

CMHAMM Healthcare Reform Vision & Initial Action Plan

January 14, 2011

Background

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act of 2010 (ACA) extending coverage to 32 million people through the expansion of Medicaid. The new Medicaid expansion population must receive benchmark or benchmark-equivalent coverage

- Benchmark plans: comparable to Federal Employee Blue Cross/Blue Shield Health Benefits, State’s employee health insurance plan, or State’s largest commercial HMO plan
- Benchmark equivalent: Actuarially equivalent to above plans
- In 2014, benchmark and benchmark equivalent plans must begin providing at least “essential health benefits” (section 1302 (b))
- “Mental health and substance use disorder services, including behavioral health treatment” are included as a category within “essential health benefits”

Source: **Barbara Edwards, Director**

Disabled and Elderly Health Programs Group

Center for Medicaid, CHIP, and Survey & Certification

Centers for Medicare & Medicaid Services

October 14, 2010 (webinar)

To prepare for the challenges and opportunities presented by health reform, Community Mental Health Affiliation of Mid-Michigan (CMHAMM) implemented an Action Plan that calls for the frequent analysis of the most current health reform information. As of January 14, 2011, our healthcare reform team, in consultation with national healthcare reform experts, has identified at least three scenarios that could significantly impact CMHAMM within the next 4 years as a result of healthcare reform:

1. PIHPs and CMHSPs remain intact and retain their ability to determine their roles in the emerging private and public markets (either in their current structure, as medical homes, or as the lead in a Specialty/Customized/Safety Net Accountable Care Organization (ACO) serving a population of persons with SPMI, DD, SED, and/or SUD).
2. The development of a regionally based system in which PIHPs and CMHSPs have some degree of independence, but are ultimately subject to direction and oversight by MDCH, a statewide vendor on contract with MDCH, or a regional health care system (in any of a number of arrangements, one of which is as a partner/member in an ACO serving a general population, which would include the specialty populations of SPMI, DD, SED, and SUD).
3. PIHPs and CMHSPs are funded by a payer, likely a large insurance provider or health care system and have limited independence

In considering these three scenarios, we see the first and second as being of the greatest benefit to the PIHP and CMHSP system and those whom we serve. So, in preparing for healthcare reform, we recommend that MACMHB's health care reform/ACA work to support its members as they take steps toward forming Specialty Accountable Care Organizations (ACO) and/or serving as key partners in general population ACOs. The formation of ACOs should improve quality of care for consumers while reducing overall costs, and allows for sustainable roles for PIHPs/CMHSPs within any of these scenarios, including the lead role of risk managing organization or that of a large specialty provider.

In all three scenarios, the regions in which the Affiliation and its members will work may be defined in a number of ways. The region may be the current Affiliation footprint or a range of others.

To position ourselves to survive and thrive in any of these scenarios, the following Vision has emerged and the proposed Approach will be taken:

Our Vision

CMHAMM and each of its affiliate members will be a regional leader in behavioral healthcare by providing efficient, effective, high quality care.

In addition to serving as a PIHP and CMHSPs, CMHAMM and each of its affiliate members will also serve as Medical Homes and/or Accountable Care Organizations and/or Federally Qualified Behavioral Health Centers, as opportunities present themselves in the healthcare market. Each of these structures will, at a minimum, include:

1. The ability to achieve high performance as measured by internal and external quality indicators and outcome measurements (i.e. people getting and staying well) and performance measures for payment systems that emphasize value (lower cost & higher quality of care) – in systems that may tie payments to outcomes and performance measures
2. Sustained evidence based practices (EBP) to gain a competitive advantage attracting partners looking to demonstrate a higher standard of care at a reduced overall cost (as a result of high efficacy)
3. Integrated primary care and behavioral health - when appropriate, to include child welfare, criminal and juvenile justice, education, etc.
4. The ability to thrive under various payment structures, including: Potentially Preventable Events (PPEs), FFS with Bonus or Shared Savings, Bundled Payments/Episodes of Care, Global (Capitated) Payments. Accountable Care Organizations payment structures could take on characteristics similar to one or more of the tiered systems described below:

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Tier 3

Financial Risk: High

Mode of Payment: Full or partial capitation and extensive bundled payments.

Additional Incentives: Highest level of shared savings and bonuses if per beneficiary spending is below agreed-upon target, but greatest amount of risk if spending is above agreed-upon target.

Tier 2

Financial Risk: Moderate

Mode of Payment: Fee-for-service, partial capitation, some bundled payments.

Additional Incentives: More shared savings and bonuses if per beneficiary spending is below agreed-upon target, but also some risk if spending is above agreed-upon target.

Tier 1

Financial Risk: Low

Mode of Payment: Fee-for-service

Additional Incentives: Some shared savings and bonuses if per beneficiary spending is below agreed-upon target.

