"Wherever any barrier stands between you and the full rights and dignity of citizenship, we must work to remove it, in the name of simple decency and simple justice."

- President George W. Bush

Remarks by the President in Announcement of New Freedom Initiative from the White House
February 1, 2001

Dear Interested Parties,

For the last three years, the Michigan Department of Community Health (MDCH) has operated a managed specialty services program for people with serious mental illness, serious emotional disturbances, developmental disabilities, and addictive disorders. In 2002, MDCH will implement a new method for the selection of organizations to manage specialty care. These organizations are called Specialty Prepaid Health Plans (PHPs). The Centers for Medicare and Medicaid Services approved a Revised Plan for the managed specialty services program in February 2001. Since the official approval, the department has been considering various suggestions, recommendations, and approaches to implement the plan. This implementation guide presents the department's direction regarding timing, processes, requirements and procedures for selection of PHPs. It outlines preliminary information that is important to Community Mental Health Services Programs (CMHSPs), consumers, policy makers and others interested in the implementation of Michigan's Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans.

Michigan's managed care program for specialty services has been from the start: value-based, policy-oriented, and consumer-focused. The selection process to be used for specialty pre-paid health plans endorses and is constructed around four major goals or purposes for managed specialty care. These goals are freedom, community, accountability, and efficiency. The department expects that CMHSPs will take the initiative and responsibility for embracing and implementing these goals and that there will be evidence of their commitment in the applications they submit to become PHPs.

Raising expectations is critical to the continued evolution of the public mental health system: from serving people largely in segregated state-operated hospitals and centers in the past, to now providing supports in community-based settings. Each step in this evolution has required mutual action and ongoing collaboration between the state and local county-sponsored governmental agencies. This Plan for procurement builds upon the tradition of state-local partnership, and it enlarges the arrangement, affirming the essential role of consumers and families in a new, broader coalition working to secure "the full rights and dignity of citizenship" for persons with mental disabilities and addictive disorders. This guide also signals that the department is raising its expectations of CMHSPs' performance and intends to judge that performance by measuring outcomes that are important to consumers: recovery, jobs, community participation, and living independently.

Consumers, family members, advocates, CMHSPs, service providers and other community members are invited to share their written questions and comments on this implementation guide by November 1, 2001 to Barbara Mongeau via e-mail: mongeau@state.mi.us ; fax at (517) 335-6775 or in writing to the Michigan Department of Community Health.

James K. Haveman, Jr

TABLE OF CONTENTS

INTRODUCTION

1. PURPOSE OF THE IMPLEMENTATION GUIDE

For the last three years, the Michigan Department of Community Health (MDCH) has operated a managed specialty services program for persons with serious mental illness, serious emotional disturbances, developmental disabilities, and addictive disorders. In 2002, MDCH will implement a new method for the selection of organizations to manage specialty care.

The central framework for this new selection method has already been described in an earlier document published by the department ("Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans" -September 2000). This "Implementation Guide" extends and elaborates this basic structure, providing additional information about the selection method, qualifications and specifications, and the application process.

There have been a great many developments in the public specialty service system over the past decade, and the move to managed care in 1998 accelerated the pace of change. The current document does not catalogue and trace all the changes in the public specialty service system, nor does it provide a complete and final description of all the developments yet to come. Rather, the paper is designed to recognize the converging views of consumers, providers, policy makers and others who are interested in what the system will look like and provide a readiness checklist for use by CMHSPs.

Starting from the blueprint provided in the Revised Plan (September 2000), this paper provides a general outline of the projected application requirements and selection criteria. This paper offers some elaboration and clarification of concepts and conditions described in the Revised Plan, but does not provide all the details or the exact specifications that will eventually be required for application and selection. Final selection requirements will be included in the "Application for Participation" (AFP). The AFP, to be published in January 2002, will be the official vehicle for solicitation and selection of specialty PHPs.

The department is aware that since the Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans was published in September 2000, many affiliations have been created. It is expected that affiliations responding to this AFP are designed to achieve efficiencies among affiliate members--regardless of funding stream--so that consumers continue to experience a seamless system of care. The AFP will require demonstration of these efficiencies including but not limited to: maintenance of services to consumers, quality management, information systems, fiscal management and regulatory management.

1. STRUCTURE OF THE IMPLEMENTATION GUIDE

The guide chronicles system objectives, recent trends, and pending developments, and it provides a general description of likely procurement specifications and processes. It is a broad guide rather than a tight prescriptive manual. It is intended to inform, to describe a probable path of development, and to alleviate some of the apprehension that accompanies transition and change.

Section I - provides an examination of the likely AFP requirements and the process through which specialty Prepaid Health Plans (PHPs) will be selected. The technical qualifications and requirements in this Section are derived from and connected to the key values, purposes and objectives outlined in Section V. The Revised Plan indicated that an organization seeking designation as a specialty Prepaid Health Plan (PHP) must demonstrate certain capabilities and meet particular conditions and stipulations. However, these capabilities, conditions, and stipulations were not explicitly linked to values and purposes, nor were they sufficiently described and explained. A number of key concepts

are more thoroughly explained and articulated, and specific interpretations are presented for particular requirements and stipulations.

Section II - The Readiness Checklist provides a guide to the documentation that needs to be assembled to show evidence that the CMHSP can meet the department's criteria. The AFP will build on this checklist by indicating what documentation must be submitted to the department, and that which must be available locally in the event there is an on-site readiness review. The AFP will also indicate the relative weighting of the items to be scored.

Section III - describes the current situation in the public system, which revolves around the managed care program for specialty services. The decision to pursue managed care and federal waivers for specialty services has led to numerous changes in the public system, including the new stipulation related to procurement or selection of organizations to manage specialty care.

Section IV - provides a brief review of the evolution of the specialty service system, highlighting historic developments, current configuration, core principles, important policy considerations and lingering controversies.

Section V - attempts to plainly describe what we are trying to do - what we are striving to accomplish - in the Revised Plan. This section considers the greater purposes and valued ends that stimulated plan development and which will guide plan implementation.

SECTION I

1. BASIC ELEMENTS OF THE REVISED PLAN -- A REFRESHER COURSE

In Michigan's current managed specialty services program, each of the 49 CMHSPs operates as a specialty Prepaid Health Plan (PHP), responsible for providing medically necessary Medicaid covered specialty mental health, developmental disability and substance abuse services to beneficiaries residing in their service areas who require these benefits. The Substance Abuse Coordinating Agencies, under current arrangements, administer Medicaid substance abuse services, as a subcontractor of the specialty PHP (the CMHSP).

Michigan's specialty program is a "single plan - eligibility model". There is a *single* specialty PHP in each designated service area. Moreover, Medicaid beneficiaries do not "enroll" in the PHP; rather, they are *eligible* for specialty care through the PHP if they have a serious mental illness, serious emotional disturbance, developmental disability and/or addictive disorder, and require the covered benefits and levels of care available through the specialty PHP.

Michigan's program also, as noted previously, relies on "sole-source" contracting. The state contracts on a preferential basis with the county-sponsored CMHSPs to serve as the specialty PHPs.

In the Revised Plan for Procurement, the department indicated that it would retain the "single plan - eligibility model" described above, and that it would maintain a *modified* version of sole-source or preferential contracting. However, the Revised Plan indicated that the state would not in the future contract with all 49 CMHSPs for specialty PHP designation, and that if CMHSPs did not have specified capabilities and meet certain qualification requirements, the department would open selected areas for competitive solicitation.

In the submission to The Centers for Medicare and Medicaid Services, the department indicated that a CMHSP must have at least 20,000 Medicaid beneficiaries (covered lives) within their service area boundary to be eligible (as a stand-alone organization) to apply for designation as a specialty PHP. The submitted Plan noted that CMHSPs that did not meet the 20,000 covered lives criteria could join and make a consolidated application for PHP designation.

The Revised Plan sketched out qualification requirements for PHP designation. These requirements included certain administrative capabilities, cost parameters, equity and inclusion practices, service capacity, eligibility and access assurances, network composition, and enhancement of consumer opportunities.

2. AN OVERVIEW OF THE SOLICITATION PROCESS: APPLICATION AND SELECTION

The process for designation of specialty PHPs is a restricted (to CMHSPs) solicitation, initiated through issuance of an Application for Participation (AFP), proceeding through the scoring of AFP responses, and culminating in selection of specialty PHPs for the contract year beginning October 2002. A unique aspect of Michigan's Revised Plan was the proposition that a special selection panel - with consumer, family and advocacy representation - be established to assist the department in choosing specialty PHPs.

As noted earlier in the guide, shortly after the plan was submitted to The Centers for Medicare and Medicaid Services, the Legislature passed - and Governor John Engler signed into law - P.A. 409 of the Public Acts of 2000, which established a specialty services selection panel to "review and make

determinations" regarding CMH applications for PHP designation. Panel representation is specified in the statute. Governor Engler will appoint members of the specialty services panel.

The Revised Plan notes that if a CMHSP (or group of CMHSPs) in a specific area is not a successful applicant in the initial PHP solicitation, then a competitive procurement process, using established state acquisition methods, will be conducted for these "open" areas.

3. LINKING STATED PURPOSES TO APPLICATION FOR PARTICIPATION PROVISIONS: A CONCEPTUAL MODEL

In Section III of the guide we noted that the purposes or ends of the managed specialty services initiative are inextricably linked to the operational requirements of the program. The department regards managed care as a means to facilitate effective freedom for persons with mental disabilities and addictive disorders, retain valued state-county-community partnerships, ensure system accountability and integrity, and promote sustainable efficiencies.

The larger purposes or ends of the program imply that application specifications for specialty Prepaid Health Plans (PHPs) will have a different emphasis and "flavor" than standards established for other types of managed care arrangements. The department - in its submission to The Centers for Medicare and Medicaid Services on procurement - noted that:

> "Specialty PHPs must assume an important role in the protection of vulnerable populations and in securing full participation, integration and inclusion for these individuals. In short, specialty PHPs have responsibilities for ensuring freedom, opportunities for achievement, equity and participation that go far beyond the usual and customary obligations of a managed care entity."

Linking the larger purposes of the managed care program to the qualification requirements for specialty PHPs means that attention must be directed not only to standard managed care administrative capabilities, *but also to the organizational characteristics, the public policy performance and the regulatory competencies of the applicant entities.* Specialty PHPs must be value-based, policy-oriented, community-focused, administratively capable and resource-conscious organizations, operating in the public interest.

In this segment of the guide we propose four major qualification domains as the foundation for development of Application for Participation specifications. These four domains reflect the larger purposes described in Section V, and are a recompilation (using a slightly different framework) of the qualification categories outlined in the Revised Plan. The four domains are:

- ***Organizational Status and Configuration***

  In the Revised Plan, the department emphasized the special features of CMHSPs, noting that they had certain characteristic, statutorily proscribed obligations, and experience with the target population that promoted inclusion, integration and participation for these vulnerable beneficiaries. Given these assertions, the Application for Participation must verify organizational status, statutory adherence, and regulatory compliance of applicant CMHSPs, and carefully explore the composition of affiliation arrangements established by CMHSPs submitting a consolidated application for PHP designation.

  In examining organizational status and arrangements, the different roles that CMHSPs - or affiliated groups of CMHSPs - play in the specialty managed care system must be delineated and distinguished. An individual CMHSP, a lead CMHSP within an affiliated group, or a new legal entity established as a joint venture, will be applying for designation as the managed care entity

(Medicaid specialty PHP) for a geographic service area. But these same applicant organizations have other roles - besides that of the specialty PHP - within the service area. CMHSPs have certain well-defined roles and responsibilities under state statute, and they must carry out these functions and meet these obligations regardless of their participation in Medicaid specialty managed care. Within the Medicaid specialty managed care program, CMHSPs may operate services in addition to functioning as the managed care entity, or - in the case of affiliated CMHSPs - they may have some special status or distinctive responsibilities within the managed care program as the local "integrator" or coordinator of specialty services.

For the designated specialty Prepaid Health Plan, certain roles and activities are (from a contractual perspective) primary and cannot be delegated or diluted. Other roles are secondary and discretionary, and these must not interfere with or contaminate performance of primary roles and activities.

- ***Public Policy Management***

Specialty PHPs are not simply managed care organizations. Rather, as emphasized in our discussion on the purposes or ends of the specialty managed care program, specialty PHPs are also *managers of public policy.* Public policy - articulated in statutes, rules, decisions, directives, guidelines, statements, practice models, etc. - is a broad and evolving expression of the rights, aspirations, claims, considerations, expectations, restrictions and responsibilities of persons with serious mental illness, serious emotional disturbance, developmental disabilities and addictive disorders. CMHSPs - as specialty PHPs - are charged with implementing (and balancing) significant, sensitive and sometimes conflicting elements of public policy, and thus evaluation of CMHSP performance in this area is an important part of the Application for Participation.

The most significant public policy development of the past 30 years has been the effort to eliminate unjustified and unnecessary segregation, isolation and confinement of disabled individuals. The affirmative obligation on publicly-funded programs to promote community integration and inclusion of disabled individuals has been accentuated over the last several years by the Supreme Court's *Olmstead* decision, the Centers for Medicare and Medicaid Services directives, and the recent Executive Order by President Bush regarding community-based service alternatives.

Hence, the performance of applicant PHPs in protecting basic rights, promoting effective freedom, facilitating inclusion and independence, applying person-centered planning, preserving health and safety, responding to diversity, ensuring stakeholder participation, engaging in collaborative efforts and pursuing community benefit activities must be assessed and evaluated.

- ***Administrative Capabilities and Management***

The department's specialty service waiver program is a managed care plan, with all the administrative, managerial and operational complexities inherent in such an enterprise. CMHSPs selected as PHPs (either individually or through collective arrangements) must perform as managed care entities, accepting capitated payments and assuming responsibility for providing medically necessary covered specialty services to beneficiaries with serious mental illness, serious emotional disturbance, developmental disabilities and addictive disorders. A CMHSP designated as a specialty Prepaid Health Plan must be able to perform basic administrative, managerial and business functions related to the operation of the program. These functions include access, needs assessment, care planning, benefit authorization, service availability, network capacity, quality control, beneficiary notice, appeal mechanisms, rights protection, utilization management, claims payment, data reporting, and a whole host of other administrative, service delivery and business activities.

The Application for Participation will require (and verify) that applicant CMHSPs have sufficient administrative capabilities and operational expertise to perform these functions. Moreover, the Application for Participation will elicit information from applicants regarding the costs associated with carrying out these PHP administrative functions.

