

STATE OF MICHIGAN



JOHN ENGLER, Governor

**DEPARTMENT OF COMMUNITY HEALTH**

LEWIS CASS BUILDING

LANSING, MICHIGAN 48913

JAMES K. HAVEMAN, JR., Director

September 28, 1999

To All Interested Parties,

I am pleased to distribute the Department of Community Health's position paper on "Competition for Management of Publicly-Funded Specialty Services". The department is required, under the conditions of the current Medicaid waiver for managed specialty services, to submit a plan for competition along with the application for renewal of the waiver.

The department's plan for competition, outlined in this document, breaks new ground by introducing options for consumer-managed care, individual budgets and consumer-directed purchasing. The emphasis upon consumer choice and individual budgets in the plan is a natural complement to current statutory requirements for person-centered planning.

Besides circulating the position paper, the department will hold a series of public hearings around the state to solicit stakeholder reactions, comments and suggestions regarding the proposed plan for competition. The list of public hearing times, locations and dates are included in the report. Anyone who may require accommodations in order to testify on the plan should notify Barb Mongeau at (517) 373-6440 before the scheduled meeting.

The position paper can be accessed through the Michigan Department of Community Health web site, [www.mdch.state.mi.us](http://www.mdch.state.mi.us). Individuals may make copies of the plan, or copies may also be obtained from Barb Mongeau, at the telephone number listed above.

Written testimony on the paper will be received through November 30, 1999. Comments may be mailed, faxed or e-mailed to Patrick Barrie at the Michigan Department of Community Health, Lewis Cass Building, 6<sup>th</sup> Floor, 320 S. Walnut Street, Lansing, Michigan, 48913. Fax: (517) 335-3090. E-mail: [barriep@state.mi.us](mailto:barriep@state.mi.us).

Cordially,

A handwritten signature in black ink, appearing to read "James K. Haveman, Jr.", written over a large, stylized initial "J".

James K. Haveman, Jr.

**SCHEDULE FOR PUBLIC FORUMS ON  
DEPARTMENT OF COMMUNITY HEALTH'S PAPER  
"COMPETITION FOR MANAGEMENT OF  
PUBLICLY-FUNDED SPECIALTY SERVICES"**

<b>DATE</b>	<b>TIME</b>	<b>CITY</b>	<b>LOCATION</b>
October 18, 1999	8:30 a.m. to Noon	Marquette	Northern Michigan University Don H. Bottum University Center Michigan Room 540 West Kaye Avenue Marquette, MI
October 18, 1999	1:00 p.m. to 4:30 p.m.	Marquette	Northern Michigan University Don H. Bottum University Center Michigan Room 540 West Kaye Avenue Marquette, MI
October 21, 1999	8:30 a.m. to Noon	Detroit	Wayne State University McGregor Memorial Conference Center 495 West Ferry Mall Detroit, MI
October 21, 1999	1:00 p.m. to 4:30 p.m.	Detroit	Wayne State University McGregor Memorial Conference Center 495 West Ferry Mall Detroit, MI
October 25, 1999	8:30 a.m. to Noon	Gaylord	Holiday Inn of Gaylord Alpine and Hemlock Rooms 833 West Main Gaylord, MI
October 25, 1999	1:00 p.m. to 4:30 p.m.	Gaylord	Holiday Inn of Gaylord Alpine and Hemlock Rooms 833 West Main Gaylord, MI
November 1, 1999	8:30 a.m. to Noon	Kalamazoo	Western Michigan University Fetzer Center Kalamazoo, MI
November 1, 1999	1:00 p.m. to 4:30 p.m.	Kalamazoo	Western Michigan University Fetzer Center Kalamazoo, MI
November 5, 1999	8:30 a.m. to Noon	Lansing	G. Mennen Williams Building Auditorium 525 West Ottawa Lansing, MI
November 5, 1999	1:00 p.m. to 4:30 p.m.	Lansing	G. Mennen Williams Building Auditorium 525 West Ottawa Lansing, MI

**NOTE:** The sessions on each day (morning and afternoon) will be **repeat** sessions, so individuals will only need to attend one of the sessions.

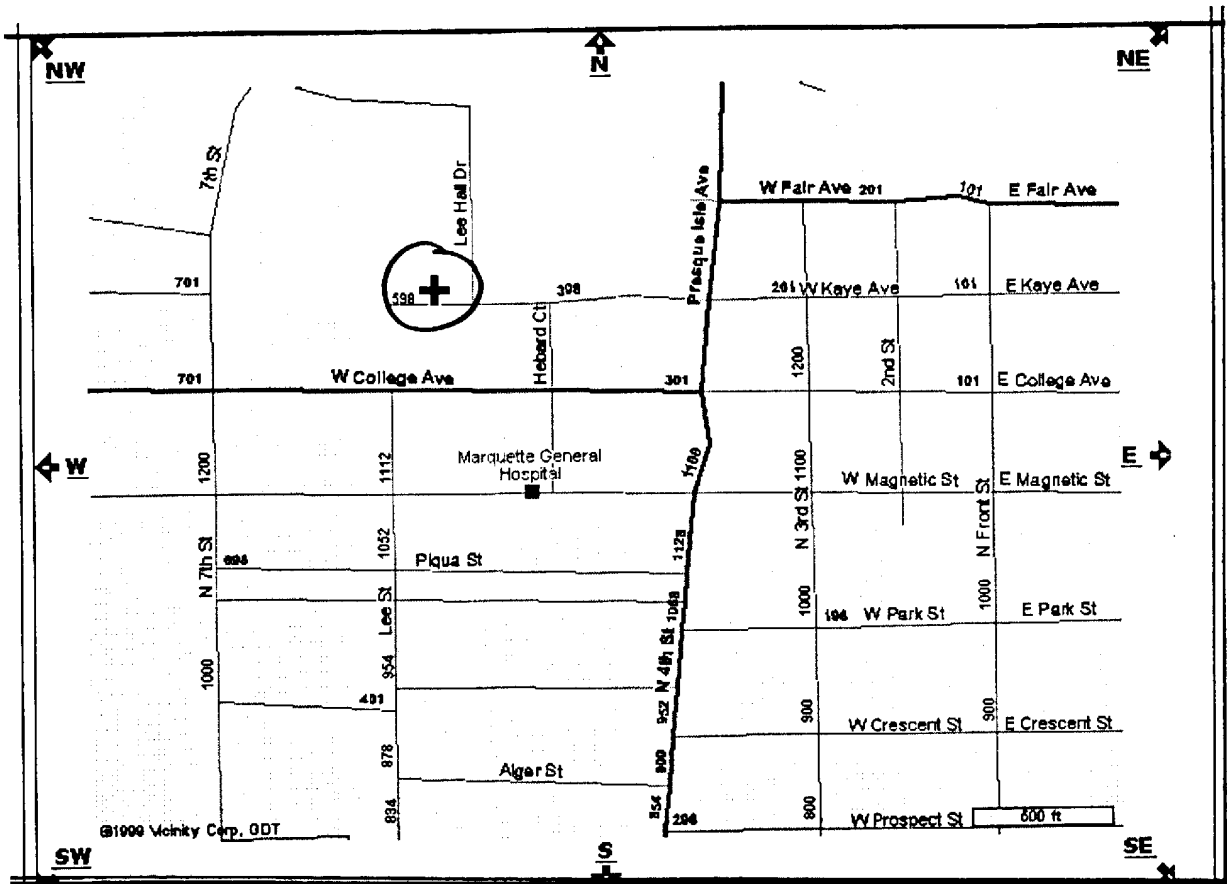
# DIRECTIONS TO DON H. BOTTUM UNIVERSITY CENTER AT NORTHERN MICHIGAN UNIVERSITY (Marquette, Michigan)

## From the West (Airport area)

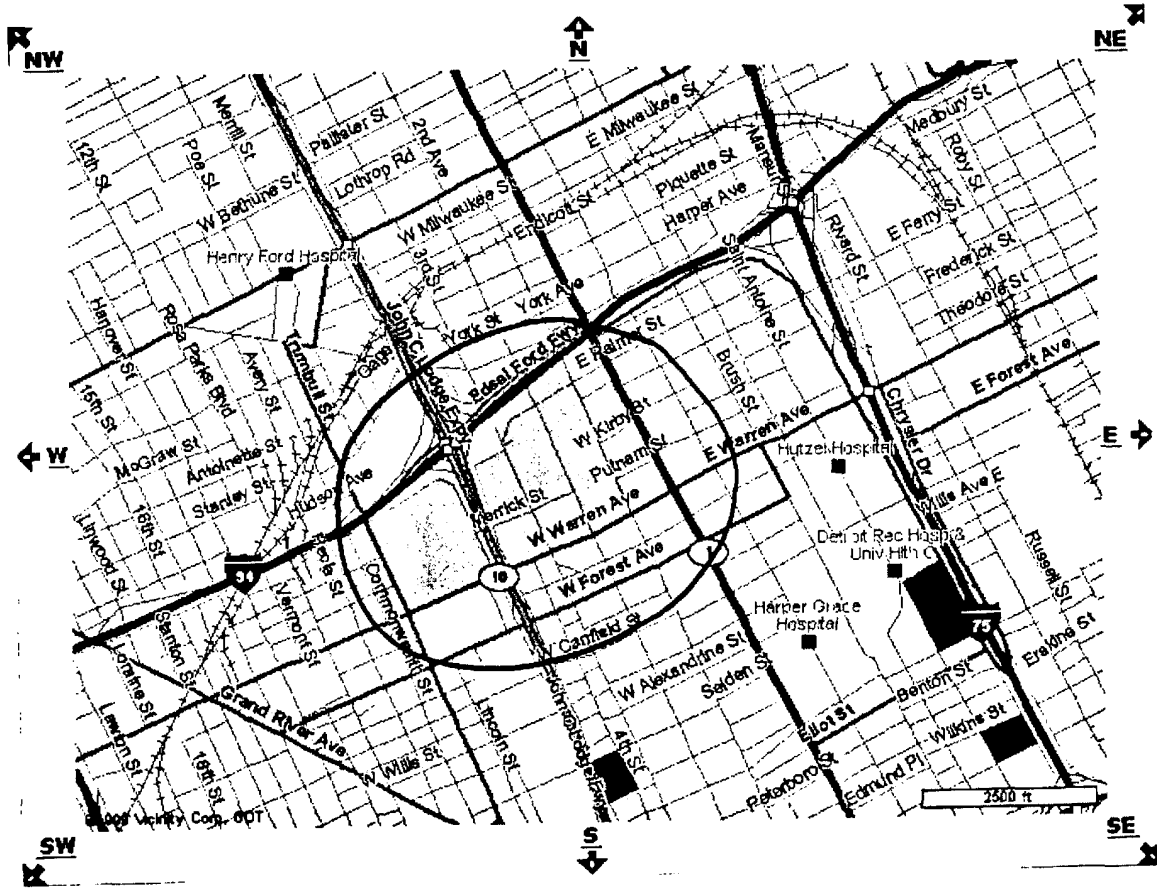
Follow US 41/M 28 East into Marquette. Merge left onto Washington Street just past the Marquette Mall (which will be on your right). Follow the signs that say Downtown Marquette or Marquette Business District. Do not take the US 41 Bypass. Stay on Washington Street to Fourth Street and turn left at the stop light. Follow Fourth Street to Kaye Avenue and turn left at the stop light. You will now be on the edge of the NMU campus. Follow Kaye Avenue for about a block and a half and park. The Don H. Bottum University Center will be on your right. Use the Kaye Street entrance and follow the signs inside the building directing you where to go.

## From the East

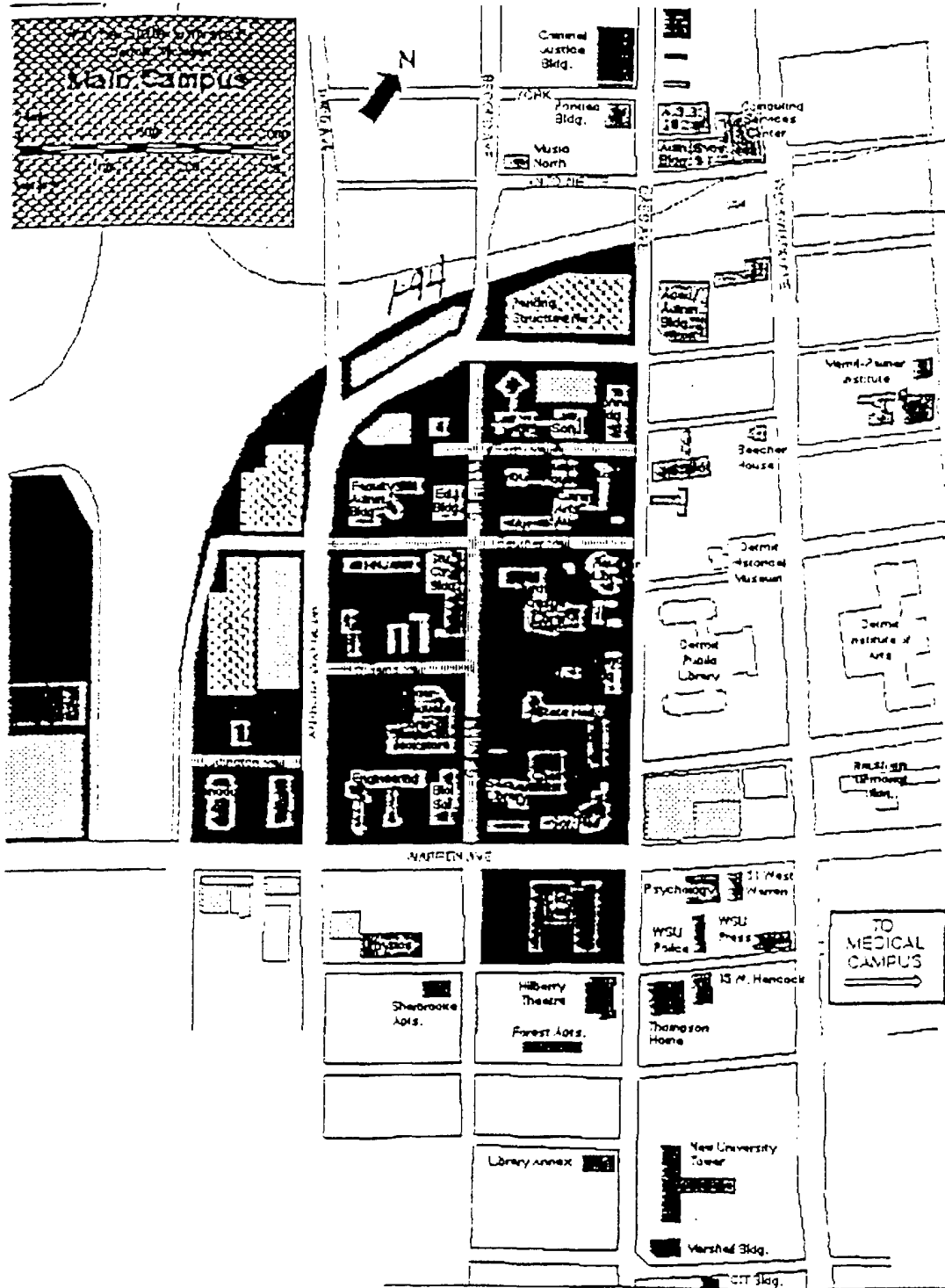
Follow US 41/M 28 West/South into Marquette. Follow the signs that say Downtown Marquette or Marquette Business District. US 41/M 28 will turn into Front Street as you enter Marquette. Stay on Front Street to Washington Street and turn left at the stop light. Follow Washington Street to Fourth Street and turn right at the stop light. Follow Fourth Street to Kaye Avenue and turn left at the stop light. You will now be on the edge of the NMU campus. Follow Kaye Avenue for about a block and a half and park. The Don H. Bottum University Center will be on your right. Use the Kaye Street entrance and follow the signs inside the building directing you where to go.



