DETROIT-WAYNE COUNTY COMMUNITY MENTAL HEALTH AGENCY

MCPN OPTIONS FOR REDESIGN

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DMA
Health
Strategies

Detroit-Wayne County
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I. Executive Summary

Since October 2002, the Detroit-Wayne County Community Mental Health Agency has administered a managed care system for persons with developmental disabilities, adults with mental illnesses, and children and youth with serious emotional disturbance (SED). Combining state and Medicaid funds in a unique managed care arrangement, the Agency has five contracts with Managers of Comprehensive Provider Networks (MCPNs) – three are for individuals with developmental disabilities and two are for adults with mental illnesses and children and youth with SED. The system of care has made notable progress in the last two years, including changes in funding methods, new leadership, new initiatives for co-occurring and early onset disorders, and quality improvement efforts. However, there are many areas for continued improvement. The upcoming reprocurement of MCPN services is a major opportunity for the Agency to redefine the requirements for MCPNs and standardize many aspects of their operations.

DMA Health Strategies was retained by the Agency to conduct an analysis of the current MCPN structure and operations and to make recommendations on improvement, whether the number of MCPNs should be reduced, and on the integration of services with primary care and Medicaid Health Plans.

The findings of the review cover three broad areas: Services, Funding, and Agency Management and Oversight. The Findings lay out a range of issues that can be addressed through contract provisions, increased interagency efforts and improved communications and management processes.

Recommendations address primary care integration and improved collaboration with Medicaid Health Plans and Federally Qualified Health Centers (FQHCs) and the advantages of different models and numbers of MCPNs. A set of overall recommendations cover the following:

- **Procurement:** The agency should initiate several action steps necessary to begin procurement planning by consulting with state officials about the details of this report, seeking broader community feedback, and beginning a formal procurement planning process to develop and incorporate some of the detailed recommendations into the procurement documents.
- **Contracts:** Contracts need greater specificity and should include pay for performance methods. They should advance recovery and person-centered planning and include requirements for the implementation of a health home strategy for consumers in the care of the MCPNs.
- **Financing and Rates:** Actuaries should develop new rates for the General Fund benefits and modify existing rates as necessary. Any Wayne County resident meeting the eligibility criteria for community mental health services can be enrolled for Detroit-Wayne County services. The agency cannot deny access for these individuals. However, the Agency should establish more predictable reimbursement methods for the MCPNs which include the Agency assuming a greater degree of enrollment risk[1], and managing this through the Access Center. An opinion

[1] Enrollment risk is a term that refers to the financial liability for increased enrollment in the MCPN. Under state and federal requirements, the Agency must accept everyone who is eligible for community mental health services. Current funding methods transfer this enrollment risk to the MCPNs by monthly adjustments made to allocations based upon the available funds.

should be sought from Actuaries on the appropriate levels of Medicaid and General Fund reserves for the Agency and the MCPNs.

- **MCPNs:** The RFP should include more detailed MCPN requirements, including ones that ensure a broader availability of the full array of services across the county, performance standards, increased stakeholder and consumer representation on MCPN and provider governing boards, the implementation of primary care integration, and rules regarding payments to board members and other "related parties".
- **Agency:** The Agency should increase its focus on the coordination of services with other government agencies that manage services for people with substance use disorders, and individuals involved with child welfare or the justice system. The Agency should learn from other state and national best practices. One of the most important Agency initiatives over the next year will be to successfully redesign the Centralized Access Center and implement, integrate and manage a state General Fund benefit and waiting list. The Agency should improve its focus on prevention as funds become available. The Agency should increase the use of performance measurement tools, complying with existing standards and in implementing quality improvement efforts to meet state standards and advance clinical practice. It should continue current efforts to expand the involvement and input of consumers and family members at MCPNs and in the Agency and its various Advisory boards. Finally, several recommendations address Agency-MCPN communication, staff training and quality improvement.

The challenges of the last several years have been significant and like most states, Michigan faces continued revenue problems in 2011 and 2012 budgets as a result of reduced employment levels and the overall economy. This has forced significant reductions in state general funds to Counties. These trends in reduced state general funds will likely continue for the next couple of years and will put continued strain on services for uninsured and on the Agency's compliance with Medicaid standards and benefits. Despite these challenges, the Agency is making considerable strides in improved operations, performance and in advancing recovery. The reprocurement of the MCPNs presents a major opportunity to continue to achieve efficiencies, standardize operations and make systemic improvements in the delivery system for the benefit of over 66,000 consumers, their families and the community.

II. Introduction

DMA Health Strategies was retained by the Detroit-Wayne County Community Mental Health to provide guidance to the Board of Directors and Agency Administration on the options to be considered in the redesign of the mental health system. Specifically the Agency sought:

> "…an analysis of the current MCPN structure and its operation and making recommendations as to how the system might be more fully integrated internally and with the Detroit-Wayne County Community Mental Health System and its operations and/or other service providers to achieve more efficient and effective operations. This analysis shall include a recommendation as to whether the Agency should consider adjusting the current number of MCPNs….Providing a review of the proposed Agency Financing strategy … (and) providing consultation and recommendations on the efficient and effective integration and provision of behavioral health and primary health care to consumers."

Richard Dougherty, Ph.D. led the effort for DMA. Dr. Dougherty consulted with the Mental Health Board, met with the Detroit-Wayne County Community Mental Health Agency (DWCCMHA, Agency) leadership and staff in group and individually, met with Managers of Comprehensive Provider Networks (MCPN) leadership, held two meetings with State officials, and met with advocates and other stakeholders. In addition, Dr. Dougherty facilitated two staff retreats that reviewed options, developed consensus on several key issues and outlined requirements for effective managed mental health care in this new era. From these interviews and the review of many documents, a picture of the system and these recommendations emerged.

This report summarizes the results of that review, lays out some options for redesign and provides recommendations.