- ***Regulatory Oversight and Management***

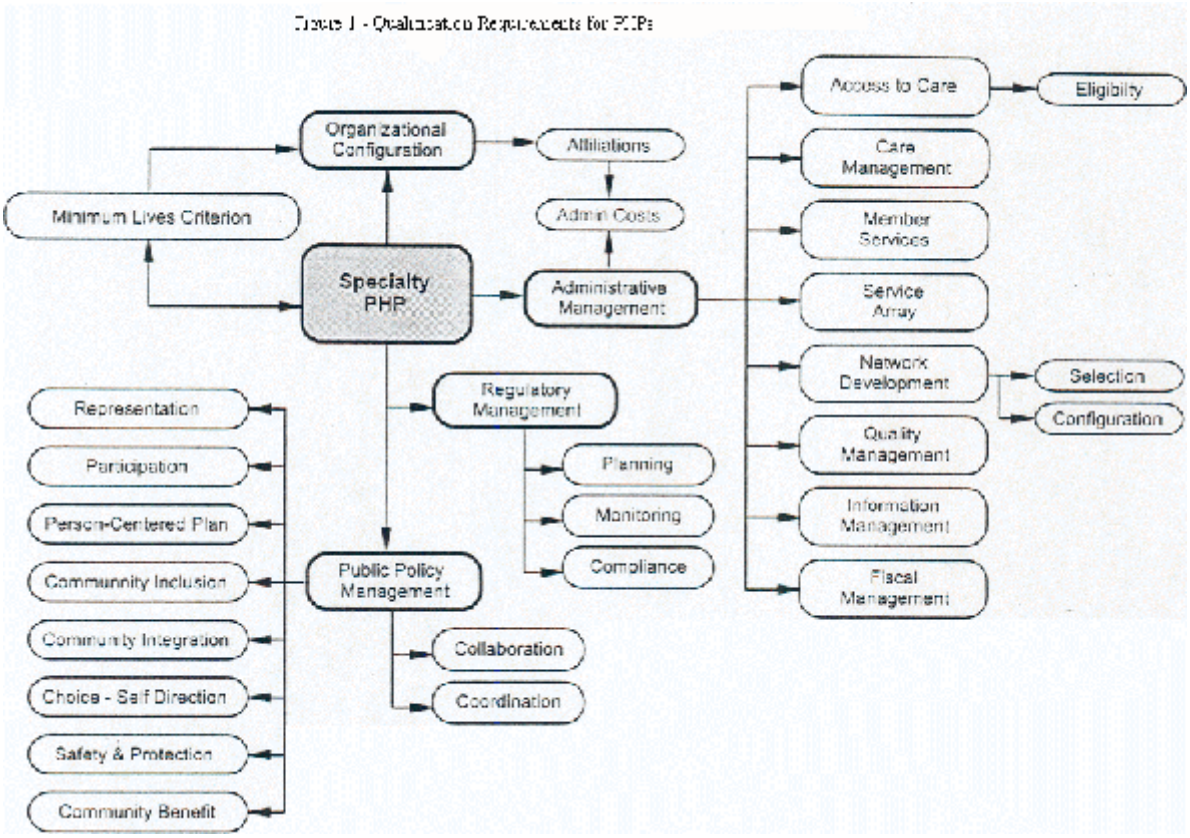
Specialty PHPs - entrusted with the care of vulnerable populations, pursuing important public policy objectives, managing formidable administrative enterprises and intricate service networks - are subject to voluminous and complex protective, procedural, clinical, and fiduciary regulations. Given the scope of regulatory concern and liability, specialty PHPs need *dynamic internal mechanisms* to assimilate, analyze, apply, monitor and enforce regulatory compliance throughout the organization and the associated network. Organizations that are well acquainted with applicable regulations, vigorously monitor compliance, recognize and manage high-risk areas, and intervene to ensure proper performance to reduce system transaction costs.[1]

The Application for Participation will assess the applicant's strategy and operational practices for monitoring regulatory adherence. addressing specific shortcomings, resolving patterns of noncompliance, and reducing risk exposure (for the consumer, the community and the PHP).

A Note on Regulatory Compliance: Just as this guide was being finalized, new federal regulations related to Medicaid managed care were published in the Federal Register (August 20, 2001). These proposed rules supercede the rules previously promulgated in the Federal Register on January 19, 2001. The proposed rules are intended to provide regulatory guidance related to provisions of the Balanced Budget Act of 1997, which made significant statutory changes in Title XIX of the Social Security Act (Medicaid). The department is studying these proposed rules and their possible impact on the future Application for Participation

As noted, each domain above is comprised of a set of interrelated components. These components are identified and discussed in some detail in the next segments of this section. The figure below (Figure 1) provides a visual representation of the qualification domains and constituent elements.

[1] Transaction costs are the costs of organizing, contracting, transferring and measuring service exchanges, and monitoring, adjusting and enforcing these arrangements



4. A CLOSER LOOK AT THE FOUR DOMAINS

The four qualification areas illustrated above are distinct but clearly interrelated. In this segment of the paper, we examine each domain in its constituent parts in some detail.

1.1. Organizational Status and Configuration

The department's Revised Plan affords *initial* consideration for specialty PHP designation to *qualified CMHSPs.* Hence, the first and most basic requirement in the initial solicitation is that the organization submitting an application (or affiliated member organizations submitting a consolidated application) be legally established and operating as a Community Mental Health Services Program (CMHSP), in one of the forms described in statute (Act 258 of the Public Acts of 1974 as amended).

All CMHSPs making -or participating in an application submission, must comply with Mental Health Code requirements on Board membership composition, must be certified per Code stipulations and must have a certified recipient rights system.

The second basic requirement established by the department for application submission is the *minimum covered lives criterion.* An individual CMHSP that has at least 20,000 Medicaid beneficiaries (covered lives) within its geographic service area may submit a standalone application for specialty PHP designation.

CMHSPs that do not meet as individual entities, the minimum covered lives criteria are entitled to participate in the submission of an application under the affiliation option. Multiple, legally affiliated, CMHSPs that meet applicable contiguity standards[2], and which have at least 20,000 Medicaid beneficiaries (covered lives) within their combined geographic service area, may submit a consolidated application for specialty PHP designation.

Michigan has permissive legislation that allows governmental entities to engage in contracts, joint ventures and consolidations. These legislative mechanisms permit either contractual arrangements or formation of an entirely new governmental entity. It should be noted, however, that the Mental Health Code does not permit affiliation formation through CMHSP sponsorship or stockholder interest in a not-for-profit entity or venture.

Current permissive legal arrangements for affiliation include the Intergovernmental Contracts Between Municipal Corporations Act (ICA), the Intergovernmental Transfer of Functions and Responsibilities Act (ITFRA), and the Urban Cooperation Act (UCA).

CMHSPs making a consolidated application for PHP designation must have established a legal affiliation arrangement under the Intergovernmental Contracts Between Municipal Corporations Act, the Intergovernmental Transfer of Functions and Responsibilities Act, or the Urban Cooperation Act. The legal agreement establishing the affiliation must be submitted as an attachment to the consolidated application.

The creation of an affiliation under the Intergovernmental Contracts Between Municipal Corporations Act or Intergovernmental Transfer of Functions and Responsibilities Act does not create a new legal entity from the "component" consortium members. Hence, affiliations formed under the Intergovernmental Contracts Between Municipal Corporations Act or Intergovernmental Transfer of Functions and Responsibilities Act that submit a consolidated application *must identify or designate* a *single CMHSP within the affiliation to act* as *the lead contractor.* If the consolidated application is approved by the specialty services selection panel, the department will contract *solely* with the lead CMHSP of the affiliation, and that CMHSP will be regarded - and must assume all contractual liabilities commensurate with this status -as the specialty PHP for the region.

[2] See Public Act No. 60 of the Public Acts of 2001

The use of the Urban Cooperation Act for affiliation formation results in the creation of a new legal entity jointly "owned" and governed by the sponsoring CMHSPs. If a new legal entity is established for purposes of submitting a consolidated application, the department will (if the application is approved) contract with the new (separately identifiable) organization - sponsored by and constituted of CMHSPs - to serve as the specialty PHP for the region.

Affiliated CMHSPs submitting a consolidated application must use caution in how they refer to consortium arrangements. It is not permissible to use a name for the affiliation that suggests or implies that the consortium has created a *separate legal entity* if in fact no such separate legal entity has been established or exists.

1.1.1. *Conditions for Individual Applicants*

CMHSPs that meet -as standalone organizations -the 20,000 minimum covered lives criteria *may* submit an individual application for PHP designation. Note, however, that *individual application* is a choice, not a requirement. The CMHSP could choose to participate in a consolidated application with affiliated CMHSPs, perhaps serving as the lead agency or primary contractor for the affiliation.

If the CMHSP does submit an individual application, it must clearly describe how it will execute the administrative obligations of a specialty PHP, and identify other roles (e.g. service provider) that it intends to fulfill in the managed care program.

If the CMHSP plans to subcontract or outsource any PHP administrative responsibilities (e.g., authorizations, claims payment), it must describe in detail the process for the vendor selection, the scope of contractor activities, and the integration of vendor functions with other PHP administrative duties performed by the CMHSP or other subcontractors. The CMHSP must fully disclose any foreseeable or potential conflict of interest situations relative to outsourcing arrangements.

An individual CMHSP serving as a specialty PHP is managing care for disabled or impaired beneficiaries, implementing public policy directives, and performing public interest and community benefit functions. If the CMHSP intends to fulfill another role in the managed care program - as a provider of direct services - it must demonstrate an organizational configuration or structural arrangement that preserves the integrity of beneficiary interests and public policy objectives in the event these conflicts with provider interests of the agency. Acceptable organizational configurations might include separate reporting responsibilities and lines of authority for PHP functions and provider activities, or special independent oversight structures (consumer, family, advocate organizations representation).

1.1.2. *Conditions for Affiliated Applicants*

The rationale for affiliation is functional consolidation of certain PHP administrative activities, to achieve scale economies, minimize total administrative costs and maximize resources available for direct services to beneficiaries. Affiliation is *not* intended to diminish the vital role that each CMHSP plays in representing community members, assuring local access, organizing and integrating the provision of services in a given area, coordinating care, implementing public policy, ensuring interagency collaboration, and preserving the public interest. Admittedly, meshing functional consolidation of administrative activities with local "service integrator" and public interest responsibilities poses significant organizational and political challenges for affiliated entities. These obstacles (e.g., feared loss of local control, cost sharing and allocation disputes, "transaction costs" associated with reaching decisions

and managing the arrangement, etc.) are formidable but not insurmountable. Since these problems are generally identifiable and can be remedied with proper planning, it is crucial that the formal agreements for affiliation anticipate and address these issues.

Affiliated CMHSPs submitting a consolidated application must provide a thorough description of the contractual (Intergovernmental Contracts Between Municipal Corporations Act or Intergovernmental Transfer of Functions and Responsibilities Act) or joint-governance (Urban Corporations Act) arrangements of the affiliation or consortium. Prior to an explanation of the legalities of the arrangement, the account must define the vision and values of the participating organizations, describe how the affiliation arrangement will actualize this vision and build upon the existing strengths of member organizations, and indicate how functional integration - to achieve economies of scale in administrative activities - will be accomplished.

The explanation of the formal legal agreement must specify the relationship, roles, rights and (financial) interests of each party, with special attention to governance issues, functional consolidation of administrative activities, cost - sharing and cost-allocation methodologies, local match obligations related to Medicaid funds, fund transfers, repurchase (contracting back) agreements, resource/asset claims, liability obligations, risk pools arrangements, contingencies, limitations, and exclusions.

Finally, the affiliation description must indicate how member boards - while affiliating to achieve functional consolidation of administrative activities -will maintain local representation, stakeholder participation, accessibility, participation, accountability, collaboration, and fulfillment of public policy and public interest responsibilities.

1.1.3. *Verifying Covered Lives*

To determine - for either individual or consolidated applications - if the 20,000 Medicaid covered lives requirement has been met, the department will compute an average monthly Medicaid eligible count, using full year Medicaid eligible months for the service area, inclusive of active spend-down and retroactive eligibility months. If the average monthly Medicaid eligible count computed by the department is within a 5% variance range from the 20,000 lives criterion, the individual applicant or consolidated applicant will be regarded as having met the standard.

1.2. Public Policy Management and Public Interest Considerations

Earlier in the guide, we indicated that - consistent with the President's "New Freedom Initiative" - the primary objective of the managed specialty services program was to enhance the capability to function, freedom to choose and opportunity to achieve for persons with serious mental illness, serious emotional disturbances, developmental disabilities, and addictive disorders. We noted that the system was in transition - moving from the deinstitutionalization period to a new era of community membership. In this new era, the status of persons with mental disabilities and addictive disorders has changed from "client" or "recipient" to consumer-citizen. For adults with serious mental illness and persons with developmental disabilities the "continuum of care" model is retreating, replaced by the concept of customized services, supports and accommodations, tailored to the unique needs of the person, and designed to maximize independence and community inclusion. Services and supports for these populations are no longer tied to typical settings or program facilities, but are supplied in a variety of settings, to support independence, productive activities, self-determination, and voluntary relationships. Finally, individual needs and desires - elicited through the person-centered planning process - are intended to drive the design of service and support arrangements, not predetermined

expectations regarding what is good for the individual. Consumer direction and consumer operation of services are encouraged, to facilitate empowerment, assumption of socially valued roles, and personal choice.

In regard to adults with serious mental illness, the significance of diversion activities to prevent entanglements with local law enforcement and the corrections system, the need for an integrated approach to co-occurring conditions (psychiatric and substance abuse disorders), and the importance of outreach to certain subgroups of adults with severe mental illness are persistent topics in public policy discussions.

For children and adolescents with serious emotional disturbances, the policy emphasis is on family-centered planning, using a "strength-based ecological approach" for assessment and intervention strategies. Specialty mental health services for children and adolescents are regarded as part of a broader community "child and family services system", which includes education, child welfare, juvenile justice and other community agencies. Collaborative planning between these agencies is heavily promoted, and the urgent need for expanded inter-agency efforts to address certain sub-populations is a continuous theme in contemporary public policy.

Public policy trends for substance abuse services have hovered between competing inclinations (enforcement, treatment, or prevention) and attitudes regarding addictive disorders. In regard to prevention and treatment, policy has recently been attentive to the pervasiveness of substance abuse disorders in a wide variety of individual, family, and community problems. A consensus has developed that service models for domestic violence, juvenile delinquency, child abuse and neglect, certain offender populations and subgroups of individuals with cooccurring disorders of mental illness and substance abuse, must integrate substance abuse perspectives and treatments into the intervention method.

Other aspects of the specialty service system are changing as well. Consumer and family participation on governing boards is significant, but progressive organizations in the current milieu go beyond this level of participation and directly seek out stakeholder input and community concerns. This is accomplished through "town-meetings", advocacy forums, advisory groups and other participatory mechanisms. Important "public goods" provided through the organization (crisis intervention and emergency services) to all citizens are publicized and access monitored. Community benefit endeavors, including information, education, prevention and consultation activities, are planned for and routinely implemented.

The Application for Participation must assess how well the applicant has absorbed, applied and implemented these emerging elements of public policy and community interest. As noted previously, the case for preferential contracting with CMHSPs rests upon their commitment to particular public policy objectives and outcomes (e.g., effective freedom), and upon their unique role in the community as an "integrator" of services for individuals with mental disabilities or addictive disorders. If a CMHSP is not adequately addressing or fully implementing vital public policy objectives, or if it is not fulfilling "integrator" functions and public interest obligations, then the rationale for preferential contracting is severely compromised.

1.2.1. From the Conceptual to the Practical

> The preceding discussion calls attention to themes, directions, and concerns that might be indicative or suggestive of public policy management and public interest performance. The items listed below are some dimensions, categories and indicators of these themes and concerns, that *will be further refined* into specifications and criteria to measure this qualification domain in

the Application for Participation. The listed items, however, lack specificity and the requisite performance standards or benchmarks essential for rating, scoring or measurement. The reader is again cautioned that we are listing relevant concerns and suggesting

assessment "vectors" (the attributes, direction, and magnitude of desired performance characteristics) for this qualification domain, not providing precise requirements or exact standards.

