



## St. Clair County Community Mental Health Authority

*Promoting Opportunities for Discovery and Recovery*

August 5, 2016

Debra B. Johnson  
Executive Director

Mr. Andy Slavitt, Acting Administrator  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Malachy Browne, MD  
Medical Director

RE: Section 1115 - Pathway to Integration

Stephen Armstrong  
Board Chairman

Dear Mr. Slavitt:

Please receive this correspondence in response to the Michigan Department of Health and Human Services (MDHHS) request for approval from the Centers for Medicare and Medicaid Services (CMS) for the Section 1115 Waiver Proposal for Persons with Severe Mental Illness, Substance Use Disorders, Intellectual and Developmental Disabilities and Children with Serious Emotional Disturbances.

By and large, I want to convey my essential support for this waiver application. Also from this broad standpoint, I would also like to suggest that additional language be considered to reference current initiatives related to a) substance abuse and prevention (ROSC, Innovation Accelerator Program) and b) Medicaid Spend-down (changes to the income disallow). More specifically, I would like to highlight twelve (12) concerns, presented in a Feedback and Suggestion format. They are discussed, as follows:

- 1) Section V., 5(d) – page 39: *Although freedom of choice will continue to be waived, PIHPs will be required (as non-provider entities) to arrange Medicaid service contracts to ensure the independent evaluation of eligibility, assessment and the development of the Individual Plan of Service to ensure compliance with Home and Community Based Setting (HBCS) final rules. Although model configuration may be optional (based on state approval), the independent evaluation of eligibility and assessment does not include the provision of emergency services that may result in a preliminary plan of service or functions related to hospital preadmission screening or discharge planning. For PIHPs who contract with CMHSPs, the PIHP will be required to monitor the CMHSP's self-referral and utilization patterns related to consumer choice and best value criteria. MDHHS will play a vital role in the policy development and promulgation of these rules as part of its HBCS statewide transition plan.*

### **Feedback**

There appears to be little detail explaining how Michigan will deal with issues related to Federal rules pertaining to Conflict Free Case Management (CFCM), Home and Community Based Services (HCSB) rule changes, or the Michigan Mental Health Code. The language used in this section inaccurately describes a change to a system that does not violate the HSBS or the CFCM requirements. It is unclear what is meant by "independent" evaluation of eligibility, assessment, and the development of the Individual Plan of Service (independent tasks per se or performed by independent entities?). If it is the latter, then it is unclear what other entity is included. Moreover, it is unclear how this section may apply alongside existing CMHSP requirements (e.g. provider assessment and planning) as noted in the Mental Health Code (section 206 and section 712), and as noted in the Code of Federal Regulations (42 CFR 438.210) (e.g. treatment planning).

### **Suggestion**

Conflict Free Case Management standards are intended to mitigate the risk inherent when a party that has a vested interest in the over (or under) utilization of services also has the authority to control the level of services provided. Michigan's system clearly delineates PIHP and CMHSP/provider functions that promote Conflict Free Case Management. Accordingly, waiver language will need to clearly define key program functions (case management, service planning, and assessment) as such operate within our provider network. Waiver language will also need to delineate other key functions as per responsible entity. Here, care management, eligibility determination and treatment authorization are managed care (PIHP) functions; whereas assessment, case management (relative to service population) and treatment planning are most effectively and appropriately provided as required at the CMHSP/provider level. As an aside, such definition clarity will better reveal the system of balanced incentives already effectively operating within our current model. As separate legal regional entities, Michigan's PIHPs operate within a capitated environment and exercise limited control over the use of savings and, as such, simply do not have a vested interest in either over-serving or the under-serving of the covered population. Moreover, PIHPs operate without a shareholder arrangement, thus precluding the need to allocate unspent revenue into investor dividends.

- 2) In subsection (e) of that same section (page 39), MDHHS denotes the prospect of contracting *outside of the PIHP and CMHSP system if the managed care entity and/or providers cannot meet the service delivery, quality, financial and reporting requirements as determined by the state.*

### **Feedback**

It is unclear whether this is an all or nothing proposition. If so, then newly formed legal regional entities and CMHSPs would be placed at risk, regardless of their performance, based upon the performance of other regional entities and CMHSPs over which they have no control. This prospect raises considerable concern. It is emphasized here that the current system has been put into place primarily to benefit the people and communities we serve, as well as to comply with the State and Federal standards.

