Status Report on the implementation of the plan to maximize uniformity and consistency in the standards required of providers contracting directly with PIHPs and CMHSPs.

(FY2013 Appropriation Bill - Public Act 200 of 2012)

July 1, 2013

Section 490: (1) The department shall develop a plan to maximize uniformity and consistency in the standards required of providers contracting directly with PIHPs and CMHSPs. 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. (2) The department shall provide a status report to the senate and house appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director on implementation of the plan by July 1 of the current fiscal year.

Michigan Department of Community Health

MDCH

Rick Snyder, Governor
James K. Haveman, Director

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION
FISCAL YEAR 2013 APPROPRIATION BILL
SECTION 490(2) BOILERPLATE REPORT

BACKGROUND

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

The workgroup has met nearly monthly, continuing from the last report, under the leadership of BHDDA staff. The workgroup consists of representatives from the Department of Community Health (DCH), PIHPs, CMHSPs, CAs, and the provider system, including psychiatric acute care and substance use residential facilities. Some of the participants were selected and recommended by the Michigan Association of Community Mental Health Boards (MACMHB). This was not an exclusive membership. Since the workgroup will continue after July 1, 2013, membership is fluid and the provider system is invited to participate. A current list of the workgroup membership is attached.

The 2013 workgroup reviewed the following categories and next steps, which included:

BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION (BHDDA):

- *DCH* will follow through and monitor implementation of reciprocity at the CMHSP level.
- *DCH* will reconsider the 2005 Office of Recipient Rights (ORR) "Coordination of Rights and Protection for Recipients of Contracted Mental Health Services Technical Advisory", to identify and support training reciprocity opportunities as follows:
- *Workgroup* will: 1) identify training requirements; 2) develop consistency in these requirements; 3) review the current requirements for best practice, and if these best practices add value, while not over-extending available staff, consider adopting these practices; 4) create reciprocity and portability expectation; 5) identify a process for ongoing review; and 6) move toward measureable competency as an outcome rather than the training method.

PERFORMANCE INDICATORS (SITE REVIEW DIMENSIONS):

- *DCH* will continue to discuss with CMS (Centers for Medicare and Medicaid) the current and future site review process.
- *Workgroup:* Identified a crosswalk with regulatory requirements from DCH, CMS, Federal (Social Security Act and Balance Budget Act).

CONTRACT LANGUAGE:

- *DCH* to complete review of its contractual requirements for the purposes of consistency in requirements across contracts, removal of outdated and unnecessary language, and for administrative simplification.
- *DCH* will look at contract language with PIHPs, CMHSPs, CAs and Federal Block grant funds to streamline and unify contracts.
- *Workgroup* to continue work on uniform contract models, recognizing that any uniform contracts must still meet unique business needs at the authority/provider level. This will involve identifying existing uniform contract models, obtaining an understanding of the basis of DCH contractual requirements, current relevance, and best practice.

CORE TRAINING REQUIREMENTS FOR DIRECT SUPPORT STAFF:

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

ELECTRONIC HEALTH RECORD (EHR)/BILLING PROCEDURES

- *DCH,* given the scope, complexity, and billing/EHRs-related discussions, must involve content specialists in both technical and business aspects. The CIO Forum, CMH Finance Officers and Michigan Association of Substance Abuse Coordinating Agencies (MASACA), Medical Service Administration, and Information Technology (IT) /Finance groups were identified as being necessary to the discussion. DCH will be responsible for coordination.
- *Workgroup* to identify the variations in the billing systems in use and to better define the problems and opportunity for uniformity and consistency.
- *DCH* will, through the 2013 Application for Participation, require uniform common policies throughout the 10 new Regional Entities.

ACCOMPLISHMENTS

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

PERFORMANCE INDICATORS (SITE REVIEW DIMENSIONS):

In lieu of the realignment of the public behavioral health system through the DCH 2013 Application for Participation of Medicaid Specialty Prepaid Inpatient Health Plans, BHDDA leadership requested from Centers for Medicare and Medicaid that the site review process to be conducted by the BHDDA cease for the remainder of the calendar year 2013, with the exception of the following waivers:

* Habilitation Supports Waiver (HSW) serving approximately 8,200 individuals with Developmental Disabilities
* Children's Waiver Program (CWP) serving approximately 469 children with Developmental Disabilities
* Waiver for Children with Serious Emotional Disturbance (SEDW) serving approximately 450 children and young adults with SED.

The legal authority for the above three waivers is 1915(c) of the Social Security Act, which specifies the six assurances that States must meet. Since 2008, CMS revised the 1915(c) application to focus on these six assurances in the Social Security Act and requires extensive documentation of the State's oversight and monitoring in the form of performance measure of these assurances and 14 sub-assurances within each of the approved waivers.

CMS granted BHDDA's request to cease site-reviews with the PIHPs with the exception of the waivers listed above.

BHDDA has met with the National Committee on Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC), to determine whether or not a mandatory specific accreditation will bring an added value to the 10 new Regional Entities. The decision will be made prior to October 1, 2013.

