
Promising Practices in Long Term Care Systems Reform: Michigan's Managed Specialty Services System

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MICHIGAN'S MANAGED SPECIALTY SERVICES SYSTEM

As home and community-based support systems continue to grow and evolve, states are examining whether their current systems reflect fundamental participant and community values. A number of states are concluding that they need to put in place systemic reforms to ensure that their home and community-based support systems promote dignity, independence, individual responsibility, choice, and self-direction.

Systemic reforms are simultaneously addressing multiple aspects of community long term support systems in order to improve responsiveness to participants' needs and preferences. These initiatives are developing entirely new ways of designing, organizing, and managing community-based supports as a system rather than as a random collection of uncoordinated individual services. In some cases, this has required states to make fundamental changes to the administrative infrastructure of their home and community-based support programs.

Two design features in particular have repeatedly emerged as essential components of systemic reform initiatives:

- *Single Entry Points*, which provide persons with a clearly identifiable place to get information, advice and access to a wide variety of community supports; and
- *Integrated Services*, which place participants, not services or providers, as the central focus of funding and service planning.

The Centers for Medicare and Medicaid Services contracted with Medstat to examine approaches nine states took to developing Single Entry Points and Integrated Services to assist persons with disabilities to live productive and full lives in integrated community settings. We conducted on-site interviews with state officials, advocacy organizations, and local program administrators and extensively reviewed written documents on policy proposals, administrative rules, and program evaluations. The emphasis of the resulting nine case study reports is on identifying transferable models that can be adapted for replication in other states and communities across the country, while acknowledging that some aspects of state systems may be unique to each state's culture, history, and traditions.

Most states have different delivery systems for each of their major population groups who require long term supports. Therefore, in each state, we are focusing on a specific system for a particular target group. In Michigan, we addressed supports for persons with developmental disabilities and mental illness.

Overview of Michigan's Managed Specialty Services System

Michigan used incremental changes over ten years to comprehensively reform its support system for persons with developmental disabilities, serious mental illness, and addictive disorders. The State moved the system toward providing an array of person-centered

supports that respond to participants' needs and preferences, using a capitated managed care framework to expand service options while assuring control over total expenditures.

During the 1990s Michigan changed its system to reflect principles of community integration and personal freedom. A 1999 document defined several principles that guide the state. It stated that persons with disabilities should be:

- Empowered to exercise choice and control over their lives, including the purchase of services or supports and the choice of providers;
- Involved in meaningful relationships with family and friends;
- Supported to live with family while children and interdependently as adults;
- Engaged in meaningful daily activities, such as school, work, and social, recreational, and volunteer activities;
- Fully included in community life and activities;
- Afforded all rights guaranteed in law, including confidentiality of service information;
- Afforded access to effective services and supports intended to reduce the personal, social, and economic consequences of their disabilities; and
- Committed to the ordinary obligations of citizenship and the responsibilities of community membership.

Community Mental Health Services Programs (CMHSPs) – the traditional, county-level community mental health providers – are the basis of Michigan's system. CMHSPs are single entry points for both Medicaid and State-funded mental health and developmental disabilities services. While striving to provide a broader array of services to participants, the system has recently transitioned to a managed care model. As a result, most CMHSPs have shifted from a community health model to a more corporate model of financing and service delivery with an increased emphasis on managing costs and monitoring service effectiveness. The program uses a 1915(b)(3) waiver to limit choice and provide mental health services not otherwise covered under the Medicaid State Plan, as well as a 1915(c) waiver for community developmental disabilities services.

The Michigan Department of Community Health (MDCH) contracts with the CMHSPs through eighteen Prepaid Inpatient Hospital Plans (PIHPs, formally called Prepaid Health Plans or PHPs).¹ Many of its 48 CMHSPs joined to create multi-county plans because the State set a minimum population threshold that a PIHP must encompass. The State also uses a population-based formula to award PIHPs grants to finance specialty services for persons who are not eligible for Medicaid. Michigan funds these grants using federal block grants and State general revenue. The grants are not based on capitation and are not related to the Medicaid payments. In 2002, total Medicaid capitation payments were \$1.52 billion and grant awards totaled \$318 million.

¹ The name change occurred to comply with new Medicaid managed care regulations which created a new class of prepaid plans and were finalized after the Michigan program began. All references to the prepaid plans will use the new terminology even when the reference is historical and refers to a period when the plans were called PHPs.