III. Background

Under the terms of both a Medicaid 1915(b) Freedom of Choice Waiver and a 1915(c) Home and Community Based Service Waiver, Michigan has contracted with counties and groups of counties across the state for the management of Medicaid services to people with severe mental illness, serious emotional disturbance (SED) and developmental disabilities. The counties function as Prepaid Inpatient Health Plans (PIHPs) under Medicaid rules, and consumers are assigned to these plans when they meet clinical criteria. A county's duties as a PIHP are outlined in contractual obligations to the Michigan Department of Community Health (42 CFR Part 438; Michigan Mental Health Code Act 258 of the Public Acts of 1974, as amended in the PIHP Contract). Responsibilities of the Agency include the delivery of a comprehensive set of services for people with mental illnesses, substance abuse disorders and developmental disabilities. Detroit-Wayne County utilizes Coordinating Agencies to deliver its substance abuse services: the Southeast Michigan Community Alliance and Detroit Bureau of Substance Abuse Prevention, Treatment & Recovery. In part because of its size, the federal government required that Detroit-Wayne County's mental health plan services be contracted out to private provider networks to ensure competition in Wayne County. This led to six initial contracts for Managers of Comprehensive Provider Networks. They were awarded in 2001-2; three for people with mental illness (MI) and children/youth with serious emotional disturbance (SED) and three for persons with developmental disabilities (DD). Two of the MI Plans merged after the first year or two of operations. The remaining five plans continue today.

Over the last eight years, three plans have experienced significant financial difficulties. The enrollment patterns of one of the MI and one of the DD plans resulted in payment or funding levels that did not meet expenses. The MI Plan soon merged with another, and this stabilized its finances. As a result, the agency expedited a full review and modification of the funding methodology for all MCPNs. Most recently, spending was not sufficiently controlled at one of the MI plans and the organization had a negative fund balance and was unable to operate. The Agency performed a detailed review, and senior leadership left the organization. A turnaround is under way and seems to be progressing reasonably well. Additionally, the new funding model has been implemented, providing more appropriate and actuarially-based funding for the MCPNs.

Federal rules require periodic open and competitive bidding of contracts for health plans in Medicaid, as well as all federal programs. While this was waived for the County-operated or sponsored PIHPs, including the state's contract with Detroit-Wayne County, the Detroit-Wayne MCPN contracts are due for reprocurement in 2011. Furthermore, there is a pent up need to reprocure in order to more fully

adopt recovery based principles, incorporate new requirements, implement central access and waiting list procedures, and incorporate other requirements. As a result, the Agency and Mental Health Board sought consulting assistance to advise them of the best design for the MCPNs and other practices that can improve services.

IV. Overview

Despite challenges, the Agency is making considerable progress in service quality, funding, and oversight of MCPNs. Over the last eight years, MCPNs have been effective at improving the oversight of care, managing utilization and improving payment timeliness with service providers. The Agency's current efforts to increase accountability, performance and quality are particularly important. These include, but are not limited to, the current work on performance contracting, MCPN funding model changes, co-occurring treatment, the Children's Initiatives, and early onset programs for schizophrenia.

The goals and standards outlined in the Agency's Application for Renewal and Recommitment contain the vision and framework for the new system, including but not limited to renewed partnerships and engagement with consumers and stakeholders, better coordination of care and administrative efficiencies. These can and should be translated into provisions for the MCPN contracts and re-procurement. The implementation of a new information system across the Agency (Mental Health-Wellness Information Network, or MH-WIN) is another opportunity for the implementation of more timely and accurate reporting using more consistent data definitions.

The Agency has been hurt by the changes in senior leadership over the last decade. However, the leadership team now is strong in most areas, and areas where improvement might be needed can be easily addressed. The appointment of the current Director, who has longevity and continuity with the Agency, is a strong stabilizing influence that will allow the Agency, to build on its past accomplishments and to address improvements by establishing better teamwork, consistent follow-through and a shared vision. It is particularly important in such critical financial times.

Notwithstanding the progress, there are many opportunities for improvement in the existing or a redesigned mental health system. The reprocurement process and the implementation of MH-WIN provide a major opportunity for accomplishing the needed improvements. This should include:

1) The development of a detailed vision for a redesigned system including the comprehensive array of services required;

2) The use of clear and specific procurement language which will be incorporated into MCPN plans and contracts;

3) Greater specificity in services and administrative oversight; and

4) Tighter and more consistent financing and reporting rules.

In short, the Detroit-Wayne County Community Mental Health Agency now has the opportunity to increase expectations and specify some new standards and more detailed operational processes. This will help to create a new and more effective type of managed care system for the next decade.

The findings from our review are outlined in the next sections. They cluster in three main areas: Services, Financing, and Agency Management and Oversight. They are followed by a description of the

minimum requirements for any MCPN, a discussion of strategies to achieve greater integration with Primary Care, options for redesign of the MCPN system and a summary of detailed recommendations.

V. Services

Detroit-Wayne County has a three level service delivery system for people with mental illness, SED and DD who are Medicaid beneficiaries or indigent (covered by general funds). The levels include: 1) Comprehensive services funded by the Agency and delivered through MCPNs for persons with SMI, SED and DD; 2) a set of direct contract provider services funded by the Agency[2]; and 3) the limited mental health services available to Medicaid eligible individuals through the Medicaid Health Plans. In addition, but outside the scope of this review, substance abuse treatment and prevention services are funded through the County Coordinating Agency. While the Agency provides a comprehensive array of services for those with SMI, SED and DD through the MCPNs, there should be more coordination of services between all of these three levels of the delivery system. This requires clear standards for the coordination of benefits and services and it requires close collaboration between the MCPNs, providers, the Agency, Medicaid Health Plans and others.

Increase the consistency of services across MCPNs

Many stakeholders see benefits to be inconsistent across MCPNs. Each MCPN technically has the full range of services available; however, this is not the experience of all consumers. This is in part because each MCPN was developed independently. In addition, services are not always available across all areas of the county. A more detailed study of this may be warranted and clear standards should be incorporated into the reprocurement.

Recovery oriented services need to expand for people with SMI.

The Agency has advanced a recovery agenda in various ways, supporting self-help groups and key advocates on different projects. The Detroit-Wayne County Community Mental Health Board approved this focus in its 2005-2007 Agency Plan. However, there is limited evidence that providers, MCPNs or others have fully adopted a recovery agenda, though there have been some efforts that should continue to be supported. Recovery based services are driven by self-help, peer support, person-centered planning and service coordination; not a medical model of care. Recovery has two discrete dimensions that need to be addressed by systems of care: first, a core set of services should be run and supported by individuals with “lived experience”. These services should seek to help peers recover based upon this experience. The use of certified peer specialists as adjunct and support staff in programs is one way to advance this aspect of recovery. The second dimension of recovery is guided by the vision that people have an innate capacity and motivation to recover and hence do not require ongoing services, instead the system should be structured to help consumers move from more intensive to less intensive levels of care. Care should shift to support services, consumer education, self-help and self-care. Both aspects of recovery are essential; both need further development in Detroit-Wayne County.

