

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

(FY2011 Appropriation Bill - Public Act 187 of 2010)

June 1, 2011

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

*Michigan Department
of Community Health*



Rick Snyder, Governor
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MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (DCH) FY11 APPROPRIATIONS SECTION 490(3) BOILERPLATE REPORT

BACKGROUND

Note, in the body of this document, the term “authority” is used for the CA, CMHSP or PIHP.

The boilerplate language was driven by service providers and their experience which suggested that accomplishing the uniformity outcomes would be dependent upon the involvement of the state authority for mental health and substance use disorder services as well as the regional authorities. While there have been successful regional initiatives that resulted in a uniform contract, training reciprocity and/or uniformity in some monitoring requirements, these have been voluntary efforts and have not been adopted across the service system. Also, it is the regional authority - either the regional Coordinating Agency (CA) for Substance Use Disorders (SUD); the Community Mental Health Services Program (CMHSP) or the Prepaid Inpatient Health Plan (PIHP) that both carries the liability (risk) and is charged with the authority and responsibility for managing the SUD, CMHSP or Medicaid specialty services benefit(s) and contracts.

Pursuant to the boilerplate requirements, the DCH Behavioral Health and Developmental Disabilities Services Administration (BHDDSA - formerly the Mental Health and Substance Abuse Administration) established a workgroup in February 2011 which met on a biweekly basis through May 2011. Although participants of the workgroup represented diverse interests – state, each type of authority and providers, the report represents the general consensus of the workgroup participants. Workgroup participants are listed in Attachment 1. It should be noted that workgroup participants were not necessarily content experts with regard to the individual subject matters (i.e. training, law, etc).

While the problems identified in the boilerplate are generally recognized, the workgroup did not conduct any analysis to determine the extent of the problem(s) resulting from lack of uniformity. Correspondingly, there is no “baseline” measure. The workgroup was tasked with the following:

- Identifying the challenges associated with uniformity and consistency in a system governed by different authorities and different state, federal and funding-specific requirements.
- For each of the content areas identified in the boilerplate to: identify various perspectives including provider, authority and state as well as opportunities for uniformity, consistency and/or reciprocity.
- To provide recommendations for the plan envisioned by the boilerplate.

The workgroup reviewed each of the areas listed in the boilerplate. These are:

- *contract language,*
- *training requirements for direct support staff,*
- *performance indicators,*
- *financial and program audits, and*
- *billing procedures*

In summary, the discussions reached the following general conclusions:

ROLE OF THE STATE: Although the DCH-BHDDSA expects the authority to manage its provider network, it does have a leadership role and influence through how it sets contractual requirements with the authorities. The state is singularly in the position to take action where needed and set the expectation(s) for authorities and to have ownership in the process of seeking uniformity and consistency. While the predominant discussion was with regard to the

CMHSP/PIHP contracts, there is applicability to the DCH/CA contract and its provider network as well. The state is also able to clarify its policy, seek legal opinions and/or identify opportunities to address risk issues that are a barrier to uniformity.

RECOGNITION OF ROLES AND RELATIONSHIPS: The potential liability to the regional authority in accepting reciprocity or in removing contractual language must be researched and addressed. This includes state co-employer concerns; removal of licensing, regulatory or state legislation references and/or reciprocity recognizing this is currently understood differently. It must be understood the authority/provider relationship is such that the authority retains responsibilities for compliance and risk.

EVOLUTIONARY SYSTEMS CHANGE PROCESS: Achieving the intent of the boilerplate requires recognition of the challenges as well as an understanding of the organizational and personal change process. It must be recognized that progress will be incremental and previous experience demonstrates that achieving uniformity takes considerable participation, time and effort.

BUILDING SUPPORT AND EXPECTATION FOR CHANGE: The organizational culture and 'will' of the organization's leadership is critical and without which change is unlikely. Broad based support and the necessary work must be from multiple directions including the state, authority trade associations and provider trade associations.

CHALLENGES

The workgroup discussions identified challenges to uniformity in contracting and oversight (monitoring) procedures as described below.