Persons with addictive disorders typically receive substance abuse services and supports through 16 Substance Abuse Coordinating Agencies (CAs) operating throughout the State. While Michigan awards State-only and block grant funds directly to CAs, it includes Medicaid funding for these services in State capitation payments to PIHPs, which fund the CAs through formal agreements. CAs received a total of \$82 million from Michigan in 2002, including \$25 million in Medicaid funds through PIHPs. Since this report primarily focuses on Michigan's system of supports for persons with developmental disabilities and mental illness, it does not address the CAs' role in detail.

Medicaid participants receive their regular medical/health services through Michigan's Medicaid capitated managed care program, whose health plan contractors are referred to as Qualified Health Plans. Most specialty services for persons with developmental disabilities, serious mental illness, and substance abuse are carved out of the physical health managed care plans and provided through the PIHPs.² The specialty plans and the Qualified Health Plans must have agreements in place to coordinate between the two systems.

To illustrate the support system development strategies Michigan employed, this report highlights the system's historical evolution and the critical roles stakeholders played in shaping its initial design. In addition, the report explains the specialty services systems' essential components and lessons other states can gain from Michigan's experiences.

Evolution of Michigan's Specialty Services System

In an ongoing effort to design and implement a flexible delivery system sensitive to participants' preferences, the Michigan Department of Community Health has transformed its system from a highly centralized, state-focused model to an intricate, collaborative model with more responsibility and decision-making capacity in the hands of the community. The decentralization of specialty services was based on a core value: individuals with serious mental illness, serious emotional disturbances, addictive disorders, and developmental disabilities should be fully integrated into local communities as participating members.

In 1974, the Michigan legislature enacted the Mental Health Code. This law authorized county-sponsored Community Mental Health Service Programs to be the management entities for specialty mental health and developmental disability services, a move representing devolution of State authority. With this change, the CMHSPs became the single entry point for publicly funded specialty services in the community.³

In the 1980s, the State began placing a greater emphasis on supporting people with developmental disabilities and mental illness in community settings. More people received community services as more State inpatient facilities closed. The State

²In general, people with severe mental illness or who have exhausted the health plan limit of 20 outpatient mental health visits are served in the PIHP system.

³ A similar change in 1978 created local coordinating agencies to manage publicly-funded substance abuse services.

transferred funds that had been used for inpatient services to CMHSPs as the transitions occurred. In the early 1990s, CMHSP responsibilities expanded to include authorization and monitoring of inpatient psychiatric hospital stays. The community-based funding expansion and the prior authorization role helped the CMHSPs build the capacity to manage a capitated system encompassing the full range of specialty supports.

Concurrent with moving facility dollars to the community, the State employed an aggressive Medicaid maximization strategy during the late 1980s with new Medicaid coverage of targeted case management, clinic services, rehabilitation services, and personal care provided in residential facilities. The State also significantly expanded its Medicaid 1915(c) waiver for persons with developmental disabilities.

In 1996, Michigan's legislature required CMHSPs to implement person-centered planning for all people using publicly funded specialty services. Participant advocacy groups had promoted the person-centered planning requirement to address a lack of focus on individual needs among the CMHSPs. Some CMHSPs had already used a person-centered planning approach in the early 1990s' Community Services Living Arrangements demonstration, which was predicated on a person-centered planning process.

While interest in person-centered planning was growing, the administration at that time advocated capitation as a way to better control overall program costs. In many ways, capitation is a theoretically ideal method to further implement person-centered planning and participant self-direction. A single Medicaid capitation—with the proper waivers—can fund a range of services not otherwise covered under Medicaid. This broader array of services can be provided within the capitation with the freedom to vary the services as participants desire, without being bound by potentially limiting Medicaid fee-for-service rules about when, for whom, and by whom the service is provided. In this way, the person-centered planning initiative came together with interest in creating a managed care system for mental health and developmental disabilities services.

The Transformation to Managed Care

In 1998, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services or CMS) approved Michigan's waiver that established the Medicaid Managed Specialty Services program covering Medicaid supports for persons with serious mental illness, serious emotional disturbances, developmental disabilities, and addictive disorders. The specialty plan was designed as a "single plan – eligibility model," that is, there was a single PIHP in each service area that provided services based on participants' need; beneficiaries did not enroll in nor elect a PIHP. When the plan initially went into effect, the State designated each of the 48 CMHSPs to operate as a specialty PIHP in its respective service area. The Substance Abuse Coordinating Agencies became designated subcontractors of the PIHPs.