Our Approach

1. **On-going education via Affiliation-sponsored dialogue series:** featuring national and state level experts on health care reform.

July 9, 2010 – CMHAMM sponsored event (Guest speaker: Ronald W. Manderscheid)

Ronald W. Manderscheid, Ph.D., currently serves as the Executive Director of the National Association of County Behavioral Health and Developmental Disability Directors. The Association represents county and local authorities in Washington, D.C., and provides a national program of technical assistance and support. Concurrently, he is Adjunct Professor at the Department of Mental Health, Bloomberg School of Public Health, Johns Hopkins University, a Member of the Secretary of Health and Human Services Advisory Committee on Healthy People 2020, and President-Elect of ACMHA—The College for Behavioral Health Leadership. Dr. Manderscheid serves on the boards of the Employee Assistance Research Foundation, the Danya Institute, the Public Manager, and the FrameWorks Institute. Previously, he served as the Director of Mental Health and Substance Use Programs at the Global Health Sector of SRA International. Throughout his career, consumer and family concerns have pervaded all of his work.

Dr. Manderscheid is currently on the Governing Council of the American Public Health Association (APHA), current President of the Federal Executive Institute Alumni Association (FEIAA) Foundation, Past President of FEIAA, and past Chair of the APHA Mental Health Section.

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He has also served as the Chairperson of the Sociological Practice Section of the American Sociological Association, and as President of the Washington Academy of Sciences and the District of Columbia Sociological Society.

October 17, 2010 – CMHAMM sponsored event (Guest speaker: Dale Jarvis)

Dale Jarvis, CPA, Director of Financial and Information Services for MCPP Healthcare Consulting, brings a diverse background as administrator, author and educator to healthcare organizations throughout the western United States. Prior to forming MCPP Healthcare Consulting, Dale was a principal and head of the Consulting Services Department for Jacobson Jarvis & Co., PC, a CPA firm. He has served as the financial director and accounting supervisor for healthcare organizations in Washington and Michigan. He also taught Health Care Financial Management at the University of Washington School of Public Health.

Dale is a co-author of *How to Thrive in Managed Behavioral Healthcare: A workbook guide to organizational and clinical quality* and *The Primary Care Performance Management System: A Team Approach to Winning in the New Healthcare Market*, both published by Manisses Communications. Dale's work focuses on:

Financial and Information System Design, Procurement and Implementation
Software Modeling to Test Clinical Designs for Financial Feasibility
Clinician and Management Reporting System Design and Development
Infrastructure Development for Healthcare Payors and Providers

February 2, 2011 – CMHAMM sponsored event (Guest speaker: James Haveman)

James K. Haveman, Jr. grew up in Grand Rapids, Michigan and has a distinguished history of human service management and volunteer work. From June, 2003 to May 2004 he was the Senior Advisor to the Ministry of Health in Iraq. Jim Haveman has been the Director of the Michigan Department of Community Health and Director of the Michigan Department of Mental Health as part of the Cabinet of Governor John Engler. Jim also served as the Executive Director of Bethany Christian Services, the largest child welfare/adoption agency in the United States, the Executive Director of the Kent County Community Mental Health Program and the Executive Director of Project Rehab, a substance abuse program located in Grand Rapids. Jim serves on the Board of Ferris State University and Youngsoft Inc. Jim is currently the President of the Haveman Group, a health and public affairs company. Jim graduated from Calvin College and has a Masters Degree from Michigan State University.

2. **On-going education via national webinars:** the distribution of webinar series information (dates, times), from DAO's office; expectation that the CEOs and/or their staff would participate in them and report back to a larger HCR group. Past webinars have included:

Get Ready for HIT Incentive Payments in 2011

Ann Boughtin and Amy Machtay, December 16, 2010

Research to Practice: Bringing Evidence-Based Practices to Your Organization

Patrick Kanary, December 14, 2010

Integrated Dual Disorders Treatment: Skills and Resources

Lindy Fox, December 8, 2010

Understanding Primary and Behavioral Health Integration

Laurie Alexander, September 15, 2010

In addition to webinars, CMHAMM has participated in various conferences and meetings in which the ACA was a primary focus, including: the statewide PIHP Clinical Directors Meeting, Improving Outcomes, Finance & Quality Through Integrated Information XXVI - Sponsored by: The Michigan Association of Community Mental Health Boards, Integrated Health Care Initiative – Sponsored by MACMHB, The Impact of Health Care Reform on Communities of Color – Sponsored by the Michigan Minority Health Coalition, Annual Capital Area Health Alliance Meeting, CMHAMM’s Improving Practices Leadership Team, CMHAMM’s Clinical, Business, Financial Health Care Reform Workgroup, CMHAMM’s Human Resources Health Care Reform Workgroup, the PIHP’s Leadership Group Meeting, the PIHP’s Program and Clinical Services Meeting, and the PIHP’s Board Meeting.

