

# Status Report on the Workgroup's Efforts to Develop a Plan to Maximize Uniformity and Consistency

(FY2012 Appropriation Bill - Public Act 63 of 2011)

June 1, 2012

**Section 490:** (1) The department shall continue a workgroup to develop a plan to maximize uniformity and consistency in the standards required of providers contracting directly with PIHPs, CMHSPs, and substance abuse coordinating agencies. These standards shall apply to community living supports, personal care services, substance abuse services, skill-building services, and other similar supports and services providers who contract with PIHPs, CMHSPs, and substance abuse coordinating agencies or their contractors. (2) The workgroup shall include representatives of the department, PIHPs, CMHSPs, substance abuse coordinating agencies, and affected providers. The standards shall include, but are not limited to, contract language, training requirements for direct support staff, performance indicators, financial and program audits, and billing procedures. (3) The department shall provide a status report on the workgroup's efforts to the senate and house appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director by June 1 of the current fiscal year.

*Michigan Department  
of Community Health*



Rick Snyder, Governor  
Olga Dazzo, Director

**Michigan Department of Community Health  
Behavioral Health and Developmental Disabilities  
Administration  
Fiscal Year 2012 Appropriations  
Section 490(3) Boilerplate Report**

**BACKGROUND**

The boilerplate language was driven by Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Provider (CMHSP) and Substance Abuse Coordinating Agency (CA) provider system. There continues to be regional successful initiatives regarding uniformity and consistency with contracts, training reciprocity, financial and programmatic audits and sharing of data through electronic health records (EHRs). While it continues to be the PIHP, CMHSP and CA that carries the responsibility for local management of the Medicaid, General Fund and Block Grant services/benefit, Behavioral Health and Developmental Disabilities Administration (BHDDA) leadership is promoting the value and commitment to refine the public system to a more efficient, simplified arrangement with providers.

The workgroup has met on a monthly basis beginning in February, 2012, under the leadership of BHDDA staff. The workgroup consists of representatives from the Department of Community Health (DCH), PIHPs, CMHSP, CA, and the provider system including psychiatric acute care and substance use residential facilities. Some of the participants were selected and recommended by the Michigan Association of Community Mental Health Boards (MACMHB). This was not an exclusive membership, and as the workgroup will continue after June 1, 2012, membership is fluid and the provider system is invited to participate. (Current workgroup members list is attached).

**Review and identified next steps from FY 2011 490(3) boilerplate report**

The 2012 workgroup reviewed the following categories and next steps, which included:

**Behavioral Health and Developmental Disabilities Administration (BHDDA):**

- *DCH* will follow through and monitor implementation of reciprocity at the CMHSP level.
- *DCH* will reconsider the 2005 Office of Recipient Rights (ORR) "Coordination of Rights and Protection for Recipients of Contracted Mental Health Services Technical Advisory," to identify and support training reciprocity opportunities as follows:
- *Workgroup* will: 1) identify training requirements, 2) develop consistency in these requirements, 3) review the current requirements for best practice, and if these add value in relation to the limits of time and staff availability, these represent and are relevant to the staff for which these apply, 4) create reciprocity and portability

expectation, 5) identify a process for ongoing review, and 6) move toward measurable competency as an outcome rather than the training method.

### **Performance Indicators (Site Review Dimensions):**

- *The Provider Alliance* is charged with identifying their provider relation Performance Indicators (Site Review Dimensions) requirements across the system.
- *Workgroup*: In the context that the Performance Indicator (Site Review Dimensions) burden is in relation to authority and local requirements, the task is to identify what these are and the source requirement, i.e. an accrediting agency, DCH, other state requirement, at authority level or is unknown. The expectation would be that each indicator has currency with regard to best practice or the issue being addressed adds value and is measurable.

### **Contract Language:**

- *DCH* to complete review of its contractual requirements for the purposes of consistency in requirements across contracts, removal of outdated language no longer necessary, and for administrative simplification.
- *DCH* to establish the charge to the authority to develop the commitment so that provider contracts are reflective of administrative simplification between the state and the authority.
- *Workgroup* to continue work on uniform contract models recognizing that any uniform contracts must still meet unique business needs at the authority provider level. This will involve identifying existing uniform contract models, obtaining an understanding of the basis of DCH contractual requirement, current relevance and best practice.

### **Core Training Requirements for Direct Support Staff:**

- *DCH*, through this and other workgroups, continues to pursue uniformity, consistency, and reciprocity where possible.
- Each authority and provider trade organization commits to their participation in this/these process(es).

### **Electronic Health Record (EHR)/Billing Procedures**

- *DCH*, given the scope, complexity, and billing/EHRs-related discussions, must involve content specialists in both technical and business aspects. The CIO Forum, CMH Finance Officers and Michigan Association of Substance Abuse Coordinating Agencies (MASACA) IT/finance groups were identified as being necessary to the discussion. DCH would be responsible for coordination.
- *Workgroup* to identify the variations in the billing system in use and to better define the problems and opportunity for uniformity and consistency.

## **ACCOMPLISHMENTS**

Although there may be overlapping topics between the boilerplate 490 and 494 reports, separate reports will be generated to the Senate and House Appropriations Subcommittees on Community Health, the Senate and House Fiscal Agencies, and State Budget Director.