In approving the initial 1915(b) waiver request in 1998, CMS stipulated that the State must transition from sole source procurements for its PIHPs (wherein the State

designated a CMHSP, or combined CMHSP, as the PIHP in a service area) to a process of full and open competitive procurements within two years.

While the federal agency felt that competitive procurement was necessary to assure quality in a system of restricted consumer choice of provider agencies, the State believed that full and open competition would counteract its efforts to achieve an integrated, streamlined local system for specialty services management. Michigan also believed that CMHSPs were uniquely positioned for the role as PIHPs due to their track record of working with the target populations, their established relationships with other community agencies, and their prior experience in managing funding streams that support local specialty service systems.

The Revised Procurement Plan

Ultimately, Michigan submitted a revised procurement plan as part of its waiver renewal application in 2000, with stakeholder input in a process described later in this report. CMS approved Michigan's revised procurement plan, a hybrid between sole source procurement and open competition. In short, Michigan retained the basic framework for specialty PIHP selection by restricting initial consideration to CMHSPs alone. However, the revised plan imposed a detailed set of qualification criteria that CMHSP applicants must meet. The plan also established a special selection committee composed primarily of advocates and program participants to evaluate specialty PIHP submissions and recommend approval or denial. If a CMHSP could not meet the qualifications, the PIHP contract would be open for competitive solicitation.

The plan also reduced the number of specialty PIHPs by specifying that a CMHSP must have at least 20,000 Medicaid beneficiaries within its geographic area to be considered as a stand-alone organization. Based on the State's initial experience with specialty PIHPs, this population threshold was necessary to achieve administrative economies of scale and the ability to safely bear financial risk. A CMHSP with less than 20,000 participants in its catchment area could affiliate with one or more other CMHSPs, so long as they shared contiguous boundaries and combined to cover at least 20,000 people.

Selection of Prepaid Inpatient Hospital Plans

In implementing the contracting approach and plan requirements, the State undertook a very deliberative process to build the capacity and understanding among Community Mental Health Services Programs to meet the new requirements. In October 2001, prior to releasing the actual Application for Participation that would govern the solicitation of proposals for PIHP awards in 2002, the State issued an Implementation Guide. This guide gave the CMHSPs additional background on the intent of the State's new contract requirements and a tool—a Readiness Checklist—to help applicants prepare information necessary for their proposals. The State actively solicited questions about the Guide's policies from all stakeholders—advocates, participants, providers, and the CMHSPs themselves—and posted responses to those questions in three separate documents on the State's Web site.

When Michigan released the Application for Participation (AFP) in January 2002, it implemented an identical process of soliciting stakeholder questions and posting policy clarifications on its Web site. To convey specific contract requirements and to place those provisions within a broader policy context, the State organized the AFP into four sections:

- *Organizational Status and Configuration*—covering requirements for the structure of PIHPs and their affiliation agreements
- *Public Policy Management and Public Interest Considerations*—highlighting that specialty prepaid health plans are not simply managed care organizations, but are also managers of public policies governing areas such as person-centered planning, health and safety, and other concerns
- *Administrative Capabilities and Management*—addressing the managerial and operational aspects of a managed care plan, such as access to care, service array, provider network development, quality assurance and fiscal management
- *Regulatory Oversight and Management*—documenting the organization’s capacity to ensure its compliance and that of its contractors with federal and State requirements.

Eighteen applications were submitted in 2002. A team of three MDCH staff independently scored each application and conducted on-site reviews to verify the information submitted. MDCH then forwarded the applications and staff reviews to the Governor’s Community Health Specialty Services Panel. This 13-member committee—composed primarily of external stakeholders including six advocacy organization representatives, three program participants and four State officials—informed decisions about whether applicants should be awarded PIHP contracts. The panel required several applicants to make significant changes as a condition of continuing in the award process.

Ultimately, the panel approved all 18 applications in August 2002. The switch became official on October 1 and Michigan went from contracting with 48 CMHSPs to contracting with 18 PIHPs, 10 of which are combinations of multiple CMHSPs that did not meet catchment area size requirements. This round of contracts expires in October 2004, at which time they may be automatically extended for up to three 1-year periods.

Stakeholder Involvement

Significant stakeholder involvement in MDCH policy development goes back to 1992, when the federal Community-Supported Living Arrangements (CSLA) demonstration started. This initiative awarded grants to Michigan and seven other states to provide supported living services—including personal assistance, habilitation services, and assistive technology—as an optional State Plan service to persons with developmental disabilities.⁴ To obtain broad-based input in designing its CSLA strategy, the Department

⁴ The CSLA grants paid for services from 1992 through 1995. Benefits were limited to individuals living in their own or their family's home or an apartment or other rental unit in which no more than three individuals receiving these services reside. Other states selected to provide CSLA services were California,

organized a series of meetings and public hearings across the State with key stakeholders, including participants and advocates. Stakeholder partnerships continued through active participation in working groups that established program standards and provided oversight of CSLA implementation.