The following items or categories might be indicative of proficiency in managing public policy and preserving the public interest:

- **T** Board composition, family and consumer representation, diversity of composition consistent with community demographic characteristics;
- **T** Opportunities for stakeholder and community input and involvement in policy formulation and implementation; existing advisory boards, scheduled community meetings, local press coverage of services and activities;
- **T** Identification of key local, individual advocates and advocacy groups, and description of any arrangements for ongoing dialogue, meetings, consultation with these individuals and entities;
- **T** Current compliance with the person-centered planning mandates, monitoring processes to insure implementation, staff training program, corrective actions taken to ensure full compliance;
- **T** Supports coordination and case management options for consumers, safeguards regarding conflict-of-interest and principal-agent problems (support coordination, case management and service provision choices);
- **T** Evidence of changes in service delivery system preference and patterns over the last three years (October 1998 -September 2001), showing increased use of flexible options, more consumer-operated services, greater choice, self-determination arrangements, increase in independent living situations and employment opportunities;
- **T** Number of persons from the CMHSP (or affiliated CMHSPs) currently in state institutions, comparison of institutional usage over the last three years, plans for full compliance with the Olmstead decision and the Executive Order on community-based alternatives;
- **T** Affirmative agency efforts to increase agency and subcontractor employment of consumers, identification of any agency organizational units specifically dedicated to consumer interests and staffed by consumers and/or family members;
- **T** Description of agency language, communication, and mobility accommodation capabilities, to ensure access by those with limited English proficiency, communication impairments, and mobility constraints;
- **T** An analysis of recipient rights complaints, local appeal and grievance activity and Medicaid fair hearing cases that proceeded to decision as well as requests for administrative hearings that were resolved locally or withdrawn;
- **T** An assessment of sentinel events, health and safety incidents, expressed community concerns or complaints related to protection, safety and security, actions taken to address concerns;
- **T** Provisions for crisis stabilization and response services, identification of Pre-admission Screening Unit(s), availability of Children's Diagnostic and Treatment Program;

- **T** Assessment of cultural and ethnic characteristics of the service area, descriptions of efforts to ensure culturally appropriate and competent services;
- **T** Identification of jail diversion policies and activities and an assessment of the impact of these interventions;
- **T** Documentation of participation on the local Multi-Purpose Collaborative Body, identification of involvement in other collaborative enterprises (Early-On, Strong Families -Safe Children), with special attention to any formal linkages (written agreements) with the juvenile justice, child welfare and local education system;
- **T** Description of any pooled funding arrangements or joint-service ventures with other community agencies;
- **T** A full account of the relationship between the CMHSP (or affiliated CMHSPs) and the local substance abuse Coordinating Agency, including sub-contracting arrangements for Medicaid funds, coordination of services, joint efforts to address co-occurring disorders, and any anticipated changes in the relationship;
- **T** Exposition of agency philosophy and practices related to services for persons with serious mental illness, serious emotional disturbances, developmental disabilities and addictive disorders, with a description of how recovery, self-determination, community linkages, relapse prevention, promotion of effective freedom and other articulated policy objectives are promoted and realized through agency practices;
- **T** Identification of all information, education, consultation, prevention, outreach, early intervention and other community benefit activities undertaken in the last twelve months;
- **T** Description of how state general fund and Medicaid savings were reinvested over the past three years with an assessment of how the reinvestment strategy promoted beneficiary or consumer well-being or reflected public interest considerations.

1.3. Administrative Capabilities and Management

The department's managed specialty services program serves individuals defined by the Centers for Medicare and Medicaid Services as having "special health care needs".[3] While circumstances differ, persons with serious mental illness, serious emotional disturbances, developmental disabilities and addictive disorders have a shared characteristic: the presence of a disability or limiting condition which constrains capabilities and impairs functioning, Both individually and collectively, these consumers require more intensive, diverse, extensive and coordinated services than those utilized by typical managed care enrollees.

Hence, given the special needs of these populations, managed care arrangements must be approached with caution and constructed with proper safeguards. In applying managed care to persons with serious mental illness, serious emotional disturbances, developmental disabilities and addictive disorders, the department's objective has been to afford consumers greater flexibility in permissible service and support arrangements. However, a managed care approach also entails resource-sensitive practices and a commitment to constrain spending within prescribed limits (aggregate capitation payments). In the department's plan, managed care involves a trade-off between flexibility and resource sensitivity, with opportunities and incentives for beneficiaries, providers and the specialty PHP to benefit from successful plan operation.

The use of waiver authority and the application of a risk-based managed care approach to specialty services also imply particular administrative obligations, managerial responsibilities and operational

[3] Report to Congress: Safeguards for individuals with Special Health Care Needs Enrolled in Medicaid Managed Care: November 2000.

capabilities. Some of these duties and stipulations are derived from federal statute, other from regulations or specific conditions attached to Michigan's waivers. Many of the new administrative, managerial, and operational burdens, however, are inherent in the managed care enterprise itself. Managed care - as a method of organizing, arranging, coordinating, supervising and financing service provision - entails certain strategies, structures, processes, functions and capabilities. Some of these activities are essential ingredients of the managed care approach to organizing, financing and delivering services. However, other parts of the "apparatus" are inhibitory mechanisms, designed specifically to restrain the managed care "engine" from possible excesses.

Specialty PHPs must possess requisite managed care administrative capabilities, but these capabilities must be applied and exercised in a manner that recognizes the special needs and aspirations of the target populations. In short, the administrative activities and operational practices of the PHP must be consistent with (and facilitate) the larger ends or goals of the managed care program.

In the following subsections, we discuss basic expectations and considerations regarding key managed care administrative functions. For brevity of presentation, we have condensed the eight functions listed on the *right side* of Figure 1 into three main categories: access issues, provider networks and accountability systems. To fulfill the functional expectations for these categories, the PHP must have certain operational capabilities and technical proficiencies.

Affiliated CMHSPs that submit a consolidated application must describe how these administrative functions are performed within the affiliation and across member organizations. Responsibility for overall direction and operation of the administrative functions must ultimately be vested in a "principal" CMHSP, which will be the lead agency, the recognized (legally accountable) specialty PHP, and the sole contractor (for Medicaid) with the department.

1.3.1. Access: Information, Entry, Care Management, Service Array and Advocacy

Access involves a number of considerations. Consumers must be informed of covered services and understand how and where to obtain such care. There must be processes in place to assess the person's needs and aspirations and to match covered services to those needs and desires. Covered services must be readily available and provision of these services must be reconciled with individual circumstances (e.g., cultural diversity, language, physical access, etc.). Mechanisms must be in place to ensure that diverse services are organized and coordinated. Finally, consumers must have somewhere to turn for assistance, should there be any breakdown or problems in these activities.

In stakeholder meetings convened by the department, access issues emerged as the paramount concern. Consumers, family members and advocacy organizations emphasized the importance of adequate information, easy entry pathways, consistent eligibility criteria, person-centered planning compliance, service availability assurances, responsive case management and supports coordination arrangements, and dynamic consumer assistance systems.

The following statements are expressions of access expectations and likely operational standards:

- **T** Specialty PHPs must establish, deploy and successfully operate a system for access to specialty care that is compatible with and responsive to the characteristics of the service area and the special needs of the targeted beneficiary populations. Access capabilities will be assessed against state and federal requirements regarding crisis response, pre-admission screening, routine service requests, and established time and distance standards.
- **T** The access system must include "enabling services" to help beneficiaries overcome barriers to services. Enabling services include information, education, outreach, and language and cultural accommodations.

- **T** The access system must, in design and operation, facilitate beneficiary entry into the specialty care system, establish eligibility for specialty care, determine condition and situation, respond to immediate problems or circumstances, and gather preliminary information regarding beneficiary needs and aspirations.
- **T** Service planning for all beneficiaries with serious mental illness, serious emotional disturbance, or developmental disabilities must be done through a person-centered planning process. For emergent or urgent circumstances, abbreviated person-centered planning approaches may be used, and expedited care authorization processes employed, with emphasis upon responding to pressing current needs.
- **T** The person-centered plan is the PHP's authorization of necessary services and supports, commensurate with covered benefits, and sufficient in amount, scope and duration to meet the intended purposes of the services and to address established beneficiary needs.
- **T** The PHP must indicate the method by which service authorizations are approved and reviewed regarding adequacy, appropriateness, duration and coverage obligations (utilization management system).
- **T** The PHP must provide a description of the process for beneficiary notice of appeal and fair hearing rights regarding coverage determination decisions; service and support authorizations; and changes, alterations, modifications or termination of services,
- **T** The PHP must describe the availability of and conditions for provision of supports coordination or case management services, beneficiary options related to supports coordination and case management arrangements, and organizational safeguards against conflict-of-interest or principal-agent problems in the provision of supports coordination or case management services.
- **T** The PHP must ensure that all covered services are available to eligible beneficiaries as necessary and authorized. The PHP must establish, maintain, and monitor a network of sufficient size, scope, and capacity to provide adequate access to all covered services. The PHP shall provide culturally appropriate and competent services to beneficiaries requiring such accommodation.
- **T** The PHP must provide medically necessary covered corrective and ameliorative services to beneficiaries referred to the PHP subsequent to an EPSDT evaluation by primary EPSDT screener. The PHP must coordinate transportation for EPSDT participants through the beneficiary's QHP or through the Family Independence Agency.
- **T** To assure adequate network capacity and service access, the PHP must evaluate likely demand for care, estimate the expected utilization of particular covered services, calculate the numbers and types of providers and provider organizations necessary to meet demand and utilization predictions, and identify highly specialized providers necessary to address special needs, including cultural diversity, limited English proficiency or other unique conditions or situations of the beneficiary population. The PHP evaluation must be on file with the department and open to inspection by beneficiaries and other interested parties.
- **T** The PHP must indicate how out-of-area services are arranged and authorized, and explain how it handles beneficiary requests to utilize out-of-network providers.
- **T** PHP must have procedures for handling circumstances of beneficiary special need, when the PHP does not have a network provider qualified to address the situation.
- **T** The PHP must provide information and assistance to beneficiaries in regard to PHP operations, eligibility, covered benefits, service requests, authorization processes, methods to obtain emergency services, care options and support arrangements,

available providers, referrals for services provided through other Medicaid programs (fee-for-service) or plans (QHPs), transportation' assistance, PHP internal grievance procedures and beneficiary fair hearing rights.

- **T** The PHP must provide comprehensive account of its beneficiary services operations including a description of how required informational material is produced and disseminated, policies and procedures for handling beneficiary inquiries and complaints, description of PHP internal grievance processes, an explanation of how beneficiaries are advised of fair hearing rights and how they are assisted to exercise these rights.
- **T** The PHP must describe how it integrates consumer and informal caregivers (family members) into its beneficiary services operations, with specific attention to consumer assistance or consumer advocacy programs, special organizational units (e.g., Office of Consumer and Family Relations, etc.) created to address consumer issues, employment of consumers and family members to provide beneficiary services, and/or the use of ombudsman arrangements.
- **T** The PHP must provide a plan that identifies how the PHP will assure that self-determination arrangements will be made available through each participating CMHSP entity. This shall include an assessment of current readiness to participate in offering self-determination arrangements to interested adult consumers with developmental disabilities and/or mental illness. The plan shall include a timetable of specific actions and deadlines for achieving compliance with DCH policy requirements, and to assure that each participating CMHSP has oriented its direct-operated and contracted providers to the principles of self-determination, and to the importance of adhering to those principles as self-determination practices are put into place. The PHP shall identify in its plan the deadline it will adhere to in developing official policy that will govern the application of self-determination and consumer-directed care options.
- **T** The PHP must provide assurance that specific covered services -outlined in the Revised Plan -meet state established "structural integrity" and "model fidelity" criteria developed for those programs. Program enrollment is maintained as verification of integrity and fidelity, and site visits confirm that program criteria are being met.
- **T** The Revised Plan indicated that the PHP must offer beneficiaries the option to choose a person-centered planning (PCP) facilitator who is external to the specialty PHP or its provider network.

1.3.2. Provider Network: Configuration, Selection, Management

To facilitate movement of persons with serious mental illness and developmental disabilities from state institutions to the community, a number of distinctive service and support arrangements were developed by -or under the auspices of -the CMHSPs. These particular service and support arrangements tend to be unique and include assertive community treatment services, habilitation services, supported employment, psychosocial rehabilitation programs, or other specialty services as reimbursable covered benefits.

The emphasis in the specialty service system has been to generate adequate service capacity and to ensure that these services are organized and coordinated as a "system of care" for the target populations. Attention has been directed at recruiting and retaining experienced providers that understand the needs of persons with serious mental illness, serious emotional disturbance, developmental disabilities and addictive disorders, and maintaining an integrated service delivery system.

The primacy of experience, asset-specific service investments, and integrated delivery systems is reflected in the Revised Plan. It does not -except for PHPs with more than 100,000 covered lives -dictate any specific configuration or selection method for the provider network. It also recognizes the special role of CMHSPs as the local "service integrator" by granting CMHSPs in an affiliation a special provider designation: "Comprehensive Specialty Services Network" (CSSN).

The Revised Plan does indicate, however, that provider network configuration and selection decisions should address principal-agent problems, facilitate choice where possible, and reflect an objective "best-value" approach to purchasing.
These considerations -principal/agent issues, choice and best value -are part of a *network development plan.* Specialty PHPs are required to establish and maintain a network of providers sufficient in number, mix and geographic distribution to meet the needs of the target populations and ensure adequate availability of covered services. In the Application for Participation, applicants will be asked to provide an estimate of necessary service capacity, and to describe in detail (network development plan) PHP processes and procedures for selecting or recruiting providers to achieve sufficient supply.

1.3.2.1. Network Development Plan - PHP with fewer than 100,000 Covered Lives

The network development plan must clearly articulate the composition, structure and characteristics of the provider network -based upon the PHP's assessment of required capacity -and establish a clear rationale for the PHP's approach to provider selection.

- **T** The network development plan must indicate the method(s) the PHP will use to acquire specific services or an integrated set of services (e.g., RFP, competitive contracting, open enrollment, sole-source arrangement, etc.) and the rationale (e.g., quality, availability, consumer preferences, coordination considerations, comparative costs inclusive of transaction costs, CSSN status, etc.) for employing particular selection methods for various services.
- **T** The network development plan must describe how consumer choice considerations are incorporated into the network configuration and selection strategies.
- **T** The network development plan must describe how the PHP promotes, supports, develops and contracts for consumer-operated and consumer-directed services.
- **T** The network development plan must include an assessment of cultural diversity and network cultural competency. The network development plan must indicate how non-network providers (nominated by consumers or proposed in self-directed service arrangement) are accommodated in the network.
- **T** The network development plan must be constructed with input from community members, and this participation must be described and documented in the plan.
- **T** The network development plan must accommodate reasonable choice for case management, supports coordination, physician-psychiatry services and personal care assistance.
- **T** Given the importance of the case management and supports coordination, the network development plan must address principal-agent issues relative to these particular "enabling" services, and describe organizational safeguards or structural arrangements (e.g., separate case management or support coordination agencies, choice among agencies, etc.) that mitigate such risks.
- **T** The network development plan must clearly describe how covered substance abuse services are handled in provider network configuration and selection. If the

specialty PHP plans to subcontract with the regional substance abuse coordinating agency for management of these services, this should be noted and a thorough assessment of CA readiness and proficiency for managing these services must be provided. If the specialty PHP does not plan to subcontract service management to the CA, the network development plan must provide a complete account of provider arrangements for substance abuse services and describe linkages with the CA for non-covered services. It must also describe the linkages with the CA to assure continuity of care for persons who lose Medicaid eligibility.