NATURE AND STRUCTURE OF THE SERVICES SYSTEM: Michigan evolved as a community-based, locally controlled and therefore relatively autonomous regional authority based system(s). These systems are:

- 16 CAs of which 8 are also the CMHSP
- 46 CMHSPs of which 38 are organized into 10 PIHP affiliations
- 18 PIHPs of which 8 are "stand alone" CMHSPs

While the state is the ultimate authority, local autonomy with regard to implementation has been the norm. This permits various local interpretations, preferences and recognition of local community culture and politics but presents a major challenge to uniformity.

The CA and CMHSP systems are based on different state law(s) and different fund source requirements. For instance, the CA system is primarily based on federal Substance Abuse Prevention and Treatment Block Grant requirements in that these federal funds represent well over 80% of all public CA funding. On the other hand, state funding for the CMHSP system represents less than 15% of all public funds and is administered through the state CMHSP system. Medicaid has evolved as the primary funding source for publicly provided services and is administered through different entities – PIHPs - which coincide with either one or more CMHSP service areas. In PIHPs consisting of multiple CMHSPs, the level of autonomy and uniformity within the affiliation varies as well.

LACK OF SHARED BENEFIT. The "burden" associated with various local requirements is not necessarily perceived or shared by the authority establishing the requirement; the service provider is primarily affected. A single collective interest is not always perceived therefore, a consensus on the need for change is missing. It must also be recognized that there is cost/time/investment to change. Consistency should be identified as a "win" if it saves time,

adds value or reduces cost over time. It should be recognized that some are “easy wins” and in some situations, the difficulties in achieving uniformity outweigh the likely benefit.

RISK, TRUST, COMPLIANCE. The authority is accountable for legal, financial and regulatory compliance. The issue of risk extends beyond the contract with the Department and state regulations. Despite attempting to be in compliance with a contract and Medicaid or other requirements, an External Review can identify issues that are new to the contract holder.

The real risks associated with non-compliance cannot be minimized and include compliance, financial (funding and audit), lawsuits, or, ultimately, authority status depending on the issue. On the other hand, some historical beliefs about risk, such as state co-employer status, adhesion contracting, historical audit decisions or situations which are believed to preclude consistency or uniformity either do not or are no longer applicable. When control of the authority is lessened, trust about the adequacy and quality of standardization must be developed. Typically, those not participating in the process are reluctant and unlikely to accept the product. Also, there is a natural resistance to change that must be considered.

STANDARDS, PROCESSES AND THE “QUALITY BAR”. While the “source” for any particular standard across the system(s) may be the same, at the authority level, the interpretation and process expectations are frequently different as well as the measurement tools. In general, the process is defined rather than the intended outcome. A function of Quality Improvement is that the bar (the goal or acceptable level) keeps changing representing a goal rather than a core requirement. Finally, ongoing compliance typically leads to new requirements and once added these are unlikely to be removed.

SUCCESSFUL METHODOLOGIES. To date, these have been regional and have proven to be time consuming, to involve multiple partners, and to require sorting through each variation and developing a sufficient ‘comfort level’ among participants to enable implementation. Based on this experience, uniformity across authorities will require more than “urging” and must be set as a state expectation while the time and effort to achieve consensus must be considered. Finally, unlike service models, administrative ‘best practices’ are not identified and then fostered for implementation on a broad scale.

COMMITMENT TO EFFICIENCY. To achieve uniformity and consistency requires a spirit of willingness and commitment to change. The experience to date is such that the state must assume a much stronger role in requiring consistency throughout the authority structure. And, it is likely that both incentives and disincentives will be necessary. Additionally, the trade associations will need to assume a more active role in developing consistency across the system. Since uniformity involves developing a common understanding and approach to compliance that then involves recognition of the benefits. The process by which the changes are made is critical. A willingness to make the investment in staff time and priority rather than significant financial resources is necessary although changes in Electronic Medical Records (EMR) and billing systems will be initially costly.

STATUS REPORT AND PLAN

ROLE OF THE STATE

There are significant state opportunities to foster uniformity through the following:

- Review all DCH/Authority contractual language and requirements to set a single state direction; assure all DCH contractual language is consistent and necessary. And, on a regular basis review all language for: current relevance, redundancy, necessity, value and whether it speaks to the intended outcome rather than process.