These positive relationships carried forward to the State's initial design of its managed specialty services program and the development of the Medicaid waivers necessary to implement the system. By the accounts of State officials and advocates alike, Michigan used a very open and collaborative process to establish the new program's details. Over 74 individuals representing advocacy groups and various stakeholders participated in work groups regularly to develop policies on matters such as service array, case management, and quality. The State financed teleconferencing to include stakeholders who were unable to physically attend meetings in Lansing. Not all discussions went smoothly—for debates on the more contentious issues, outside facilitators were used. In the end, participants and advocates got most of what they wanted, and when they did not, they reported that their viewpoints had been heard.

In September 1999, MDCH released a draft plan for complying with federal competitive procurement requirements and sought stakeholder feedback. Through a series of ten public hearings and over 750 written comments, the Department was flooded with stakeholder concerns. Among those most frequently expressed were the fear that competition would diminish local control of community-based service systems, and that a new emphasis on managed care and increased efficiency would diminish the importance of participant involvement, choice, and person-centered planning. Based on these and other stakeholder concerns, the Department moved away from proposing an open and full competitive procurement process and, as discussed previously in this report, toward a revised plan where local public agencies would continue to have a presumptive lead role.

In addition to State-level involvement, MDCH required each CMHSP to establish a stakeholder work group consisting of representatives from each target population to help develop the PIHP application. The State required at least 50 percent of work group participants to be program participants. A statement signed by work group members attesting to their involvement in application development was required as an application appendix document.

To underscore the importance of continuing stakeholder involvement, the State required applicants to describe how they promote the integration and inclusion of persons with behavioral or developmental disabilities. To demonstrate pursuit of “equity functions and community-inclusive outcomes,” applicants had to provide the following information:

- the composition of its board and advisory committees
- the number of persons with disabilities it employed

Colorado, Florida, Illinois, Maryland, Rhode Island, and Wisconsin. For more information see Brown, Samuel L.; Lakin, K. Charles; and Burwell, Brian O. “Beneficiary Centered Care in Services to Persons with Developmental Disabilities” *Health Care Financing Review* 19 (2): Winter 1997.

- the percentage of its expenditures related to participant self-direction and self-determination
- its utilization of segregated residential institutions and programs
- its State facility placements
- its efforts to ensure cultural competency

Despite stakeholder involvement during the development of the system and the change in procurement, both stakeholders and State officials acknowledge that the relationship between the State and advocates deteriorated significantly during the late 1990s and the early part of next decade. Some attributed the decline to stable—or in some cases declining—program budgets limiting the extent to which some of the provisions agreed to in the initial plan could be implemented. Others pointed to State staff reductions that diminished the time available for continuing consultations, while others suggested that the Department’s top leadership appeared less supportive of collaboration. Whatever the reasons, it was clear that the very positive relationships that were once present had changed dramatically. More recently, relations have started to recover, although adequate funding and services remain points of contention.

Single Access Points

People with mental illness or developmental disabilities seeking specialty and supportive services first contact a PIHP’s access center, a centralized point that provides outreach, information and referral, assessment, crisis intervention and service planning. Access centers are the entry point for all publicly-funded specialty services, including Medicaid services. MDCH chose not to mandate a particular structure for access centers, opting instead to define access-related requirements while allowing PIHPs to determine the arrangements that would work best in their communities.

PIHPs are required to serve people with developmental disabilities, serious mental illness, and serious emotional disturbances whether or not they are Medicaid eligible. To ensure that persons know where to turn for assistance, PIHPs must conduct a range of outreach activities to the general public through such vehicles as media campaigns, public advertising, the Internet, and service fairs. The State also expects PIHPs to provide up-to-date information about services and how to access them in specific places where target populations might be present such as emergency rooms, homeless shelters, senior centers, nursing homes, and clinics. Outreach materials must be written at a 4th grade reading level, available in multiple languages and alternative formats, and submitted to MDCH for review.

Each PIHP employs customer service representatives who are typically located at the access center. Customer service staff orient new participants about accessing supports, answer benefits-related questions, channel participant complaints and grievances, and track recurring organizational problem areas. Because they are often themselves participants or family members, they bring personal experiences to their role that help them function as a participant-advocate.