There needs to be an increased emphasis on person-centered services.

Person-centered services are at the heart of Michigan’s waiver program for mental health services. Many aspects of the waiver and the administration of the plan revolve around a person-centered approach. This is far more prevalent in Detroit-Wayne’s MCPNs that serve people with developmental disabilities (DD) than it is in those that serve people with mental illness or SED. However, even within

[2] These include but are not limited to children and youth program pilots, jail diversion, jail mental health services, juvenile detention services, school based services and Family Resource Centers.

the DD systems, there are quite different levels of support for true person-centered work. One MCPN uses independent support brokers for all their service planning and many of their consumers self-direct their care. Another MCPN uses independent brokers for only a portion of their population.

Standardize Clinical and Administrative Processes

Clinical and administrative processes need to be standardized. This should begin with a clearer process for screening, enrollment and choice in the MCPN system. This will be achieved in part through the re-design of the centralized Access Center. Other more standardized processes should be defined in a reprocurement. This should include requirements for utilization management, clinical standards, quality review, etc.

Coordination with other agencies needs to be increased.

A few examples of organized efforts that reach outside the mental health systems to coordinate services with children or adults in other state and local systems are emerging in Wayne County. Currently, these primarily focus on the Children's System of Care and criminal justice system (Mental Health Courts, jail diversion, police training programs, etc.). Through the Wayne County Human Services Community Collaborative, the Agency can build on and expand these efforts. The Agency can and should take further steps to coordinate care by including requirements in the reprocurement for MCPNs to support these interagency collaborations. The Agency can also learn from the pioneering efforts in other parts of the country with child welfare and with other health systems. The specific coordination issues for MCPNs are different for each agency and are compounded by the fact that each system's funding streams mix state and Agency responsibilities – but the children and the consumers are the same!

There are systemic barriers in the transition from residential services to independent living.

Most stakeholders and leaders acknowledged the large number of people who are in group homes and similar group housing around the community. MCPNs felt it was difficult to manage these expenditures because many of the group home operators are heavily invested in the properties they have utilized for decades. Consumers reported that they want more alternatives. There is an increasing emphasis on efforts to improve quality of these services, but there should be a similar emphasis on moving adults to more independent living arrangements when it is their choice and is possible. The Agency and MCPNs should work with the Michigan Association for Assisted Living and representatives of the Group Home Association to move individuals into supportive housing arrangements. Self-determination and consumer choice should guide all decisions about consumer housing. These values must be developed further in services for people with mental illness; they are more evident in services for people with developmental disabilities

Utilization management efforts seem limited to acute hospital.

A policy to implement more consistent UM activities across different MCPNS should be considered to manage both acute inpatient and state hospital resources. The goals should include cost control as well as keeping individuals in the community and maximizing their potential for independence. Agency staff also reported the need for increased client turnover through greater use of utilization management for residential services and Assertive Community Treatment (intensive community-based intervention supports and care coordination). However, most MCPNs reported that these services were being routinely reviewed. To increase their mutual understanding, the Agency and MCPN leadership may benefit from a focused review of UM where turnover rates and the different types of UM activities for each MCPN are reviewed and improvement opportunities are identified.

Where is the "clinical home"?

Each MCPN differs somewhat in the way that providers and consumers are linked. The Agency holds the MCPN responsible and service planning should include responsibility for care coordination. But when needed services aren't accessed or coordinated, who should be held responsible for correcting these problems? A "clinical home" for hospital, residential and ambulatory services should have the responsibility for the coordination of care with other agencies and within the MCPN assigned to them. MCPN reporting to the Agency should clearly identify the clinical home for all enrollees and develop reports on client needs and utilization patterns for each "home" so these can be used for QI efforts. This is consistent with national trends to develop medical or health homes and Wayne County providers have a number of excellent examples of health home programs. The standards for practice should be expanded to include all MCPNs for adults with mental illnesses and developmental disorders and children with serious emotional disturbance.

When should cases be closed?

The Agency's new payment methodology stops payments for individuals who have not received a service for 120 days. Payment begins when encounters resume. These are good policies, but they were developed from payment rules, not from clinical criteria. The Agency, in consultation with MCPNs and other stakeholders should develop clear clinical policies, aligned with clinical criteria and the payment rules, about what services should be provided to inactive members as well as when consumers should be disenrolled from the MCPN system and return to the services funded by their managed care organizations.

There needs to be greater focus on mental health outreach and prevention.

The Agency's MCPN system, like many other managed care systems across the country, is set up primarily to provide a comprehensive set of benefits for individuals enrolled with the plans rather than reaching out to identify and or prevent mental illness or SED. A few direct contracts held by the Agency address prevention and outreach. The Agency sponsors Health Fairs and outreach to faith based communities, but there were few signs of any systemic integration of these efforts with the MCPNs. The initial mental health services of individuals eligible for Medicaid may be provided by the Medicaid Health Plans (MHPs). Unfortunately, there is little financial incentive for the Agency, MCPNs or providers to prevent mental illnesses, provide health promotion services, etc. At the same time there is a clear, long-term, public health necessity for outreach and prevention services. Despite pressure to cut funding, the Agency needs to continue to provide these services through General Funds and - if they are not explicitly part of the waiver - possibly through administrative Medicaid claims. Furthermore, the MCPNs need to have procedures for collaboration with the Medicaid Health Plans to transition consumers whose symptoms and functioning improve back into the care of the MHPs. In turn, there need to be procedures to identify individuals in MHPs whose symptoms and functioning worsen, and refer them to the Access Center and MCPN enrollment. These requirements need to be incorporated into the RFP.

The drop in GF Funding may reduce service innovation.