- **T** The network development plan must also indicate how the specialty PHP provides integrated care for individuals with co-occurring psychiatric and substance abuse disorders.

1.3.2.2. Network Development Plan - PHPs with more than 100,000 Covered Lives

For specialty PHPs that serve an area with more than 100,000 covered lives, network development plan requirements are more extensive. The network development plan for these PHPs must meet all the requirements above. In addition, the plan must indicate how the PHP will carry out the requirement -contained in the Revised Plan -that there be at least two "provider sponsored specialty networks" (PSSNs) for each special population (adults with mental illness and/or addictive disorders; children with emotional disorders and/or addictive disorders; and persons with developmental disabilities).

The intent of this requirement was to foster development of integrated and coordinated systems of care, align payment incentives, and address choice. The department realizes, however, that PSSN evolution must accommodate both the need to retain some form of geographically based care responsibilities and the opportunities for competitive contracting and beneficiary choice.

- **T** The network development plan must describe how PSSNs will be configured (e.g., scope of services, geographic range, variations by target population, etc.) and describe how existing community-based organizations and essential provider organizations will be integrated into the PSSNs.
- **T** The network development plan must explain the proposed structure and functions of PSSNs (e.g., entity status, governance, consumer and family representation, administrative responsibilities, clinical obligations, legal and liability issues, delegation, risk sharing arrangements, etc.).
- **T** The network development plan must describe any anticipated "default" geographic responsibilities of the PSSNs and describe consumer options to choose between PSSNs.
- **T** The network development plan must describe how the PSSNs will be recruited and selected.
- **T** If the specialty PHP elects to keep certain services outside of the PSSN scope of responsibility, the network development plan must assess how this will affect coordination of care and the alignment of incentives within the system.
- **T** The network development plan for PHPs with more than 100,000 beneficiaries must also indicate how culturally specific services will be accommodated (inside the PSSNs or outside these arrangements with direct access).

As a companion piece to the network development plan, specialty PHP applicants will be required to submit a *network management plan.* The PHP -as the prime contractor - devolves certain activities and responsibilities to its subcontractors (provider network).

The network management plan describes the PHP contract management methods, staffing standards, payment arrangements, and performance monitoring system.

T The network management plan must describe contracting processes and specifications for network providers. The plan must clearly establish that contracting practices facilitate appropriate delegation of relevant administrative, service and performance requirements; that contracts are executed in a timely manner; and that provisional or transitional contracts are used only under carefully delineated circumstances. The plan must describe how provider contracts are made available to the public for inspection.

T PHPs policies and procedures for credentialing providers for network participation must be included in the network management plan.

T A Provider Manual must accompany the network management plan. The manual must include all policies, procedures, forms, instructional materials, and other information used to support and supervise network operation.

T The network management plan must describe all provider payment arrangements (e.g., rates, schedule for payments, risk assumption, third-party liability collections, incentive systems, etc.).

T The network management plan must indicate how the PHP supervises subcontractor performance, the standards used to support such monitoring, tracking methods, corrective measures and sanctions, family and consumer involvement in monitoring provider performance, and public access to provider performance characteristics.

1.3.3. *Accountability: Quality Management, Information Systems, Fiscal Operations*

The quality management system, the information management system, and the fiscal operations of the PHP are the *foundations for accountability.* Deficiencies in these operational systems will severely compromise PHP performance, stifling necessary feedback and correction loops.

It is not the intent of this guide to review all of the many and highly specific requirements related to quality, data, and financial activities of specialty PHPs. Interested readers may investigate these details by reviewing current law and regulations, proposed rules related to provisions of the BBA (August 20, 2001), federal quality improvement guidance for managed care programs, federal directions regarding managed care for persons with special health care needs, rules and regulations related to implementation of the Health Insurance Portability and Accountability Act (HIPAA), The Centers for Medicare and Medicaid Services site review recommendations, waiver approval conditions, and the current state managed care contract with CMHSPs. What should be clear from this listing of materials, however, is that quality, data, and fiscal operations are closely regulated and highly scrutinized.

Several years ago Michigan developed a basic framework for quality assessment, and the quality management considerations for specialty PHPs are embedded in this established approach. The approach focuses on both prospective assurances of quality (structures and processes) and concurrent indicators of process, performance and outcomes.

T The specialty PHP must meet certain prospective assurances of quality, including certification or accreditation, certified rights system, evidence of an operational internal quality management system, an established health information system to support quality management activities, and a history of compliance with external (MDCH) quality management and monitoring requirements (including results from past MDCH site visits).

- **T** The specialty PHP must also describe how it measures, monitors, reports, and improves certain process, performances, and outcomes on an ongoing basis, consistent with the MDCH Mission-Based Performance Indicator System. The applicant PHP must assess its compliance with the Mission- Based Performance Indicator System requirements (timeliness of data submission), describe historic performance in specified areas, and indicate corrective actions taken to address problems or variances. Consumer satisfaction data must be analyzed and assessed in the Application for Participation submission
- **T** The specialty PHP must describe how consumers, family members and the community are involved in quality management activities and processes.
- **T** The specialty PHP must indicate how network providers are integrated into the PHP's quality management system.
- **T** The specialty PHP must comply with Medicaid managed care requirements (established in the waiver approval and in federal regulations) for quality assessment and performance improvement programs.

The PHP applicant must have an information management system sufficient to support core operational activities.

- **T** The PHP must deploy and maintain information management system and data processing capabilities sufficient for collection, storage, retrieval, and reporting of required demographic, service encounter, program element and cost allocation data sets.
- **T** The information system must support authorization, utilization management and claims processing activities, and ensure timely reimbursement for approved services.
- **T** The information system should support other critical administrative, care management, quality assessment, compliance monitoring and fiscal functions of the PHP, and should interface with provider subsystems to ensure efficient collection and reporting of data.
- **T** The information management system must include protection and security features to ensure confidentiality and safeguard against data loss or corruption.
- **T** The information system must comply with HIPAA requirements for code and transaction sets, and applicable regulations for privacy and security.

The specialty PHP must demonstrate fiscal viability, prudent financial practice, and the ability to manage risk.

- **T** The applicant PHP will be required to submit audited financial statements to establish financial status, solvency and future viability.
- **T** The specialty PHP must certify that budgeting, accounting and costing systems comply with applicable state and federal laws and regulations, and are consistent with established professional standards. The financial management system must accurately track revenues and obligations, support claims processing activities, generate timely financial statements, determine appropriate cost allocations and ensure the fiscal viability of the organization.
- **T** The PHP must establish, report and track administrative costs for PHP core administrative functions.
- **T** The PHP must submit a *risk management plan* that describes PHP processes and procedures for controlling financial risk. The plan should include operational practices (authorization systems, care management activities, utilization management, third party liability recovery, network payment arrangements and provider risk management, tracking

incurred liabilities, etc.) and fiscal mechanisms (e.g. internal service fund, reinsurance, risk pools, etc.) utilized to monitor and manage uncertainty.

T The PHP must agree to comply with MDCH requirements regarding reinvestment of any savings from the managed care program.

1.4. Regulatory Management

The managed care program imposes a large number of requirements on the specialty PHP and that entity, in turn, imposes duties on subcontractors and/or affiliate members. The PHP must manage these obligations, as well as manage services.

The volume and scope of the regulations and requirements are impressive, as are the consequences of non-compliance. Adverse health and safety outcomes, rights violations, administrative hearings, fraud and abuse, monetary sanctions, and loss of contract are just some examples of what can result from ignorance, neglect or simple non-compliance. Regulatory management is a proactive, preventive approach to identifying, monitoring and controlling the risks associated with complex duties, obligations, rules, regulations, and requirements.

Regulatory management is also one of those activities that can be performed more efficiently and effectively as a regional function, rather than individually through smaller decentralized structures. The regulatory environment is complex, and managing these complexities requires certain expertise, infrastructure and monitoring systems that are expensive to develop and maintain on a small scale.

The Application for Participation will inquire into the regulatory management practices of the applicant PHP, assessing PHP understanding of critical obligations, duties, liabilities and risks, monitoring and measurement processes utilized to detect hazards and patterns, and strategies employed to prevent and/or correct emerging compliance problems.

T The PHP must describe established processes and practices for ensuring regulatory compliance. This account must indicate where regulatory management and compliance responsibilities are located in the organization, what analytic resources are devoted to regulatory identification, comprehension, interpretation, and dissemination, and how compliance monitoring activities are carried out.

T The PHP must describe the "tools" it uses to promote regulatory compliance, including information dissemination, technical assistance, surveys, voluntary commitments, review teams, compliance audits and enforcement (sanctions) activities.

T The PHP must provide its assessment of high-risk compliance areas, citing specific regulations, likelihood of adverse occurrences, frequency or volume of activities, and severity of consequences for non-performance. The PHP must indicate how it approaches regulatory and risk management in these areas.

Section II

Mental Health and Substance Abuse Services
Application for Participation
Readiness Checklist

The Readiness Checklist provides a guide to the documentation that needs to be assembled to show evidence that the CMHSP can meet the department's criteria. The AFP will build on this checklist by indicating what documentation must be submitted to the department, and which documentation must be available locally in the event there is an on-site readiness review. The AFP will also indicate the relative weighting of the items to be scored.

I. Qualifying Criteria

1.1. Organizational Status and Configuration

All CMHSPs making - or participating in - an application submission must:

1.1.1. document the involvement of primary consumers, family members, and advocates in the development and approval of the response to the AFP and:

1.1.1.1. provide a plan for ongoing involvement of primary consumers, family members, and advocates in the implementation of the resulting contract

1.1.2. be legally established and operating as a Community Mental Health Services Program (CMHSP), in one of the forms described in statute (Act 258 of the Public Acts of 1974 as amended)

1.1.3 comply with the Mental Health Code, Section 222(1) requirements on Board membership composition and a broad and diverse representation of the community

1.1.4. be certified per the Mental Health Code requirements

1.1.5. must have a certified recipient rights system

1.1.6 meet the minimum covered lives criterion:

1.1.6.1: Standalone applicants must have a minimum of 20,000 covered lives

1.1.6.2: Consolidated applicants must have a minimum of 20,000 covered lives within their combined geographic service area

Consolidated applications only:

1.1.6. Affiliate members must meet applicable contiguity standards in Public Act No. 60 or Public Acts 2001 unless otherwise stipulated by other acts of law

1.1.7. Define the vision and values of the participating organizations that:

1.1.7.1. describe how the affiliation arrangement will actualize this vision and build upon the existing strengths of member organizations

1.1.7.2. indicate how functional integration - to achieve economies of scale in administrative activities - will be accomplished.

. 1.1.8. CMHSPs must have established a legal affiliation arrangement under the Intergovernmental Contracts Between Municipal Corporations Act (ICA), the Intergovernmental Transfer of Functions and Responsibilities Act (ITFRA), or the Urban Cooperation Act (UCA)

1.1.8.1. The legal agreement establishing the affiliation must be submitted as an attachment to the consolidated application and it must specify:

1.1.8.1.1. the relationship between the parties

1.1.8.1.2. the roles of each party

1.1.8.1.3. rights of each party

1.1.8.1.4. governance issues

1.1.8.1.5. functional consolidation of administrative activities including fiscal management, rights protection, information management, and quality management

1.1.8.1.6. assurances that affiliate members will comply with federal and state standards and regulations; and that

1.1.8.1.6.1. there are processes for addressing any non-compliance

1.1.8.1.7. financial interests of each party, including:

1.1.8.1.7.1. cost-sharing

1.1.8.1.7.2. cost-allocation methodologies

1.1.8.1.7.3. local match obligations related to Medicaid funds, fund transfers, repurchase (contracting back) agreements

1.1.8.1.7.4 resource/asset claims, liability obligations, risk obligations and risk management

1.1.8.1.7.5 contingencies, limitations, and exclusions.

1.1.8.1.8. dispute resolution mechanisms

1.1.9. Member boards must maintain local representation, stakeholder participation, accessibility, participation, accountability, collaboration, and fulfillment of public policy and public interest responsibilities

1.1.10. Affiliations formed under the Intergovernmental Contracts Between Municipal Corporations Act or Intergovernmental Transfer of Functions and Responsibilities Act that submit a consolidated application must identify or designate a single CMHSP within the affiliation to act as the applicant

Each applicant must be prepared to:

1.1.11. Describe how it will execute administrative obligations of a specialty PHP

1.1.12. Describe other roles (e.g. service provider) that it intends to fulfill in the managed care program and how any apparent conflict of interest would be resolved

CMHSPs planning to subcontract or outsource any PHP administrative responsibilities (e.g., authorizations, claims payment) must have a description of:

1.1.13. the process for the vendor selection

1.1.14. the scope of contractor activities

1.1.15. the integration of vendor functions with other PHP administrative duties performed by the CMHSP or other subcontractors

1.1.16. foreseeable or potential conflict of interest situations relative to outsourcing arrangements

CMHSPs planning to be a provider of direct services must have:

1.1.17. an organizational configuration or structural arrangement that:

1.1.17.1. preserves the integrity of beneficiary interests and public policy objectives in the event these conflict with provider interests of the agency

1.1.17.2. requires separate reporting responsibilities and lines of authority for PHP functions and provider activities

1.1.17.3. requires special independent oversight structures (consumer, family, advocate organizations representation).

II. Scoring Criteria

Note: in this section the PHP needs to be prepared to submit or have available for state review, for each function: descriptions, examples, defensible numbers served, FTEs dedicated, and costs. In addition, PHPs that are affiliations must be prepared to specify how these functions will be addressed in the affiliation agreement; how the performance of affiliate members will be monitored and improved; how the functions will be consolidated across the affiliation regardless of funding streams (Medicaid, block grants, general fund, etc.); and how the affiliation will ensure among its members uniformity of policies, procedures, and practice (e.g., health and safety, person-centered planning, grievance and appeals, customer services, after-hours coverage, and access).

1.2. Public Policy Management and Public Interest Considerations

Stakeholder and Community Input

1.2.1. Opportunities for stakeholder and community input and their involvement in policy formulation and implementation must be available through:

1.2.1.1. existing advisory boards

1.2.1.2. scheduled community meetings

1.2.1.3. local press coverage of services and activities

1.2.1.4. self-disclosure by consumer members of CMHSP board and other advisory committees

1.2.1.5. other opportunities

1.2.2. Interested parties should represent the scope and diversity of the community

1.2.3. The names of key local individual advocates and advocacy groups must be available

1.2.3.1.and any arrangements for ongoing dialogue, meetings, consultation with these individuals and entities

Person-centered Planning Policy Implementation

1.2.4. Assess how the CMHSP, and each affiliate member have:

1.2.4.1. integrated person-centered planning into all organizational practices.

1.2.4.2. supported its implementation

For example, those staff who support and those who develop plans with people receiving services should be able to answer the seven following questions: (1) What is important to the person? (2)What is important for the person? (3) Is what is important for the person being addressed in the context of what is important to the person? (4) Is there a "good" balance between what is important to the person and what is important for the person? (5) What does the person want to learn, what else do we need to learn? (6) What needs to stay the same (be maintained or enhanced?) (7) What needs to change?