When an individual approaches a PIHP access center for assistance, staff first determine if there is an emergency need for assistance. If so, they arrange an assessment and immediate access to crisis intervention services. In other instances, a professional from the PIHP is expected to meet participants face-to-face within 14 days to establish clinical eligibility for services. MDCH provides PIHPs with detailed guidelines that describe the clinical and functional factors to assess when determining clinical eligibility, but it does not provide a specific assessment tool. A more in-depth exploration of specific treatment and/or support options is reserved for the person-centered planning process, described in the following section. If an individual requires a Medicaid financial eligibility assessment, the PIHP refers him or her to the local Michigan Family Independence Agency (FIA) office.

Person-Centered Services

This series of case studies on state long term supports initiatives focuses on two primary components of systemic reforms. The first, as described in the previous section of this report, is single entry points, designed to be an identifiable organization where people can get information, objective advice, and access to a wide range of community supports. The other essential component is a system of person-centered services that places participants, not services or providers, at the center of funding and service planning.

Person-centered services systems, as presented in the following sections of this report, have two key features. First, they enable persons to make meaningful choices about their living arrangements, the types of supports they receive, and the manner in which services are provided. Second, by designing person-centered quality management and payment systems, a state's ability to achieve intended participant outcomes and program goals is enhanced.

Person-Centered Planning and Self-determination

The State has been working to address provider concerns and to ensure that person-centered planning and self-determination are viable options in all areas of the State. MDCH developed new PIHP contract language specifying these PIHP responsibilities and developed implementation guidelines. The State also sent a recent policy document to PIHPs that specifically addressed barriers to satisfactory implementation that PIHPs have raised, including conflicts of interest where providers believe in the value of personal choice, but also have real investment in existing programs and services. Also, the Office of Recipient Rights within MDCH now provides annual training at each CMHSP on the goals and requirements of person-centered planning and self-direction.

Person-centered planning—planning services on an individual basis considering the person's strengths, choices, and preferences—started in Michigan in the previously described Community-Supported Living Arrangements (CSLA) program. Reflecting stakeholder guidance, person-centered planning was the cornerstone of the CSLA program. Michigan has required CMHSPs to use person-centered planning since 1996,

when Michigan's legislature enacted this requirement as an amendment to the Mental Health Code.

The essential elements of person-centered planning that PIHPs are to perform include:

- Implementing a specified pre-planning meeting format where the participant is given the opportunity to express his/her wishes and needs
- Allowing the participant to select who facilitates planning meetings
- Including the participant's family, friends, and other informal supports in the planning process
- Providing participants the option, as a covered benefit, of choosing a person-centered planning facilitator who is external to the PIHP and its providers
- Allowing the participant to modify the planning process at any time
- Discussing all potential treatment and support options with the participant
- Providing the participant with the continuous opportunity to express his/her needs and wishes as well as to give feedback

In addition to offering person-centered planning, each PIHP must develop policies specifying their procedure for making self-determination available for adults with developmental disabilities and mental illness. Self-determination gives participants flexibility to choose their own supports and providers—including non-clinical supports—within a budget based on the person's needs rather than the person's services. To facilitate self-determination, Michigan required PIHPs to assure the following:

- Participants are able to access services and supports from any willing and qualified provider entity
- Participants are not required to utilize PIHP-employed direct support personnel or a PIHP-operated or -contracted program/service
- PIHPs assist participants in selecting, employing, and directing support personnel
- PIHPs select and make available qualified third-party entities which participants may select to serve as their fiscal intermediaries⁵

Michigan required person-centered planning and self-direction before the managed care model was implemented in 1998. CMHSPs and providers expressed concern that person-centered planning would create demand for new services and increase cost pressures in the system. Theoretically, the capitated payment system would allow participants to select the service mix that best suits their needs and preferences within existing budgets by allowing more local flexibility in determining the service mix.

However, CMHSPs have not fully implemented person-centered planning and self-determination and CMHSPs have varied in their fidelity to person-centered planning

⁵ The contracted functions of an intermediary may include: payroll agent for direct support personnel employed by the participant, payment agent for participant-held agreements to purchase services from providers, provision of timely periodic reports on the individual budget, provision of timely accounting to the PIHP for the funds transferred to it, and other supportive services that strengthen the role of the participant as an employer.

principles. There are multiple reasons for this. First, as other States and providers have found, self-determination requires a new way of thinking and operating.⁶ Self-determination can be a threat to traditional providers and their revenue stream, and therefore often faces resistance. Second, the PIHPs have needed considerably more operational policies, encouragement, guidance, and oversight in implementing person-centered planning and self-determination than Michigan originally anticipated. As a result, implementation is slower than the State expected. Third, Michigan is moving to implement self-determination for people with developmental disabilities, where the concept is familiar, and for people with mental illness, where the concept is less fully developed or common. Fourth, enforcement has proven difficult because it is hard to quantify the failure of person-centered planning and self-determination for penalty purposes.