- Establish clear expectations with regard to consistency (if not uniformity) in requirements and expectations as well as acceptance of reciprocity. This may include the development of both incentives and disincentives as part of the contract between the state and authorities.
- Understand and address the authority's liabilities and their risk and when needed and feasible, consider means by which this risk can be reduced.

CONTRACT LANGUAGE

DCH has multiple contracts with authorities that for CMH/PIHPs, generally contain the same boilerplate language but the underlying requirements are different. Structurally, state contractual language has evolved over the years and requirements can be difficult to locate within the contract and there are differences in requirements between these contracts. Contract language, for all authorities including the state, is at least in part protective in that it is responsive to litigation and risk. Authorities may interpret state standards differently, may use different language and/or may approach the requirement differently. Additionally, there are different views of quality and consequently the standard itself may vary across authorities. From the provider perspective, this leads to "chasing the interpretation". From the authority's perspective, there is risk including that associated with accepting reciprocity in standards or site reviews.

Workgroup discussions concluded that a number of issues are, at their core, contractual matters. Needing resolution are those contractual requirements that are repetitive to licensing requirements or are legal obligations. Of concern to the authority is potential liability or risk resulting from the contract being "silent" as to these requirements while the provider perspective is these are duplicative and add unnecessary burden.

NEXT STEPS:

- DCH to complete review of its contractual requirements for the purposes of consistency in requirements across contracts, removal of outdated language no longer necessary and for administrative simplification.
- DCH to establish the charge to the authority to develop the commitment so that provider contracts are reflective of administrative simplification between the state and the authority.
- Workgroup to continue work on uniform contract models recognizing that any uniform contract must still meet unique business needs at the authority/provider level. This will involve identify existing uniform contract model(s), obtaining an understanding of the basis of DCH contractual requirements, current relevance and best practice. The plan should also include how use of uniform contract model(s) can be made mandatory.

CORE TRAINING REQUIREMENTS FOR DIRECT SUPPORT STAFF

This area was identified by the work group as the most important focus and possibly the least challenging category in which to achieve uniformity through reciprocity. The principle being that DCH required training, with conditions, should be reciprocal and portable. A number of authorities currently accept core direct support staff core training as well as recipient rights training and provide "portability" (meaning recognition, verification and acceptance that a direct support staff has successfully completed training). Additionally, there are a number of both state and regional training update requirements. In that regard, these should represent best practice, add value and be relevant to the staff for which the training requirement applies.

ACTION TO DATE: DCH has proposed that language providing, minimally, for reciprocity and portability for core training requirements of direct support staff be included in the FY12 DCH/PIHP and CMHSP authority contracts.

NEXT STEPS:

- DCH-follow through and monitor implementation of reciprocity at CMHSP level
- DCH-reconsider the 2005 ORR “Coordination of Rights Protection for Recipients of Contracted Mental Health Services Technical Advisory to identify and support training reciprocity opportunities.
- Workgroup to 1) identify other training requirements; 2) develop consistency in these requirements; 3) review the current requirements for best practice, if these add value in relation to the limits of time and staff availability these represent and are relevant to the staff for which these apply; 4) create reciprocity and portability expectations; 5) identify a process for ongoing review; and 6) move toward measurable competency as an outcome rather than the training method.

PERFORMANCE INDICATORS

The boilerplate speaks to uniformity of Performance Indicators (PI) at the provider level which was understood by the workgroup to be intended to address overlap and variations in both authority and local provider requirements resulting in multiple standards. Distinguishing compliance from improvement and the associated administrative burden and cost in relation to value is necessary. Plus, there are provider specific performance indicators and external requirements of accrediting agencies requiring Quality Improvement in various forms/methods and that measures be in place relative to effectiveness, efficiency and satisfaction. Measures also result from various audits, litigation and compliance activities.