**DIRECTIONS TO MCGREGOR MEMORIAL CONFERENCE CENTER  
AT WAYNE STATE UNIVERSITY  
(495 West Ferry Mall, Detroit, Michigan)**



SEE REVERSE FOR MAP OF MAIN CAMPUS



Main Campus

MICHIGAN

TO MEDICAL CAMPUS

Central Justice Bldg.

J.P.K. Juries Bldg.

Music North

Consulting Services Center

Acad. Admin. Bldg.

Merrill-Powell Institute

Beecher House

Detroit Historical Museum

Detroit Public Library

Detroit Institute of Arts

Registrar Building

Psychology

31 West Warren

WGLI Police

WGLI Press

15 W. Hancock

Thomson Home

Sherbrooke Apts.

Hilberry Theatre

Forest Apts.

New University Tower

Marshfield Bldg.

CIT Bldg.

Library Annex

N



**DIRECTIONS TO FETZER CENTER  
AT WESTERN MICHIGAN UNIVERSITY  
(Kalamazoo, Michigan)**

**From I-94 Detroit (East) and Chicago (West)**

At Exit #75, turn north onto Oakland Drive, drive 2.7 miles; turn left onto Howard Street, go 1.1 miles; turn right onto West Michigan Avenue. Turn left at the second street, Rankin Avenue, then turn right onto Business Court. Turn left into the large parking lot, then immediately right into the Fetzer Center parking area, Lot 72F.

**From US 131 (North) Grand Rapids, Muskegon**

At Exit #36A, turn east onto Stadium Drive, drive 2.2 miles to Howard Street; turn left and go 0.6 miles; turn right onto West Michigan Avenue. Turn left at the second street, Rankin Avenue, then right onto Business Court. Turn left into the large parking lot, then immediately right into the Fetzer Center parking area, Lot 72F.

**From M-43 North of Kalamazoo**

Follow westbound M-43 through downtown Kalamazoo (Gull Road - Riverview Avenue - East Michigan Avenue - Kalamazoo Avenue - West Main Street) until reaching Solon Street (the fourth traffic light after Kalamazoo Avenue merges with West Main Street and becomes two-way traffic, near Kalamazoo College.) Turn left onto Solon and drive south 0.5 miles where Solon turns into Howard Street. At the light turn left onto West Michigan Avenue. Turn left at the second street, Rankin Avenue, then right onto Business Court. Turn left into the large parking lot, then immediately right into the Fetzer Center parking area, Lot 72F.

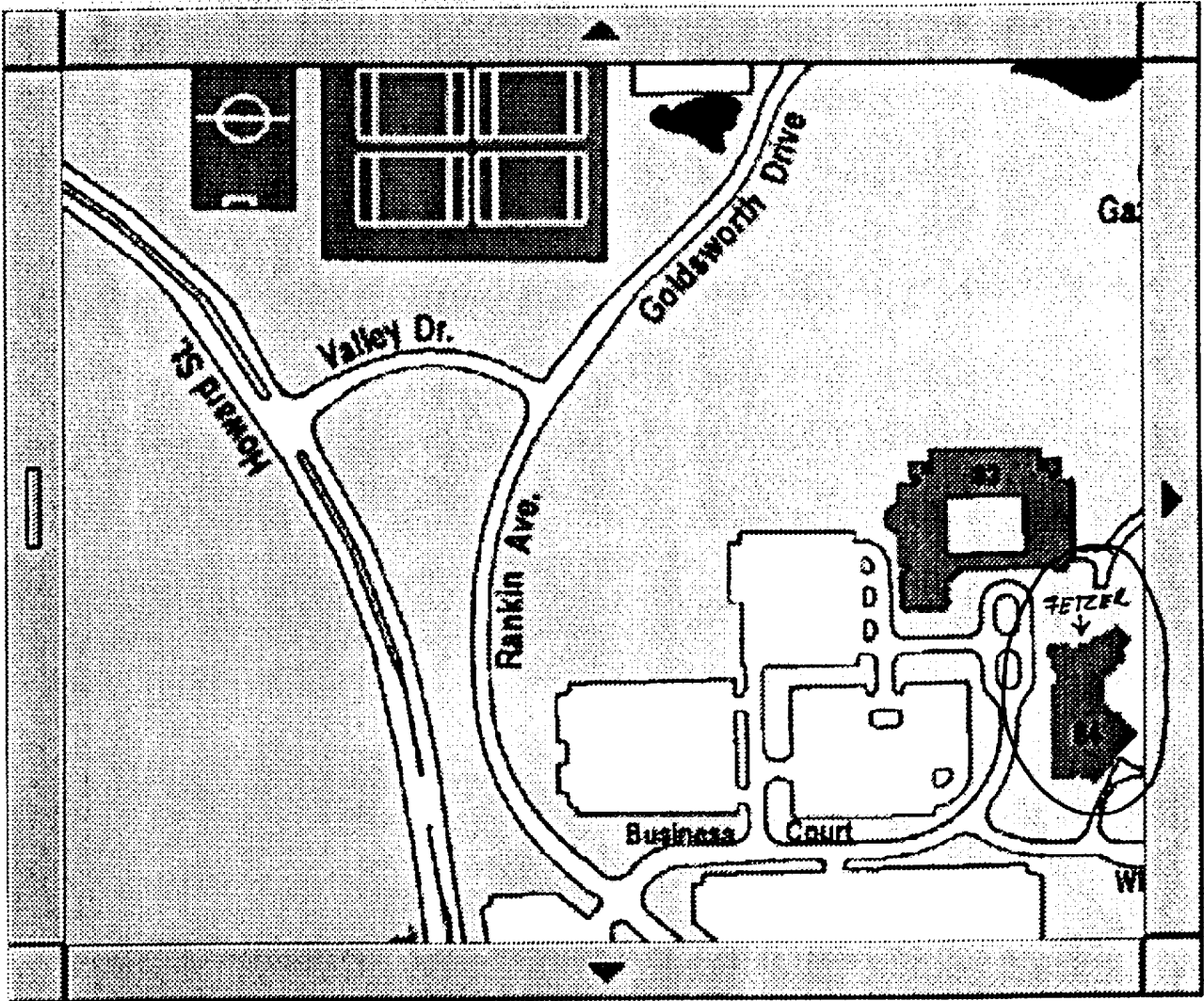
**From Downtown Kalamazoo**

Drive westerly on Stadium Drive (Business Route 131). At Howard Street turn right and drive 0.6 miles; at the light turn right onto West Michigan Avenue. Turn left at the second street, Rankin Avenue, then turn right onto Business Court. Turn left into the large parking lot, then immediately right into the Fetzer Center parking area, Lot 72F.

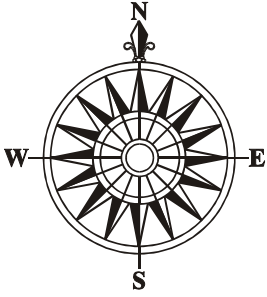
**From M-43 West of Kalamazoo**

Drive easterly past US 131 and after 1.9 miles, turn right onto Solon Avenue and drive south 0.5 miles where Solon turns into Howard Street. At the light, turn left onto West Michigan Avenue. Turn left at the second street, Rankin Avenue, then right onto Business Court. Turn left into the large parking lot, then immediately right into the Fetzer Center parking area, Lot 72F.

SEE REVERSE FOR MAP OF CAMPUS







**NEW DIRECTIONS FOR MICHIGAN'S PUBLIC SYSTEM**

# **COMPETITION FOR MANAGEMENT OF PUBLICLY-FUNDED SPECIALTY SERVICES**

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***SUPPORTING CONSUMER-DIRECTED SERVICES***

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**

SEPTEMBER, 1999

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## **EXECUTIVE SUMMARY**

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The past quarter century has been marked by vast changes in the publicly-funded specialty services system - the intricate network of state facilities, local governmental programs and private service providers which collectively deliver necessary treatments, services and supports to persons with mental illness, developmental disabilities and addictive disorders. In the first wave of change, responsibility and funding for specialty services was devolved from the state to the counties and local systems of specialty care were developed. Today, the forces of competition, integration and consumer choice have unleashed a second wave of change in the public system. This document traces the evolution of the publicly-funded specialty services system, identifies current trends and charts a course for future development of the system.

### **DEVOLUTION: TRANSFER OF AUTHORITY FROM THE STATE TO THE COUNTIES**

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Michigan's publicly-funded system for providing care, treatment, services and supports to adults with serious mental illness, children with serious emotional disorders, persons with developmental disabilities and individuals with substance abuse disorders has been transformed over the past twenty-five years. The passage of P.A. 258 (the Mental Health Code) in 1974 promoted the transfer of authority and funding for specialty mental health and developmental disability services from the state to county-sponsored community mental health services programs (CMHSPs). The revision of the Public Health Code in 1978 sanctioned the creation of county designated substance abuse coordinating agencies (CAs) to organize and manage publicly-funded substance abuse services.

Reflecting the devolution of authority and funding, the public mental health system (which serves individuals with mental illness and persons with developmental disabilities) has rapidly shifted from state-operated institutional programs to county organized community-based care arrangements. During this same period, the publicly-funded substance abuse system has developed from the ground up, establishing local administrative capabilities and community service delivery capacity.

Compared to historic patterns of neglect and/or institutional confinement, the last quarter-century has been a period of explosive growth and steady improvement in publicly-funded services for adults with serious mental illness, children with serious emotional disorders, persons with developmental disabilities and individuals with addictive disorders. County-sponsored entities (CMHSPs and CAs) have assumed full responsibility for organizing and managing local systems of specialty care, and as the capacity of county systems has increased, utilization of state institutions has fallen dramatically, leading to the closure of many antiquated facilities.

The expansion of county-organized specialty care systems has reflected a core civic value - codified in law - that persons with mental illness, addictive disorders and developmental disabilities should be fully included as participating members of local communities. Inclusion implies accommodation and ongoing assistance for individuals with disabilities and addictions, and has required local publicly-funded systems to develop service options which support consumers in the community.

### **FUNDING FOR COUNTY-BASED SYSTEMS AND THE INTRODUCTION OF MANAGED CARE**

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Funding to support community-based services initially was confined to state and county general fund appropriations. These funds were used to build the organizational and service delivery infrastructure for community care and to provide services and supports to priority

populations. Gradually, funds connected with federal grants and reimbursement related to federal/state match programs (Medicaid) were introduced into the public system and were used along with state/local funds to support the evolving system of community care. These different funding sources caused confusion and service delivery problems for CMHSPs, CAs and consumers, since each funding source had different regulations and did not pay for the full range of appropriate alternative services desired by consumers.

In the 1990s, the state has pursued a number of groundbreaking strategies to simplify service administration, integrate funding streams, and increase service and support options. Unnecessary state institutional capacity was eliminated and savings were directed back into the community system. Revisions were made to the Mental Health Code to increase the flexibility of funding arrangements (carry-forward) and to promote consumer-directed service models. Governor Engler unified state administration of health and health-related services by creating the Department of Community Health. Finally, in October 1998, the department introduced managed care into the publicly-funded specialty service system.

With the implementation of the managed care program, multiple sources of public funding (Medicaid, state general fund appropriations, federal block grant dollars, etc.) which support vulnerable populations and specialty care services were consolidated under the authority of local, county-sponsored entities (community mental health services programs and substance abuse coordinating agencies).

### **CONDITIONS ATTACHED TO FEDERAL APPROVAL OF MANAGED CARE**

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To utilize Medicaid funds in the managed specialty services program, the state had to seek approval from the federal government. As a condition of approval, the federal government stipulated that the department must submit a plan to begin **competitive procurement** for management of the Medicaid specialty services and supports covered under the plan. The introduction of competitive selection into the publicly-funded specialty care system would allow non-governmental organizations (both non-profit and for-profit entities) to compete with CMHSPs and CAs for the right to manage certain public funds for specialty services.

Even before the federal government had stipulated competitive selection for management of Medicaid-funded specialty services, the department had considered the benefits that competition could bring to the public system. However, despite the attraction of competition, a workable model - one that addressed legal constraints, funding restrictions, legacy assets, workforce commitments and residual obligations to public capital investment - had not been developed. Federal requirements have accelerated the search for a practical model of competition.

The department believes that rather than merely meeting federal stipulations, a plan for competition must go beyond these stipulations and incorporate system change objectives that benefit communities and consumers. These additional system change objectives include closer integration with organized community health systems and increased choice for consumers.

### **MODELS FOR COMPETITION**

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Funding streams (e.g., Medicaid funds, state general fund allocations, federal block grants, restricted purpose revenues, local match, etc.) that support specialty services and underwrite local systems of care are deeply interrelated and entwined. State law compels a preferential role for county-sponsored entities in the management of specialty services, but this favoritism

clashes with federal regulations regarding Medicaid, which require competitive bidding. How can this tension between state preferences and federal stipulations be resolved?

Various models for competition or for reconfiguration of the existing specialty services system have been proposed (e.g., bidding Medicaid funds and services; county right of first opportunity; generic long-term care plan; splitting DD services from MH/SA services; etc.), but the department does not regard these alternative models as viable options.

## **THE DEPARTMENT'S PLAN**

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Instead of preserving state preferential treatment for county-sponsored entities, the department proposes to extend competitive procurement to include all service populations (state priorities, eligible beneficiaries, federally mandated groups), all management responsibilities, all service options and settings, and all available funding for specialty services (state appropriations - with concomitant local match obligations - federal block grant dollars and Medicaid capitation).

Under this proposition, the department would bid out management of both the Medicaid funds for specialty services and other funds currently assigned by state statute or practice exclusively to county-sponsored entities. In a competitively "neutral" process (level playing field), the department would award management contracts for each designated service area to a single public, private, or public-private partnership organization in that locality or region which submitted a proposal most responsive to the purchasing specifications outlined in the bid packet. Organizations selected through the competitive process will manage all specialty services (mental health, developmental disabilities and substance abuse) in the designated service area.

The department's plan maintains the service carve-out structure for specialty care and preserves the principle that system management should be decentralized and devolved to a single managing entity in each defined geographic service area. However, while sustaining the concepts of a specialty system (carve-out structure) and decentralized system management, the department's plan allows new entrants (private sector entities) to compete to become both the manager of Medicaid-funded specialty services and the designated entity for managing non-Medicaid public funds for priority populations. The plan calls for a reduction in the number of managing entities (compared to the current structure) by introducing size, scope and efficiency requirements for managing entities.

### *Consumer Managed Care*

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The department's plan also requires managing entities to adopt an innovative model of managed care, one which permits consumers to use vouchers, individual budgets and other forms of consumer-directed purchasing to obtain routine community and personal supports, while retaining more systematic and traditional managed care techniques if service and support needs intensify and require higher cost interventions.

