan's HCBS service array and the equally broad range of persons eligible to receive HCBS services. [i]

3. **Unlike many other states, Michigan's CCBHCs and Behavioral Health Homes provide HCBS and non-HCBS services**. The use of the alternative approach outlined above ensures that the state's CCBHCs and Behavioral Health Homes can comply with the HCBS requirements related to conflict mitigation while also complying with the CCBHC and Behavioral Health Home requirements mandating the linking, under the same provider organization, access, planning, case management, and service delivery.

4. Michigan's **CMHSPs and PIHPs are governmental bodies funded via shared-risk pre-paid capitation system**. Given these two characteristics, the conflicts that the CMS rule is intended to address – those of a private provider receiving financial gain by also holding the plan development and case management roles – are not present in Michigan's system.

In many other states, the Medicaid-funded behavioral health system is dominated by private non-profit and private for-profit organizations, for whom self-referral and authorization-related private gain concerns often lead to structural mitigation models – **unlike Michigan's governmental CMHSP and PIHP system.** The funds retain their public identity subject to reporting, accounting, and government oversight.

5. Given that the state's CMHSPs and PIHPs (the latter as provider-sponsored plans) hold the service authorization and financial responsibility for the services provided by the system, **the movement of the development of the person-centered plan and case management from the state's CMHSPs only serves to delink the plan development and its Medicaid authorization.** Such delinking will lead to the mismatch of the initial person-centered plan from the final authorized plan – a mismatch which will lead to confusion and frustration for the person served.

6. **Michigan's current HCBS plan** currently requires the offering of: independent PCP facilitator, independent case manager, choice of provider, and Self-Determination/Self-Directed Budget arrangements to mitigate conflicts of interest. This design sets the stage for CMS understanding the value of the alternative approach outlined above. [ii]

7. Over the last several years, **CMS has been supportive of innovation by states** – innovations that run counter to longstanding CMS regulations. Examples include CMS's approval of: the use of Medicaid dollars to fund brief inpatient stays at Institutions for Mental Disease (IMD); the suspension of Medicaid eligibility, rather than loss of eligibility, when a beneficiary is incarcerated; and the approval of state waivers that provide up to 6 months of rental assistance and other far-from-traditional Medicaid expenditures.

This history of the support for innovation, by CMS, provides a strong context for CMS's approval of the alternative confliction mitigation approach, outlined above.

[i] **CMHSPs as comprehensive service providers as defined by statute (Michigan Mental Health Code)**: Michigan's CMHSPs have been designed, with that design imbedded in state law, as comprehensive mental/behavioral health services providers. This role is underscored by 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**.

> 330.1206 Community mental health services program; purpose; services.
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> 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:
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> > (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**.

[ii] Existing sound structural and procedural mitigation approaches, which would form the foundation for any revised approaches, **are outlined in Michigan's 1915(i) State plan HCBS State plan (Attachment 3.1–i.2)** the relevant sections of which are underscored below:

> The right of every individual receiving public mental health services in Michigan to the development of an individual plan of services and supports using the person-centered planning process is established by law in Chapter 7 of the Michigan Mental Health Code. Through the MDHHS/PIHP contract, MDHHS delegates the responsibility for the authorization of the service plan to the PIHPs.
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> The PIHPs delegate the responsibilities of plan development to CMHSP supports coordinator or other qualified staff chosen by the individual or family. These individuals responsible for the IPOS are not providers of any HCBS for that individual and are not the same people responsible for the independent HCBS needs assessment. The CMHSPs authorize the implementation of service through a separate service provider entity. The development of the IPOS through the person-centered planning (PCP) process is led by the beneficiary with the involvement of allies chosen by the beneficiary to ensure that the service plan development is conducted in the best interests of the beneficiary. <u>The beneficiary has the option of choosing an independent facilitator (not employed by</u>

or affiliated with the PIHP) to facilitate the planning process. In addition, the PIHP, through its Customer Services Handbook and the one-on-one involvement of a supports coordinator, supports coordinator assistant, or independent supports broker are required to provide full information and disclosure to beneficiaries about the array of services and supports available and the choice of providers.

The beneficiary has the option to choose his or her supports coordinator employed by a PIHP subcontractor or can choose an independent supports coordinator (not employed directly by or affiliated with the PIHP except through the provider network) or select a supports coordinator assistant or independent supports broker. This range of flexible options enables the beneficiary to identify who he or she wants to assist with service plan development that meets the beneficiary's interests and needs. Person-centered planning is one of the areas that QMP Site Review Team addresses during biennial reviews of each PIHP.

The MDHHS/BHDDA has several safeguards in place to assure that the independent assessment, independent eligibility evaluation, development of the Individual Plan of Service (IPOS), and delivery of 1915(i) services by the PIHP provider network are free from conflict of interest through the following:

1) The mandated separation required in the MDHHS/PIHP contract that assures the assessor(s) of eligibility will not make final determinations about the amount, scope and duration of 1915i services;

2) The MDHHS/PIHP contract assures the provider responsible for the independent HCBS needs assessment are separate from the case manager/supports coordinator providers responsible for the development of the IPOS;

3) All Medicaid beneficiaries are supported in exercising their right to free choice of providers and are provided information about the full range of 1915(i) services, not just the services furnished by the entity that is responsible for the person-centered service plan development.

All beneficiaries are advised about the Medicaid Fair Hearing process in the Customer Services Handbook that is provided by the PIHP to the individual at the onset of services, at least annually at the person-centered planning meeting and upon request of the individual at any time. The Medicaid Fair Hearings process is available to the individual to appeal decisions made related to 1915(i) services.

This may include beneficiaries who believe they were incorrectly determined ineligible for 1915(i) services; beneficiaries who believe the amount, scope, and duration of services determined through the person-centered planning process is inadequate to meet their needs; and if 1915(i) services are reduced, suspended or terminated. Adequate Notice of Medicaid Fair Hearing rights is provided at the time the person-centered plan of service is developed and Advanced Notice of Medicaid Fair Hearing rights is provided prior to any reduction, elimination, suspension or termination of services;

4) The results of the individual needs assessment, including any other historical assessment or evaluation results, may be used as part of the information utilized in developing the individual plan of services (IPOS). Oversight/coordination of the IPOS is done by a case manager or supports coordinator or other qualified staff chosen by the individual or family, is not a provider of any other service for that individual, and is not the professional/entity that completes the individual needs assessment/authorization for eligibility or services;

5) The PIHP performs the utilization management managed care function to authorize the amount, scope and duration of 1915i services. PIHP utilization management staff are completely separate from the sub-contracted staff and entities performing evaluation, assessment, planning, and delivery of 1915i services.