Flexible funds and grants are generally the way new services are developed in most government systems. Medicaid and the overall health system's reliance on and requirements for encounters and documentation for each service stifles innovation in many ways, and it is the Agency's responsibility to ensure that there are methods to maintain this healthy creativity in the delivery system. In the absence of available General Funds, other ways to foster innovation and creativity should be explored. Coordinating events and planning with local foundations is one approach that might work. The system needs to build on the current University collaborations between the Agency and Wayne State and Eastern Michigan University. Similarly, efforts to raise public awareness of particularly creative services could community support and interagency collaborations aimed at securing federal grants. Holding

annual events and making service awards can be one or several methods to increase this public awareness.

VI. Financing Issues

As noted earlier, over the last eight years, three of the MCPNs have had serious financial difficulties. The payment methodology was a contributing factor for two of them; however this was compounded by insufficient funding available to the Agency, as well as by trends of increasing enrollment. As a result, revenue per person has declined over the last number of years and hence individual utilization levels and payments to providers have also declined. Any Wayne County resident meeting the eligibility criteria for community mental health services can be enrolled for Detroit-Wayne County services. The agency cannot deny access for these individuals and there is resulting financial risk that has to be managed by the Agency. The Agency's policies and the MCPN reprocurement must address these payment and funding issues directly – ensuring that the system is properly funded for required services and functions.

Uncertain monthly payments increase MCPN risk.
Over the last decade, similar to trends across the country, Medicaid utilization and spending has increased and general fund spending has declined. This is largely a result of the lack of additional State revenue to the Agency each year and the increasing demands on General Fund revenues for the Medicaid match. To control its risk, the Agency has developed a payment methodology that adjusts funding calculations (based upon risk scores) for MCPNs each month to match the amount of funds available. MCPNs' monthly revenue levels are not predictable; they may vary month to month even if enrollment is unchanged. This limits the Agency's risk for increased enrollment and utilization, but it increases the risk to the MCPNs and may contribute to financial instability of the MCPNs and their providers. This method also reduces the "attractiveness" of the MCPNs to outside contractors in any procurement.

General Fund benefit changes will require further changes in funding methods.
Currently individuals who are not eligible for Medicaid but who have serious mental illness or SED and otherwise meet clinical eligibility rules are eligible for MCPN enrollment and for the full array of benefits. The reduced funding available for the General Fund requires reductions in benefit levels for individuals funded by General Fund dollars. This may require new risk scores or, at a minimum, separate funding bands for General Fund enrollees. The same is true of ABW and MICHILD services. As the population for each funding band may be different, risk scores may need to be differentiated. These changes need to occur this summer, a year prior to the reprocurement. This will have the most significant effect on the MCPNs serving people with mental illness or SED. It is possible that it will not affect MCPNs serving the DD at all.

Policies on risk and reserves need to be clarified.
State rules for retained reserves (savings) and Internal Service Funds need to be clarified for the reprocurement. The 7.5% limit on reserve funds applies to Medicaid and General Funds. Counties and MCPNs may also retain a 7.5% Internal Service Fund for reinvestments in Medicaid services. From the state's perspective, reserves and ISF funding retained by the Agency and the MCPNs must be considered together. Different rules apply for each pot of funding, but it is not precisely clear how the reserves within individual MCPNs and those retained by the Agency would be categorized. Both MCPNs and the Agency have some level of risk, though the funding methods and the monthly payment adjustments

transfer most of the risk to the MCPNs. Ultimately, the operational and financial risk falls to the Agency in the event of MCPN default. As a result of these shared risks, both the MCPNs and the Agency should retain some level of funding, though the MCPN reserves may need to higher. Quantifying these levels and agreeing on them in advance is a challenge, but ideally the reprocurement should contain greater specificity in this area. Since MCPNs have minimized their reserves in the past through retroactive rate adjustments, the rules for this practice should be explicit in the new procurement. In addition, particular attention should be paid to regulating allowable payments to Board members and "related parties"[3].

Improve Medicaid eligibility procedures.
Currently, MCPNs use different processes to refer clients for eligibility and assess need. The implementation of a more fully centralized CMH Access System will help to ensure that all clients who meet Medicaid eligibility criteria are determined eligible. This is a major initiative of the Agency over the next year. The Access System will occur at the point of initial enrollment with Community Access for MCPN services, though it should be accompanied with a broader community effort to enroll people on Medicaid to expand health coverage for the poor and categorically needy. The Agency will also need to work with the state to reduce the current error rate on the eligibility (834) record. The importance of the accuracy of this record increases significantly with the planned changes to Medicaid and General Fund benefits and rates.

Continue efforts to implement performance incentives.
The current work of the Agency with Open Minds is very important. Ideally, contracts being renewed for Fiscal Year 2010-2011 should lay the groundwork for incentivizing performance through payment reforms. Strategies might include a combination of withholds and penalties. It will be important to build in contracting flexibility so that incentives can be modified should strategies and goals change. Modifications should include both the performance categories and specific levels and types of incentives. As new funds become available, the Agency should strongly consider possible adoption of more deliverable-based reimbursement or small bonus payments for goal attainment, as well as withholds and penalties.

VII. Agency Management and Oversight

A number of areas need attention in the Agency's management and oversight of the MCPN system. These include the specificity of contract language, the routine use of data for management decisions, reducing duplication of effort, aligning quality initiatives, improving reports, continuing efforts to reduce state hospital use, and increasing the role and input from consumers and families.

Update and increase specificity of contract language.
Contracts need greater specificity and should incorporate performance based outcomes. Contracts should more clearly identify the procedures and the outcomes required. Greater specificity about programmatic standards, operational requirements and required reporting will significantly increase the Agency's ability to manage the MCPN contracts and ultimately to improve the coordination and quality of services. It will also give the Agency a clearer role in monitoring the contracts and performance of the MCPNs. The work of the Agency with Open Minds should increase the use of payment mechanisms that

[3] A "related party" is broadly defined as entity or individual who has decision making authority or financial interest in the actions of the other party. Tax, accounting and regulatory rules require disclosure of these relationships and limit the activities that the related party can engage in.

are designed to increase performance levels (i.e. pay for performance). The reprocurement is the ideal time to develop the required specificity. Those areas where the Agency can be clear about processes and standards should be specified in the RFP; for other areas the Agency should require MCPNs to submit a plan as part of their proposals that would ultimately be incorporated into their contracts.