### *Linking Specialty Services to Primary Health Care*

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Finally, the department's plan encourages new organizational and service delivery configurations that link the specialty services system with the provision of physical health care. The state is keenly interested in proposals which achieve administrative, operational and clinical integration between the managed specialty plan and an organized community health care delivery system, an established health care network or a Qualified Health Plan.

# NEW DIRECTIONS FOR THE PUBLIC SPECIALTY SYSTEM

## INTRODUCTION

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Michigan's publicly-funded system for providing care, treatment, services and supports to adults with serious mental illness, children with serious emotional disorders, persons with developmental disabilities and individuals with substance abuse disorders has been dramatically modified over the past twenty-five years. Successive waves of change have washed over the publicly-funded system, steadily transforming administrative responsibilities, service arrangements, consumer rights, available funding, and legal obligations. The public mental health system has evolved from traditional state-operated institutional programs to a county-based community care system, and the publicly-funded substance abuse system has developed from the ground up, simultaneously forming state and local organizational structures and establishing a statewide service delivery system.

As we reach the end of the decade and approach the millenium, the pace of change in the public system is accelerating. Both the state and the federal governments are striving to control the growth of public spending, putting increased pressure on public programs to operate efficiently. At the same time, demand for publicly-funded specialty services is rising and consumers and families are demanding more choice and control over the services and supports purchased on their behalf. As public sector agencies struggle to respond to these challenges, revolutionary developments within the larger health care system swirl around them.

While grappling with the problems of today, the public system must also reshape itself for the future. The persistent demand for efficiency and increased accountability, the compelling call for greater consumer voice and control, the vigorous press for integration of health services, and incremental adjustment in funding arrangements are driving the publicly-funded specialty system toward a new configuration.

The Michigan Department of Community Health (MDCH) has prepared this document to familiarize stakeholders of the system - consumers, family members, advocates, county and state officials, local governmental agencies, service providers, managed care organizations and the general public - with the department's views regarding future developments in the publicly-funded specialty service system. Given the prominence of MDCH as a purchaser of specialty services on behalf of vulnerable individuals, it is essential that the department clearly articulate the kinds of systems and services that it intends to purchase in the future.

The department's perspective on future developments is organized around a number of contemporary themes and trends. These themes and trends are already at work transforming the current public system, and the influence of these factors will increase over time. The themes and trends that will reshape the public system are:

- Competition for management of public funds and purchasing specifications that reflect a search for value;
- Introduction of new forms of managed care for publicly-funded specialty services which combine public-sponsor group models and individual ownership (consumer directed purchasing) approaches;

## Competition for Management of Publicly-Funded Specialty Services

- Continuing use of prospective payment systems which offer both enhanced flexibility and incentives for efficient management;
- Transition from provider or program-driven delivery systems to consumer or participant-driven service and support arrangements;
- Sustained emphasis on consumer-valued outcomes, quality management and improvement, system performance indicators and achievement of public policy objectives
- Renewed attention to community benefit obligations, community complements and responsible citizenship; and
- Innovations in specialty system - health system integration, within the context of emerging organized community delivery systems.

The objective of this paper is to describe and further explain these themes and trends and to suggest how they will interact to alter the present structure of the publicly-funded specialty services system.

# **AN ORIENTATION TO THE SPECIALTY SERVICE SYSTEM**

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## **WHAT IS THE PUBLICLY-FUNDED SPECIALTY SERVICE SYSTEM?**

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Throughout the document, there are repeated references to the publicly-funded specialty service "system". The concept of a public "system" refers to an intricate network of state government programs, local governmental agencies, and private not-for-profit service providers that collaboratively assemble and provide necessary services and supports to persons with mental disabilities and addictive disorders.

As used in this document, the term "publicly-funded specialty service system" refers to the organization, management and delivery of certain distinctive treatments, services and supports required by adults with serious mental illness, children with serious emotional disturbances, persons with developmental disabilities and individuals with addictive disorders, paid for by public funds (local, state and/or federal) and administered through a designated publicly accountable entity.

## **WHAT ARE THE SYSTEM'S CORE PRINCIPLES AND EMERGING SERVICE PERSPECTIVES?**

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The publicly-funded mental health system is grounded upon constitutional and statutory commitment to provide care and protection for vulnerable populations. Initially that care centered on the provision of basic needs in government-operated institutions. While treatment and training objectives were recognized, these goals were compromised by the characteristics of large institutions and the lack of funding for necessary services and supports. In the 1960s and 1970s, a renewed emphasis upon personal rights triggered the deinstitutionalization movement and the transition to the model of community-based services and supports. The community-based service model of the time - while an advance over previous custodial models of care - retained a limited and passive role for consumers and families, restricting their involvement in decisions about care and support arrangements. This model was - in essence - more of a human service system model (where decisions for service and support were made exclusively by human service professionals) than a true community and person-centered approach to persons with mental illness and persons with developmental disabilities.

In the substance abuse community, efforts in the 1960s and 1970s were directed to moving the public attitudes away from the idea that substance abuse was simply a personal failure toward the disease concept of addictive disorders and the notion that recovery from these conditions was possible and obtainable through proper treatment and sustained participation in follow-up services.

Gradually, both the mental health and the substance abuse services systems have come to emphasize the personhood (those qualities that confer and reflect the distinct individuality of the person) and citizenship of the individual with a mental illness, developmental disability or substance abuse disorder. In this context of personhood and citizenship, individuals have a claim to exercise more control over service and support arrangements, and with this freedom comes responsibility for contributing to the community and using public resources wisely.

Principles relating to community inclusion, personal freedom, choice and responsibility have emerged as core aspirations of the publicly-funded system. These principles are vital to any contemporary system, which should assist individuals to 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 daily activities that are meaningful, such as school, work, social, recreational and volunteering;
- 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;
- Committed to the ordinary obligations of citizenship and the responsibilities of community membership.

Beyond these core principles and defining values, the contemporary public system affirms certain perspectives and essential themes. For persons with serious mental illness and individuals with substance abuse disorders, recovery provides an organizing concept for service delivery. For children with serious emotional disturbance, the "strength" model and "ecological" orientation illuminate treatment activities. For persons with a developmental disability, the philosophy of self-determination and consumer control provides a coherent theme for support arrangements. In addition to these service and support paradigms, the public system has also embraced prevention efforts and community involvement as defining attributes.

#### *The Recovery Paradigm in Mental Health and Substance Abuse*

The concept of recovery has emerged over the last decade as a consistent theme within both the mental health and the substance abuse communities. From the perspective of the mental health system, recovery has come to mean that persons with serious mental illnesses can regain control over significant aspects of their lives and develop a sense of identity and purpose, despite experiencing exacerbations and/or the persistence of symptoms and impairments. The recovery vision emphasizes both positive individual expectations (hope, empowerment, and self-directedness) and organized interventions (treatments, rehabilitation, and environmental supports). The recovery concept looks beyond symptom alleviation to the kind of life experiences and situations - including social, vocational, educational, relational, and residential - needed and desired by a person with a serious mental illness.

Recovery within the context of substance abuse refers to the struggle of the person who is abusing substances from denial of the illness to recognition that safe use of alcohol and/or drugs is not possible. During this struggle, the person progresses from the illusion of control, through a series of strategies to manage use, followed by repeated failures and adverse consequences to final acceptance of addiction and the need for abstinence. This progression is uneven and fraught with opportunities for relapse, and recovery requires acceptance, ongoing support, interventions, new coping skills and familiarity with a sobriety-based lifestyle.

#### *Children, Adolescents and Families: Strengths-Based, Ecological Orientation*

Traditionally, service planning for children and adolescents with serious emotional disorders revolved around assessments that emphasized individual and/or family pathology and deficits. The strengths-based ecological approach accentuates the particular assets, coping skills and the unique history of the child/adolescent and family, as well as noting developmental problems, unmet needs and caregiver limitations. This orientation does not restrict its attention to developmental and family system issues alone, but also considers the larger "ecosystem" - neighborhood, school, religious institutions, social groups, community - in which child

development and family functioning unfold. The strength-based, ecological perspective drives the development of a child-and-family-centered service and support plan that leverages identified strengths to promote change, engages families in a collaborative partnership and encourages involvement of communal support systems (extended family, neighbors, church communities, educators, etc.) to provide assistance and to aid in the resolution of problems.

*Choice and Control: Self-Determination and Consumer Directed Services*

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The philosophy of self-determination emphasizes participation and the restoration of personal control for individuals with a developmental disability. The person with a developmental disability, involving freely chosen family or friends, becomes the key decision-maker, identifying needed supports, determining how they can best be provided and controlling a certain sum of dollars to purchase these supports.

Self-determination forms the philosophical underpinning for various approaches to consumers direction, resource control, and management of service delivery. The degree or extent of consumer direction, control and management may vary, from the individual independently making all decisions, controlling allocated resources and managing services directly to a person using a representative to organize, manage and reimburse needed services and supports. The unifying and critical value in self-determination and consumer-directed choice models is the person's opportunity to make choices about living arrangements, competitive employment, relationships, organizational affiliations and personal support needs, coupled with the ability to control necessary resources, whether or not the consumer actually takes responsibility for managing some or all aspects of the services and supports.

Self-determination and consumer-directed support models focus attention back to the core issue of supporting the person with a developmental disability to live a life in the community, instead of providing resources for a "program".

These three perspectives (recovery, strengths/ecological, and consumer choice) converge around the core themes of hope, individuality, diversity in personal needs and support solutions, empowerment, participation, and community.

*Prevention*

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While certain philosophies illuminate service and support efforts, the public system has traditionally also been committed to proactive interventions aimed at individuals at high risk or with a predisposition to develop a substance abuse disorder or emotional disturbance. Prevention efforts are targeted at certain malleable risk factors of individuals or families that can be influenced through application of evidence-based interventions. Prevention in the public system has steadily become a more focused and targeted enterprise, carefully defining the conditions, populations and interventions that hold the most promise for successful application of preventive techniques.

*Community*

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Finally, the contemporary public system is deeply rooted in the spirit of community. Principles related to community participation, citizen governance, local accountability and social responsibility are woven into the fabric of the current public system. The local mental health and substance abuse systems are part of a responsive community; one that is inclusionary, adapts to the needs of its members, and yet affirms that each member, including those persons with mental disabilities or addictive disorders, owes something to the rest of the society.

The core principles, fundamental themes and key perspectives of the public system have been pursued through various programmatic models. The community support approach (which emphasizes outreach, treatment, housing, peer support, employment, etc.) defines the essential components of an organized network of community services for adults with mental illness. The systems of care model (introduced through the Child and Adolescent Service System Program - CASSP) has provided the conceptual framework for organizing services for children with serious emotional disorders. For persons with developmental disabilities, the concept of "normalization" - making available to disabled persons patterns and conditions of everyday life as close as possible to the norms and patterns of mainstream society - was an important idea that guided the initial formation of community systems. Finally, the disease concept of addiction generated the development of a wide spectrum of community services with differing levels of service intensity and support.

## **HOW HAS THE SYSTEM EVOLVED AND WHAT DOES IT LOOK LIKE TODAY?**

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The present structure of the publicly-funded specialty service system emerged during a period of tumultuous change. This modern epoch - marked by the development of a community-based care system - remedied many deficiencies of the former public system, but also contained its own set of limitations and contradictions.

### *Formation and Current Structure of the Publicly-Funded Specialty System*

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In Michigan, governmental involvement in the care of persons with mental illness, developmental disabilities and addictive disorders stretches back to the 1800s. In the early part of the 19<sup>th</sup> century, responsibility for persons who were regarded as "insane" or "feeble-minded" was left to various localities (cities and counties). However, in the latter part of that century, the state began to construct institutions for the care of such persons and responsibility passed from local communities to state asylums and "training" schools. For over 60 years, each of these state-established institutions was considered a separate agency, with its legislative appropriation and governance. It was not until the 1930s that the state consolidated control over all institutions in one body, the State Hospital Commission. In 1945, the Department of Mental Health was established and became the entity responsible for the state facility system.

The current configuration of the publicly-funded specialty services system is the culmination of over thirty years of transition. Prior to the 1970s, the primary means by which the state discharged its obligations to persons with a mental illness or a developmental disability was through the operation of large state institutions. Depending upon the mood and tenor of the times, public intervention in addictive disorders oscillated between institutional placement (asylum) and incarceration. In the past quarter century, however, state-operated institutions have been largely supplanted by the development of a community-based care system, organized around county-sponsored entities. For mental health and developmental disability services, these county-sponsored entities are community mental health services programs (CMHSPs)<sup>1</sup>. The community care system for substance abuse is organized around designated county-sponsored coordinating agencies (CAs).

These decisive changes in the public system reflect the interaction of various factors. Society's perceptions regarding persons with disabilities have dramatically shifted and fundamental rights have been confirmed and established in law. The advantages of community-based care

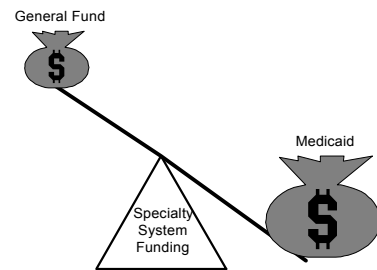
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<sup>1</sup> While the terms "county-based" or "county-sponsored" are used in regard to the CMHSPs and CAs, it is important to note that one city, Detroit, plays a significant role in the governance of public mental health services and public substance abuse services.

arrangements over institutional placements have been recognized and verified by research. Models that decentralize management and operation of the publicly-funded system (from the state to county entities) have been widely implemented. Funding arrangements have been matured and alternative sources of reimbursement have been identified and maximized. Finally, scientific discoveries, service system research and advocacy efforts have continually called attention to new treatments, different service models and more individualized support options.

The enactment of the Mental Health Code in 1974 created the legal framework for devolution of authority and funding for specialized mental health and developmental disabilities services from the state to the county-sponsored CMHSPs. Following the passage of this legislation, the department and the CMHSPs negotiated contractual provisions and funding mechanisms that actualized the transfer of control and resources from the state to local CMHSPs. Under the new arrangement, referred to as "full management", county CMHSPs became the single entry and exit point for publicly-funded mental health and developmental disability services. Reflecting this new authority and responding to the incentives of full management, CMHSPs began to move individuals from state facilities to placement in community settings.

While the transfer of state funds from institutions to CMHSPs provided the initial funding for the development of community services, the Medicaid program became a significant additional source of financial support for community programs and services. Medicaid is a federal assistance program funded jointly by the state and federal governments and administered by the state. Many adults with serious mental illness, children with serious emotional disturbances and persons with developmental disabilities returning to the community were eligible for Medicaid due to the extent of their disabilities and limited financial resources. In recognition of the special needs of these beneficiaries, the state elected to expand the scope of Medicaid coverage to include several new services - targeted case management, rehabilitation services, clinic services, personal care, home and community-based waiver services - specifically tailored to the needs of disabled individuals. Extending Medicaid coverage to include these new services allowed the state (and CMHSPs) to draw down federal financial participation for consumers covered by Medicaid who needed community-based specialty services. The expansion of Medicaid services covered under the state plan was also budget neutral for the state, since the CMHSPs agreed to put up a portion of their state general fund appropriation as the required state "match" for those specialty services which were billed to Medicaid. Over time, Medicaid reimbursement became intertwined with state general fund dollars in the financial foundation of the community-based special system for persons with serious mental illness and developmental disabilities.