### **Suggestion**

It is essential that, in serving the best interests of our beneficiaries, our communities, and our panel of committed providers, we minimize disruption to those persons we serve and the networks that support them. In this regard, two recommendations are offered:

- MDHHS should clearly indicate its ongoing commitment to QI/QM constructs and practices that operate within progressive behavioral health systems. Thus, in the event a PIHP/CMHSP is not meeting expectations in the domains listed above, a path of correction and support for systems improvement should be followed to ensure an effective service system as well as avoid jeopardizing great personal, financial, social, and governmental costs.
  - MDHHS should clearly indicate in this waiver that each Regional PIHP/local CMHSP will succeed or fail based upon their own efforts and merits and not based upon the performance of entities that are completely outside of their control.
- 3) In Appendix B, under *Essential Elements for Person/Family Centered Planning* (page 63-64), the request reads that *The following characteristics are essential to the successful use of the PCP process with an individual and his/her allies.*
- *Person-Directed. The individual directs the planning process (with necessary supports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.*

### **Feedback**

The prospect that the person-served should unilaterally decide when and where meetings are held is neither reasonable nor feasible. In practice, CMHSP staff must balance the needs and requests of many people across their respective case-loads. Moreover, meetings could possibly be held in places not conducive to team facilitation or privacy.

### **Suggestion**

Alternative language should be inserted indicating that the person *suggests and approves* when and where planning meetings are held, as opposed to *decides*. Such language will doubtless incorporate the person's intent to drive the process as well as ensure that such decisions do not merely adhere to program convenience.

- 4) In the same section, #8 states *Wellness and Well-Being, Issues of wellness, well-being, health and primary care coordination or integration, supports needed for an individual to continue to live independently as he or she desires, and other concerns specific to the individual's personal health goals or support needed for the individual to live the way they want to live are discussed and plans to address them are developed. If so desired by the individual, these issues can be addressed outside of the PCP meeting.*

### **Feedback / Suggestion**

The language seems to state that the topics of wellness, coordination, integration, etc. are required elements of the process and must be addressed in the process (in our outside of the actual PCP meeting) regardless of whether the person wishes to address them. This seems to be inconsistent with other language in section #6 indicating that the person completely controls what will be discussed. It would appear that language is needed to incorporate consumer choice as well as medically-necessary approach to service assessment and planning.

- 5) Section V.9 (page 41-42): *The MDHHS has retained Milliman Inc. to develop actuarially sound rates using published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board, CMS 42 and federal regulations to ensure compliance with 42 CFR §438.6(c). Capitation rates will include all State Plan, §1915(b) and §1915(c) Waivers as outlined in Exhibit 1. Capitation rate values will be developed using PIHP submitted encounter data and Medicaid Utilization Net Cost Reports (MUNC) and will vary by benefit type and program code. Program code categories include the TANF, and the Aged, Blind, and Disabled (DAB) populations. Rate adjustment factors will be developed to reflect age, gender and geographic region for each benefit category. As with the current §1915(b) and §1915(c) Waivers, PIHPs are responsible for all Medicaid beneficiaries within a geographic catchment area who meet criteria for the Specialty Service System. Because of this broad responsibility, the Per Member per Month (PMPM) payments will be based on the entire Medicaid eligible population as opposed to enrolled beneficiaries.*

### **Feedback / Suggestion**

Capitation payments should be structured around specific groups of people, as they require very different services and supports. The TANF and DAB groups are far too generic.