### **Performance Indicators (Site Review Dimensions):**

A workgroup was convened by BHDDA to look at Performance Indicators (Site Review Dimensions) review during the annual site review process. In an attempt to eliminate and reduce redundancies, 50-60 Performance Indicators (Site Review Dimensions) have been removed during the site review process, resulting in approximately 20% fewer indicators. The workgroup brought forth and reviewed a list of duplicative reports requested by DCH. The list was expanded upon through a separate subcommittee of the 490 Workgroup. A document had been produced consisting of Review Dimensions, identified Regulatory Basis, Site Review Evaluations and Activities, and who conducts the review. The document will be shared with national accrediting entities to look at possible overlaps in review processes. Conference calls with The Joint Commission (JC), the Commission on Accreditation on Rehabilitation Facilities (CARF), and the Council on Accreditation (COA) have been conducted, as well as with Centers for Medicare and Medicaid (CMS) to look at reducing duplicative audits/reviews while protecting the most vulnerable individuals that Michigan serves and keeping within the Federal requirements.

Both PIHPs and CAs have waived an annual site review in specific areas, if 100% compliance is achieved.

### **Financial and Program Verification:**

BHDDA, through FY 2013 contract negotiations with MACMHB, the CFI committee, has been exploring new monetary incentives for the next contract cycle for high performing PIHPs. In addition, as the system evolves through the Dual Eligible initiative, Medicaid Expansion/Integration, the commitment to simplification and efficiencies remains a strategic priority for DCH.

PIHP/CMHSP contracts are continuously being reviewed and refined. Updates and edits to outdated language, redundancies and inconsistencies among “technical advisory, technical requirement, policy, and practice standards” are ongoing. In efforts to guide the behavioral health system to a more performance based system, for the first time, monetary incentives were introduced into the PIHP contracts.

### **Contract Language:**

In efforts to promote reciprocity, BHDDA, in FY2012, included language in the CMHSP contract under section 6.4.1 Provider Contracts: “CMHSP and their provider networks shall accept staff training provided by other CMHSPs and their provider networks to meet their training requirements when: 1) staff training is substantially similar to their own training, and 2) staff member completion of such training can be verified.”

This is applicable to any staff training area. This includes any required staff training in the areas of abuse and neglect (recipient rights), person centered planning, cultural diversity, HIPAA, limited English proficient, grievance and appeals, as well as DHS-approved training direct care workers in specialized residential settings, and certificates earned from special clinical training in evidenced based, best and promising practices such as ACT, DBT, PMTO, FPE, and motivational interviewing.

### **Core Training Requirements for Direct Support Staff:**

There have been multiple efforts over the years through various workgroups to look at training standards, uniformity and reciprocity. The group agreed that until the DCH takes the lead on promoting training efficiency standards, lack of trust among PIHPs, CMHSPs, CAs and provider systems would remain. Showing competency, and/or testing out were areas that the system agreed would bear some merit. A document was drafted and shared with the group to look at MDCH/PIHP/CMHSP/CA provider Reciprocity and Efficiency Standards. A survey was sent to the CMHSPs asking various questions of current status of training efficiency and reciprocity. The conclusion is that a substantial number of CMHSPs are reluctant to fully accept another entity's training.

The Office of Recipient Rights (ORR) has also convened a workgroup to look at establishing minimum standards for content and competencies for statewide training. Variations and disparities within the system for ORR training have been identified. Volunteers from the workgroup agreed to look at already developed training modules for direct care staff, and to invite DHS to a workgroup meeting to look at required adult foster care training standards.

### **Electronic Health Record/Billing Procedures:**

The PIHP/CMHSP/CA and provider network have made regional unique progress with regards to EHRs. The DCH has not mandated one particular record or vendor. The need for consistent 'system communication' is crucial. The Data Exchange Committee was recently given the charge to look at duplicative/multiple entries into electronic health records especially by those providers contracted with multiple PIHP/CMHSPs and/or CAs. The group consists of Chief Information Officers, provider representatives, clinicians, and DCH staff. A system wide analysis is being conducted to determine the level of variation and to set a standard of data elements. In anticipation of the integration of physical health with behavioral health, important interfaces and 'bridges' must exist.

## ***CONCLUSION***

The inclusive workgroup members from throughout the system have a strong commitment to proceed in common DCH to look for value added endeavors that aim to reduce, eliminate duplication and overall redundancies, and maximize uniformity and consistency in provider standards. As overall health care evolves both at a federal and

state level, the increased awareness and collective interest to move the system forward within all contracting entities is apparent.

Topics for next steps:

- Continue to reinforce the value of continuing the 490 Workgroup's effort.
- Continue to look at all contracts throughout the Behavioral Health and Developmental Disabilities Administration for simplification and redundancies, and wherever possible, consolidate.
- Build upon the initial combined site review for PIHP/CA that represents a combined system for efficiencies – including monitoring for reciprocity for Direct Care training and Recipient Rights training.
- Share with CMHSP the system data standards determined through the Data Exchange Workgroup and consider them for contract inclusion.
- Build on the Values of the Behavioral Health System to realign and reduce overall administrative inefficiencies.
- Continue to work with MSA and BHDDA to streamline Waivers wherever possible.

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