Provider Network

In developing its provider network, a PIHP must have providers in a sufficient number, mix, and geographic distribution to meet the target populations' needs and to ensure adequate service availability. Taken as a whole, each plan's provider network must offer participants a choice of case management services, supports coordination, psychiatric services, and personal assistance. In addition, PIHPs must meet federal Medicaid health plan and state cultural competence requirements and include participant-operated services, geographic accessibility, and out of network coverage.

PIHPs can select providers through a variety of methods including competitive contracting, open enrollment, and sole source selection. If the PIHP also provides direct services, it must ensure that an external provider of the same services is available to participants and that discrete organizational oversight structures are established to prevent conflict of interest. The PIHPs are not permitted to shift their risk to providers or any subcontracted provider network.

Michigan set unique network requirements for PIHPs with more than 100,000 Medicaid participants in their area. As a practical matter, these provisions only apply to Wayne County (Detroit), which is by far the State's most populous county. The Detroit-Wayne County Community Mental Health Agency must establish at least two Provider Sponsored Specialty Networks for each target population—persons with mental illness and persons with developmental disabilities—in order to assure competition and consumer choice. Three networks are under contract for each target population.

System Management

Financing and Payment System

To finance Medicaid specialty services, MDCH pays each PIHP a capitated payment for each Medicaid participant in the service area. The Department makes a prepaid monthly

⁶ For more information on other States' experiences with implementing self determination, please refer to the New Hampshire and Pennsylvania case studies referenced in the Bibliography.

payment to each PIHP based on an estimate of enrollees from the prior month. As in an enrollment model, payment does not necessarily reflect people who actually use services in a particular month.

The amount of the capitation payment is determined by three variables. The first is the person's Medicaid eligibility category: Disabled/Aged/Blind, Developmentally Disabled, and TANF/other. The second variable is an intensity factor for each PIHP to account for regional variation in the historical utilization of mental health, developmental disabilities, and substance abuse services. The third variable is based on the number of Medicaid eligibles in each eligibility group in the PIHP's coverage area.

MDCH uses a shared risk, or risk corridor, arrangement with the PIHPs. Risk corridors limit plan risk or financial liability at the extreme, while encouraging prudent use of resources under normal operating conditions. Using this risk corridor strategy, each PIHP is responsible for their expenditures according to the following structure:

- If a PIHP spends less than 95 percent of their contracted funds, it must return all unexpended funds under 95 percent to MDCH
- If a PIHP spends between 95 percent and 100 percent of their contracted funds, the PIHP may retain all operating budget funds
- PIHPs are fully financially responsible for all expenses above the operating budget between 100 percent and 105 percent of the funds contracted
- PIHPs are financially responsible for half of the expenses between 105 percent and 110 percent of the funds contracted
- PIHPs are not financially responsible for any expenses incurred over 110 percent of the funds contracted

PIHPs have certain obligations about the use of savings. The state limits investments in administrative capacity and infrastructure improvements to 15 percent of the Medicaid savings, and MDCH must approve these expenditures. The PIHP may set aside the remaining savings as reserve funds for up to one year.⁷ After one year, the PIHP must use the money for new or expanded treatment, support, and/or service models; community education, prevention, and/or early intervention activities; and research and evaluation of treatments and supports.

Media reports in 2003 questioned the percentage of statewide funding for administrative costs under this contracting system. *The Detroit News* reported that up to 40 percent of budgeted dollars go to administration rather than direct services. Different PIHPs responded that their administrative load is only ten percent or less, depending on the PIHP. The State Senate Fiscal Agency estimated that overall administrative costs do not exceed 15 percent.

⁷ The Department recently revised PIHP contracts to limit the length of time PIHPs may retain savings. When the State realized many PIHPs were retaining savings from their Medicaid pre-payments as risk reserves for upcoming years, it required that savings be reinvested within one year.