However, the increasing dependence of the CMHSP system on Medicaid revenues carried with it a number of complications and restrictions. Medicaid funding imposed additional administrative and clinical practice requirements on the CMHSPs, increasing overhead costs. Also, state efforts to confine reimbursement for specialty Medicaid services exclusively to CMHSPs increasingly required CMHSPs to contort themselves into configurations which met federal requirements (e.g., Organized Health Care Delivery Systems, Prepaid Health Plans, etc.) for disbursement of federal matching funds. The final consequence is that requirements related to federal funding participation will ultimately result in CMHSPs (which were formed to pursue state and local policy objectives and system development) having to compete for the right to manage the bulk of public funds available for community-based specialty services.

In 1978, Article 6 of the revised Public Health Code created an office of substance abuse services and directed the development of local substance abuse Coordinating Agencies (CAs). The CAs became the main reservoir for federal block grant funds that flowed from the federal government for substance abuse treatment and prevention. They organized and administered a network of community-based substance abuse providers.

The growth of the community-based substance abuse system, however, has been much more modest, and reflects limitations in available funds. The department provided federal block grant funds and a limited amount of state general fund dollars to the CAs to underwrite the cost of substance abuse treatment for priority populations. Consistent with public health concerns, these priority populations include pregnant women and injecting drug users. CAs organize the local continuum of care - which includes outpatient, intensive outpatient, residential care and methadone maintenance - but they generally do not directly provide any services. Besides federal block grant funds and state general fund allocations, CAs also received some local funding and a portion of the liquor tax collections. Beyond treatment-related expenditures, CAs are required to commit a significant percentage of available funds to prevention efforts.

While the department utilized Medicaid reimbursement to support community services for persons with mental illness and developmental disabilities, it did not aggressively pursue Medicaid reimbursement for community-based substance abuse services. Lacking available state funds to "match" federal financial participation, the department restricted the type and amount of substance abuse services that could be billed to Medicaid. When Medicaid was available to fund community-based services, the CAs were not directly involved in these arrangements.

### **MANAGED CARE AS A VEHICLE FOR SYSTEM CHANGE**

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The principal objective of system change efforts of the past twenty-five years has been to affirm and actualize the right of disabled individuals to be included in society and to obtain needed services and supports within their own communities. To realize this objective, authority and resources were channeled to CMHSPs so they could develop a community-based care system with an array of treatment, service and support options. In the substance abuse field, state policy was directed toward providing interventions to high-need and at-risk populations through a network of locally organized providers who understood the special needs of the target population.

Building the foundation for the community-based care system required local entities to assemble an adequate supply and variety of community-based services, and to maximize all forms of reimbursement to pay for these care arrangements. However, the different funding streams that supported community services and supports gradually became an obstacle to effective management of the system. State general fund allocations, Medicaid reimbursement, block grants, consumer funds, other insurance payments and local "match" amounts all contributed to the fiscal base of community-based care arrangements, and each payer had different requirements and restrictions. In addition, the different funding streams contained incentives that pushed providers to offer particular services and to try to maximize reimbursement for those services. The multiple streams, conflicting incentives and disparate requirements made it difficult to effectively organize and manage the community system and to fix accountability. In addition, the flow of funds created a provider-driven system that supplied those services that the various payers were willing to fund or reimburse.

The department had used a number of tactics to counter system features that foster fragmentation. On the mental health side, CMHSPs were able to direct, if not totally control, the multiple funding streams that paid for community-based services and supports. And

through revisions to the Mental Health Code in 1996, CMHSPs could reconstitute themselves under a new organizational option that permitted greater administrative control and flexibility (authority status). The revised Code also took a step to reverse the drift toward a “provider-driven” system, by mandating implementation of “person-centered” planning processes.

In June 1996, the department announced a new initiative to counter funding fragmentation, increase flexibility in service arrangements and enhance accountability. This strategy was the introduction of managed care, previously utilized only for acute health care arrangements, into the publicly-funded long-term specialty care system. In October 1998, under authority granted by Public Act 336 of the Public Acts of 1998 (FY 99 Appropriations Act) and with the approval of the federal Health Care Financing Administration (HCFA), the department initiated a ground breaking specialty managed care program for publicly-funded mental health, substance abuse, and developmental disabilities services. With the implementation of the managed care program, multiple sources of public funding (Medicaid, state general fund appropriations, federal block grant dollars, etc.) which support vulnerable populations and specialty care services were consolidated under the authority of local, county-sponsored entities (community mental health services programs and substance abuse coordinating agencies). Under the managed program, CMHSPs and CAs receive Medicaid "capitation" payments, along with state allocations, federal grants and other public funds, and in return are required to provide specialty services to all Medicaid recipients and designated priority populations who reside in the service area and need such care. The CMHSPs and CAs are "at-risk" if the cost of providing such care exceeds the payments that they receive from the state.

Managed Care is a method of organizing and financing specialty services intended to increase access, consolidate resources, permit flexible care arrangements, and increase accountability.

In Medicaid, there are two types of program waivers: 1915b Freedom of Choice (FOC) waivers and 1915c Home and Community-Based Service (HCBS) waivers. Michigan has both 1915b and 1915c waivers for specialty services.

The inclusion of Medicaid funds in the new capitated managed care plan was made possible through a waiver - under Section 1915(b) of the Social Security Act - granted to the state by the Health Care Financing Administration (HCFA). Under the approved 1915(b) waiver - which is effective from October 1, 1998, through September 30, 2000 - most Medicaid-covered mental health, substance abuse and specialized developmental disability services have been removed ("carved-out") from Medicaid primary physical health care plans and arrangements. The department now contracts on a sole source basis with the county-sponsored CMHSPs - which are designated as “**Prepaid Health Plans**” (PHPs) under federal regulations - to manage Medicaid specialty mental health and developmental disability services and supports on a prepaid, shared-risk basis. Under the terms of the HCFA waiver approval, and consistent with the requirements of the fiscal year 1999 Appropriations Act, P. A. 336, CMHSPs subcontract with the regional substance abuse Coordinating Agencies to manage Medicaid substance abuse services under the waiver. The new 1915(b) waiver also operates in conjunction with Michigan's previously approved Medicaid Home and Community-Based Habilitation Supports Waiver for persons with developmental disabilities, authorized under the provisions of 1915(c) of the Social Security Act.

## **WAIVER CONDITIONS AND ENTRY DEREGULATION**

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As a condition of the 1915(b) Waiver approval, HCFA stipulated that the department must submit a plan to begin **competitive procurement** for management of the specialty services

and supports covered under the plan. The introduction of competitive selection into the publicly-funded specialty care system would allow non-governmental organizations (both non-profit and for-profit entities) to compete with CMHSPs and CAs for the right to manage public funds for specialty services.

Whether we are describing the historic state institution system or the current community-based care arrangements, the publicly-funded specialty service system has traditionally operated as a governmental monopoly. The intensity and duration of services and support needs for persons with serious mental illness and persons with developmental disabilities can be very costly, prohibitively expensive for individuals and families and representing unfavorable actuarial risk for insurers. Low-income individuals with addictive disorder are without means to pay for necessary treatment services. Lacking sufficient personal resources to offset the cost of care and supports, and absent an adequate number of private entities willing and able to underwrite or supply necessary services, government has traditionally furnished the funds for specialty care and has (when necessary) assumed direct responsibility for the delivery of specialty services and supports. Historical legal restrictions and limitations placed upon the rights of persons with mental illness, developmental disabilities and addictive disorders (e.g., involuntary commitments, placement orders, state ward status, guardianship, designation as an incapacitated person, etc.) has reinforced the role of the government in the public specialty services system.

"Competitive Procurement: HCFA is granting Michigan in this first approval letter a deviation from the open procurement rules as provided in 45 CFR 74.4. However, the State will:

1. Provide to HCFA no later than two years from the approval date of this waiver, a detailed plan to shift from sole source procurements for its Prepaid Health Plan (PHP) contracts to full and open competitive procurement which comply with the Federal procurement rules at 45 CFR Part 74. This plan must be approved by HCFA as part of the approval process for the first renewal application for this waiver. The plan must detail how the State: (a) will facilitate the development of and entry into the marketplace quality private sector participants (including for-profit and not-for-profit entities); (b) will assist county mental health boards and other interested public entities, if any, to prepare to compete on equal footing with private sector competitors; and (c) will include beneficiaries and their families in the preparation process to ease their transition to an open marketplace and to minimize disruption in their care and services should new entities become their managed care plans.
2. Ensure that prior to the completion of the first renewal period, within four years of the initial approval of this waiver, all contracts coming up for renewal will be openly and competitively bid.
3. Enter into contracts with county mental health boards subsequent to the approval of this waiver that will be of no longer duration than 36 months, in order to ensure that new, openly and competitively bid contracts can and will be awarded prior to the end of the first renewal period, no later than four years after the initial approval date of this waiver."

Letter from Sally Richardson, Director of HCFA, to James K. Haveman, Jr., Director of MDCH, June 26, 1998

Over the next several years, the system will transition from a governmental monopoly to a competitive "market" arrangement in which public and private agencies "bid" for the right to manage public funds for specialty services. This type of change is referred to as "**entry deregulation**". Private entities will be able to "enter" a sphere of activity that previously (in Michigan) was the exclusive domain of government.

## **A CLOSER LOOK AT THE FEDERAL COMPETITIVE PROCUREMENT REQUIREMENTS**

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As noted previously, when the plan for managed specialty services and supports was approved by HCFA, one of the conditions of approval was that by the point of first renewal of the waiver, (i.e., for the renewal effective October 1, 2000) the department must submit to HCFA a plan to competitively procure Prepaid Health Plans (PHPs) to manage the Medicaid specialty services and supports. Under the initial terms of the waiver, the department has been able to contract exclusively with CMHSPs - as public PHPs - to manage these funds. In the next phase, the department must devise and eventually implement a plan for competitive selection of specialty service PHPs.

Competitively bid contracts for the specialty care carve-out must be awarded no later than four years after the initial implementation date of the waiver; that is they must be in effect by October 1, 2002.

HCFA's position on competitive bidding is consistent with the provisions of Title 42, Section 434.6 of the Code of Federal Regulations, which states that "...all contracts under this part must...include provisions that define a sound and complete procurement contract, as required by 45 CFR part 74". The section referenced (45 CFR part 74) indicates that "...all procurement transactions shall be conducted in a manner to provide, to the maximum extent practical, open and free competition". PHP contracts with the Medicaid agency for the provision of Medicaid state plan services fall within the ambit of these regulations.

## **DEPARTMENTAL CONSIDERATION OF COMPETITION PRIOR TO HCFA STIPULATIONS**

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Even before HCFA stipulated competitive selection for management of Medicaid-funded specialty services, the department had considered the benefits that competition could bring to the public specialty services system. In the initial phase of system development, the monopoly arrangement and the designation of an exclusive geographic franchise (county and multi-county service areas) fostered the controlled growth of an organized community-based service delivery system. During this initial period, publicly-funded community-based care was an emerging service industry, characterized by the rapid proliferation of care arrangements and the expansion of local service capacity. CMHSPs and CAs gradually built the administrative and operational infrastructure necessary to manage system growth and to coordinate fragmented service components.

In recent years, however, community-based services and supports have become a "mature service industry" with slower growth and greater attention to system effectiveness, efficiencies, consumer participation (voice) and satisfaction, implementation of best practices and attainment of selected outcomes. Individual CMHSPs and CAs have exhibited differential competencies in this environment, with variation in performance. Competition was considered as both as an antidote to uneven performance by public entities and as means to afford individual consumers an "exit" option in situations where their "voice" had not prompted system improvement. However, despite the attraction of competition, a workable model - one that addressed legal constraints, funding restrictions, legacy assets, workforce commitments and residual obligations to public capital investment - had not yet been developed.

The HCFA requirement has accelerated the search for a practical model of competition. Under the waiver condition, the department must detail how it will competitively select PHPs to manage Medicaid specialty services and supports. Since Medicaid funds account for over 70% of all funds utilized to support community-based specialty services, entities selected to manage Medicaid specialty services and supports will control the dominant share of all public resources devoted to specialty care.



## **COMBINING COMPETITION WITH OTHER CHANGE OBJECTIVES AND EMERGING POSSIBILITIES**

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The introduction to this document identified some contemporary themes and trends that were reshaping the publicly-funded specialty services system. A plan for competition should be consistent with the direction and velocity of these forces, and should incorporate other desirable system change objectives.

These other themes and forces are reverberating through both the specialty system and the larger community health system. Both systems are feeling the impact of aggressive purchasers who are utilizing competition as a tool for enhancing value. Value from the purchaser's perspective means the acquisition of a service with a standard set of quality attributes or outcomes at a lower price, or a purchase at the usual or customary price that has either quality-enhancing features or a unique configuration that raises the buyer's satisfaction or performance in some essential dimension.

Responding to the purchaser's search for value, health care organizations are increasingly collaborating to lower costs (scale economies), integrate complementary service components, and improve outcomes. One emerging model for collaboration is the organized community delivery systems (OCDS). An OCDS is characterized by some level of integration or coordination among different, but complementary, health organizations and/or service providers within a community or region. The level of administrative, clinical and financial integration between the partners varies in different configurations. The possible configurations include horizontal forms of integration between similarly situated or segmented partners (either within a community or over a larger region) and various vertical combinations, which bring together partners with differentiated service components, provider competencies, or managerial attributes.

While payers search for value and health care organizations seek partners, consumers - whether privately insured or covered through public-sponsor agencies - are increasingly concerned about choice. Early managed care models paid little heed to individual preferences and often adopted an adversarial posture toward consumers. This insensitivity produced a backlash of complaints, negative publicity and calls for legislation to protect consumers. Whether we are describing specialty or mainstream health care systems, consumers actively resist care systems that are unreasonably restrictive and inimical to their needs. Contemporary sensibilities favor managed care arrangements that facilitate choice and offer consumers options.

## MODELS FOR COMPETITION

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In contemplating the future, the department has not ignored the evidence from other states that procurement for specialty services can degenerate into dysfunctional competition. These situations - characterized by a narrow focus on price as opposed to value and by lack of knowledge regarding how specialty systems operate - have resulted in litigation over contract awards, destabilization of existing service arrangements, and depreciation of publicly-funded service capacity and capital assets. Michigan cannot afford to go down the road of dysfunctional competition and squander the progress of the last thirty years. We must identify - and model for others - a process of "productive competition" that encourages efficient use of public dollars, increases consumer choice, control and satisfaction and strengthens communities.

### SURVEYING THE TERRAIN

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The publicly-funded specialty services system is a vast and complicated enterprise. It is composed of state-operated institutions and an enormous array of community services organized through county-sponsored CMHSPs and CAs. The specialty system is simultaneously involved in proceedings which restrict (e.g., involuntary commitment, institutional placement, court-ordered treatment, etc.) and activities which protect (e.g., recipient rights, beneficiary protections for Medicaid recipients, etc.) the rights of consumers. Funding for the system comes from a wide assortment of sources including state general fund allocations, Medicaid capitation payments, federal block grants, local match contributions and (for substance abuse) fees from certain assessments and portions of the state liquor tax. The current contract between the department and the CMHSPs and CAs for specialty services is simultaneously a "**defined contribution**" arrangement (state or federal contributions are fixed and distributed by formula and benefits or services for any individual vary depending upon priority status and available resources) and a "**defined benefit**" agreement (entitled Medicaid beneficiaries are eligible to receive certain defined covered benefits).