Care Management

1.2.5. There must be a policy basis that insures consistency across the applicant's area in the provision of supports coordination and case management options for consumers

1.2.6. Prepare an analysis of changes in service delivery system patterns over the last three years (October 1998 – September 2001) across populations (MI, DD, SA, co-occurring, ages, cultural backgrounds):

1.2.6.1. increased use of flexible options

1.2.6.2. more consumer-operated services

1.2.6.3. greater choice

1.2.6.4. self-determination arrangements

1.2.6.5. increase in independent living situations

1.2.6.6. increase in employment opportunities

1.2.7. Analyze the numbers and demographics of persons from the CMHSP (and the affiliate members) currently in state institutions:

1.2.7.1. compare institutional usage over the last three years

1.2.7.2. develop plans for providing community-based alternatives for the populations no longer needing institutional care

Employment

1.2.8. The PHP and affiliate members must demonstrate affirmative efforts to increase agency and subcontractor employment of consumers, and be able to:

1.2.8.1. identify any agency organizational units specifically dedicated to consumer interests and staffed by consumers and/or family members

Accommodations

1.2.9. Compile the PHP's policies that ensure access by persons with:

1.2.9.1. Limited-English Proficiency

1.2.9.2. diverse ethnic or cultural backgrounds

1.2.9.3. communication impairments

1.2.9.4. mobility constraints

Rights

1.2.10. The PHP and its affiliate members must assure standardized access to and response from:

1.2.10.1. Office of Recipient Rights

1.2.10.2. Local appeal and grievance mechanisms,

1.2.10.3. Administrative Hearings

1.2.10.4. Use information from the complaints to improve the service delivery system

Health and Safety

1.2.11. Assure there are policies for each below, a record of actions taken, and the mechanisms to reduce occurrences:

1.2.11.1. sentinel events
1.2.11.2. health and safety critical incidents

Public Interest

1.2.12. Review the applicant's provisions for:
1.2.12.1 crisis stabilization and response services
1.2.12.2. Pre-admission Screening Unit(s)
1.2.12.3. Children's Diagnostic and Treatment Program

1.2.13. Assess cultural and ethnic characteristics of the service area, and
1.2.13.1. efforts to ensure culturally appropriate and competent services

1.2.14. Identify jail diversion policies and activities for the period 10/1/98-9/30/01
1.2.14.1. the number of people diverted, and
1.2.14.2. the impact of these interventions

1.2.15. Assess community concerns or complaints related to protection, safety, and security

Coordination and Collaboration

1.2.16. The PHP and its affiliate members must have evidence of participation in the local Multi-Purpose Collaborative Body, and
1.2.16.1. Involvement in other collaborative enterprises (Early-On, Strong Families -Safe Children), with special attention to any formal linkages (written agreements) with:
1.2.16.1.1. the juvenile justice system
1.2.16.1.2. child welfare system
1.2.16.1.3. local education system

1.2.17. Account for any pooled funding arrangements or joint-service ventures with other community agencies across the service area

1.2.18. Describe the relationship between the CMHSP (or affiliated CMHSPs) and the local substance abuse Coordinating Agency:
1.2.18.1. sub-contracting arrangements for Medicaid funds
1.2.18.2. coordination of services
1.2.18.3. joint-efforts to address co-occurring disorders
1.2.18.4. any anticipated changes in the relationship

Agency Practices

1.2.19. Review the following policies and be prepared to give examples of how they were implemented by the PHP and its affiliates for persons with serious mental illness, serious emotional disturbances, developmental disabilities and addictive disorders:
1.2.19.1. recovery
1.2.19.2. self-determination
1.2.19.3. community linkages
1.2.19.4. relapse prevention
1.2.19.5. promotion of effective freedom

1.2.20. Identify all of the following activities undertaken in the last twelve months:
1.2.20.1. information and education
1.2.20.2. consultation
1.2.20.3. prevention (indirect models)
1.2.20.4. outreach
1.2.20.5. early intervention
1.2.20.6. other community benefit activities

Reinvestment

1.2.21. Prepare an account of how were state general fund and Medicaid savings were reinvested over the past three years and

1.2.21.1. assess how (include percent of funds) the reinvestment strategy promoted beneficiary or consumer well-being or reflected public interest considerations

1.3. Administrative Capabilities and Management

Access to Care

1.3.1. Compare the PHP's capabilities under access to federal and state timeliness standards for:

1.3.1.1. crisis response
1.3.1.2. pre-admission screening
1.3.1.3. routine service requests
1.3.1.4. distance to programs in urban and rural areas

1.3.2. The following "enabling services" should be in place:

1.3.2.1. information, education, and outreach
1.3.2.2. language, cultural, and demographic accommodations

1.3.3. The access system must facilitate beneficiary entry into the specialty care system across population groups and the service area and

1.3.3.1. establish eligibility for specialty care
1.3.3.2. determine condition and situation
1.3.3.3. respond to immediate problems or circumstances
1.3.3.4. gather preliminary information regarding beneficiary needs and aspirations
1.3.3.5. ensure that potential beneficiaries are not inappropriately denied access to assessment

Person-centered Planning Practices

1.3.4. Be prepared to describe how beneficiaries are informed of their right to person-centered planning, including:

1.3.4.1. options for abbreviated person-centered planning approaches in emergency or urgent situations
1.3.4.2. options for external facilitation [Information about PCP facilitation will be issued by the department]

1.3.5. Determine how the PHP and its affiliate members:

1.3.5.1. assessed the success of PCP implementation
1.3.5.2. made improvements in the implementation based on assessment
1.3.5.3. have complied with the 17 elements of person-centered planning in the past three years
1.3.5.4. have initiated independent or external PCP facilitation
1.3.5.5. monitor processes to insure implementation of PCP
1.3.5.6. take corrective actions to ensure full compliance with PCP standards
1.3.5.7. provide or arrange for training of staff in PCP

Service Authorization

1.3.6. Indicate the method by which service authorizations are approved and reviewed regarding:

1.3.6.1. adequacy
1.3.6.2. appropriateness
1.3.6.3. duration
1.3.6.4. coverage obligations (utilization management system)

Appeals and Grievances [Note: there will be additional criteria following the department's analysis of Balanced Budget Act of 1997 recently published rules for public comment]

1.3.7. Describe the process for beneficiary notice of appeal and fair hearing rights regarding:
- 1.3.7.1. coverage determination decisions
- 1.3.7.2. service and support authorizations
- 1.3.7.3. changes, alterations, modifications or termination of services

Case Management

1.3.8. The PHP must analyze:
- 1.3.8.1. the availability of and conditions for provision of supports coordination or case management services
- 1.3.8.2. beneficiary options related to supports coordination and case management arrangements
- 1.3.8.3. organizational safeguards against conflict-of-interest or principal-agent problems in the provision of supports coordination or case management services

Service Array

1.3.9. The PHP must document that all covered services are available to eligible beneficiaries as necessary and authorized, and:
- 1.3.9.1. provide a comprehensive description of the size, scope, and capacity of all covered services, and
- 1.3.9.2. describe how these services are provided in a culturally and age appropriate and competent manner to beneficiaries requiring such accommodation

1.3.10. Be prepared to describe the covered corrective and ameliorative services provided to beneficiaries referred to the PHP subsequent to an EPSDT evaluation by a primary EPSDT screener, and
- 1.3.10.1. how the PHP coordinates transportation for EPSDT participants through the beneficiary's QHP or through the Family Independence Agency

1.3.11. Evaluate the likely demand for care:
- 1.3.11.1. estimating the expected utilization of particular covered services
- 1.3.11.2. calculating the numbers and types of providers and provider organizations necessary to meet demand and utilization predictions
- 1.3.11.3. identifying highly specialized providers necessary to address:
  - 1.3.11.3.1. special needs (such as age-appropriate)
  - 1.3.11.3.2. cultural diversity
  - 1.3.11.3.3. other unique conditions or situations of the beneficiary population

1.3.12. The PHP and its affiliate members must demonstrate how it will meet the minimum lives requirement in its provision of ACT, PSR, Home-based services, and consumer-run programs

1.3.13. Indicate how out-of-area services are arranged and authorized
- 1.3.13.1.explain how it handles beneficiary requests to utilize out-of-network providers

1.3.14. Define the procedures for handling circumstances of beneficiary special need, when the PHP does not have a network provider qualified to address the situation.

1.3.15. The PHP must provide assurance that specific covered services meet state established "structural integrity" and "model fidelity" criteria developed for those programs:
- 1.3.15.1. Consumer-run Programs
  - 1.3.15.1.1. describe organizational capacity to develop and foster consumer-run programs.
  - 1.3.15.1.2. describe consumer-run programs available in the service area.
- 1.3.15.2 Clubhouse
  - 1.3.15.2.1. describe clubhouse admission and selection criteria .

1.3.15.2.2.provide the number of active members (defined by at least one day of attendance a month) who were employed in full or part time work in the last six months; of those, identify the number of members employed in CMH settings

1.3.15.2.3. describe recruitment strategies or program components targeted at attracting persons with serious mental illness living independently

1.3.15.3 Home-based Services

1.3.15.3.1. describe the availability of home-based services in the service area

1.3.15.3.2. describe how family members are involved in the planning, development and delivery of home-based services

1.3.15.4 ACT

1.3.15.4.1. describe ACT admission and selection criteria used to identify individuals appropriate for assertive community treatment

1.3.15.4.2. describe how ACT services are utilized to decrease use of psychiatric inpatient , crisis residential and supervised residential.

1.3.15.4.3. identify the number of persons served by ACT in the last fiscal year and the number of psychiatric inpatient admissions, re-admissions and length of inpatient stay

1.3.15.4.4. (For multiple county service areas or out of network provider arrangements) describe the geographic area served by the team and assurances that services are accessible throughout the service area.

Customer Services

1.3.16. Develop a comprehensive account of the beneficiary services operations including:

1.3.16.1. a description of how required informational material is produced and disseminated

1.3.16.2. policies and procedures for handling beneficiary inquiries and complaints

1.3.16.3. the role of customer services in the grievance and appeals processes

1.3.16.4. how it integrates consumer and informal caregivers (family members) into its beneficiary services operations, with specific attention to:

1.3.16.5.1. consumer assistance or consumer advocacy programs

1.3.16.5.2. special organizational units (e.g., Office of Consumer and Family Relations, etc.) created to address consumer issues, employment of consumers and family members to provide beneficiary services, and/or the use of ombudsman arrangements

1.3.16.5. how customer services efforts have improved consumer access

1.3.16.6. a description of the quality improvements made organizationally as a result of customer services operations

1.3.16.7. a description and/or policy reflecting how access to customer services is assured for all people located in the service area

Self-Determination

1.3.17. Be prepared to submit a plan for the implementation of the self determination policy or a description of the status of current implementation with:

1.3.17.1. proposed or current numbers served and their demographics

1.3.17.2. an analysis of the successes and challenges

Provider Network: Configuration, Selection, Management [Note: there will be additional criteria following the department's analysis of Balanced Budget Act of 1997 recently published rules for public comment]

<u>PHP with fewer than 100,000 covered lives</u> (PHPs with more than 100,000 lives skip to section 1.3.19)

1.3.18 (1.3.2.1 in Guide) Be prepared to submit a <u>network development plan</u> that:

1.3.18.1. clearly articulates, based on the PHP's assessment of required provider network capacity:

1.3.18.1.1. the composition

1.3.18.1.2. structure
1.3.18.1.3. characteristics

1.3.18.2. establishes a clear rationale for the PHP's approach to provider selection

1.3.18.3. indicates the method(s) the PHP will use to acquire specific services or an integrated set of services (e.g., RFP, competitive contracting, open enrollment, sole-source arrangement, etc.)

1.3.18.4. explains the rationale (e.g., quality, availability, consumer preferences, coordination considerations, comparative costs inclusive of transaction costs, Comprehensive Specialty Services Network (CSSN) status, etc.) for employing particular selection methods for various services

1.3.18.5. describes how consumer choice considerations have been incorporated into the network configuration and selection strategies

1.3.18.6. describes how consumer-operated and consumer-directed services are:

1.3.18.6.1 promoted
1.3.18.6.2. supported
1.3.18.6.3. developed
1.3.18.6.4. contracted

1.3.18.7. includes a cultural assessment of itself and its provider network that addresses the ethnic/cultural/racial profile of the geographic area served; compliance with Title VI of the Civil Rights Act of 1964 as delineated in the guidance published August 30, 2000 in the Federal Register by the Health and Human Services Office for Civil Rights regarding language assistance for persons with Limited English Proficiency:

1.3.18.7.1. major strengths of the applicant organization and its provider network regarding the provision of culturally competent and linguistically appropriate services
1.3.18.7.2. major weaknesses and planned efforts to address these weaknesses

1.3.18.8. indicates how non-network providers (nominated by consumers or proposed in self-directed service arrangement or otherwise needed to meet a special individual need) are accommodated in the network

1.3.18.9. shows evidence of input from community members

1.3.18.10. accommodates reasonable choice for case management, supports coordination, physician-psychiatry services and personal care assistance

1.3.18.11. addresses principal-agent issues relative to these particular "enabling" services

1.3.18.12. describes organizational safeguards or structural arrangements (e.g., separate case management or support coordination agencies, choice among agencies, etc.) that mitigate such risks

1.3.18.13. indicates how the PHP provides integrated care for individuals with co-occurring psychiatric and substance abuse disorders

<u>PHPs with greater than 100,000 Covered Lives</u> [Note: there will be additional criteria following the department's analysis of Balanced Budget Act of 1997 recently published rules for public comment]

1.3.19. (1.3.2.2 in Guide) Be prepared to submit a network <u>development plan</u> that:

1.3.19.1. describes how Provider Sponsored Specialty Networks (PSSNs) will be configured (e.g., scope of services, geographic range, variations by target population, etc.)