- 6) Section V.9 and 10 (page 41-42): *Quality based payments related to the Demonstration goals as outlined in section I, will be developed as part of phase 2 of the demonstration. MDHHS intends to hold back up to 1.0% of capitation payments to be redistributed based on meeting the demonstration expectations through the implementation of complex care management, joint PIHP and MHP performance incentives, and meeting quality/cost indicators to be further defined in the evaluation component of the demonstration. MDHHS plans to continue incentive payments outside of the normal capitation methodology to PIHPs who service foster children and children in Child Protective Services (CPS) with Serious Emotional Disturbances under this §1115 Demonstration.*

*Quality based payments related to the Demonstration goals as outlined in section I, will be developed as part of phase 2 of the demonstration. MDHHS intends to hold back up to 1.0% of capitation payments to be redistributed based on meeting the demonstration expectations through the implementation of complex care management, joint PIHP and MHP performance incentives, and meeting quality/cost indicators to be further defined in the evaluation component of the demonstration. MDHHS plans to continue incentive payments outside of the normal capitation methodology to PIHPs who service foster children and children in Child Protective Services (CPS) with Serious Emotional Disturbances under this §1115 Demonstration.*

**Feedback / Suggestion**

The incentives and withholds system should be outside of the actuarially sound rebasing process. Additionally, the MHPs and PIHPs/CMHs should be required to develop a system for the sharing of savings in physical healthcare costs (reduced emergency room visits, reduced physical health inpatient admissions and readmissions, etc.) brought about through healthcare integration efforts.

- 7) In the Individual Plan of Service section (page 66-67), #4, it states: *The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.*

**Feedback**

Correction: the amount, scope, and duration of medically necessary services and supports are authorized by the **PIHP** and obtained through the community mental health system (and this is consistent with our current model that is compliant with Conflict Free Case Management guidelines).

- 8) In the OAPIP Standards (page 70), II reads *The QAPIP must be accountable to a Governing Body that is a Community Mental Health Services Program Board of Directors.*

**Feedback / Suggestion**

Possibly this is referring to QAPIP systems that also operate at the CMHSP level, but this should clearly read that the QAPIP must be accountable to a Governing Body at the level of a Regional Entity/PIHP Board of Directors.

- 9) QAPIP section XVI (page 76), states *The PIHPs shall continually evaluate its oversight of "vulnerable" people in order to determine opportunities for improving oversight of their care and their outcomes.*

**Feedback / Suggestion**

The term, "vulnerable" may meaningfully apply to the entire CMHSP service population. If the term is meant to apply to certain populations, circumstances, etc. then it should be clearly defined.

- 10) The MDHHS Self-Determination Overview (page 77) states *The public mental health system must offer arrangements that support self-determination, assuring methods for the person to exert direct control over how, by whom, and to what ends they are served and supported.*

**Feedback / Suggestion**

While the principle of Self-Determination helps drive the service system, other clinical considerations such as fidelity to Evidence-Based Practices and adherence to CMS Medical Necessity criteria for services and supports also combine to promote service efficiency and effectiveness and, accordingly, should be made explicit in this section.

- 11) Also in this section pertaining to Qualified Providers, it states that *Qualified providers chosen by the beneficiary, but who are not currently in the network or on the provider panel, should be placed on the provider panel.*

**Feedback / Suggestion**

This language seems too inclusive. Entities also have an essential responsibility to control the makeup of its provider panel, as per assessed community need, costs, and quality indicators. The term "qualified" should be defined so as to include the entity's responsibility to carry out its stewardship responsibilities in terms of panel providers that receive Medicaid funding, as well as to offer consumer choice.

Thank you for taking the time to review this correspondence. I appreciate having this timely opportunity to provide my feedback and suggestions. I enthusiastically support these collective efforts to improve the system of care for the people we serve and our communities.

- 12) Appendix D, Section II.D: *Risk*

**Feedback / Suggestion**

Include a discussion of risk, including possible explanations and risk factors this proposal presents.

Sincerely,



Debra B. Johnson  
Executive Director

cc: St. Clair County CMH Authority Board  
Region 10 PIHP Board  
Michael McCartan, Chief Executive Officer, Region 10 PIHP Dan  
Russell, Chief Executive Officer, Genesee Health Systems  
Jim Johnson, Executive Director, Sanilac County Community Mental Health  
Robert Sprague, Chief Executive Officer, Lapeer County Community Mental Health