There is a need for more data driven policy and management.
MCPNs file encounter data routinely with the Agency. However these data are not readily available for Agency management and policy development. While the implementation of the new state of the art management information system (MH-WIN) is likely to improve data integrity and timeliness, the Agency needs to develop routine reports and a performance dashboard that provide measures for MCPN operations. These should include penetration rate, utilization rates, per capita expenditure levels by service type, length of stay, state mandated measures, and others.

Eliminate duplication of effort and improve coordination where possible.
MCPNs cited a number of examples where agency divisions conducted duplicative site visits or audits. While these are often required by the state, the duplication of effort increases administrative costs for MCPNs, detracts from Agency and MCPN time available for other activities and could be confusing for MCPNs. This can be minimized by better coordinating MCPN oversight activities among the various Agency divisions. One strategy would be to use the Managed Care Operations office as a central hub for communications with the MCPNs, particularly as it relates to compliance-related activities. They can coordinate the timing and focus of state and Agency mandated visits. There is also a need to focus on standardizing tools and forms for reporting and monitoring.

Improve alignment of quality and measurement across the Agency
The Agency's quality program is working on many of the right issues but the approach is generally compliance oriented and the MCPNs do not seem to be embracing the need for continuous improvement. Quality management activities are primarily focused on improving compliance with state mandated performance measures. This should continue but should also be accompanied by an approach that focuses on annual or bi-annual, county-wide performance improvement goals for all MCPNs. These should be implemented in a collaborative way that includes workgroups of MCPN and provider staff with input from consumers.

Standardize reporting from MCPNs to Agency.
Currently, each MCPN reports to the Agency in a different manner and in different formats. Standardizing these reports as a part of the reprocurement or as a requirement of the new contract will help to ensure comparability of the data and facilitate the consolidation of reports for Agency-wide analysis and reporting. These reports and the required formats must be consistent with the requirements of the Michigan Performance Indicators.

Ensure an Independent MCPN Enrollment Process.
Currently, many individuals seeking access to services, particularly services for people with mental illness or SED, initially are seen by providers who are affiliated with one of the MCPNs. There was no evidence that any provider did not fully communicate that consumers have a choice of any MCPN. However, the system is harmed by any appearance of conflict that occurs when a network member self-refers to its MCPN. The implementation of a more centralized Community Access system provides an opportunity to ensure that consumers are fully informed about their options and that eligibility for the program is conducted impartially.

Develop strategy to monitor and reduce state hospital use.
State hospital use remains a significant concern of state officials. Rightly or wrongly they perceive that Detroit-Wayne individuals use the hospital disproportionately. Costs for state hospital use are less than the costs of serving an individual in the community. Recent efforts have lowered the utilization rates, but maintaining progress requires a sustained and consistent focus. This should be a county-wide effort, covering the two MI MCPNs as well as the DD MCPNs. It should be aimed at enhancing community-based service delivery and documenting effectiveness and cost savings. The Agency may want to consider incentives or other financing approaches for the community services required by these individuals.

Increase consumer and family input.
The Agency supports the goals and mission of consumer and family mental health advocates and has made progress in making Detroit-Wayne more of a consumer and family driven system. The Agency has helped to create the Consumer Family Advocate Council, the Community Planning Council and the Peer Core Implementation Team for Systems Transformation. There is also some financial support for these organizations. The Agency also has several consumer employees who are integrated into operations. To continue to advance the recovery agenda and achieve programmatic objectives, such as reducing the reliance on hospital and residential services, a stronger consumer voice throughout the system will be needed. MCPNs should be more active in adopting the principles of recovery and consumer direction. The Agency and MCPNs should invest time and, if needed, resources in developing a group of leaders from the consumer community. Currently several key advocates with leadership potential appear to be capable of becoming more actively involved in Agency and MCPN governance and other advisory functions. This should be a priority for MCPNs serving persons with mental illnesses and serious emotional disturbance.

VIII. Key Components and Requirement of an MCPN

Medicaid and state rules specify certain key components and minimum requirements needed of every managed care system. These MCPN functions must fit with and not overlap the Agency's organization and staffing. Some of them can be performed by the MCPN, the Agency or perhaps even another entity. They must also be developed in a manner to ensure compliance with the two Medicaid waivers and with state and federal statutory and regulatory requirements.

MCPNs must include the following minimum functions:

- **Core Principles:** The MCPN should be driven by a set of core principles. These principles should be based upon the vision, mission and values advanced by the Agency. The values range from self-determination to efficiency. They should be a foundation for the MCPN system to achieve the intended outcomes of social justice, equity and personal health and improvement.
- **Covered Services:** These should include all services required under the state 1915(b) and (c) waivers for Medicaid enrollees as well as any additional Agency required services.
- **MCPN Enrollment requirements:** These policies and standards must be aligned with the Agency's policies and procedures for the Access System. They should include MCPN requirements for timely development of a service plan after individuals have been enrolled and periodic review to determine the need for continued services.

- **Access to Services:** Service access within each MCPN must meet local, state and federal standards for access to services. These include timeliness of first appointments and service plans as well as access to clinically appropriate standards.
- **Special Service Requirements:** The MCPNs are responsible for implementing Evidenced Based Practices and services for special populations. MCPNs should be required to advance the Agency's work in developing Assertive Community Treatment, Integrated Dual Disorder Treatment, Supported Housing, Supported Education, Treatments for Co-Occurring disorders and other culturally and linguistically appropriate services required by specific racial and ethnic groups in the county.
- **Health education requirements** include but are not limited to efforts to educate consumers with mental illnesses and developmental disabilities on the health consequences of diet, exercise and smoking behaviors. MCPN efforts should also support the Agency's work with community health fairs and other activities to more broadly advance a public health agenda for county residents. The MCPNs should also ensure that all service plans include health education and health service goals.
- **Coordination of care:** Care coordination should include requirements for service planning, coordination of access to the needed services and monitoring activities. Coordinated services should include all covered services as well as access to health care, education, vocational and other community services.
- **Utilization Management:** MCPNs must meet all applicable state and federal utilization management standards. These should cover acute and state hospital care as well as residential services.
- **Network Management:** The MCPN is responsible for maintaining a comprehensive network of providers who will provide services according to the standards of the Agency. This requires contracting, credentialing and monitoring functions within the MCPN.
- **Quality Management and Improvement:** Quality improvement should be an integral practice for all MCPN operations and services. Quality improvement initiatives should be guided by the goals of the Agency's Application for Renewal and Recovery and be done in collaboration with other Agency improvement initiatives.
- **Performance Standards:** These should include, but not be limited to, the Michigan Performance Indicators and those indicated in the Application for renewal and Recovery.
- **Data and Reporting Requirements:** The RFP should specify all MCPN data and reporting requirements designed to allow the Agency to meet state and federal reporting requirements. These shall include the goals set forth by the Agency's Application for Renewal and Recovery as well as the Michigan Performance Indicators.