The publicly-funded system has responsibilities that cross service boundaries and transcend categorical limitations. The system is involved in jail diversion activities and criminal justice sanctions (e.g., mandatory substance abuse treatment). CMHSPs and CAs participate in the Multi-Purpose Collaborative Bodies (MPCBs) which are the major driving force behind local human service system integration. CMHSPs assist developmentally disabled individuals in transitioning from school to employment. Both CMHSPs and CAs are involved in prevention activities, with CAs directing a major portion of their budgets to such activities. Finally, CMHSPs have responsibilities for certain "public goods", such as maintaining 24-hour emergency service coverage within their service areas.

### UNDERSTANDING THE NEW RULES

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As noted previously, the current specialty service system is managed exclusively by the county-sponsored CMHSPs and CAs, which are public (or in the case of some CAs, quasi-public) agencies designated by state law as having the authority and responsibility to organize and to provide or arrange necessary specialty services within their designated service areas. Medicaid, however, has progressively provided a greater share of the funding for the county-sponsored specialty care system, evoking federal stipulations for competitive procurement. Thus, while state policy over the last twenty-five years has emphasized local decision-making and the devolution of responsibility and funding from the state to county-sponsored entities, parallel financing strategies during that same time - designed to maximize Medicaid

reimbursement - have brought us full circle, with the re-emergence of the state as a powerful purchaser with the added leverage afforded by competition.

Under current statutes, the department is obligated to provide state funds appropriated by the legislature to CMHSPs for provision of certain mandated services to Code-defined priority populations. The Code does not specifically refer to Medicaid funds, which are governed by federal statutes and requirements.

The Public Health Code (P.A. 368) directs the state department to manage and coordinate all state administered public funds for substance abuse services and to distribute these funds according to an annual comprehensive plan and statutory (appropriations) directives. These state administered funds have generally been regarded as state general fund appropriations, federal block grant dollars received by the state, and certain revenues generated through a special tax (with use of tax funds restricted by the enabling legislation). Medicaid funds that support substance abuse treatment, however, do not fall under the ambit of state law related to administration of funds for substance abuse services.

Public Act 368 (Article 6) requires the department to designate (subject to the approval of the affected county board or boards of commissioners) substance abuse coordinating agencies<sup>2</sup>. Historically, state administered funds for substance abuse treatment and prevention have been allocated to coordinating agencies which submit an annual budget application to the state office requesting state administered funds.

Medicaid comprises over 70% of the appropriated funding for specialty services in the FY 2000 budget<sup>3</sup>. It is this portion of specialty services funding that the department is required to competitively bid.

Thus, approximately 1/3<sup>rd</sup> of available funds for specialty services would be conveyed - under existing statutes - to the county-sponsored CMHSPs and CAs. However, the other 2/3<sup>rd</sup>s (over \$1.2 billion dollars) would be awarded through "full and open" competitive procurement to either a public or a private organization.

This condition - in which state requirements direct some funds to county-sponsored entities while federal stipulations mandate competition between public entities and private sector organizations for the management of Medicaid specialty funds - could erode cohesiveness and accountability within the specialty service system, disrupting the long-standing partnership between the state and the counties, leaving consumers caught between various funding arrangements and service mandates and interrupting existing care arrangements.

## **VISUALIZING NEW CONFIGURATIONS**

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We are caught in a paradox. State history and the current service structure point one way while federal program mandates and funding requirements seem to lead in another direction. Given these confusing signs, can we chart a stable course for the future?

It is not easy to visualize possible new arrangements for managing specialty services. We are constrained by experience and familiarity with the current system. Competition – used properly - has the potential to move the specialty system forward into the future, liberating it from archaic service philosophies and inefficient management practices. However, it also exposes the system to the possibility of "market failures" characterized by aggressive cost shifting,

<sup>2</sup> In a city which has created a local health department or joined in a district health department under part 24, the administrator may designate a city coordinating agency or city-county regional coordinating agency, which designation is subject to approval by the affected mayor, city council, and county board of commissioners.

<sup>3</sup> Medicaid represents a much higher percentage of community mental health funding than it does for community substance abuse services.

inequities in care access and resource distribution, service fragmentation, and abandonment of the community benefit perspective.

We need to formulate models for the future that are consistent with the public interest, retain positive features of the present system, introduce advantages characteristic of market-oriented arrangements and which fit with existing forces driving change in the larger health care system.

## **FIRST STEPS AND FALSE STARTS**

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The looming challenge posed by competition has prompted various stakeholders to advocate different designs for the bid process or to recommend entirely new models for management of specialty services. A few of these suggested approaches are described below. For reasons outlined in the discussion of each alternative, the department regards each of these options as problematic and inadvisable.

### *Alternative One: Open Competitive Procurement for Medicaid Funds Only*

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HCFA requirements for eventual "full and open competitive procurement" for Prepaid Health Plan (PHP) specialty contracts apply only to the Medicaid funds - currently paid on a capitated basis to county-sponsored CMHSPs and CAs - and not to other funding sources which support specialty care services. The most direct way to satisfy the requirement for competitive procurement would be to put only these funds - incorporated in the PHP contracts - out for bid, while maintaining CMHSP and CA control over all other non-Medicaid sources of funding for specialty care.

Under this arrangement, CMHSPs would remain the statutorily designated recipient of general fund allocations, with the attendant local match obligations linked to those funds. The CMHSPs would retain involvement and responsibility for use of state facilities, and for other code-defined mandated services and activities.

Medicaid plays a smaller role in funding substance abuse services, so the exclusion of these funds from the CA financial base would have less of an impact on these entities. CAs would continue to receive state funds, federal block grant dollars, local contributions, and revenues related to liquor tax collections and local court contracts. The service and prevention responsibilities of the CAs would be commensurate with the priorities and stipulations of these funding sources.

In this scenario, PHP contracts for Medicaid-covered specialty services would be subject to open procurement and both public bodies (such as CMHSPs and CAs) and private entities would be eligible to bid for these contracts. Some legislative action would be needed so that CMHSPs and CAs could meet the bid criteria and to assure a "level playing field" for the procurement. It is likely that bid specifications would not always conform to existing CMHSP or CA geographic service areas.

While alternative one is by far the easiest to implement and requires fewer legislative changes, it does have some significant drawbacks. As noted previously, Medicaid accounts for over 70% of the funds supporting community-based services. If private entities are the successful bidders - and particularly if the service areas are larger and different from existing public "catchment" areas - problems may develop due to the fragmented funding base and divided service obligations. One entity, accountable to the state through a PHP contract, will control the bulk of the resources for mental health and developmental disabilities care. Another (public) entity, accountable to the local governing board, the community and the state, will control a smaller pot of funds comprised of state and local funds. The state selected PHPs,

responsible for Medicaid services, are governed by federal requirements and the language of their contracts with the state. The community entities - CMHSPs and CAs - are governed by specific state statutes and funding priorities.

In this model, funding and reimbursement for community-based care is fragmented, as is the accountability for program operation and outcomes. Agencies providing services would likely have to have contracts with both the PHPs and the county-sponsored entities, since each would pay for some services, for some consumers, under certain conditions.

Splitting responsibility for Medicaid recipients and funds from state designated priority populations and appropriations may foster confusion and disputes about eligibility, care obligations, payment issues, service coordination and accountability. Michigan has pursued a "comprehensive" model of specialty care, one in which responsibility for all service area residents (statutorily defined priority populations, entitled Medicaid beneficiaries, block grant mandated groups, etc.), all coverage options and settings (community treatment, services and supports, state hospital services, etc.), and all sources of public funding (state allocations, block grant dollars, Medicaid, local contributions) for specialty services are vested in a single accountable entity. An approach that splits these funding streams and service obligations is a step backward.

*Alternative Two: County Right of "First Opportunity"*

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Recognition of the difficulties entailed by splitting Medicaid and non-Medicaid funds has prompted an interest in what is known as the "county right of first opportunity" alternative. As described previously, counties in Michigan have a fundamental role in organizing, providing or arranging specialty services. County-sponsored entities (CMHSPs and CAs) have had over twenty years of experience building local care systems and working with persons with serious mental illness, serious emotional disturbances, developmental disabilities or addictive disorders. These entities have contracted with private agencies within the community and have coordinated activities with other health and human service systems. The central position of these entities in the publicly-funded specialty services system is also recognized in statute (Mental Health Code and Public Health Code).

However, although CMHSPs and CAs are statutorily recognized, county-based public and quasi-public agencies that organize public specialty services and have a claim to certain state and local funds, federal regulations do not give these entities exclusive right to federal funds such as block grant dollars and Medicaid funding. Indeed, as indicated in previous sections, the department is *required*, under the waiver approval granted by HCFA, to proceed with competitive procurement for management of the Medicaid funds.

County-sponsored CMHSPs and CAs have taken note of the HCFA requirement for competitive procurement, but believe that grounds exist for the department to give preferential treatment to county-sponsored entities in a procurement process. They point to the example of Pennsylvania, where HCFA has sanctioned a procurement process in which counties have the "right of first opportunity". Under this arrangement, the Commonwealth of Pennsylvania conducts competition for management of Medicaid mental health and substance abuse services. The procurement specifications incorporate stringent administrative, fiscal and programmatic standards. Counties and other organizations may submit a bid under the procurement, but the county bid is opened first. If the county submits an acceptable proposal and demonstrates through a rigorous readiness review that it is capable of implementing the program, then the county is awarded the bid. Counties are permitted to partner with other organizations (e.g., for-profit managed behavioral health care companies) to acquire needed

administrative capacity and/or to manage financial risk. If the county declines to submit a bid or if their proposal is unacceptable, then bids from private organizations are opened and scored.

The Pennsylvania model of county "right of first opportunity" does seem to be appealing for Michigan, given the similarity of the public system in both states. Both Pennsylvania and Michigan have county-based specialty service systems, with statutorily specific functions reserved to county-sponsored entities.

Right of first opportunity would retain county-sponsored, locally accountable managing entities as the designee for all sources of public funding for specialty services, responsible for both priority populations and entitled Medicaid beneficiaries. Moreover, the rigorous purchasing specifications implied by the model and exposure to possible failure - losing the bid by submitting an unacceptable proposal - would "raise the bar" for public agencies that wish to continue as managing entities.

However, this model would not compel any level of administrative efficiencies, nor would it promote unification of mental health and substance abuse services or encourage affiliation of specialty services with mainstream community health care. Further, it does not address potential conflicts within those public agencies that function as both a manager and a provider of specialty services. This limits the model's potential for altering service philosophies and practice patterns (from "sponsored" group service programs to individual choice and control approaches).

Given the plain language of the waiver approval letter, it seems unlikely to the department that HCFA would support a county "right of first opportunity" plan for Michigan. HCFA's approval letter clearly endorses open competition between public and private organizations for management of public funds. The precise and very specific language of the waiver approval has convinced the department that "right of first opportunity" is not a viable proposal.

#### *Alternative Three: A Generic Long-Term Care Plan*

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Another option suggested takes an entirely different approach to specialty services and to competition for management of the public funds. This approach accentuates the long-term service and support needs of persons with severe mental illness and persons with developmental disabilities. Advocates of this model promote the inclusion of specialty service consumers into a more generic managed long-term care plan. This plan would also serve persons with physical disabilities, elderly individuals needing personal assistance and other populations with functional impairments. President Clinton proposed such a generic system for long-term care in the Health Security Act of 1993.

Under this proposal, the state would not continue along the existing population and service based carve-out path, but would instead shift strategy toward the development of a comprehensive long-term care program. A generic managed long-term care plan would offer a single point of entry for all persons with disabilities, ensure attention to physical health care needs, provide options for long-term care planning (case management, supports coordination, personal agents, etc.), and encourage substitution of more flexible community supports for rigid traditional service models.

Advocates of the model predict that new configurations of health care providers and organizations offering personal supports would emerge and compete to manage the long-term support needs of persons with serious mental illness and persons with developmental disabilities, as well as other disabled populations. They also believe that consolidating the management of current standalone population-based disability systems under competitively selected managed care entities (MCEs) would reduce administrative costs, eliminate

duplication and improve the coordination of physical health care and long-term services and supports.

Despite its apparent simplicity and intuitive appeal, many advocates for persons with mental illness and developmental disabilities view inclusion in a generic plan as a step backward. They believe a generic plan would fall under state auspices, reversing the trend toward local and personal control of services and diminishing their "voice" and participation in the specialty or long-term care system. They are also skeptical that a generic plan would retain essential principles and emerging philosophies (recovery, self-determination, etc.) of the current specialty care system. Finally, there is concern that resources accumulated for specialty care - and any future savings achieved through management of specialty services - would be dispersed into the wider pool of elder and disabled individuals, and would not be available to meet the needs of persons currently on waiting lists and new applicants with serious mental illness and developmental disabilities.

A generic managed long-term care plan has little in common with the current community-based specialty system organized by county-sponsored entities. The model has potential for cost savings and administrative efficiencies, but lacks a firm connection to the current local governance structure for specialty services and offers limited opportunities for community participation and consumer voice. Competition is restricted - for the most part - to a choice of managing entities, and does not reach down to a level where consumers control resources directly and retain an "exit" option by choosing service and support providers.

This approach - built around enrollment and defined benefits - has enormous difficulty incorporating the defined contribution component (state or federal contributions distributed by formula with eligibility and services dependent upon priority status and available resources) of the specialty service system. Nor is this model readily able to accommodate state facility services and local match obligations. It does not address services needed by children and adolescents with serious emotional disturbances and it does not incorporate substance abuse services. The generic long-term care model is silent about these and other complications.

#### *Alternative Four: Splitting MH/SA and DD Services*

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Currently county-sponsored entities manage population-based (persons with serious mental illness, serious emotional disturbance, developmental disabilities or addictive disorders) specialty service systems utilizing various sources of funding to support care arrangements for these consumers. Alternative three - the generic long-term care model - suggests moving two disability populations (persons with serious mental illness and persons with developmental disabilities) out of the county-sponsored system and into a managed long-term care plan. In the section above, we noted the complications incurred by this approach.

In trying to remedy these problems, some proponents of the generic long-term care model, along with those who advocate inclusion of Medicaid behavioral health (mental health and substance abuse) benefits into Medicaid physical health care plans, have proposed a variation of the generic plan outlined above. Under this proposal, only persons with a developmental disability would be included in the generic long-term care plan. Responsibility for the developmentally disabled - and the specialty services and supports required by these consumers - would be transferred from CMHSPs to the managed care entities (MCEs) selected by the state to manage long-term care. Proponents of this approach note that most persons with developmental disabilities are Medicaid eligible and that the bulk of the funds for DD specialty services are directly linked to Medicaid. Hence, by this logic, persons with developmental disabilities "fit" well into the eligibility-enrollment driven generic long-term care plan.