NEXT STEPS:

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

FINANCIAL AND PROGRAM VERIFICATION

This was operationalized as involving multiple verification interpretations in that each authority makes its interpretation and over time audit, administrative law judge, legal or other findings typically lead to additional contractual requirements. These are then not regularly reviewed to remove those no longer needed or relevant. Also, the specific audit/review tools of the authorities are different. The administrative burden associated with these audits falls into three categories: 1) contract/administrative compliance; 2) clinical record/treatment review; and 3) claims verification including monitoring models for staffing grants. The workgroup recommends reciprocity when possible; recognizing reciprocity needs to be balanced by the financial risk to the provider and the authority. Also, that “good standing” should have its benefits in terms of the frequency and nature of these reviews.

ACTION TO DATE: (1) DCH is involved in a comprehensive review of the DCH site monitoring process for the PIHP/CMHSP systems which is separate from the charge to this workgroup. An expectation of this workgroup is that any state-level streamlining and simplification extend to the providers as well. (2) It is expected that the FY12 DCH/PIHP/CMHSP contract will establish a joint commitment to explore opportunities for deemed status. (3) Expected FY12 DCH appropriations boilerplate will also require continued attention to these issues.

NEXT STEPS:

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

EMR/ BILLING PROCEDURES

With regard to EMR, uniformity is not as essential as compatibility. The goal of the EMR within the industry and among users is that it can interface with multiple systems including primary care, hospitals and other payors as well as authorities. Also, these systems must operate within federal requirements. Such interface would eliminate duplicative, manual entry. Additionally, the development of Health Information Exchanges in Michigan should also be considered.

This content area has substantial opportunities for uniformity but is also most challenging and complicated given the multiple requirements and systems. In particular, there will be significant costs involved in any changes. In general, there are both differences in technology (data systems) and in content requirements.

Two aspects were identified in the work group discussion:

- (1) Billing. While there are uniform requirements with regard to billing and claims processing, payment rates are different. Some authorities contract and pay at daily rates, others service-specific (unbundled) costs; cost allocation methods vary across authorities as does use of specific billing codes and the billing cycle. Some authorities require providers to enter bills within their systems with the resulting need for providers to also enter this information into their accounting systems. This would be the priority category for compatibility, uniformity and/or consistency.
- (2) Electronic Medical Records. There is no state requirement for use of a single system nor are local systems 'the same'. Some authorities require provider data entry directly into their EMR rather than accepting electronic transmittal of data across systems through some means of interface.

ACTION TO DATE. DCH has proposed CMHSP/PIHP contract language for FY12 which would set an expectation for CMHSPs to make progress in reducing duplicate data entry requirements across the CMHSP and provider systems.

NEXT STEPS:

- DCH - Given the scope and complexity, billing/EMR-related discussions must involve content specialists in both technical and business aspects. The CIO Forum, CMH finance officers and the MASACA IT/Finance groups were identified as being necessary to the discussion. DCH would be responsible for coordination.
- Workgroup – to identify the variations in the billing systems in use and to better define the problem(s) and identify opportunities for uniformity and consistency.

CONCLUSION

GENERAL RECOMMENDATIONS FUNDAMENTAL TO PROGRESS ON UNIFORMITY AND CONSISTENCY

Given both the challenges and the 'lessons learned' in similar efforts, a successful plan for uniformity and consistency must begin with recognizing absolute uniformity in requirements is unlikely. The process needs to identify the state standard and its origin, derivations and commonalities in local interpretations and then determine the best practice that results in compliance and represents achievable outcome that both permits varying processes and

resolves differences among authorities. Processes are less relevant (than outcomes) and affected by the size of the organization.

It was the conclusion of the group that essential next steps include:

- Establishing a commitment and collective “buy in” on the part of the department and authorities through their trade organizations, and providers through their trade organizations, to continue to pursue uniformity, consistency and the associated benefits.
- Keeping the field informed through regular updates and sharing best practices and demonstrated benefits at conferences and through other opportunities.
- Providing this or a similar workgroup with continuity in membership as well as the legitimacy to further develop and pursue implementation of this plan as an explicit change process and to serve as a point of coordination and collaboration.

The workgroup also recognized that continued progress will require:

- recognition that progress will be incremental and
- that the momentum developed through this workgroup continue and
- that the work in achieving success must be both shared and focused

490 WORKGROUP

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