To accomplish this will require a Request for Proposal (RFP) and resulting contract that include detailed performance specifications for the MCPN. The RFP should optimize the level of detail so as to ensure accountability but not to stifle creativity and innovation in responses. It should be guided by the Agency's specifications for the minimum MCPN requirements discussed above as well as the decisions made by the Agency on two additional areas: coordination with primary care, FQHCs and Medicaid Health Plans and the numbers of MCPNs. These are discussed below.

IX. Recommendations on Coordination with Primary Care, Federally Qualified Health Centers and Medicaid Health Plans

Medicaid eligible individuals are enrolled with Medicaid Health Plans (MHPs) and, when they need services for more serious conditions, in MCPNs as well. The MHPs include Molina, Total, BlueCaid, Great Lakes, HPM, Midwest, Omnicare, and ProCare. Initial mental health services are generally received within those MHPs. An earlier section of this report discusses the need to clarify the processes for step-up and step-down of coverage between the MHPs and the MCPNs. But once an individual is evaluated as meeting the clinical or development criteria for MCPN enrollment, primary care services must then be coordinated between the MCPN and MHPs. People with dual eligibility, chronic illnesses and tribal eligibility who are enrolled with MCPNs receive their physical health services from fee for service Medicaid and many of them receive primary care services from FQHCs.

Individual needs for mental health and physical health vary and the strategy that is best used to address those joint needs will vary depending upon the scope of their needs and the frequency with which they utilize the different services. This is perhaps most simply understood through the "Quadrant Model"[4]. The Quadrant Model addresses different combinations of high and low levels of behavioral and physical health needs, resulting in four basic population groupings, as illustrated to the right.

Figure 1: Quadrant Model

2 High BH	**4** High BH
1 Low BH Low PH	**3** Low BH High

Behavioral Health Risk

Physical Health Risk

Several strategies can be employed to better coordinate care but in all categories, primary care physicians need standardized screening tools to help them identify mental and developmental needs and access to specialty services. Individuals in Quadrants 1 and 3, with low behavioral health needs but with the full range of physical health needs, are best served by psychiatric consultation services to the general health physicians who have primary responsibility for coordinating care. Individuals in Quadrant 2 and 4 with high mental health needs and varying levels of physical health needs will likely have someone coordinating their mental health care. In quadrant 2, where behavioral health needs are high and physical health needs are low, this care manager should be a mental health professional who should also have the responsibility for coordinating services with the primary care clinicians. In Quadrant 4, where both behavioral health and physical health needs are high, there is likely to be a more significant need for physical health care coordination. Many planners have called for RN's or other medical staff to be out-stationed at community mental health centers or other mental health organizations. A more detailed and comprehensive summary of the different possible models of behavioral health integration in primary care can be found in a new publication by the Milbank Memorial Fund[5]. It outlines eight practice

[4] Mauer, Barbara J. "Behavioral Health/Primary Care Integration: The Four Quadrant Model and Evidence Based Practices". National Council for Community Behavioral Health, February 2006.

[5] Collins, Chris, et al. "Evolving Models of Behavioral Health Integration in Primary Care" Milbank Memorial Fund, May, 2010. http://www.milbank.org/reports/10430EvolvingCare/10430EvolvingCare.html

models ranging from collaboration between separate providers, collocation and reverse collocations on through to Collaborative Systems of Care.

MCPNs need to develop their own strategies to respond to the health care needs of their members. They can do this by partnering with some of the larger Medicaid Health Plans and FQHCs in their area to address the chronic health care needs of their members. Following the quadrant model, they can work with these health payers to agree on strategies to provide psychiatric consults to primary care for mental health needs and deploy nurse clinicians to CMHC sites for physical health needs. Using these approaches, they can avoid cost increases by working in a more integrated manner. The methods by which these costs are covered should be negotiated between the plans and among providers. "Clinical homes" or "health care homes" are another valuable strategy to consider. At a minimum, all Individual Service Plans should include strategies to address physical health needs and these requirements should be made more explicit so that audits can look for provider compliance. The Agency should provide guidance to the MCPNs about a standard set of screening tools and care management protocols for primary care physicians and other care managers. Finally, a set of performance metrics are needed to assess integration activities. Each MCPN should be required to have an annual physical/mental health integration plan and to demonstrate quantifiable progress and partnerships in effectively coordinating care.

Some providers, including some affiliated with MCPNs, are piloting different integration and collaboration models. The outcomes of these efforts may provide valuable information for the Agency and MCPNs to encourage progress on the integration of care.

X. Recommendations on the Number of MCPNs

During the last procurement in 2001, contracts were awarded to six MCPNs; three for people with developmental disabilities and three for people with mental illnesses or SED. After a year or two, one of the MI MCPNs began experiencing operational and financial problems and merged with another. While the remaining five MCPNs are all operating under the same basic MCPN contract with a standards set of benefits, the needs of the populations and the array of service used are very different for the MCPNs serving people with MI compared to those serving people with DD. One management entity is the administrator for two MCPNs, one an MI and the other a DD MCPN. Another MCPN is notable because it is the only organization serving as both a provider and MCPN. The other MCPNs are managed quite independently and they have unique identities and services.

The different needs of the populations and the different funding levels would seem to argue for separate MCPN organizations. Since the MCPNs are provider sponsored, the MCPNs did in fact arise to meet the discrete needs of people with DD, mental illness and serious emotional disturbance. However, the management of two of the MCPNs by a single administrative entity illustrates that the basic operational processes of network management, claims payment, utilization management, and quality used by both DD and MI MCPNs are the same, though they may need adaptation for the different populations.

There are a finite number of options for the Agency and the Board to consider regarding the number of MCPNs. Each has unique advantages and disadvantages that are summarized in the table on the following page.