While individuals with a developmental disability would be transferred to long-term care plans, service responsibilities and funding for persons with mental illness, serious emotional disturbances and addictive disorders would be carved up in a different fashion. Medicaid funds related to specialty mental health and substance abuse services would be included in the capitation rates paid to Medicaid-contracted Qualified Health Plans (QHPs), which would assume responsibility for Medicaid mental health and substance abuse benefits. CMHSPs and CAs would continue to receive general fund allocations, block grant funds and other resources for care of persons with serious mental illness, serious emotional disturbances and addictive disorders and would be obliged to serve state designated priority populations with these funds. CMHSPs would also continue to carry out responsibilities related to state facility utilization. This proposal is silent on how Medicaid mental health and substance abuse benefits would be managed for those beneficiaries who cannot be required to enroll in Medicaid managed physical health care. Presumably, mental health and substance abuse benefits for these beneficiaries would be administered on a fee-for-service basis.

Advocates of this approach point out competition for management of the long-term care plan (which includes specialty developmental disabilities services) and the competition of the mainstream QHPs (which would now include Medicaid funds for specialty mental health and substance abuse services) satisfy Medicaid requirements related to competitive procurement, and hence the state would not need to proceed with a competitive bid for specialty mental health, developmental disability and substance abuse services. However, this alternative would also completely eliminate the current 1915(b) Medicaid waiver for specialty services.

This modified plan (separating specialty DD services from MH/SA services and further splitting MH/SA funding between QHPs and county-sponsored entities) suffers from all the problems noted in the critique of alternative three (which we will not repeat here) plus a host of additional difficulties. CMHSP administrative and operational capacity is structured and scaled to manage services for both populations (persons with serious mental illness, serious emotional disturbances and developmental disabilities). Separating populations could cause steep and significant depreciation of publicly-funded administration infrastructure and service capacity. Further, in proposing the movement of some MH/SA funds to the QHPs, this alternative bifurcates the funding streams which support community-based specialty care systems and it leans heavily on private intermediary organizations (QHPs) with only tenuous connection to the county-sponsored entities that are statutorily responsible for MH/SA - and DD - services.

### **PRIORITIES: COMPETITION, COMPREHENSIVENESS, CONTINUITY, OR NEW CONFIGURATIONS?**

The four alternatives described above clearly reflect priorities that are related to - but are distinct from - the primary issue of competition for management of specialty services. Alternative one (bidding only Medicaid funds and services) concentrates on minimal requirements for competition, but sacrifices the comprehensiveness of the current system. Alternative two (right of first opportunity) gives lip service to competition, but subordinates it to comprehensiveness and the continuity of existing service arrangements. Alternatives three (generic long-term care) and four (splitting DD services from MH/SA services) are clearly directed more toward dismantling stand-alone population-based disability systems in favor of either larger, different or entirely reconfigured service arrangements. These alternatives are only tangentially interested in the immediate issue of competition.

The department does not regard these alternative models as viable options for Michigan's specialty service system, nor does it regard them as credible plans for competitive procurement. In the next section of the paper, the department proposes options that would



## Competition for Management of Publicly-Funded Specialty Services

promote competition and address other priorities - such as comprehensiveness, continuity, and new configurations - that are also a part of the public interest.

## **THE MDCH PLAN FOR COMPETITIVE PROCUREMENT**

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As we have discussed, the major complication for the future direction of the publicly-funded specialty system is that state law compels a preferential role for county-sponsored entities in the organization, management, funding and delivery of specialty services. This statutorily mandated favoritism clashes with requirements related to Medicaid managed specialty care, which obliges the state to competitively select Prepaid Health Plans (PHPs) to manage Medicaid covered and funded specialty services.

The tension between state preferences and federal stipulations of competitive neutrality has spawned various suggestions for competition or for reconfiguration of the existing specialty services system. For reasons outlined in the previous sections, the department does not believe that these alternatives strike the right balance between competition and other important considerations.

A persistent problem within publicly-funded specialty services is the variability among local systems. The state - as a purchaser - devotes an inordinate amount of time and energy to addressing substandard practices or differential competencies among certain local CMHSPs and CAs. Some county-sponsored entities are proactive, innovative and effective, and enjoy widespread consumer and community support. Others have difficulty complying with minimum standards and are held in low esteem by consumers, family members and the public.

In the current arrangement, neither the state as a purchaser, nor the consumer as a service recipient, have many options when faced with substandard or poorly performing local systems. The state uses legal and contractual mechanisms to force compliance and consumers avail themselves of legal remedies and public participation in various forums to vent complaints. However, both the state (in its efforts to enforce compliance from "outliers") and consumers (attempting to change local practices) have limited leverage to force change. Competition would afford both the state and consumers with a powerful tool to promote best practices and competent system performance. Competition would provide - beyond enforcement actions, individual consumer legal redress, and the exercise of "voice" (consumer participation) - an exit option for both the state and the consumer.

From the department's perspective, competition is of paramount value in the plan for the future of the public system. The department's plan elevates competition to a place of prominence in the procurement, but also meshes competition with the need for comprehensiveness, and continuity of care in the public system. Essential public governance functions, critical regulations and consumer protections are retained to ensure public oversight and a "floor" of acceptable activity, but market mechanisms are utilized to identify and select managing organizations that are the most competent, consumer-focused, community-oriented and efficient organizations to manage specialty care.

### **BASIC FRAMEWORK OF THE DEPARTMENT'S PROPOSAL: COMPETITIVE NEUTRALITY**

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The department recognizes that the funding streams (e.g., Medicaid funds, state general fund allocations, federal block grants, restricted purpose revenues, local match, etc.) which support specialty services and collectively underwrite local systems of care are deeply interrelated and entwined. Since these reimbursement streams have become intertwined in the financial foundation of the community-based specialty system, splitting them apart is impractical and unfeasible. Further, the department endorses the idea that system management must remain decentralized and devolved to local entities to retain and to preserve opportunities for local solutions, participation and community collaboration.

Recognizing this interconnectedness of state general fund dollars and Medicaid funds, CMHSPs and CAs have argued for the county "right of first opportunity". The department, however, proposes a plan that moves 180 degrees and turns the notion of right of first opportunity on its head. Instead of preserving state preferential treatment for county-sponsored entities, the department proposes to extend competitive procurement to include all service populations (state priorities, eligible beneficiaries, federally mandated groups), all management responsibilities, all service options and settings, and all available funding for specialty services (state appropriations- with concomitant local match obligations - federal block grant dollars and Medicaid capitation).

Under this proposition, the department would bid out management of both the Medicaid funds for specialty services and other funds currently assigned by state statute or practice exclusively to county-sponsored entities. In a competitively "neutral" process (level playing field), the department would award management contracts for each designated service area to a single public, private, or public-private partnership organization in that locality or region which submitted a proposal most responsive to the purchasing specifications outlined in the bid packet.

A competitively neutral process means designing the procurement so that all qualified bidders - public, not-for-profit and private for-profit - are treated in an equal fashion in the bidding process. To the extent possible, all barriers to the public entity flexibility are removed, as are some special privileges or protections currently afforded these entities. Similarly, private entities are required to - if they are successful bidders - to take on legal responsibilities and procedural obligations currently borne only by public sector entities.

The state as purchaser of specialty services is the "public-sponsor" which subsidizes care - either through Medicaid, state general funds, restricted revenues, or federal block grant dollars - for persons needing specialty mental health, developmental disability or addiction services. For some individuals, the state's payment as a "public-sponsor" is contingent upon a local contribution (match) for the cost of care.

In the competitively neutral procurement process, the state as primary public sponsor (in conjunction with consumers and family members) would choose among managed specialty plans (MSP) competing to manage specialty care in a given locality or region of the state. Only those MSPs that submit responsive proposals would be considered in the procurement. A "responsive proposal" would be one which describes experience with the target or covered populations, an ability to manage both "defined contribution" and "defined benefit" arrangements, proficiency in "consumer-choice" service models, sufficient administrative infrastructure and operational capacity to efficiently manage the system, certification of risk bearing capabilities, independent price calculations, and a willingness to fulfill all conditions of participation (which include assumption of public interest functions and obligations).

#### *Advantages of the Framework*

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The department's proposal recognizes that persons with serious mental illness, serious emotional disturbances, developmental disabilities and/or addictive disorders require a specialized service system and hence the proposal preserves the service carve-out structure for specialty care. As noted previously, under a carve-out model, covered mental health, substance abuse and specialized developmental disability services are removed ("carved-out") from Medicaid primary physical health care plans and are managed through a separate managed care system. Under the department's plan, the entities chosen to manage specialty services will administer both Medicaid funds for covered specialty services and other public

funds (state general funds, federal block grant dollars, etc.) available for the care of designated populations and entitled beneficiaries.

The proposed framework also preserves the principle that system management should be decentralized and devolved to a single managing entity in each defined geographic service area, responsible for all service area residents (statutorily defined priority populations, entitled Medicaid beneficiaries, block grant mandated groups, etc.), all coverage options and settings (community treatment, services and supports, state hospital services, etc.), and all sources of public funding (state allocations, block grant dollars, Medicaid, local contributions) for specialty services.

However, while sustaining the concepts of a specialty system (carve-out structure) and decentralized system management, the department's plan allows new entrants (private sector entities) to compete to become both the PHP for Medicaid-funded specialty services and the designated entity for managing non-Medicaid public funds for priority populations (these entities - which have combined responsibilities - are referred to hereafter as managed specialty plans or MSPs). The plan reduces the number of managing entities (compared to the current structure) by specifying certain size, scope and efficiency considerations for managing entities. The department's plan departs further from past practice by requiring managing entities to adopt a new model of managed care which allows consumers to opt for individual budgets and purchasing authority for routine community and personal supports, while retaining more systematic and traditional managed care techniques if service and support needs intensify requiring higher cost interventions.

Requiring successful bidders to assume responsibility for both state general funds (and priority populations) and Medicaid capitation payments (for entitled beneficiaries) ensures the continued prominence of the state Mental Health Code in guiding system operation. If Medicaid funds alone were put out for procurement, the selected contractors would not incur all of the responsibilities and enforceable obligations described in the Code.

#### *Difficulties Posed by the Framework*

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As noted before, federal requirements stipulate that Medicaid funds for specialty services (which comprise 2/3<sup>rd</sup> of the total budget) must be procured through a competitively neutral process. Currently, state general fund dollars and other state controlled resources (the other 1/3<sup>rd</sup> of the specialty service budget) are conveyed exclusively to county-sponsored entities.

A competitive procurement that rolls in both priority groups and eligible members; combines existing benefits, state-mandated services and different care settings; and encompasses all sources of funding within a competitively neutral bid process will require substantial changes to various statutes. These changes would be necessary both to allow public entities to compete on an "equal footing" and to permit private entities - if they are successful bidders - to receive designated state funds and to assume public sector responsibilities specified by state law. In essence, competitive neutrality requires that public agencies be granted increased flexibility to operate like private concerns, while private entities would be allowed to assume certain public governance functions. This is sometimes referred to as "privatizing" the public sector and "governmentalizing" the private sector.

Specifically, revisions would be required to the Mental Health Code and to the Public Health Code to allow CMHSPs and CAs much greater latitude in the formation and capitalization of partnership arrangements - for a public purpose - with other organizations (public and private). Changes would also be needed in Chapter 2 of the Mental Health Code to permit successful private bidders to assume statutory duties now reserved exclusively to county-sponsored entities. This would likely require the addition of a new type of Community Mental Health

Services Program - a non-governmental state-designated CMHSP - as an option under the Code. The addition of another type of CMHSP entails consideration of how county match requirements apply under these circumstances.

Beyond these changes to the basic state law governing mental health and substance abuse services, modification to the HMO Act would be needed to permit public entities to be licensed to bear risk and to enter full risk contracts for management of publicly-funded services. The Municipal Finance Act and the Uniform Budgeting and Accounting Act would also likely need revision to facilitate assumption of financial risk by public entities, without violating current financial management, budgeting and accounting expectations for municipal corporations. Finally, a section of the Management and Budget Act, which gives preferential treatment to private business in state procurements, would need to be amended to ensure competitive neutrality rather than preferential treatment for private sector firms.

Aside from legal issues related to competitive neutrality, the department's plan also entails potentially significant "switching costs" and matters of "stranded" public assets. Switching costs refers to both expenses and non-monetary costs that purchasers (the state) and consumers face when they switch from one "supplier" (e.g., an existing CMHSP or CA) to another (a different entity selected in the competitive bid process). The stranded assets issue involves potential depreciation in legacy investments and human and capital assets - buildings, equipment, care facilities, professional workforce - financed by public funds and representing residual liabilities for counties and county-sponsored entities.

#### **TEMPTING ALTERNATIVE: THE TWO-PLAN MODEL**

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The current specialty services system is a disability or condition-based, service area specific public monopoly. The department's plan would continue a monopoly arrangement, although private entities would be able to compete for exclusive (albeit time-limited) management rights, and the number of geographic monopoly areas would be reduced. The department's plan allows the state to escape perpetual sole-source arrangements by periodic rebidding and would permit consumers to "exit" monopoly control through individual budgets and other arrangements.

However, despite these features, a plausible case could be made that the department's plan may simply trade in public monopolies for private ones. The plan also does little to nurture true competition in the marketplace. By selecting one vendor (manager) in each region, it may cause other potential suppliers to exit the market or to simply go out of business.

Certain provisions within the Balanced Budget Act (BBA) of 1997 suggest another way the department might organize competition for management of publicly-funded specialty services. This other, very tempting approach, would permit consumer choice *between* competing managed specialty plans. In this model, all public funds (Medicaid, state general fund appropriations, federal block grants, etc.) are brought together, but instead of selecting one plan to manage specialty services, two managed care entities are chosen in each region. Medicaid recipients - and individuals not eligible for Medicaid but who qualify for participation in the plan because of clinical need - are eligible to enroll in the managed specialty services system and are offered a choice of plans.

This approach is of great interest because it retains the concept of consolidated funding streams, responsibility for priority populations and entitled beneficiaries, unified management of mental health and substance abuse services (within each plan), local competition and consumer choice. It also cultivates a competitive marketplace by maintaining a number of suppliers.

However, there are some problems with the two-plan model which might make it difficult to implement and problematic to operate. The competition between plans envisioned in the two-plan model is only feasible with a very large population base. To utilize the two-plan model, the department would have large service area designations, reducing the number of regions in the state to roughly six or seven areas. In some of these areas, even a very wide geographic designation would not include a large enough population to support two plans, and in these areas there would continue to be only one plan with exclusive management rights.

Beyond the very large population size required to support a two-plan model, there are questions related to participation of county-sponsored entities in a two-plan model; issues regarding how priority populations would be identified, "sponsored" and allowed to pick a plan; problems due to what is referred to as "adverse selection"; and other difficulties best described as the "deterioration" of consumer "voice".

Conceivably, in any "region" large enough to support two-plans, there would be multiple, county-based, public entities within the region. It is unclear how they would align themselves in this situation. Would they combine together as one plan, or would they differentially partner with private organizations, some county-sponsored entities being a part of one plan, others allied with the second plan within the region? Under these conditions, who would be responsible for statutorily designated public functions within the region - both plans, the governmental entities in each plan, or some other designated agency?