FINANCIAL AND PROGRAM VERIFICATION:

Current contracts now include monetary incentives for high performing PIHPs. In addition, as the system evolves through the Dual Eligible initiative and Integration, the commitment to simplification and efficiencies will remain a strategic priority for DCH. Through the 2013 Application for Participation for the Medicaid Specialty Prepaid Inpatient Health Plans process, DCH will utilize an enhanced performance incentive structure for contracts effective January 1, 2014. DCH will withhold a portion of the approved capitation payment from each PIHP for performance incentive awards. In addition, sanctions will be identified to assure remedial actions to resolve outstanding

contract violation and performance concerns. DCH may delay up to 25% of the scheduled payment amount to the PIHP until compliance is achieved.

PIHP/CMHSP contracts are continuously being reviewed and refined. Updates and edits to outdated language, redundancies and inconsistencies among "technical advisory, technical requirement, policy, and practice standards" are ongoing. In an effort to guide the behavioral health system to a more performance-based system, for the second contract year, monetary incentives were introduced into the PIHP contracts.

DCH is working with the actuary to re-develop the rate structures for the January 1, 2014, waiver renewal for the 10 Regional Entities. The methodology and adjusters increase the percentage of the ratio reflecting morbidity and decrease the percentage that is based on history and geography. This will move the process to a rate structure based on a common statewide structure where adjusters are entirely based on morbidity differences or cost-of-living methodologies common to other areas of health care.

DCH is in the process of implementing a statewide standardized assessment tool for adults with Intellectual and Developmental Disabilities (I/DD). Single CMHSP PIHPs will be required to report both the administrative cost of the PIHP functions directly performed by the PIHP and those functions carried out by the CMHSP, core providers, or managed care provider networks. DCH will require reporting all administrative costs of both the PIHP and administrative costs for direct services for the CMHSP. The intention is to place a "cap" on the administrative cost percentage for those direct services.

CONTRACT LANGUAGE:

In efforts to promote reciprocity, the BHDDA, in FY 2013, included language in the CMHSP contract under section 6.4.1 Provider Contracts: "CMHSPs and their provider networks shall accept staff training provided by other CMHSPs and their provider networks to meet their training requirements when: 1) staff training is substantially similar to their own training, and 2) staff member completion of such training can be verified".

This is applicable to any staff training area. It includes any required staff training in the areas of abuse and neglect (recipient rights), person centered planning, cultural diversity, HIPAA, limited English proficient, grievance and appeals, as well as Michigan Department of Human Services (MDHS)-approved training of direct care workers in specialized residential settings, and certificates earned from special clinical training in evidenced based, best and promising practices such as Assertive Community Treatment (ACT), Dialectical Behavioral Treatment (DBT), Parent Management Training – Oregon Model (PMTO), Family Psychoeducation (FPE), and motivational interviewing.

CORE TRAINING REQUIREMENTS FOR DIRECT SUPPORT STAFF:

There have been multiple efforts over the years through various workgroups to look at training standards, uniformity, and reciprocity. The group agreed that until the DCH takes the lead on promoting training efficiency standards, lack of trust among PIHPs,

CMHSPs, CAs and provider systems would remain. Showing competency, and/or testing were areas that the system agreed would bear some merit. A document was drafted and shared with the group to look at MDCH/PIHP/CMHSP/CA provider Reciprocity and Efficiency Standards. A survey was sent to the CMHSPs asking various questions of current status of training efficiency and reciprocity. The conclusion is that a substantial number of CMHSPs are reluctant to fully accept another entity's training.

Through the 2013 Application for Participation of Medicaid Specialty Prepaid Inpatient Health Plans process, common "regional" policies and practices are required.

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

ELECTRONIC HEALTH RECORD/BILLING PROCEDURES:

The PIHP/CMHSP/CA and provider networks have made individual regional progress with regards to EHRs. The DCH has not mandated one particular record or vendor. The need for consistent "system communication" is crucial. The Data Exchange Committee has developed standards of required "data elements" to reduce duplicative/multiple entries into electronic health records, especially by those providers who may be in a contractual relationship with multiple PIHPs/CMHSPs. In anticipation of the integration of physical health with behavioral health, important interfaces and "bridges" have been developed and piloted within selected PIHPs. Implementation of these bridges and interfaces between Medicaid physical health and behavioral health will continue this calendar and fiscal year.

CONCLUSION

The inclusive workgroup members from throughout the system have a strong commitment to proceed in coordination with DCH to look for value added endeavors that aim to reduce or eliminate duplication and overall redundancies, and maximize uniformity and consistency in provider standards.

As overall health care evolves both at a federal and state level, the increased awareness and collective interest to move the system forward within all contracting entities is apparent.

Topics for next steps:

- Continue to reinforce the value of continuing the 490 Workgroup's effort.
- Continue to look at all contracts throughout the Behavioral Health and Developmental Disabilities Administration for simplification and redundancies, and wherever possible, consolidate as the integration of CAs into PIHPs evolves.
- Continue combined site review for PIHP/CA that represents a combined system for efficiencies – including monitoring for reciprocity for Direct Care training and Recipient Rights training.
- Eliminate the calendar year PIHP site review process, excluding the 1915 (c) waivers.
- Implement the data standards determined through the Data Exchange Workgroup and mandate in the contract for January 1, 2014.
- Build on the Values of the Behavioral Health System to realign and reduce overall administrative inefficiencies.
- Continue to work with MSA and BHDDA to streamline Waivers wherever possible.

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