

PROMISING PRACTICES IN HOME AND COMMUNITY-BASED SERVICES

Michigan -- Person Centered Planning for People with Mental Illness, Addiction Disorders, and Developmental Disabilities

Issue: Increasing Access and Choice Through Person-Centered Planning

Summary

The State of Michigan combined several funding sources in its contracts with local community mental health agencies, which serve people with developmental disabilities, mental illness, and addiction disorders. To ensure access and improve choice, the contracts require local agencies offer a wide array of services and use a person-centered planning process to determine a person's service plan. In the first two years of using this model, access to services improved and costs were reduced.

Introduction

To offer more service options and improve service coordination among several programs, the State of Michigan developed a model to finance services for people with mental illness, addiction disorders, and developmental disabilities. The model combines several funding streams into one managed care contract, making it is easier for a person and his or her

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CMHSP to create one person-centered plan for services from several payment sources. Michigan contracts with its Community Mental Health Services Programs (CMHSPs) as health plans for these services. Rather than present people a choice among prepaid health plans, Michigan's model focuses choice at the level of selecting services and providers.

This report briefly describes Michigan's model, its implementation, the impact of the model to date, and recent changes to the model. The document is based on interviews with current and former state staff who implemented the model, a conference presentation by a state staff person, and written reports from the state.

Background

CMHSPs are public agencies, sponsored by one or more counties, which plan and implement publicly funded services for people with mental

illness, addiction disorders, and development disabilities. Michigan calls services for these populations "specialty services," a phrase this report also uses. Within its service area, each CMHSP is a single access point for people seeking publicly funded specialty services, including Medicaid and other state-funded services.

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CMHSPs were established in the 1970s and their duties have expanded since then. For example, in the 1980s CMHSPs were given the option to serve people discharged from a state hospital, using money the state would otherwise have spent for that person's hospitalization. In the early 1990s CMHSPs' responsibilities expanded to include authorization and monitoring of inpatient psychiatric hospital stays.

In the mid-1990s, Michigan passed legislation aimed at increasing individual choice and responsibility in specialty services. The law required person-centered planning – a process for planning services based on a person's strengths, choices, and preferences – for publicly funded specialty services. People could choose among available services and providers, yet new options, including peer-delivered services and in-home mental health services, were not available in all parts of the state.

Intervention

Michigan implemented the new financing model in 1998. All Medicaid participants who receive specialty services receive them through this model. Each CMHSP serves as the sole primary health plan for specialty services in its area. This model is separate from Medicaid financing for medical services. Michigan has required most Medicaid participants to join Medicaid managed care plans since 1997, but mainstream Medicaid managed care plans do not cover specialty services.

To increase service options, CMHSPs' managed care contracts include a minimum set of services that must be available, including newly developed services. The contracts also give CMHSPs flexibility to offer additional services. The state expected that cost savings from implementing the managed care model would enable CMHSPs to afford the development of new services.

Michigan pays CMHSPs a set amount for each person each month (capitated payment), instead of paying the specialty service providers directly for each service. The capitated payment is based on the historical costs for specialty services. This requirement added financial management and other managed care functions to the CMHSPs' duties to plan and implement specialty services in a region. Each CMHSP has a contract with the state containing guidelines for operating a health plan (e.g., claims processing, customer service). CMHSP contracts also include provisions to ensure people have prompt access to services.

Michigan uses a combination of Medicaid waivers authorized by sections 1915(b) and 1915(c) of the Social Security Act to secure Medicaid payment for the managed care model. The 1915(b) waivers allow Michigan to restrict participants to CMHSPs and their contracted providers. The 1915(c) waiver, a home and community-based services waiver for people with developmental disabilities, was changed to include these services in the managed care benefit package.

Implementation

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was preparing the CMHSPs to become managed care plans. CMHSPs had to develop several new organizational functions, including information systems, claims processing, financial management, and appeal and grievance procedures. The CMHSP association and state staff provided a great deal of training and technical assistance to CMHSPs. CMHSPs also could subcontract with existing health plans to build this capacity.

Previous expansions of CMHSPs' duties eased the transition to a managed care model. CMHSPs authorized inpatient services as well as coordinating outpatient, in-home, and community services, so they had previous experience with the entire spectrum of specialty services. This made the transition to managed care easier than it would have been for an agency that had not had experience in both community and institutional services.

A precise dollar figure for state implementation costs is not available because these costs were not tracked separately. The state used existing staff to implement the managed care model, which required several employees working full-time for more than two years.

Impact

Michigan developed a set of performance indicators for CMHSPs before implementing the managed care model. Several access indicators suggest that access has improved since the model began. For example, among all target populations (people with mental illness, developmental disabilities, and addiction disorders) the wait between an assessment for non-emergency services and receipt of services decreased. Also, the proportion of people with serious mental illness using services increased. Other indicators suggest little or no change: for example, the proportion of Medicaid participants using specialty services remained constant.

In state fiscal year 2000, Michigan spent \$1.8 billion on specialty services, serving over 244,000 people. This included over 180,000 people with mental illness and over 31,000 people with developmental disabilities. An independent evaluation concluded the transition to a managed care model reduced costs for each target population. Estimated savings for mental health services were \$0.01 per eligible person per month (PEPM), while savings for

addiction disorders services were \$0.12 PEPM, and savings for developmental disabilities services were \$10.16 PEPM.

Contact Information

For more information about Michigan's managed care for people with mental illness, addiction

disorders, and developmental disabilities, please call Irene Kazieczko of Michigan's Department of Community Health at (517) 373-4783 or kazieczko@state.mi.us. Information about the model is available on the Internet at <http://www.mdch.state.mi.us>.

Some Discussion Questions:

When services for people with disabilities are provided through a different health plan than medical services, what coordination of care issues arise?

Would a similar model be effective for other target populations?

One of a series of reports by The MEDSTAT Group for the U.S. Centers for Medicare & Medicaid Services (CMS) highlighting promising practices in home and community-based services. The entire series will be available online at CMS' web site, <http://www.cms.gov>. This report is intended to share information about different approaches to offering home and community-based services. This report is not an endorsement of any practice.