Moreover, who would make the decision that a particular person - not covered through Medicaid - was indeed a member of a state or federally designated "priority" population, and hence should be "sponsored" by public funds and allowed to enroll in one of the two specialty plans? Would this be some "third-party" enrollment broker, contracted through the state? In addition, converting "defined contribution" state general fund formula dollars or block grant funds into a "sponsored" capitation payment is very difficult. What if too many individuals are designated as eligible for public "sponsorship"; will individuals with more severe conditions be simply turned away because funds are already "attached" to someone else? The two plan approach - in essence a managed competition model - is more compatible with insured individuals and defined benefit contracts (such as Medicaid) than it is with the notion of covered communities (geographic service areas) and priority populations.

Another problem with the two-plan model is the possibility - indeed even the probability - of adverse selection. Adverse selection refers to circumstances in which persons with high service and support needs enroll unevenly in one plan, creating financial difficulties for the plan favored by these consumers. Although the problem of adverse selection can theoretically be corrected through "risk adjustment" of capitation rates and premiums, in practice such risk adjustment is extremely tricky and problematic.

Finally, some observers have pointed to deterioration in public participation and consumer "voice" in two-plan systems. This is particularly true where one plan is dominated primarily by private sector entities while the competing plan is composed of public sector agencies. The private plan may be successful in attracting some of the more vocal "substitute-seeking" consumers of the present public system. This leaves behind more dispossessed and less vociferous consumers (e.g., homeless mentally ill) who are less likely to complain. If this situation becomes widespread, there may be deterioration in the public sector organization, since there is little vocal opposition or active complaints to the operation of the public plan.

#### *A Possible Solution to the Shortcoming of the Two-Plan Model*

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Some of the problems posed by the two-plan model might be surmounted if several county-based entities (merged or affiliated) - instead of the state - became the "market-maker" for a

two-plan model in a certain geographic area. Under this arrangement, the affiliated counties would accept all funds from the state with the stipulations that they (the counties) would *collectively procure* two managed specialty plans to serve the region. The county-entities could not be providers under this arrangement, or else they would have to formally "spin-off" their provider functions and keep them at arms length, ensuring that selected plans could freely choose to include or exclude these providers from the service network. The sole responsibilities of the county-entities would be to: a) collectively select (in full and open competition) two-plans to serve the region; b) enroll consumers into the plans (giving each consumer a choice between the selected plans); c) designate which non-Medicaid consumers would be designated as a "publicly-sponsored" priority population member and enrolled in a plan; d) adjust rates for adverse selection; and e) monitor plan contracts and performance.

It is unclear if HCFA would permit this form of county-based purchasing. HCFA's reaction to Minnesota's proposals - in which counties could elect to become Medicaid "brokers", accepting financial risk and setting up managed care plans - has been lukewarm at best. Given the uncertainty of HCFA's position (which seems to regard county-based purchasing as a form of sole-source contracting), this "solution" may not be feasible at the present time.

*Two-Plan Model: Further Development Needed*

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Despite the inherent potential of the two-plan model to invigorate competition by spreading contracts among multiple organizations, difficulties assigning "public" functions and allotting public-sponsorship, the likelihood of adverse selection, the possible dissipation of consumer "voice" and the large population size needed to support this form of managed competition mitigate the initial enthusiasm for this model. Moreover, while the "choice" between plans seems attractive, provisions which "lock-in" Medicaid beneficiaries to a particular plan for up to twelve months<sup>4</sup> suppress the "exit" option for consumers. It seems, at this point in time, that a single managing entity in each region is preferable to the less fettered competitive environment promised in the two-plan model.

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<sup>B</sup> Beneficiaries must be allowed to disenroll from a plan "for cause" at any time, and "without cause" during the first 90 days of enrollment and then at least every 12 months thereafter.

## **DESIGN AND STRUCTURE OF THE PROPOSED SYSTEM**

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While the basic framework of the department's plan for competition has already been presented, the current section attempts to put some meat on the bare bones of the plan. This section does not provide extensive details of a finished plan or specifications for a future Request for Proposals (RFP). Obviously, discussions with stakeholders, legislative activity and negotiations with HCFA may substantially alter the department proposal. However, given these limitations, the section does briefly address some elementary design issues and core plan responsibilities.

### **POTENTIAL BIDDERS AND PROCUREMENT TIMEFRAME**

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Within 180 days of HCFA approval of the plan for competition and concurrent confirmation of waiver renewal, the state intends to issue a Request for Proposals (RFP) to secure a limited number of Managed Specialty Plans (MSPs) to administer the specialty services carve-out program. One MSP will be chosen to administer the specialty services program in each designated geographic service area.

Under the current configuration of the managed specialty services program, the state contracts with 49 CMHSPs (mental health and developmental disability services) and 15 CAs (prevention and treatment of addictive disorders). Under the RFP process, the state plans to contract with far fewer entities for the management of specialty services. MSPs selected through the competitive process will manage all specialty services (mental health, developmental disabilities and substance abuse) in the designated service area.

Current public agencies (CMHSPs and CAs), an organized consortium of public agencies, public - private partnership arrangements, provider-sponsored organizations, for-profit or not-for-profit corporations, and other organizations who meet requirements outlined in the bid package may submit a response to the RFP. Organizations submitting bids must be licensed in Michigan to bear financial risk or must be in the process of obtaining such licensure.

The state recognizes that public entities are currently subject to specific legal regulations that restrict their ability to enter into affiliations, joint ventures and partnerships and to obtain licensure under the HMO Act. These restrictions and limitations would have to be addressed and resolved by the legislature prior to the issuance of an RFP. Similarly, existing statutes define a CMHSP as a county-sponsored governmental entity and a CA as a jointly (state-and-county) designated public or quasi-public organization. Since successful bidders will be required to carry out public functions currently performed by these public or quasi-public entities, the statutory definition of a CMHSP and/or a CA must be modified to allow non-public, non-governmental organizations to be certified as a CMHSP or CA. Successful bidders - the Managed Specialty Plans - will be the Medicaid Prepaid Health Plan (PHP), the designated Community Mental Health Services Program (CMHSP) and the specified Coordinating Agency (CA) for the geographic service area.

Beyond legal obstacles posed by current state statutes, formation of any new organization (affiliations, networks, and partnerships) entails legal risks that are outside the scope of this document. Antitrust considerations, fraud and abuse limitations, liability, labor and regulatory concerns are just some of the legal issues related to the formation of new organizational arrangements. The state urges entities considering new organizational structures to exercise due diligence in the formation of these structures.



### *Manager and Provider?*

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Some CMHSPs, in addition to administering and managing a local community-based system of care, directly operate many component services within that system. Similarly, entities collaborating to form a provider-sponsored managed care organization retain direct service programs. Some observers question whether these two roles – manager and provider – are compatible in a managed care environment and whether the state should accept bid submissions from organizations with significant ownership of provider services and programs.

This argument - reflecting the antiquated "foxes guarding the henhouse" line of reasoning - is specious. It asserts that manager-provider overlap introduces some special conflict of interest. However, earlier models of managed care, which split manager and provider roles, were cumbersome, adversarial and subject to similar conflict of interest conundrums.

Plans - at risk for financial expenditures and clinical outcomes - have to assemble a comprehensive, coordinated and integrated set of specialty services to meet the needs of consumers. Strategies for obtaining and assembling the set of specialty services have different costs and benefits. Directly operating most of the necessary services and supports may yield economies due to combined operations (e.g., using case managers or service coordinators to assist both mentally ill and developmentally disabled consumers), offer a stable supply of services and greater internal control, and improve coordination of care. However, direct provision of services often involves higher fixed costs, less flexibility to make change, and may dull incentives for organizational performance.

The reverse is true for managing entities that obtain needed services from contract providers. This strategy reduces fixed costs and (theoretically) increases flexibility, but imposes greater coordination and monitoring costs upon the organization. In some large service areas, there may be significant difficulties in transmitting needed clinical information between the various components of the service system.

Recognizing these advantages and disadvantages, many managing entities follow a middle path: directly providing certain critical services and other activities which they can efficiently operate in-house, and obtaining other services (often those with significant fixed costs) from providers in the marketplace.

While the department will not prescribe how bidders or managing organizations assemble their provider networks, it will insist that consumers be afforded a reasonable choice of providers and an opportunity for consumer-directed purchasing, and that "unaffiliated" providers receive fair consideration for inclusion in the plan's provider network.

### *System and Consumer Managed Care*

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As described previously, organizations competing to become MSPs must implement a managed care model that combines elements of system management/group sponsorship with individual ownership/consumer-directed purchasing components. Under this approach, traditional systemic managed care strategies are applied to consumers with high, intensive and/or restrictive support needs. However, for a certain "base" level of services and supports, consumers may request a consumer-directed purchasing option (e.g., an individual budget allotment with spending and reimbursement authority; a voucher; a contribution to a consumer/family collaborative or cooperative which purchases the agreed upon services; etc.). This "consumer-managed care" approach allows consumers to operate directly in the market. However, if the consumer's condition changes or support needs increase (requiring more structured, tightly coordinated care arrangements) the MSP may correspondingly intensify its involvement in the management of consumer care.

The consumer managed care element of the model must also allow consumers to "nominate" psychiatrists outside the network as their primary treating psychiatrist. Physicians who accept this "nomination" by the consumer would have to agree to care coordination protocols specified by the MSP and would have to submit treatment plans for MSP review.

The focus upon choice and consumer control must not be construed as permitting MSPs to neglect their obligations to care for consumers. Some persons with mental illness have limited understanding of the need for treatment due to the impact of mental illness on judgement and self-perceptions. The MSP will be expected to provide vigorous outreach to such individuals.

### *Considerations Related to the Number of Managing Entities*

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Earlier, the department stated its intention - under an RFP process - to contract with fewer entities to manage specialty services. This document does not, however, identify the number of managing entities, nor does it offer a map of possible regions or provide specific size or capacity requirements.

These omissions are, of course, deliberate. While certain size (e.g. number of eligibles, covered populations, etc.) and capacity requirements will be indicated in the actual RFP, the vagueness of these specifications in the current paper allows stakeholders to advise the department regarding these dimensions. In truth, we do not know with absolute precision which size is too small and which is too large. Nor do we understand which capacity dimensions are the most efficient and responsive.

To structure the debate about size and capacity requirements and the number of managing entities, some considerations may prove useful. These considerations are scale and scope economies, and risk estimation, variance and uncertainty.

Managed care systems involve a variety of administrative functions and activities that are both "scale" and "scope" sensitive. Economies of scale refer to advantages that accrue from larger size: the transaction costs of certain core administrative activities (e.g., claims processing) or participant acquisition costs for infrastructure (e.g., management information systems) decrease when spread over a larger volume or bigger network. Economies of scope indicate the benefits diversified organizations may reap from sharing operations, functions, processes, specialized knowledge or acquisition costs over several "business lines", products or services. Access systems capable of serving adults with serious mental illness, children with serious emotional disturbances, persons with a developmental disability and individuals with addictive disorders illustrate a potential area for scope economies.

The department's determination to reduce the number of managing entities rests, in part, on the conviction that administrative and managerial scale and scope economies can be realized by requiring that managing entities conform to certain "size" (e.g., covered lives, service area population, etc.) and/or capacity requirements. However, as noted above, it is not clear what size and capacity yield optimum efficiencies. While one may assume that very small size imposes disadvantages in scale and scope, the same may be true of very large organizations. Large organizations (both in terms of size and capacities) may foster excessive bureaucratization, dull performance incentives, or loss of organizational focus.

Risk estimation introduces another consideration related to size. Accepting full risk for specialty services places the contractor at risk for changes in the characteristics of the covered group, variations in volume and types of services used, growth in the number of service users per 1,000 population, and increases in the cost of producing or the price of obtaining particular types of services. Estimates of variance from historical patterns are less reliable with a small population, increasing the level of uncertainty for the managing entity. Small organizations

covering a small group will likely have less ability to absorb significant variations in demand, utilization or cost, and hence may be at significant danger for insolvency.

*Virtual Integration and Organized Community Delivery Systems*

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The genteel pre-competition world of health care has been rapidly eclipsed by today's hyper-competitive environment. The old world may have been more benign for providers and insured consumers, but this benevolence came at a steep price for employers and public purchasers. The trajectory of health care cost inflation - plotted in double-digit annual growth rates - was and is simply unsustainable. The introduction of managed care and implementation of risk-based payment systems ignited competition for the health care dollar and propelled a wave of consolidation and system integration designed to amplify market presence and power.

Initially, consolidation and integration efforts revolved around direct ownership of essential administrative, care components and suppliers (vertical integration). However, gradually another model for collaboration developed which brought together clusters of affiliated community health care entities, their cohesiveness achieved not by ownership but through long-standing patterns of mutual involvement and interdependence. In this arrangement, interdependent and affiliated payers, providers and/or suppliers, operating under common interests and aligned incentives, began to focus upon individual patient care and on the goal of constantly improving performance, outcomes and community health status. Instead of trying to control the uncertain health care environment by market domination and ownership, these providers and organizations regard each other as fulfilling complementary roles or functions thereby enhancing the total effectiveness and efficiency of the system. Tangible evidence of these reciprocal arrangements are found in streamlined referral processes, co-location of providers and programs, shared care protocols, mutual health care promotion activities, joint contributions for infrastructure enhancements, connectivity between information systems, and coordination of strategic initiatives.

This form of collaboration, referred to as virtual integration, does not (and should not) suppress all competitive maneuvering and organizational self-interest. Rather, virtual integration provides a strategy for health care organizations and providers to configure themselves in organized community delivery systems (OCDS) or networks. In larger communities, there will often be several competing OCDS, each oriented toward particular market segments, purchasers and consumers.

The publicly-funded specialty service system has historically closely cooperated with other community service agencies and organizations (e.g., social services, child welfare, public housing, courts, juvenile justice, education, job training, municipal jails, etc.). However, collaboration between the specialty service system and other health care organizations and professionals has been rudimentary and underdeveloped. Regardless of the reasons for minimal systematic collaboration in the past, the time is ripe for closer integration between the specialty service system and emerging organized community delivery systems. This is particularly true for OCDS or health care networks that enroll or treat large numbers of publicly-sponsored (Medicaid, indigent care funds) patients.

The department is keenly interested in proposals that connect (through virtual integration arrangements) the Managed Specialty Plan with an OCDS, health care network or Qualified Health Plan. New and innovative configurations - such as the Urban Cooperation Entity proposed by a CMHSP, a CA and an Academic Medical Center, or the strategy articulated by several CMHSPs and CAs to acquire an equity stake in a not-for-profit health plan which serves most of the Medicaid beneficiaries in the region, or the enhanced collaboration activities between several CMHSPs and a managed care network comprised of and owned by Federal

Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) - are very attractive to the department and represent added value to the state. The necessity of closer collaboration between the specialty service system and mainstream health care is even more compelling when we consider the significantly reduced life expectancy of persons with severe mental illness and persons with persistent addictive disorders.

**Sidebar: The Fuzzy Logic of Medical Markets and County Boundaries**

The publicly-funded specialty system has historically operated within political boundaries (counties). Closer integration with mainstream health care systems may require some "blurring" of bidding region boundaries, to permit bids which include a specified portion (belonging to a recognized medical market) of a county.