Detroit-Wayne County Mental Health Services
Options For MCPN Redesign and Improvement

Option	Advantages	Disadvantages
1. Maintain Existing Basic MCPN Structure *Procurement would allow for 2-3 MCPNs for MI and DD. New contract could require various improvements such as reducing the variation in utilization management standards; Continue to work on improving management and oversight*	• Minimizes disruption • Maintains level of choice of plans • Does not require major new MCPN investments • Maintains the "provider" network focus • Continues existing business relationships • Rates that continue to fluctuate with the availability of funds maintains a lower level of risk for the Agency	• Keeping the same structure provides less opportunity for major system redesign and for reorganization of existing staff and MCPNs • More of an incremental approach and thus larger change may be hard to sustain • May be more difficult to make benefits more consistent across the county • Continued need to monitor 5-6 MCPNs • May continue variability in provider rates across the MCPNs • Less likely to attract new bidders • If management is not improved, the new structure may not improve care
2. Reduce Number of MCPNs to Four - with DD and MI as a separate focus *RFP would specify that only 2 MCPNs would be selected per disability. New contract could require various improvements such as reducing the variation in utilization management standards; Continue to work on improving management and oversight* *Four MCPNS would be required to keep consumer choice under this approach*	• Disruption is minimized since re-enrollment is limited to only one group of MCPN enrollees from the one DD MCPN that would not be renewed • Only one MCPN has to merge or be eliminated • There is a greater clarity of focus on either DD or MI, potentially allowing for more depth of expertise in one or the other.	• Maintaining choice will require 4 MCPNs which is not a very large reduction in the current number • It would require change in DD only • If management is not improved, the new structure may not improve care • Separate standards and monitoring would be required for DD and MI Reduction in the number of MCPNs from 5 to 4 does little to create improved economies of scale in either MCPN or Agency structures • Specialization in either DD or MI leaves it unclear about where co-occurring MI/DD disorders would be treated, and whether either type of MCPN would be fully qualified to do so

Option	Advantages	Disadvantages
3. Reduce the number of MCPNS to Two or Three – all MCPNs serve both DD and MI *The MCPN functions are somewhat generic despite the unique characteristics of the populations. This could be collaboration between MI and DD agencies.*	• Consolidates network, contracting, claims payment, quality functions • BHPI currently does a version of this in Detroit-Wayne County • Greatest likelihood of economies of scale in Agency oversight and monitoring and long term savings • Allows for creation of new governance options in MCPNs • Can require broader geographic spread of each MCPN • Involves the greatest opportunity for restructuring • The new administrative entity can increase consistency of MCPN reporting and administration • All MCPNs would have the capacity to serve co-occurring DD/MI disorders.	• Advocates and families may feel that the specific needs of individuals with MI, ED and DD will not be met by MCPNs that serve both populations • Will Likely need population focused advisory boards for each MCPN to address above concerns • Contracting, service and authorization requirements are very different for the different populations. Separate AND shared DD and MI policies are needed • Savings not likely to be realized by Agency in the short term - Existing 4.5% cap on administrative rates is already low by most standards • For most current MCPNs, this will require considerable change in MCPN governance. They will need to maintain their "Provider" Network structure and develop new managed care governance structures. • Likely to require new MCPN investments by some MCPNs to finance the consolidated administrative changes
4. Reduce Number of MCPNS to Two *Each MCPN would specialize in either the DD or the MI population*	• Keeps population specialization in each MCPN • Reduces the number of MCPNS to reduce Agency oversight and administrative costs	• No consumer choice of Plans and as a result this is probably not compliant with waiver provisions • May require waiver changes • State may object • Similar to option rejected previously • Separate standards are required • Question of which MCPN would best serve co-occurring disorders
5. Move to an Agency Run Provider Network *Similar to other Counties*	• Agency may feel greater control • May appear to have some administrative efficiencies – though the 4.5% is already quite low • Could implement comprehensive provider models within the Agency run network, though this might require a different type of enrollment	• Would require changes in waiver and CMS approval • Agency would have to provide or purchase needed administrative services – claims, pharmacy, etc. • Exposes Agency to far more financial risk
6. Increase the Number of MCPNs *Could be similar to Core Provider concept*	• Increases choice and reduces access barriers	• Increased cost of monitoring • Likely to continue separate population focus • Increased risk of problems (fraud, abuse) for Agency • Lower enrollment increases risk for the Plans
7. Implement Full Risk Insurance Model	• May avoid concerns about combined reserve levels between MCPNs and Agency	• Would require increased financial reserves and insurance licensure for current providers

Option	Advantages	Disadvantages
		• Existing "provider network" contractors would not qualify as currently organized • Likely to increase rates or reduce service levels. • Lack of experience in existing insurance companies • Would require waiver changes if not provider sponsored

Based upon the above analysis, options 1 and 3 are the most viable – Option 1 because it is least disruptive and Option 3 because it is likely to be the most efficient. Option 1 does not involve a significant change in structure of the MCPNs. Option 2 seems a somewhat arbitrary change given that the current number of MCPNs is five. Option 3, on the other hand, would seek increased efficiencies through consolidation of the administrative functions provided by the MCPNs. Options 4-7 all require changes in the federal Medicaid waiver and as a result are not likely to be feasible. In any event, to achieve the improvements needed, the Agency's focus should be on increasing the specificity of the RFP and contract, using the procurement process to focus some investments from the MCPNs and to solicit competitive bids from other qualified, provider sponsored organizations. No financial savings are anticipated for the Agency in any of these approaches because of the implementation costs and the needed investments in infrastructure support. Over the long term, Option 3 is likely to be the most efficient by increasing scale for the MCPNs and reducing Agency oversight costs

XI. Overall Recommendations

Based upon the findings outlined above and the discussion about improving primary care and health plan coordination, we offer the following detailed recommendations action steps for the Board to consider. They include activities in each of the following six areas: Procurement Planning; Contract Revisions; Rates and Reserves; MCPN Requirements; Agency Initiatives and Agency and Staff Development.

1. Procurement Planning

1.1 The Agency should seek input from State administrators on the recommendations in this report for the number of MCPNs as well as other items. This should be a formal process that ensures that the two recommended options (or the Agency's preferred option) are permissible under the waiver and identifies any other applicable state provisions.