1.3.19.2. describes how existing community-based organizations and essential provider organizations will be integrated into the PSSNs

1.3.19.3.explains the proposed structure and functions of PSSNs (e.g., entity status, governance, consumer and family representation, administrative responsibilities, clinical obligations, legal and liability issues, delegation, risk sharing arrangements, etc.)
1.3.19.4. describes any anticipated "default" geographic responsibilities of the PSSNs
1.3.19.5. describes consumer options to choose between PSSNs
1.3.19.6. describes how the PSSNs will be recruited and selected
1.3.19.7. if the specialty PHP elects to keep certain services outside of the PSSN scope of responsibility, assesses how this will affect coordination of care and the alignment of incentives within the system
1.3.19.8. indicates how culturally and linguistically specific services will be accommodated

1.3.20. All specialty PHP applicants will be asked to submit a network management plan that:
1.3.20.1. describes contracting processes and specifications for network providers
1.3.20.2. establishes:
1.3.20.2.1. contracting practices that facilitate appropriate delegation of relevant administrative, service and performance requirements
1.3.20.2.2. provisions for dispute resolution
1.3.20.2.3. contracts that are executed in a timely manner
1.3.20.2.4. provisional or transitional contracts are used only under carefully delineated circumstances.
1.3.20.3. describes how provider contracts are made available to the public for inspection
1.3.20.4. includes the history since 10/1/98 of the PHP's disputes with contractors and the resolution of those disputes
1.3.20.5. includes PHPs policies and procedures for credentialing providers for network participation
1.3.20.6. is accompanied by a provider manual that includes all:
1.3.20.6.1. policies
1.3.20.6.2. procedures
1.3.20.6.3. forms
1.3.20.6.4. instructional materials
1.3.20.6.5. other information used to support and supervise network operation.
1.3.20.7. describes all provider payment arrangements (e.g., rates, schedule for payments, risk assumption, third-party liability collections, incentive systems, etc.).
1.3.20.8. indicates how the PHP supervises subcontractor performance:
1.3.20.8.1. the standards used to support such monitoring
1.3.20.8.2. tracking methods
1.3.20.8.3. corrective measures and sanctions
1.3.20.8.4. family and consumer involvement in monitoring provider performance
1.3.20.8.5.public access to provider performance characteristics

Quality Management
1.3.21. The specialty PHP must have:
1.3.21.1. evidence of an operational internal quality management system
1.3.21.2. evidence of an established health information system to support quality management activities
1.3.21.3. a history of each affiliate member's scores from MDCH site visits during the period 10/1/98 to 9/30/01
1.3.21.3.1. actions taken to improve compliance when citations on the same dimensions have continued for more than one year
1.3.21.3.2. a plan for how affiliate members that have continuing citations will be brought into compliance
1.3.21.4. a description of how the PHP and its affiliate members:

1.3.21.4.1. measure, monitor, and report on performance indicators consistent with the MDCH Mission-Based Performance Indicator System (MBPIS)
1.3.21.4.2. improve the processes, performances, and outcomes on an ongoing basis; specifically the outcomes important to consumers:
1.3.21.4.2.1. Employment
1.3.21.4.2.2. Independent living
1.3.21.4.2.3. Inclusion in the community
1.3.21.4.2.4. Recovery
1.3.21.4.3. have met the timeliness standards for data submission

1.3.21.5. description of historic (10/1/98-9/30/01) performance by affiliate members on all MBPIS standards
1.3.21.5.1. indicating corrective actions taken to address problems or variances
1.3.21.5.2. including plans to bring areas of continuing non-compliance with standards into compliance

1.3.21.6. an analysis of local consumer satisfaction survey data

1.3.21.7. a description of how consumers, family members and the community are involved in quality management activities and processes that includes:
1.3.21.7.1. numbers of consumers, family members, and interested parties involved, and how they reflect the demographics of the area
1.3.21.7.2. numbers and types of activities

1.3.21.8. an indication of how network providers are integrated into the PHP's quality management system

1.3.21.9. evidence of compliance with Medicaid managed care requirements (established in the waiver approval and in federal regulations) for quality assessment and performance improvement programs (QAPIP) that includes:
1.3.21.9.1. a brief description of the status of the two mandatory performance improvement projects and other projects the PHP and/or its affiliates chose
1.3.21.9.2. a list of locally-developed performance indicators and results

Information System

1.3.22. The PHP must examine the sufficiency of its (or its vendor's, if applicable) information management system to support core operational activities of the affiliation, including:
1.3.22.1. how it deploys and maintains an information management system and data processing capabilities sufficient for:
1.3.22.1.1. collection, storage, retrieval, and reporting of all required data for all its affiliate members: demographic, service encounter, program element and cost allocation data sets

1.3.22.2. how it supports authorization, utilization management and claims processing activities

1.3.22.3. how it ensures timely reimbursement for approved services

1.3.22.4. how it supports other critical administrative, care management, quality assessment, compliance monitoring and fiscal functions of the PHP

1.3.22.5. how it interfaces with provider subsystems to ensure efficient collection and reporting of data

1.3.22.6. protection and security features to ensure confidentiality and safeguard against data loss or corruption

1.3.22.7. a plan for complying with HIPAA requirements for code and transaction sets, and applicable regulations for privacy and security

1.3.22.8. status on compliance with the state Uniform Billing Project

Fiscal Management

1.3.23.The PHP must demonstrate fiscal viability, prudent financial practice, and the ability to manage risk by:

1.3.23.1. submitting audited financial statements to establish financial status, solvency and future viability

1.3.23.2. certifying that budgeting, accounting and costing systems comply with applicable state and federal laws and regulations, and are consistent with established professional standards

1.3.23.3. showing how the financial management system accurately:

1.3.23.3.1. tracks revenues and obligations

1.3.23.3.2. supports claims processing activities

1.3.23.3.3. generates timely financial statements

1.3.23.3.4. determines appropriate cost allocations

1.3.23.3.5. ensures the fiscal viability of the organization.

1.3.23.4. establishing, reporting and tracking administrative costs for PHP core administrative functions

1.3.23.5. submitting a risk management plan that describes PHP processes and procedures for controlling financial risk and includes:

1.3.23.5.1. operational practices (authorization systems, care management activities, utilization management, third party liability recovery, network payment arrangements and provider risk management, tracking incurred liabilities, etc.)

1.3.23.5.2. fiscal mechanisms (e.g. internal service fund, reinsurance, risk pools, etc.) utilized to monitor and manage uncertainty

Substance Abuse

[Note: if the PHP will not be contracting with an existing substance abuse coordinating agency(ies) for management or services oversight, but will instead perform these functions, the PHP must provide all information below. If the PHP will contract with an existing coordinating agency(ies) for substance abuse services, complete items 1.3.26, 1.3.27 and 1.3.28]

1.3.24. Be prepared to describe the PHP's experience in managing substance abuse services, including:

1.3.24.1. administration of covered services (including knowledge of methadone) 1.3.24.2. confidentiality

1.3.24.3. recipient rights

1.3.24.4. licensing rules

1.3.24.5. collection of data (admission, discharge, activity, performance indicators, sentinel events)

1.3.24.6. linkages with primary health, juvenile justice, local courts, Family Independence Agency, Michigan Department of Corrections, housing, employment, education, and local Public Health agencies

1.3.24.5. a description of how substance abuse treatment recipients and advocates will be included in policy and planning decisions for substance abuse

1.3.25. If applicable, prepare an account of the PHP's history as a substance abuse services provider (contractor)

1.3.26. List all substance abuse Medicaid services to be provided under the PHP (or affiliated member) contract with the state

1.3.27. List the current license numbers issued by the Michigan Department of Consumer and Industry Services applicable to the services listed in 4.3.24. above, and:

1.3.27.1. enclose a copy of the notification of accreditation (on awarding agency letterhead) specific to a drug and alcohol program for each of the respective agencies listed in 1.3.26. three above with the effective dates for accreditation

1.3.28. Describe the relationship(s) that ensure continuity of care across the region, with existing substance abuse Coordinating Agency(ies) which have oversight for public sector non-Medicaid services for any county within the PHP's region, including:

1.3.28.1. agency names
1.3.28.2. length of relationship(s)
1.3.28.3. nature of relationship
1.3.28.4. population covered (Medicaid or non-Medicaid)

1.3.29. Develop a detailed narrative plan on how the PHP will successfully address the following:

1.3.29.1. providing or contracting for covered services (mandated) including:

1.3.29.1.1. client choice of provider
1.3.29.1.2. geographic accessibility
1.3.29.1.3 plans to provide allowable services
1.3.29.1.4. how individual treatment planning will have an impact on this determination.

1.3.29.2. transition of Medicaid funded clients from existing Coordinating Agency responsibility to the proposed PHP as of October 1, 2002.

1.3.29.3 development of provider panel and establishment of rates for services, including:

1.3.29.3.1. areas where rates for similar services will be different than the same services for non-Medicaid services contracted by a regional Coordinating Agency with the same provider
1.3.29.3.2 the rationale if an existing Medicaid contractor will be significantly financially adversely impacted by redistribution of existing services or rate development

1.3.29.4. coordination with the Coordinating Agency of service delivery for clients who may move from Medicaid to non-Medicaid public sector-funded and vise versa (monthly determination), including a description of :

1.3.29.4.1 assessment and referral
1.3.29.4.2 client service information
1.3.29.4.3. case management
1.3.29.4.4. referrals
1.3.29.4.5. follow-up information

1.4. Regulatory Management

1.4.1. The PHP must have established processes and practices for ensuring regulatory compliance, indicating:

1.4.1.1. where regulatory management and compliance responsibilities are located in the organization
1.4.1.2. what analytic resources are devoted to regulatory identification, comprehension, interpretation, and dissemination
1.4.1.3. how compliance-monitoring activities are carried out

1.4.2 Compile the "tools" used to promote regulatory compliance, including:

1.4.2.1. information dissemination
1.4.2.2. technical assistance
1.4.2.3. surveys
1.4.2.4. voluntary commitment to compliance
1.4.2.5. review teams and compliance audits
1.4.2.6. enforcement (sanctions) activities.

1.4.3. Assess high-risk compliance areas:

1.4.3.1. citing specific regulations

1.4.3.2. likelihood of adverse occurrences
1.4.3.3. frequency or volume of activities
1.4.3.4. severity of consequences for non-performance
1.4.4. Consider how it approaches regulatory and risk management in these areas
1.4.5. Develop a plan for compliance with:
1.4.5.1. HIPAA transaction standards (by 10/01/02)
1.4.5.2. HIPAA privacy rules (by 3/03)
1.4.5.3. Balanced Budget Act of 1997

SECTION III

MICHIGAN'S MANAGED SPECIALTY SERVICES PROGRAM: THE 1915(8) AND 1915(c) WAIVERS

On February 20, 2001, the federal Centers for Medicare and Medicaid Services (CMS) - formerly known as the Health Care Financing Administration (HCFA) approved Michigan's request to renew its 1915(b) Medicaid waiver for managed specialty services and supports. In approving the waiver renewal submission, the Centers for Medicare and Medicaid Services also granted the state's request for a continued deviation from federal open procurement requirements, so that the state could implement its "Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans," which was transmitted to CMS as part of the waiver renewal submission.

Michigan's 1915(b) Medicaid Managed Specialty Services and Support program waiver was initially approved by the federal government in June 1998. Under the waiver, nearly all Medicaid state plan specialty services related to mental health and developmental disability services, as well as outpatient substance abuse services, have been "carved out" (removed) from Medicaid primary physical health care plans and arrangements and placed under the management of specialty care Prepaid Health Plans (PHPs).[4] The 1915(b) program was designed to operate in conjunction with Michigan's already existing 1915(c) Habilitation Supports Waiver for persons with developmental disabilities. Michigan is one of a handful of states that have opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a broad continuum of community services and supports for targeted disabled individuals. The combined managed care program was implemented in October 1998.

Utilizing the federal exemption, the department currently contracts - on a sole source basis - with Michigan's 49 county-sponsored Community Mental Health Services Programs (CMHSPs), to serve as the specialty PHPs and manage Medicaid state plan specialty mental health, substance abuse and developmental disabilities services - as well as 1915(c) Habilitation Supports waiver services - on a prepaid, shared-risk basis. Under existing arrangements, CMHSPs sub-contract with regional substance abuse Coordinating Agencies (CAs) to manage Medicaid substance abuse benefits under the waiver.

With the implementation of the managed specialty services and supports program, multiple sources of public funding (Medicaid, state general fund appropriations, federal block grant dollars, etc.) that 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 care program, CMHSPs receive Medicaid "capitation" payments, along with state allocations, federal grants and other public funds, and in return are obligated to provide medically necessary specialty services to Medicaid beneficiaries and designated priority populations (within the limits of appropriated funds) who reside in the service area and need specialized care. The CMHSPs are at partial-risk if the cost of providing such care exceeds the payments that they receive from the state.

Medicaid 1915(b) program waivers are approved for two-year periods, and can be renewed on an ongoing basis if a state reapplies prior to the end of each two-year cycle. Medicaid 1915(c) Home and Community-Based Services program waivers are initially approved for three years, but after successful completion of the initial three-year period, the waiver may be subsequently renewed for five-year intervals.

By coincidence of timing, Michigan's 1915(b) Managed Specialty Service Waiver and the 1915(c) Habilitation Supports Waiver both came up for renewal in 2000. Staff from the regional office of The Centers for Medicare and Medicaid Services conducted site visits to assess these two waivers in June and July

[4] A specialty Prepaid Health Plan (PHP) is a managed care entity that provides Medicaid covered specialty services -under a contract with the state and on the basis of prepaid capitation fees -to beneficiaries who need such care.

2000. In the report on the 1915(b) waiver, The Centers for Medicare and Medicaid Services indicated that the review team was "...generally pleased with the State's administration of the waiver and commends the Michigan Department of Community Health (MDCH) on the great strides the Department has taken in the implementation of the program." The review report did establish a number of findings and recommendations to improve the operation and implementation of the program. The final report on the 1915(c) habilitation supports waiver indicated that "... MDCH continues to operate in full compliance with the statutory assurances of the waiver."

On October 2, 2000, the Centers for Medicare and Medicaid Services' regional office notified MDCH that it had renewed the 1915(c) waiver for an additional five-year period. The renewal of the 1915(b) waiver was delayed, however, due to the State of Michigan's request to CMS for an extension of the existing waiver while controversies regarding plans for future procurement of specialty Prepaid Health Plans were resolved. The divergent opinions within the state over the procurement issue were finally resolved in the summer of 2000, and Michigan submitted all required renewal information to the Centers for Medicare and Medicaid Services (CMS) in late September 2000. As noted above, CMS approved the renewal of Michigan's 1915(b) managed specialty service waiver - including the Revised Plan for Procurement - in February 2001.

THE REVISED PLAN FOR PROCUREMENT

In granting Michigan's initial request for a 1915(b} specialty services waiver (June, 1998) the Centers for Medicare and Medicaid Services had stipulated that within two years the state must submit "... a detailed plan to shift from sole source procurements for its Prepaid Health Plan (PHP) contracts to full and open competitive procurements which comply with the Federal procurement rules at 45 CFR Part 74." Michigan attempted to meet this condition of the initial waiver approval, but eventually concluded: "that...open and full competition for specialty PHP contracts - required by HCFA and previously agreed to by the state - is not practical at this time."[5]

In arguing against "open and full" competition, the MDCH called attention to the basic purpose of the managed specialty program - to achieve unified local system management for both Medicaid benefits and the specialty services/supports paid for through other funding arrangements. The state further noted that specialty PHPs operate within a unique institutional (legal) framework, employ particular processes and practices that promote freedom, equity, empowerment and participation for disabled individuals, and pursue distinctive (support, accommodation, community inclusion) kinds of outcomes for beneficiaries. Finally, MDCH pointed out that specialty PHPs also have singular economic characteristics - a condition of bilateral dependency between purchaser and supplier - that rendered classic market competition for these contracts unfeasible or of little utility.

As an alternative to competive procurement, MDCH indicated that it would refine its existing method for selecting specialty Prepaid Health Plans (PHPs). Specifically, MDCH proposed retention of the basic elements of the managed care program (i.e., an eligibility model for specialty services; the designation of a single specialty PHP per service area, etc.) and maintenance of the basic framework for specialty PHP selection (restrict initial consideration to CMHSPs). However, the MDCH plan submitted to the Centers for Medicare and Medicaid Services committed the state to a reduction in the number of specialty PHPs, imposition of rigorous qualification criteria, and utilization of a special selection committee (with beneficiaries, family and advocacy representation on the committee) to evaluate specialty PHP submissions from the restricted pool (CMHSPs) of initial applicants.