**CORE CONSIDERATIONS AND KEY FUNCTIONS FOR MANAGED SPECIALTY PLANS (MSPs)**

Potential bidders for management of publicly-funded specialty services must attend to a number of core considerations and essential functions. These considerations and functions are catalogued and briefly explained below. This synopsis is not an exhaustive listing or comprehensive descriptions of all significant issues, plan requirements, technical specifications or performance requirements.

- Eligibility/Covered Populations

All Medicaid beneficiaries residing in the geographic area who require covered specialty mental health, substance abuse, or developmental disabilities services will be covered through the MSP. In addition, state defined priority populations for mental health and developmental disability services, and federally defined priorities for block grant funded substance abuse services are eligible for services (extent of coverage or number of priority individuals served is dependent upon appropriated general funds and/or federal block grant allocations).

Medicaid covers the majority of persons with developmental disabilities. Unlike persons with developmental disabilities, not all individuals with serious mental illness or addictive disorders are covered for Medicaid, although there is a substantial overlap between Medicaid eligibility and state priority population designation for persons with serious mental illness.

- Benefits and Mandated Services

All specialty mental health, substance abuse and developmental disability services defined in the state Medicaid plan (including Home and Community-Based Waiver Services) or included in the description of "alternative services" in the department's approved 1915b waiver for specialty services are part of the benefit package for Medicaid recipients needing specialty care. Many state plan services and waiver alternatives are specifically designed to address the service and support needs of persons with serious mental illness, serious emotional disturbances and developmental disabilities.

All necessary services<sup>5</sup> defined in the Mental Health Code for persons with serious mental illness, serious emotional disturbance, or developmental disabilities are also

<sup>5</sup> **330.1206 Community mental health services program; purpose; services. [M.S.A. 14.800(206)]**

Sec. 206. (1) The purpose of a community mental health services program shall be to provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic service area, regardless of an individual's ability to pay. The array of mental health services shall include, at a minimum, all of the following:

covered for populations that meet priority designations. Required substance abuse services defined in the Public Health Code and in federal Substance Abuse Prevention and Treatment (SAPT) block grant requirements must be available to priority populations, subject to limitations imposed by funding level allocations.

The MSP must provide 24-hour, 7 day per week emergency services coverage, as stipulated by the Mental Health Code. Screening and authorization for state facility admissions will be the responsibility of the MSP, as is discharge planning and appropriate placement. To accommodate requests for state facility admission, the MSP must have a designated preadmission screening unit and must also identify a children's diagnostic and treatment service to respond to the mental health needs of minors. The MSP will carry out statutorily mandated jail diversion activities and school-to-community transition services.

The MSP is responsible for medically necessary specialty mental health services for Medicaid beneficiaries. The department is interested in adding the basic or primary Medicaid mental health benefit (outpatient services) - currently provided either through Qualified Health Plans (QHPs) or through the psychiatrists (type 10/11) in the Medicaid fee-for-service system - into the managed specialty services carve-out.

The department is also interested in stakeholder recommendations regarding whether on not selected psychotropic pharmaceuticals should be added to the list of MSP covered benefits.

- Access to Care and Authorization for Services

The MSP must have an access system which provides timely telephonic and face-to-face screening and triage for all consumers who request or present for specialty services, regardless of their disability-specific needs. The MSP must also have a care authorization process that facilitates prompt follow-up, return visits and initiation of treatment. The authorization system should be linked to consumer service tracking and utilization management activities.

- Service Planning and Care Management

Service planning activities for specialty mental health and developmental disability services must conform to the person-centered requirements<sup>6</sup> of the Mental Health Code. Treatment planning for addictive disorders must utilize a Client-driven<sup>@</sup>

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(a) Crisis stabilization and response including a 24-hour, 7-day per week, crisis emergency service that is prepared to respond to persons experiencing acute emotional, behavioral, or social dysfunctions, and the provision of inpatient or other protective environment for treatment.

(b) Identification, assessment, and diagnosis to determine the specific needs of the recipient and to develop an individual plan of services.

(c) Planning, linking, coordinating, follow-up, and monitoring to assist the recipient in gaining access to services.

(d) Specialized mental health recipient training, treatment, and support, including therapeutic clinical interactions, socialization and adaptive skill and coping skill training, health and rehabilitative services, and pre-vocational and vocational services.

(e) Recipient rights services.

(f) Mental health advocacy.

(g) Prevention activities that serve to inform and educate with the intent of reducing the risk of severe recipient dysfunction.

(h) Any other service approved by the department.

(2) Services shall promote the best interests of the individual and shall be designed to increase independence, improve quality of life, and support community integration and inclusion. Services for children and families shall promote the best interests of the individual receiving services and shall be designed to strengthen and preserve the family unit if appropriate. The community mental health services program shall deliver services in a manner that demonstrates they are based upon recipient choice and involvement, and shall include wraparound services when appropriate.

<sup>6</sup> Sec. 700 (g): "Person-centered planning" means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

approach (individualized service arrangements, variable length of stay depending upon condition, intensity of care linked to severity, changes in treatment plan based upon consumer response to care, etc). Care management responsibilities entail facilitating and coordinating care arrangements through case management, supports coordination and other assistive modalities. Alternative service delivery arrangements - participant-driven service models such as individual resource allocations, personal budgets, vouchers, etc. - must be identified and presented during service planning activities. Integrated services for individuals with co-existing conditions must be available.

- Service Delivery System

MSPs are responsible for organizing a comprehensive system to provide needed services and supports. The MSP will assemble the network, credential providers and organizations, and establish subcontract agreements, as necessary, with providers. The MSP is responsible for paying providers (in a timely fashion) for authorized services at the negotiated reimbursement rate. The MSP is responsible for developing a "culturally competent" system of care, which reflects the diversity of the individuals and communities being served by the plan.

- Price Determination, Risk Assumption and Payment System

State general funds, liquor tax revenues, and federal block grant funds are distributed by formula. Service responsibilities are commensurate with available funds and priority population status. The department maintains that regardless of whether the county-sponsored CMHSP is selected as the MSP for the service area, the county remains liable for certain financial obligations (generally 10% - with some exceptions - "of the net costs of any service that is provided by the department, directly or by contract, to a resident of that county") associated with the expenditure of state funds.

Separate capitation payments will be made for Medicaid developmental disability services and Medicaid mental health/substance abuse services. Because persons with developmental disabilities are not equally distributed around the state, the department will set DD capitation rates for each region (with multiple rate cells reflecting demographic and eligibility categories). Capitation rates for mental health/substance abuse services will also be derived by the state for each region (with multiple rate cells in each region) and an internal upper and lower limit for bids will be maintained by the state. Bidders will be required to make an independent price determination for mental health and substance abuse services (by demographic and eligibility categories) in each region for which they submit a bid. The state will utilize a best-and-final-offer process to allow otherwise qualified bidders with initial price determination outside of the established limits to adjust price bids.

MSPs will assume full financial risk for specialty services. Contractors must guarantee (through reinsurance or other mechanisms) their ability to assume costs in excess of aggregate capitation payments.

- Financial Management

MSP contractors must have financial management systems that meet established specifications. This includes a financial accrual/reporting system which accurately captures and records enrollments (premiums due), receivables due from first and third parties, and service utilization and incurred claims. The system must maintain monthly tallies of enrollment, prepayment revenue, formula funds, services rendered (utilization) and costs incurred. The system must also support individual resource allocations and

fiscal intermediary activities for consumers who choose personal budgets and individual service authority.

- Management Information System

The MSP must have a management information system (MIS) that captures and reports membership characteristics, client demographic, diagnostic and service (event, encounter, activity) data, traces service authorization and service utilization, facilitates claims administration and records grievances, appeals, rights complaints, and sentinel events.

- Quality Management and Performance Monitoring

The importance of quality management requires elaboration beyond what has been provided under other bulleted sections. In addition to its statutory responsibilities, the department has the responsibility to assure that public tax revenues are used to purchase services that are of value. Value-based purchasing requires a focus on price, quality, the achievement of valued outcomes and indicators of system performance along key dimensions. Elements of quality management and performance monitoring include:

*Certification/Accreditation:* Bidders must meet the established criteria to be certified as a manager of public mental health funds. This would minimally require that they demonstrate that they are accredited by a national accrediting body for the management and/or delivery of mental health, developmental disability or substance abuse services. They would also be required to have a Recipient Rights System that is determined to be in substantial compliance with Chapter 7 and 7a of the Michigan Mental Health Code.

The accreditation bodies which previously have been granted “deemed status” under the current mental health code certification system include: Joint Commission on Accreditation of Healthcare Organizations (JCAHO); CARF - the Rehabilitation Accreditation Organization; Council On Accreditation (COA); and The Council. These may need to be re-evaluated for their conformance with required management or administrative service functions. Other accrediting bodies that accredit managed care organizations (e.g., NCQA) must be evaluated and considered for deemed status.

*Internal Quality Improvement Program:* The prospective managing entity must demonstrate that it has an ongoing quality assessment and performance improvement program. This program must demonstrate the capacity to achieve minimum performance levels on standardized quality measures as established by the state, conduct performance improvement projects in both clinical and non-clinical areas, solicit and utilize customer feedback, and have mechanisms to detect both under utilization and over utilization of services. The information from these efforts must be shared with the managing entity’s governing body for follow up actions necessary to continuously improve the services and supports offered, including but not limited to service authorization and delivery processes, the development or revision of practice guidelines, and the recredentialing of providers.

*Consumer Demographic, Service Utilization and Client Outcome Data:* A uniform set of consumer demographic, service use and client outcome data will be required for each consumer and will be submitted to the department. This data set will consolidate the Center for Substance Abuse Treatment (CSAT) requirements, the Center for Mental Health Services’ FN-11 recommendations, existing CMHSP data requirements and client outcome variables to be determined.

*Performance Indicator Data:* Indicators that will monitor the domains of Access, Cost/Solvency, and Outcome will be required. As noted previously, personal outcomes and public policy objectives revolve around the dimensions of quality of life. Therefore, indicators that measure consumer outcomes beyond other measurement systems such as the Health Employer Data Information Set (HEDIS) will be required. The reporting of indicator data may begin to move from only aggregate reporting to consumer level information which will be risk adjusted.

*Consumer Appeal, Complaint and Grievance Data:* The managing entity will be required to maintain information on appeals, complaints, and grievances and report to the department: 1) the number and nature of all appeals, complaints and grievances; 2) the time frames within which they were resolved, and the decisions; 3) the number and nature of expedited reviews and the decisions; and 4) any trends relating to specific providers or services. Other data may be required as defined in the final federal regulations governing the Balanced Budget Act (BBA) of 1997.

- Consumer Protection

Consumer protection is another component requiring more substantial description. While competition in health care markets has been shown to have beneficial effects on quality and price, it is understood that the incentives created by the market may lead to adverse outcomes for individuals. Consumer protections are actions, usually taken by government, to make adjustments to the market to assure that the individual does not experience adverse effects. Within the managed care environment, the incentive to manage funds within the existing capitation rates potentially leads to withholding or delaying care. Therefore, consumer protections for this market are intended to assure that medically necessary care is provided.

Consumer protection actions have been the focus of both federal and state efforts. For example, the federal BBA of 1997 lists 21 consumer protections in Medicaid managed care, including but limited not to: adequate capacity and services; bans on “gag” rules; grievance procedures; quality assessment and improvement strategies; disclosure requirements; etc. The eventual rules for implementation of this act will finalize the operational requirements in these areas. Until then, the existing provisions of 42 CFR regarding access to “fair hearings” by independent evaluators will continue.

While some guidance exists at the federal level for persons receiving federally-funded health care (e.g., Medicaid), Michigan passed legislation in 1996 that established Michigan’s Patient Bill of Rights. This guaranteed that all persons receiving health care from HMOs:

- receive written information about their health care coverage, including its cost, how to file a complaint, how emergencies would be handled, etc.;
- if participating in a plan where a choice of providers is available, have access to additional information about potential providers;
- have access to an expedited complaint process;
- receive from their doctors information on all health care options (prohibition of “gag” clauses); and
- are provided medically necessary emergency care.

The future direction of managed specialty mental health and substance abuse services will require that bidders demonstrate that they have policies and procedures to assure



that they will meet these requirements. Once selected, the managing entity will need to demonstrate that it is assuring these protections.

- Consumer Responsibilities

“In a health system that protects consumer’s rights, it is reasonable to expect and encourage consumers to assume reasonable responsibilities. Greater individual involvement by consumers in their health care increases the likelihood of achieving the best outcomes and helps support a quality improvement, cost conscious environment” (President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry, 1997). Some of the relevant responsibilities identified included:

- ❑ Become involved in specific health care decisions;
- ❑ Disclose relevant information related to their wants and needs;
- ❑ Use the health plan’s internal complaint and appeal process to address concerns that may arise;
- ❑ Be aware of a health care provider’s obligation to be reasonably efficient and equitable in providing care to other patients and the community;
- ❑ Report wrongdoing and fraud to appropriate resources or legal authorities

Michigan agrees with this direction and has already included in statute the requirements for person-centered planning where consumers identify wants and needs and thereby direct their own care. Further, Michigan has been a leader in the development of self-determination models of consumer directed health care. An explicit principle of this approach is the responsible use of resources. Michigan’s direction for specialty services will continue to further assure consumer protections and to expect consumer responsibilities.

- Community Benefit Obligations

Public systems of services and supports provide significant contributions in the local communities and fill important public health and public safety roles. Community members expect certain types of goods and services to be assured through the publicly-funded system. These community obligations are often also constitutionally and/or legally mandated. Specialty mental health, substance abuse and developmental disabilities services are an important part of the public health and safety assurances on which communities depend.

Publicly-funded programs and agencies also serve in complementary, interrelated roles with each other, each performing as part of an important network of essential services and supports for the community and its residents. For example, CMHSPs provide community education regarding the needs of persons with disabilities, and they provide training and technical assistance to community members and organizations, to enable them to better meet the needs of their own constituencies. Benefits such as these are especially important for schools and for law enforcement and criminal justice systems. Prevention efforts directed toward the general population and at-risk individuals also contribute to a healthier community

Publicly-funded agencies also provide a service to the community at large in times of crisis or other situational need. For example, mental health staff provide counseling and support to community members following natural disasters or when other emergencies, accidents or tragedies occur locally.

## Competition for Management of Publicly-Funded Specialty Services

MSPs selected through competitive procurement will be expected to pursue these same community benefit obligations.

## **NEXT STEPS**

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As noted in the introductory section, the department developed this document to familiarize stakeholders with the state perspective on the future of the publicly-funded specialty services system. A key consideration for future planning is the federal requirement for competitive selection of entities to manage publicly-funded specialty services. The bulk of this document has been devoted to exploring models for competition and the legal, technical, operational, and policy problems posed by each of these approaches. The department provided its own proposal for competition, combining procurement with a new model of managed care that affords consumers greater choice and control.

The department will now proceed to distribute this document to interested parties. Stakeholder forums are also being scheduled in October at various sites across the state to obtain direct feedback from consumers, family members, advocates, public entities, providers, private organizations, governmental officials and the general public. Those who cannot attend these forums are invited to share their reactions, comments and concerns by mailing a response to the department, or by e-mailing the department at [barriep@state.mi.us](mailto:barriep@state.mi.us).