It is likely more dollars are spent on administration under the new system than under the old, fee-for-service system. Tracking prepaid payments, expenditures, and utilization under the managed care system creates administrative costs at the state and PIHP level, as well as for subcontractors where applicable (such as Detroit). All these costs are cumulative. Although the fee-for-service system also entails administrative costs, a capitation contracting systems typically has higher administrative costs than a fee-for-service system. However, greater administrative load is supposed to be offset by new service efficiencies that enable people to use more effective services and to have equivalent or improved outcomes. This phenomenon can result in greater funding of administration relative to services.

Quality Management System

Michigan's quality management system for its specialty services program relies on multiple approaches. Generally speaking, the State's quality assurance strategies fall into two categories: prospective and retrospective. Much of the prospective quality assurance activities are typical for Medicaid managed care programs, such as a precontract review of plan capabilities and a requirement that all providers meet state licensure or other appropriate standards.

Michigan's retrospective review activities, however, include several practices not common for home and community-based services programs. The State uses several methods to monitor the quality of services and supports on an ongoing basis, including annual site visits, performance outcome measures, and participant surveys.

The MDCH Division of Quality Management and Planning conducts annual, two-phase site visits to each PIHP, with each phase separated by 4-6 months. The review teams include MDCH staff, a clinician, a master's degree nurse, and at least one participant. The participants on the review team come from a pool of participant-advocates employed by various disability organizations.

Participant satisfaction and local stakeholder input have been key quality components in Michigan, and the Department measures both components at each site visit. MDCH staff review clinical records for a 10 percent sample of people served by the PIHP and interview a sub-sample of these participants. The interviewers ask participants and their families about service delivery, the planning process, and health and safety issues. To verify the extent of stakeholder involvement in PIHP planning and operation, MDCH staff interview key participant groups involved in the PIHP's application. After the visit, MDCH staff require the PIHP to develop a plan of correction if needed. If a plan of correction is necessary, MDCH staff visit a second time to verify whether the PIHP implemented the correction plan. The second visit includes interviews with some of the same participants interviewed during the first visit.

The Department also developed a Mission-Based Performance Outcomes Indicator System that requires each CMHSP to report aggregated performance indicator data on a quarterly basis. CMHSPs submit these data electronically. Forty indicators measure

CMHSP performance in three quality domains: access, efficiency, and outcomes. Examples of outcome indicators include the percentage of people in supported employment and the percent of people living in their own homes. Access indicators include the timeliness of inpatient screening, the timeliness of outpatient assessments, and the percent of people denied services as a result of a negative assessment.⁸

The State compares data across all CMHSPs to identify outliers. MDCH staff examine CMHSPs showing exceptional performance for possible identification of replicable best practices and they examine negative outliers for possible sanctions, plans for improvement, or contract termination. An annual report shows the year's results and compares results longitudinally at the state, PIHP, and CMHSP levels.

Two written surveys feed into the Department's retrospective quality assurance initiatives: a participant satisfaction survey and a quality of life survey. These surveys provide a snapshot of participant satisfaction and quality of life and are meant to give the State a cross-sectional view of current participant well-being. Two separate samples—one of individuals with developmental disabilities and one of adults with mental illness—receive both the quality of life survey and the Mental Health Statistical Improvement Program participant satisfaction questionnaire. The State has not been satisfied with the survey response rates and was looking for ways to improve the sample in terms of response rates and sample design so that Detroit participants were not overrepresented.⁹

The MDCH Office of Recipient Rights (ORR) conducts a separate annual site visit to review the PIHP's system for reporting neglect and abuse and for investigating and mediating complaints. PIHPs must maintain an incident management system that identifies sentinel events for investigation and resolution. ORR maintains a statewide system for appeals of complaint investigation results and trains CMHSPs on protecting participant rights.

ORR recently initiated a survey to determine participant satisfaction with person-centered planning and the extent to which CMHSPs offer this planning. The survey involves face-to-face interviews with participants within one week of their initial planning session. The first year survey results identified considerable room for improvement in person-centered planning implementation. ORR now includes training on person-centered planning and self-direction in its annual participant rights training.

Lessons Learned

Michigan's Medicaid Managed Specialty Services program provides a decentralized, community-based service delivery system for individuals with mental illness, developmental disabilities, or addiction disorders. The State has chosen to use a managed care/capitation payment approach to offer an array of services at the local level

⁸ For more information about the performance outcome indicator system, please refer to the report "HCBS Quality: Michigan's Mission-Based Performance Indicator System" referenced in the Bibliography.