MDCH also promised the Centers for Medicare and Medicaid Services that "...if a CMHSP does not meet the qualifications set by MDCH and as adjudged by the committee, the area will be declared vacant in

[5] State of Michigan, Department of Community Health; Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans (September 2000), page 12.

regard to a specialty PHP and open for competitive solicitation. Both public entities and private organizations will be permitted to bid in these open regions."[6]

In the February 2001 letter approving the 1915(b) waiver renewal, the Centers for Medicare and Medicaid Services indicated that MDCH could "...implement its revised plan for procurement as provided to HCFA (CMS) in the Waiver's renewal application."

The Revised Plan submitted to the Centers for Medicare and Medicaid Services provided an outline of the qualification areas that would be evaluated in selecting specialty PHPs through the procurement process. These qualification areas and considerations included:

- *Administrative Capabilities*
- *Administrative Costs*
- *Equity Functions and Community Inclusive Practices and Outcomes*
- *Service Array*
- *Service Eligibility*
- *Provider Network Selection, Composition and Configuration*
- *Facilitating Consumer Choice and the Opportunity to Achieve*
- *Quality Management and Enforcement Actions*

Since the submission and approval of the Revised Plan, discussions with parties within the system have generated a list of other important qualifications and conditions that are interrelated to the above bullets.

IMPLEMENTATION OF THE REVISED PLAN

In January 2002, MDCH plans to release an "Application for Participation" (AFP) for specialty Prepaid Health Plans. The Application for Participation will contain all relevant specifications that must be met by Community Mental Health Services Programs (CMHSPs) seeking to be designated as the Medicaid specialty Prepaid Health Plan (PHP) - in a particular geographic service area - for contracts beginning October 2002. The completed Application for Participation will be due back to MDCH in March 2002.

Public Act 409, of the Public Acts of 2000, authorized the Governor to "...create a specialty services panel within the department of community health to review and make determinations regarding applications for participation submitted by community mental health services programs or other managing entities." The specialty service panel will assess the responses submitted by CMHSPs to the Application for Participation based upon requirements laid out within the AFP.

This paper communicates (in Section IV) current MDCH thinking regarding contents and specifications for the future Application for Participation (AFP), and the mechanics of the selection process. As noted above, it builds upon concepts first articulated in the Revised Plan for Procurement submitted to the Centers for Medicare and Medicaid Services last September. It also includes suggestions and recommendations submitted by workgroups composed of consumer, family and advocacy representatives. These workgroups were convened earlier this year by the department to solicit stakeholder perspectives on the Application for Participation.

Upon release of this implementation guide, the department will accept written reactions, comments, and suggestions from interested parties through Friday, October 26,2001. At the end of the comment period, the department will begin preparation of the final and official Application for Participation (AFP), scheduled for release in late January 2002.

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[6] Ibid, page 12

THE LARGER CONTEXT

The design of the managed specialty services program and the composition of the plan for procurement cannot be understood apart from earlier developments, and persistent policy objectives of the public system.

It is helpful to briefly consider past developments, enduring principles, policy objectives, and ongoing controversies within the publicly-funded specialty services system.

SECTION IV

A BRIEF HISTORY OF THE PUBLICLY-FUNDED SPECIALTY SERVICES SYSTEM

Purpose and Evolution of the Public System

The purpose of the publicly-funded specialty service system is to assist, support, treat, care for, and protect vulnerable individuals who have a serious mental illness, serious emotional disturbance, developmental disability, and/or an addictive disorder. The system was developed and organized to meet certain constitutional assurances and statutory directives regarding these target populations.

Originally, care in the specialty system was organized around large institutions, which were constructed to provide asylum, treatment, education, and training. The humane intentions and objectives of these facilities - conceived during a period of rapid industrialization and urbanization - were eventually overwhelmed by resource constraints. Institutions for persons with mental illness and developmental disabilities were confronted with many more "residents" than could possibly be accommodated within the available resources and facilities, and the environment in these institutions gradually became less therapeutic and educational and more regimented, bureaucratic, drab and impoverished.

In the 1970s, new attitudes toward persons with mental illness, developmental disabilities and addictive disorders -combined with legal challenges to prevailing conditions in state facilities - generated intense public discussion regarding the care, treatment and support of persons with these disabilities and conditions. Out of this dialogue, a social consensus emerged - codified in state statute - that persons with serious mental illness and developmental disabilities should be served in the "least restrictive setting", consistent with condition. In the substance abuse field, intoxication and dependency were increasingly regarded as public health problems, amenable to treatment, intervention, and prevention.

To implement the principle of least restrictive setting (reduce the census at institutions) for persons with mental illness and developmental disabilities, and to implement a public health approach to substance disorders - the state needed to establish organized systems of services and supports in communities throughout the state. Michigan (similar to other large states) concluded that this development could best be achieved by involving local units of government - counties - in the endeavor.

Counties, responding to commitments and incentives enacted in law, sponsored the creation of Community Mental Health Services Programs (CMHSPs) and regional substance abuse Coordinating Agencies (CAs). The CMHSPs became the single entry and exit point for state facilities, authorizing admissions and arranging discharges. In carrying out these responsibilities, the CMHSPs developed an array of community services to forestall facility admission, support disabled persons in the community, and to facilitate community reintegration for individuals discharged from state facilities. The Coordinating Agencies supervised the establishment and operation of a continuum of community prevention and treatment services for substance abuse.

Persons with serious mental illness, developmental disabilities and relapsing addictive disorders often have significant impairments and capacity limitations, and sustaining and accommodating these individuals in the community requires an array of care management activities, specialized treatments, rehabilitative services, and on-going supports. The spectrum of necessary services and supports must be configured into a coherent and coordinated network (a system of care) to meet the multiple and changing needs of individuals with these conditions.

A special challenge to organized, publicly-funded, community systems of care is the many different funding provisions, eligibility requirements, and benefit specifications that underwrite community-based service and support arrangements. Legal and regulatory constraints make it difficult to

implement "single stream" eligibility and funding approaches, but many states (including Michigan) have pursued an alternative method of coordination: the consolidated management of these multiple policies, programs, and payment sources through a single local (county-sponsored) entity.

Thus, throughout the 1980s and 1990s, Michigan attempted to tightly coordinate new funding sources (Medicaid, federal block grant funds, etc.), coverage options and support arrangements for these populations with the existing funding allocations, programs and service activities of the extant county-based systems of care. This tight coordination became ever more important in the early 1990s, as the state closed 15 programs at 12 state institutions and transferred funding and care responsibility for individuals in these facilities to the CMHSPs.

Toward the end of the decade, it became ever more challenging and complicated to retain (under existing regulations) the tight coordination of program, services, and funding sources. These complications - along with intense consumer interest in more flexible, individualized service options - led the state to seek out new organizational, financing and service delivery models. This search culminated in the managed specialty services program of 1998, which legitimized unified local system management, consolidated funding streams, provided incentives for more efficient administrative and care management practices, and sanctioned alternative, more flexible, service and support arrangements.

Current System Configuration

Community mental health in Michigan is an interrelated and interacting group of locally administered systems, operated by county-sponsored governmental entities and organized around specific target population groups (persons with serious mental illness, serious emotional disturbances and developmental disabilities). The existence of these county-sponsored entities and their responsibilities for particular target populations reflects the specific path - codified in statute - that Michigan chose for moving individuals from state institutions to less restrictive home and community settings. These established organizations (there are currently 49 CMHSPs) are the single entry point, care manager and local service delivery structure for the target populations residing in the service area. As noted, over the last twenty years, the state has steadily integrated certain Medicaid covered home and community services into these local management and delivery systems.

Coordinating Agencies are also designated upon county determination, established (by statute) to serve a particular target population (with substance abuse disorders). The Coordinating Agencies, however, generally cover a larger geographic service area - they are more regional in scope (there are currently 15 Coordinating Agencies). In recent years, with the implementation of the managed specialty services program, the Coordinating Agencies have managed and coordinated multiple federal (including - as subcontractors to the CMHSPs - Medicaid funds), state, and local public funding sources for substance abuse services. State policy over the last five years has also encouraged closer collaboration - and possible integration - of CMHSP and CA administrative operations.

In summary, the publicly-funded specialty services system in Michigan has been:

- *Designed around target populations (i.e., persons with serious mental illness, developmental disabilities, addictive disorders);*
- *Organized through decentralized, county-sponsored local management structures, established by statute;*
- *Supported through* a *consolidated funding arrangement, which brings together - under local management -all funding sources that underwrite community-based systems of care for these populations; and*

- *Connected to other community health and human service systems through collaborative partnership structures and formal interagency agreements.*

This "target populations/local management/consolidated funding" model has successfully concentrated community interest, stakeholder involvement, professional expertise, service delivery development, and resource deployment on the specific needs and interests of persons with mental illness, developmental disabilities, and addictive disorders. The focus on local collaboration has forged necessary linkages for care coordination and cooperative community solutions to complex situations.

Core Principles

Over the past thirty years, a consensus has emerged - established in law, preserved by judicial review, and reflected in policy - that unjustified isolation or segregation of individuals with disabilities in institutions is discriminatory and unwarranted. Thus, the contemporary specialty services system affirms the principles of community inclusion, integration, participation, and accommodation.

The system recognizes that persons with serious mental illness, developmental disabilities, and addictive disorders have certain attributes, impairments, limitations, or circumstances that constrain their functional capabilities, personal autonomy, life choices, and achievement opportunities. To reduce or minimize these constraints, the system provides various treatments, interventions, services, supports, and accommodations. In accord with basic principles, the system looks for community alternatives to more restrictive care, involves consumers in system governance, addresses cultural diversity, service planning and care decisions, promotes choice wherever possible, and seeks support arrangements that facilitate independence, personal responsibility and involvement in community life. In fostering inclusion, participation and involvement, the system acknowledges an affirmative obligation to counter stigma and limit stereotypes applied to persons with these disabilities and disorders.

Recent System Trends and Policy Developments

The publicly-funded specialty service system has steadily evolved - in recent decades - along a fairly predictable and recognizable path. The trajectory of the system has clearly been moving away from prolonged institutional care and toward community-based service alternatives. Management of the system has devolved from the state to decentralized local administration, and funding arrangements have progressively been consolidated and brought under unified local management. Consumer-directed service models have emerged as an alternative to exclusive professionally managed programs, and the provision of services and supports has become more individualized and flexible. The entire system has become more cost conscious and outcome focused during the last decade, and organizations have moved away from isolated, self-contained operation to partnerships, coordination, multi-party ventures, and community collaboration to pool resources and better address local needs.

Preferences, Expectations and Ethical Norms

Besides the basic friction over priorities, eligibility, resources, and benefit levels, consumers and interested parties also have different *preferences, expectations, and ethical perspectives* regarding specialty care. Most interested parties agree that the specialty system should enhance the capability to function, freedom to choose and the opportunity to achieve for persons with serious mental illness, developmental disabilities and addictive disorders. However, those involved often hold different perceptions about the best way to realize these objectives, and about which ethical norms should be paramount in these endeavors.

Many feel that the consummate value in the specialty system should be *liberty, choice, and self-determination.* Other interested parties - while not disputing the importance of liberty and choice, - emphasize *health and safety* (for both the individual and the community) as the principal value, and urge pro-active interventions and regulatory oversight to achieve these ends. Still other interested parties regard *equity and social justice* considerations (access, representation, promotion of inclusion, attention to the least well off, etc.) as preeminent ethical norms for publicly-funded services. Finally, while all recognize the obligation of the specialty system to use resources wisely, some are especially attentive to the issue of *efficiency* (most useful outputs from given set of inputs) and *distributional fairness* (who benefits, who pays) of publicly-funded programs.

SECTION V

THE INTERSECTION OF PAST, PRESENT AND FUTURE

The Department of Community Health has indicated earlier in this guide -and in other publications (including the Revised Plan) - that managed care for specialty services is a *vehicle* - a device - through which particular aspirations are realized and certain results are attained. We have noted that the managed care program is a means to larger ends.

The Revised Plan for Procurement, clearly suggests that the plan endorses and is constructed around four major goals or purposes for managed specialty care. These goals are freedom, community, accountability, and efficiency.

- **T** Freedom encompasses *basic liberty protections* (constitutional and statutory restrictions against unwarranted governmental interference) as well as *effective freedom,* which is the realization of social citizenship and full community membership.

- **T** Community refers to a shift in intergovernmental relationships, in which authority, resources and decisions related to health and human service programs are transferred from state agencies to local governance *structures.* Community direction, participation, and voice are accentuated and public interest considerations are explicitly promoted. Collaboration and partnerships among community agencies are cultivated to generate creative approaches to refractory community problems.

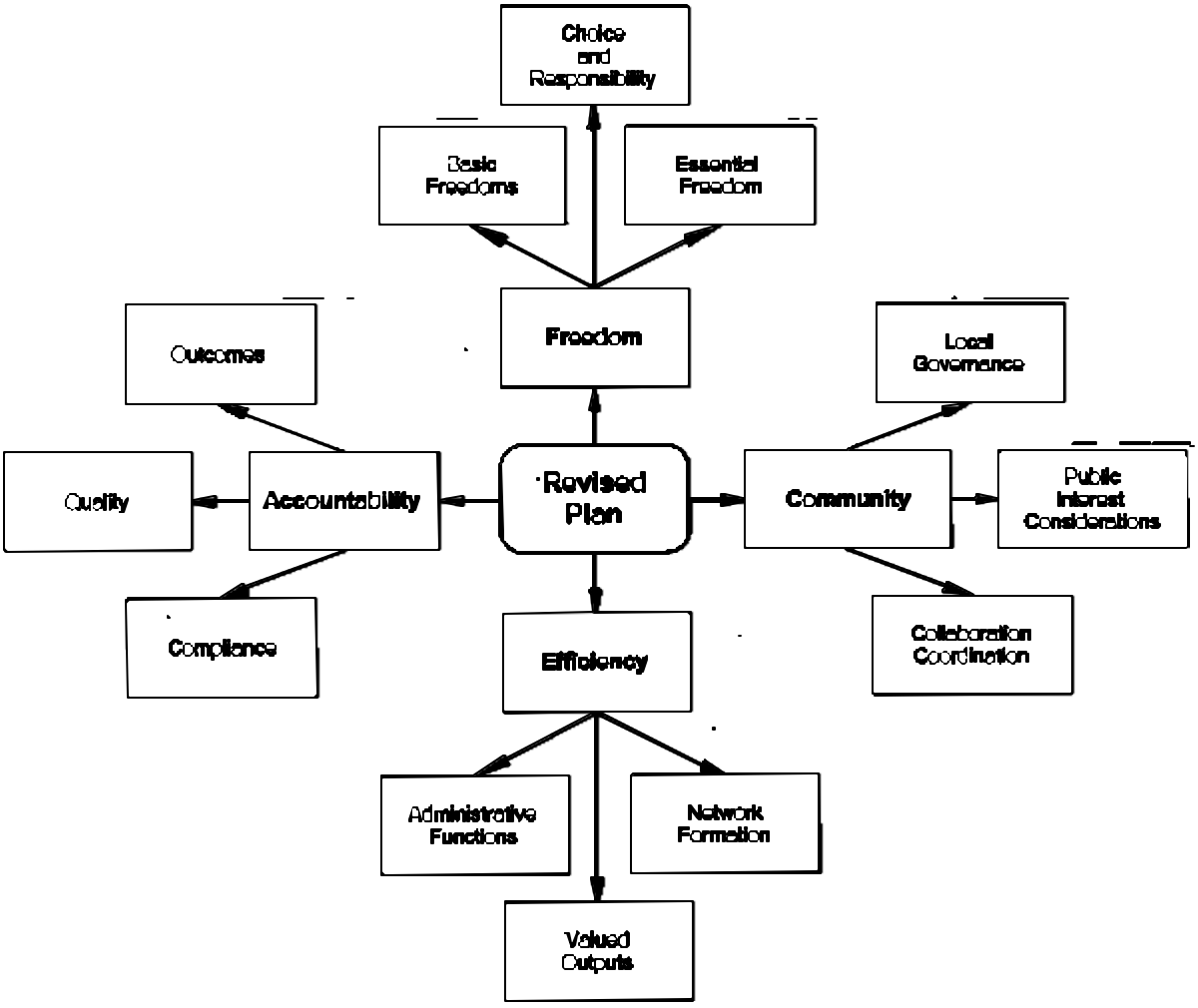
- **T** Accountability is a commitment to reach certain outcomes, achieve specified results, measure and improve quality, and ensure regulatory compliance and prudent practice. Fulfillment of the commitment is verified and pertinent data regarding activities are public and easily obtainable.