1.2 The Detroit-Wayne Mental Health Board should hold formal community discussions prior to considering options for reducing the numbers of MCPNs. This meeting should be facilitated and should invite consumer, family, provider, MCPN and other stakeholder input. Following the meeting, the Board should deliberate, seek additional information that it may require, such as the costs of reenrollment, and make a decision.

1.3 Many of the services, financing and oversight recommendations in the body of this report can and should be reviewed and incorporated into the RFP and contracts. To accomplish this, the Agency should hold a series of internal planning meetings to develop standards and recommendations for the RFP and future contract. Where possible these should identify the

specific procedures that will be required or they should require that a plan be developed by the MCPN during the implementation period.

2. Contract revisions

The Agency should:

2.1 Implement greater specificity in the contracts regarding program standards and procedures. These standards should be consistent with the vision and goals set forth to the State in the Agency's Application for Renewal and Recovery. This is best done as a part of the reprocurement process.

2.2 Implement pay for performance reimbursement methods through contractual provisions. Reporting can include an array of meaningful measures, while incentives should be limited to and focused on the most meaningful measures.

2.3 Advance recovery orientation and use of person-centered planning particularly for people with MI.

2.4 Develop contract provisions around the designation of a Health Home for the consumer within all of the MCPNs, using the Quadrant model to determine what type of professional will coordinate clinical home services. These providers will be responsible for coordinating certain aspects of care within the MCPN and between MCPNs and the Medicaid Health Plans.

3. Rates and Reserves

3.1 The Agency's actuaries should review the Agency's plan for separate funding bands for Medicaid, GF, ABW and MICHILD to determine whether to recommend new risk scores for fund allocation. As a part of this review, they should consider whether risk scores should also change because of differences in the populations served in each funding band.

3.2 Establish predictable reimbursement levels each month based upon these risk scores. Any Wayne County resident meeting the eligibility criteria for community mental health services can be enrolled for Detroit-Wayne County services. The agency cannot deny access for these individuals. This means that the Agency would be subject to some level of enrollment risk, something that can be better managed through the new provisions of the contract with the Access Center.

3.3 An actuarial opinion should be sought on the appropriate levels of Medicaid and General Fund reserves for the Agency and the MCPNs. The Agency needs to seek full clarity on the State's rules for risk reserves and reinvestment from the Internal Service Fund.

4. MCPN requirements

4.1 Include provisions and requirements in the RFP that describe the scope of services, populations and the number of MCPNs required. Include requirements that will ensure a full array of services across the county to increase access and achieve the goals outlined in the Agency's Application for Renewal and Recovery. Ensure that all minimum requirements are met.

4.2 If there are significant changes in the structure or form of the MCPNs, use the procurement to ensure that the populations and stakeholders are adequately represented and that structure, functions and performance standards of all MCPNs are consistent. This should include provisions to require the appointment of consumers and/or families to the governing and advisory boards of the MCPNs. In addition, MCPNs should require their providers to include consumers/families in their governance as a condition of network participation. Also develop plans in advance for any needed transition between MCPNs.

4.3 Include procurement provisions that require MCPNs to conduct special projects to implement and incrementally expand on primary care integration initiatives.

4.4 Consider options for overseeing MCPN financial relationships with providers, provider sponsors and board members. These should include allowable rates and reimbursement levels for all providers, administrative services and the terms of leases and other contractual obligations.

5. Agency Initiatives

5.1 Ensure that the RFP includes requirements for MCPNs to work collaboratively with all Agency initiatives including children's system of care, criminal justice and other efforts that may be advanced by the Community Collaborative. Require MCPNs to coordinate with staff of other state and local agencies – including schools, criminal justice, law enforcement personnel, etc.

5.2 Ensure successful implementation of the redesigned centralized Community Access System, ensuring choice, standardizing the process by which consumers enter the system and ensuring that clinical standards and criteria for MCPN enrollment are applied uniformly.

5.3 Establish more focus on mental health outreach and prevention. Develop strategies to use General Funds for this purpose as they become available again.

5.4 Enhance service innovation by continuing current Agency practices of bringing in outside program and clinical experts, identifying academic resources and research grant opportunities and developing methods to learn from each other and share innovations. Consider reaching out to other states and large metropolitan areas at annual events in order to learn from their efforts.

5.5 Increase focus on performance measurement as an integral part of the reporting processes, quality improvement and management planning.

5.6 Increase the speed with which consumer complaints are identified and resolved.

5.7 Demonstrate the importance of increasing consumer and family input in governance at the Providers and MCPNs by continuing to lead by example at the Agency level. It may require accommodation for some; for others, the consumer voice may challenge assumptions. For most organizations that have made the transformation to be more consumer-centered, the change has been extraordinary.

6. Agency and Staff Development

6.1 Develop protocols for communicating with MCPNs to include the MCO Division or another designee in order to schedule monitoring, site visits or record reviews. Designating one

individual as the primary contact point for contract oversight and policy will help to improve communications. One of this person's goals should be to reduce duplication of effort. The Agency should provide routine opportunities for other more informal communication through regular MCPN meetings and other activities.

6.2 Implement a cross-system collaborative training program to focus on managed care, utilization management, quality improvement, and other evidence based practices. Also consider team building efforts within the Agency and across MCPNs.

6.3 Use quality improvement strategies as an overarching management approach across Agency and MCPN staff to advance learning and improve performance in several key areas, including but not limited to reducing reliance on residential housing and state hospital utilization.

XII. Conclusion

For the last nine years, Detroit-Wayne County has participated in a unique social experiment – managing care for individuals with mental illness and developmental disabilities by providing a choice of comprehensive provider networks. The Michigan 1915(b) waiver is remarkable for its inclusion of services for persons with developmental disabilities into a managed care framework with service for persons with mental illness and substance abuse. Detroit-Wayne has taken this one step further with the creation of MCPNs for the delivery of a comprehensive array of services in a provider sponsored network. While some of the MCPNs have had financial problems, the Agency has addressed those with a minimum of disruption. The financial challenges of the last several years for the Agency have been significant. Like most states, Michigan faces continued revenue problems in 2011 and 2012 budgets as a result of reduced employment levels and the overall economy. Despite these challenges, the Agency has made considerable strides in recent years in maintaining and improving services, building a framework for more recovery oriented services, stabilizing leadership and maintaining compliance with state and federal rules. The MCPN reprocurement presents a major opportunity for continuing to increase efficiency and improve operations and service quality.