⁹ More information on the Mental Health Statistical Improvement Program can be found online at <http://www.mhsip.org/>.

with administrative flexibility and to promote person-centered planning. Michigan's experiences offer several lessons for other states. In designing and implementing the Medicaid Managed Specialty Services System, the State developed creative processes and strategies with the potential to be replicable in other States. These strategies include increasing local public agencies' ability to manage funds and administer programs; including stakeholders in the decision-making process from the beginning; and developing a close and open working relationship with CMS.

System capacity—The State of Michigan had already built a strong system of local public agencies that could be the basis of the new program. In the 1980s CMHSPs were given the option to serve individuals discharged from a State hospital, managing the money the State would otherwise have spent on facility services. Later, in the early 1990s, CMHSPs' responsibilities expanded to include authorization and monitoring of inpatient psychiatric hospital stays. This steady evolution of the CMHSP system, coupled with improved collection of service utilization data, gave the State the capacity to build capitation rates and implement the managed specialty services program.

Pre-Implementation Data— While Michigan collected enough service utilization information to inform capitation rate setting, it was only beginning to capture this data when it first implemented the managed care system. State staff indicated system implementation might have been easier if they had more data before implementation. Similarly, State staff thought that better information on the relationship between functional ability and service needs would have led to more accurate capitation rates, even though advocates did not want functional assessment information to go into rate development at the time.

Technical expertise and guidance—MDCH learned valuable lessons about how to implement new requirements within a decentralized program structure. States need to provide hands-on guidance for new initiatives like person-centered planning and self-determination to be successfully adopted. States must have the capacity to effectively convey the philosophy driving reforms, to train local agencies, and to give them the resources necessary to implement a new service delivery system. Michigan is still struggling to ensure that person-centered planning and participant self-direction are fully implemented and truly available to all system participants. On more than one occasion, MDCH developed program guidelines only to learn later that specific training at the local level would be necessary to move implementation/adoption along. The State is still working to improve oversight of local program implementation.

Stakeholder involvement—A key factor in the program's early success was the involvement of diligent and active advocates, family members, and other stakeholders. These contributors met with MDCH staff, gained an understanding of the system and the philosophy behind it, and disseminated that information into the community. The State successfully fostered this involvement from the program's inception to its implementation by actively seeking feedback and incorporating that information into system design and implementation. Later, the relationship between the State and advocate stakeholders deteriorated, possibly because MDCH staff cuts decreased staff

availability or because new department leadership was less interested in collaboration. The weakened relationship, which has improved in recent years, may have contributed to other problems, such as the inability to obtain increased funding.

Federal Partnership—Designing and implementing a managed specialty services system that focuses on personal choice and self-determination is a difficult and complex undertaking. From its earliest ruminations, MDCH was open and forthcoming, both internally and with CMS. This attitude allowed the State and CMS to develop a truly collaborative relationship whereby the initial system design was a joint effort that could not have been realized in isolation.

Balancing Needs of Distinct Populations in a Highly Integrated System—Michigan embarked on an ambitious project to integrate service delivery and funding at the local level for two distinct clinical populations: people with severe mental illness and people with developmental disabilities. Apart from funding issues, it can be difficult to raise and address issues particular to one population within such a highly integrated system. For instance, State staff and advocates believe that self-determination in the developmental disability system has declined somewhat as a result of a broad policy focus.

Effect of Funding Limitations—When the system of capitated specialty services was designed, MDCH and stakeholders anticipated expanded services and a renewed focus on participant control and independence. However, large expectations for the new system came up against significant funding constraints when the system was implemented. Also, because Medicaid became a much greater share of the CMHSP budget, CMHSPs increased their focus on Medicaid-eligible individuals. Advocates suggested that CMHSPs reduced their attention to people not eligible for Medicaid.

In response to criticisms Michigan newspapers raised in the summer of 2003, the Governor has created a commission to look at where the system came from and where it is headed. The press criticisms mostly focused on perceived failures of the system for people not eligible for Medicaid who had serious mental illnesses. The commission will debate how the system should best meet the needs of both Medicaid-eligible people and other people who need specialty services.

Michigan recently received approval for a waiver that may improve service access for people who have not been Medicaid participants. The waiver covers single, childless adults with incomes up to 35 percent of the federal poverty level who are not otherwise eligible for Medicaid coverage. This coverage will come through a waiver of Title XXI, the State Children's Health Insurance Program, and is authorized by section 1115 of the Social Security Act. The state anticipates that some 62,000 adults will be eligible. The State sent policy guidance to the PIHP/CMHSPs alerting them to this new covered population and the Medicaid mental health services they are eligible to receive.

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