- **T** Efficiency is a many-sided concept, and assessments regarding efficiency differ depending upon the context in which it is evaluated. Relevant efficiency considerations mentioned in the Revised Plan include administrative expenditures, service production expenses, valued outputs, quality attributes and transaction costs.

Efficiency comparisons in the specialty service system are problematic due to the need to include relevant non-economic factors (inclusion, equity, justice) into the deliberations.

The four goals - and elements and aspects related to the realization of these goals -are depicted in Figure 2 below:

Figure 2: The Larger Ends of Specialty Managed Care



In this section of the guide we will link proposed qualifications and requirements of the Application for Participation (AFP) to the goals, purposes, aspirations and ends listed above. However, since the Revised Plan did not completely articulate the meaning and implications of these goals, some additional elaboration is required.

Freedom

Literature on managed care typically highlights various strategies and techniques associated with organizing services, managing utilization, controlling costs, and measuring outcomes. The consideration of freedom in a paper on selection criteria for managed care entities might seem strange to those that have not been involved with specialty populations, and who approach managed care from the standard or typical perspective.

Those involved in the specialty services system and those who appreciate the history of public policy towards persons with psychiatric and developmental disabilities and addictive disorders, however, understand all too well the reason for this preoccupation with freedom. As previously noted, neglect, oppression, segregation and discrimination have marked the history of public policy toward persons with psychiatric and developmental disabilities and addictive disorders.

Modern efforts to reverse these practices concentrated initially upon restraining and -regulating state control, through new standards for involuntary commitment, requirements for active treatment of institutionalized persons, and the establishment of the principle of "least restrictive environment".

These initial endeavors can be characterized as efforts to restore *basic freedoms* to persons with serious mental illnesses, developmental disabilities, and addictive disorders. Basic freedoms are fundamental constitutional and statutory protections that safeguard all citizens from unwarranted or overly restrictive governmental interference with personal liberty.

Efforts to re-establish basic freedoms were largely successful, as witnessed by the spate of legal decisions and statutory modifications during the 1970s and 1980s. Institutional confinement receded, replaced by community-based programs and services. In this "era of deinstitutionalization", the new community arrangements that emerged -while less coercive and restrictive than institutional care - retained significant elements of paternalism, separatism and segregation. Services were provided in the community, but the settings, practices, and processes utilized kept persons with disabilities and impairments isolated from mainstream community activities and experiences. Moreover, services were generally designed in accordance with professionally determined expectations - with limited consumer input or participation - rather than around the goals, desires, needs, and choices of the individual.

In this context, it became increasingly apparent that protection of basic freedoms for persons with psychiatric and developmental disabilities must be supplemented by affirmative actions to achieve *effective freedom.* Effective freedom refers to the realization of social citizenship and full community membership. Citizens are able to build upon basic freedoms - to effectively unlock the potential of liberty -by making choices, pursing personal goals, engaging in productive activity, establishing a wide range of associations and relationships, participating in community events, and living in real homes.

The contemporary public specialty is making the transition from the "era of deinstitutionalization" to the "era of community membership." In the former era, consumer participation was limited, and standard programmatic approaches were applied, without consideration of unique needs or personal aspirations. In the emerging era, the importance of personal agency, participation, and choice is now clearly recognized. Services and supports are intended to assist and accommodate individual efforts to achieve greater independence, self-determination, supportive relationships, valued social roles, realization of potential, wider opportunities, productive activity, and normalized living arrangements.

The public specialty service system has been moving toward the effective freedom paradigm for several years. A 1996 amendment to the Mental Health Code made "person-centered planning" a statutory requirement for all persons served through the public mental health system. In the person-centered planning process, consumers direct planning efforts, actively participate in identifying personal needs and objectives, and select and design service arrangements and supports to address their particular needs and aspirations.

The effective freedom approach has also been reflected in the department's policies on inclusion, consumerism, housing and employment, and in promotion of recovery, rehabilitation and self-

determination as core service philosophies for the specialty system. The managed care waiver further fostered the "era of community membership" and facilitation of effective freedom by liberalizing service and support definitions and increasing flexibility in care arrangements.

Beyond these efforts and accomplishments, the Revised Plan contains several provisions - which will be reflected in application requirements - to accelerate the realization of effective freedom for persons with serious mental illness, developmental disabilities, and addictive disorders. These provisions include the option for independent facilitation of person-centered planning, expansion of consumer-directed and consumer-operated service and support arrangements, and heightened attention to - and broader opportunities for - consumer choice.

It must be stressed that while the two types of freedom mentioned thus far (basic freedom and effective freedom) have obvious instrumental value (e.g., protection of rights, increased possibilities, etc.), the opportunity to make choices (the *freedom to choose)* is - in and of itself - directly conducive to personal well-being. Making choices is a fundamental attribute of personhood, and hence choice opportunities must become pervasive within the system.

Cautions, Caveats and Reservations

The emphasis upon basic freedom, effective freedom and choice does not condone abandonment or neglect of health and safety concerns. There are certainly situations in which severe mental illness temporarily erodes the person's capacity for self-determination and informed choice. Intervention in these instances and provision of essential treatments helps restore capacity and can enhance essential freedom.

There are also situations in which the exercise of freedom and choice might expose the person to significant foreseeable risks or could significantly compromise and undermine the person's well-being (health and safety). These are difficult situations, which require balancing respect for the right to choose against obligations to assure safety and protect well-being.

Community

There has much discussion over the past several years about "new federalism" - the changing relationship between the federal and state governments, as they attempt to clarify respective roles and responsibilities. "Devolution" - the transfer of responsibilities and activities from the national to state government is a significant aspect of the new federalism.

However, the other side of this transformation, the devolution of authority, funding, and responsibilities from the state to local governments, has not been as widely publicized, although it has been proceeding rapidly for many years now. Certainly, the public mental health system (CMHSPs) and the public substance abuse system (Coordinating Agencies) are clear early examples of devolution, established through statute more than 20 years ago.

In the public specialty services system, the devolution of authority and responsibility has been extended in recent years through the managed care program. In this initiative, community-based governmental entities assumed state obligations for management of specified Medicaid benefits, while retaining their responsibility to administer other federal, state and local funds. In the lengthy process of developing the Revised Plan for Procurement, the department discovered that those invested in the system strongly valued local control of the managed care program, since this arrangement assured consumer and family participation in program governance and oversight.

Multiple factors have prompted renewed interest in community and local governance for health and human service programs. There is growing recognition that communities are different, and that one-size-fits-all state programs cannot accommodate these variations. This recognition is coupled with an awareness that local officials often have a better appreciation of community needs and resources, and hence are able to fashion more efficient, integrated, service arrangements and solutions to meet identified needs. There is also heightened realization that local governance mobilizes community involvement and participation in problem identification and resolution. Finally, local entities should be

more accountable to local citizens, community pressures, and individual consumers than higher-level governmental jurisdictions or private companies.
The principle of local governance and devolution has been augmented in recent years by the concept of *community collaboration.* In the first phase of devolution, specific categorical funds, services and target population responsibilities were transferred to designated local governance and management structures. Community collaboration goes one step further, emphasizing the utility (better outcomes) that is obtained when various categorically separate local entities *combine* efforts and jointly address complex consumer or community problems that cross narrow categorical boundaries. Initial efforts to foster such collaboration focused heavily on children's services, creating new voluntary structures to facilitate local coordination (Multi-Purpose Collaborative Bodies), promote early intervention, and explore methods for pooling resources. More recent collaborative prescriptions have emphasized substance abuse issues (as a thread running through multiple community problems), the mental health-correction system interface, and the coordination of specialty services with local physical health care organizations.

Whether managing particular categorical/population-specific services, or collaborating with other agencies to address community problems, local governance entities shoulder broad *public interest* responsibilities within their jurisdictions. Public interest considerations include protection of basic rights, promotion of inclusion and integration, equitable representation, public involvement and open proceeding, recognition of diversity, preservation of public safety, provision of certain "public goods" (e.g. emergency services) and essential safety-net services available to all, comprehensive planning and needs assessment, prevention and consultation efforts to promote community health and well-being, and outreach activities to vulnerable populations.

The Revised Plan struggled with the issue of how to maintain local governance, preserve public interest performance, and encourage increased community collaboration, while simultaneously addressing efficiency concerns. While the case for local control of *certain* activities is well established (e.g., increased participation, better outcomes, greater accountability, etc.) there remain unresolved questions about the efficacy of local management of other functions. Specifically, when particular administrative functions have "economy of scale" properties, the possibility of functional consolidation - redistributing functions from local management to regional operation - must be explored.

Accountability

Over the past ten years there has been a growing interest in the performance characteristics of the specialty services system, and a commensurate concern with accountability. Most persons with serious mental illness, developmental disabilities, and addictive disorders are now served through the locally managed, decentralized, community-based care system. Interested parties want to verify that persons with mental disabilities and addictive disorders are receiving timely and appropriate services, that basic liberties are protected and essential freedom promoted, that quality is monitored and improved, and that public funds are being prudently spent. Accountability is ultimately about *integrity:* ensuring that the specialty services system is fulfilling its mission, purposes, promises and objectives for persons with serious mental illness, developmental disabilities and addictive disorders.

The interest in accountability has spawned an array of indicators, categories, measurements and reports to profile system activities and performance. Some performance criteria gauge broad results and outputs (e.g., penetration rates, access, service utilization, cost information), while other address client and community related outcomes (e.g. housing, employment, quality of life, sentinel events). The Revised Plan indicated the importance of systematic collection and reliable reporting of these performance dimensions, to facilitate comparative assessment of managing entities (report cards) and to identify opportunities for system improvement.

The *quality* of *care* rendered in the system is an important preoccupation, but an optimal framework for establishing and improving quality remains elusive. In many everyday transactions, the attributes of a particular good or service being exchanged are readily apparent, so the purchaser can verify these characteristics before proceeding with the exchange. The transfer or exchange of specialty services, however, presents particular problems. For one thing, the ultimate purchaser of the services and

supports (the state) is not the actual consumer of the service. This split between purchaser and consumer creates problems for quality assessment, since the purchaser and the intended beneficiary (consumer) may have different ideas about what constitutes quality and hence about what should be monitored and measured. Not only can the purchaser and the consumer have differing conceptions of quality, other interested parties (local managing entities, family members, advocates, community members, taxpayers, etc.) may be concerned about particular dimensions of quality that are totally distinct from those considered important by the state or actual consumers.

Compounding the quality assessment problems is the fact that many specialty services are "experience goods". While we can describe some desirable attributes of the service before it is delivered, other valued attributes can only be identified through experience and direct receipt of the service.

Recognizing that quality is - to some extent - in the eyes of the beholder, and that evaluations of quality differ depending upon perspective, the Revised Plan suggested that consumers, family members, and community members become *arbitrators* of quality considerations. State monitoring and oversight of particular structural, process and outcome domains remains important, and local quality monitoring and improvement activities are still required. However, if the purposes of the specialty system are to promote effective freedom for persons with mental disabilities and addictive disorders, support families and caregivers, and enhance community health and welfare, then personal (consumer), family, and community perspectives on quality must be integrated into local deliberations. This can only be accomplished by the full involvement of consumers, family members, and community parties in all aspects (design, measurement, evaluation, improvement plans) of local quality assessment activities.

Besides outcome domains, performance categories, and quality measures, accountability requires *compliance* with a broad array of state and federal statutes, rules and regulations. As local managing entities have assumed more authority and responsibility, they have not always recognized the increase in compliance obligations that are attached to these new roles and expanded activities. All system participants must be aware of and responsive to these heightened compliance expectations.

Efficiency

Some conflicts and paradoxes emerge from the purposes articulated in the Revised Plan. The importance of governmental entities (i.e., organizations with ".. .specific statutorily proscribed equity and justice functions") in managing specialty services is emphasized, and value aspects of local governance and management structures (e.g., stakeholder representation, open meetings, asset-specific investments, relational contracting, etc.) are affirmed. However, in the name of efficiency, the Revised Plan restricts individual or independent application for specialty PHP designation to governmental entities (CMHSPs) of a certain size, requiring others to form "affiliations" as a condition of application.

The efficiency rationale for the requirement is that administrative functions and activities associated with the operation of a specialty PHP have "economy of scale" properties. Economies of scale mean that average cost of activity performance declines as output or volume increases. Allowing each CMHSP - regardless of the number of Medicaid covered lives in the service area - to independently establish or maintain specialty PHP administrative functions would generate or sustain excess administrative capacity (due to economy of scale properties) and raise the total costs of operating the managed care system. Redistribution of these functions from exclusive local control to participatory regional-level operation seems a reasonable compromise under these circumstances.

The Revised Plan also applies efficiency considerations to the formation of the provider network for the specialty PHP. There is no easy rule of thumb to determine whether and under what conditions a specialty PHP should contract for or directly operate a given covered service. Public payers are typically the only purchasers of certain specialty services, altering the supply and demand characteristics from standard market model assumptions. Viable supply alternatives differ for specific

services and by geographic location. Coordination and contracting complications (transaction costs) influence make-or-buy decisions for the PHP, as does consideration of relevant non-economic factors (e.g., supplier commitment to inclusion, consumer participation, etc.). Efficiency considerations do not dictate any specific provider arrangements (i.e., there is no explicit preference for either contracting or directly providing a given service) and PHPs retain discretion regarding provider network composition, consistent with their care management, quality assurance, and cost-containment responsibilities. Efficiency considerations do require that the specialty PHP conduct an assessment of the *comparative efficiency* of contracting vs. directly providing a particular service or program, that network participation decisions not be arbitrary or discriminatory, and that - to the extent feasible for a given activity - consumers have a choice of providers.

Efficiency in a generic sense means generating a greater amount of outputs from a given set of inputs. This definition, however, can be misleading in considering efficiency for specialty services, since a PHP (or subcontractor) might be a proficient supplier, but producing *the wrong outputs* (services not valued by consumers). To ensure that services supplied are valued by consumers and promote effective freedom, self- directed service options must be available in every PHP.