3. **Workgroups** focused on operations which will need to be refined and/or improved to ensure that our organizations and those whom we serve fare well in any of a number of potential futures:
 - A. Clinical, business, and financing practices (ability to practice and receive payments in a wide variety of payment environments)
 1. Research local, statewide, & national outcomes to determine what the expectations are from payers
 2. Make recommendations to CEOs as to which outcome measures should be pursued by our organization(s)
 3. Make recommendations to CEOs on how to change practices so that the organizations will meet the outcomes required of the system and thrive in the emerging financing environment
 4. Make recommendations to CEOs on how to train, supervise, and coach staff to foster high performance related to the outcomes required of the system and ensure the organization’s thrive in the emerging financing environment
 5. Make recommendations to CEOs on Federal demonstration grants to be pursued

B. Human resources

1. Research anticipated workforce demand related to healthcare reform
Key Stakeholders (Source: An Action Plan for Behavioral Health Workforce Development – SAMHSA 2007)

Proposed actions vary in their relevance to the range of stakeholders that have a role in this plan. Key stakeholders include the following:

o **Federal Government.** While the federal government cannot carry the full burden of workforce improvement, Congress and federal agencies have a critical role in this agenda.

o **State, County, & Local Governments.** It can be argued that states have the largest influence on behavioral health care and, in turn, on the workforce that provides mental health and addiction services. In states where care is financed, organized, or delivered through county or local governments, these jurisdictions also have considerable impact on workforce development and practice.

o **Foundations.** Innovation in health care is frequently driven by the nation's private philanthropic and charitable foundations as they draw attention to unmet needs and fund efforts to address those needs.

o **Payers.** Through their purchasing activities, public and private payers exert enormous influence on services and related workforce practices. Medicare, Medicaid, and private health insurers largely create the financing context that drives the organization and delivery of services and the activities of the workforce.

o **Oversight Organizations.** Bodies that accredit training programs and provider organizations, and credential, certify, or license individuals and prevention and treatment programs, exert tremendous influence over training, education, and the activities of the workforce (Institute of Medicine [IOM], 2003). These organizations constitute critical *levers of change* for improving workforce development.

o **Advocates.** Another form of oversight and influence is provided by advocacy organizations, which shape the financing and delivery of prevention and treatment services.

o **Professional & Trade Associations.** A wide range of organizations exists that are designed to support a specific sector of the field, segment of the workforce, or category of provider. As they seek to strengthen the quality of care and federal, state, and local support for their areas of interest, associations also exert considerable influence on workforce development and practice.

o **Education & Training Programs.** Graduate programs at universities and professional schools have a major role in developing the workforce of the future. Similarly, a diverse array of training programs seeks to provide continuing education and development to people currently in the workforce.

o **Service Providers.** Agencies and systems that employ a workforce for the purpose of providing prevention and treatment services shape recruitment and retention practices, continuing education, staff development, the use of best practices, the provision of supervision and mentoring, and a host of other activities that have an impact on the size and effectiveness of the workforce.

o **Technical Assistance Organizations.** A broad range of organizations provides consultation and technical assistance to the behavioral health field on topics that affect workforce development and practice. The section of the report on infrastructure development recommends that existing technical assistance capacities be linked through a proposed National Workforce Technical Assistance Structure.

o **Communities.** Communities are central to identifying and addressing their behavioral health needs. They share responsibility for linking to local behavioral health systems and supporting the workforce within those systems.

o **Individuals.** Persons in recovery, family members, and practitioners can assume individual responsibility for elements of the agenda to strengthen the workforce. At a minimum, each person can ensure that he or she has a personal plan of development to strengthen knowledge and skills, and each can advocate for broader, system-level changes.

2. Identify skill sets needed related to healthcare reform
3. Make recommendations to the CEOs with regard to recruitment activities relative to anticipated workforce demand and skill sets needed, as identified in items 1 & 2 of this section
4. Present recommendations to the CEOs related to training employees on changes to their benefits package as a result of healthcare reform
5. Make recommendations to CEOs on Federal demonstration grants to be pursued

4. **Chief Executive Officers Group focused on ensuring a strong role for our organizations in the emerging environment:**
 - A. Ensuring a strong role in the public market (primarily Medicaid) and private markets (primarily the insurance pool/exchange market)
 1. Developing the clinical/business/financing model which will ensure that we will flourish in the emerging public and private markets
 2. Developing local and regional partners
 3. Developing statewide partners
 - B. Developing a unified behavioral healthcare model integrated in the PIHP's region and in the local healthcare networks/markets of each of its affiliate members
 - C. Identifying behavioral healthcare models, used in other states, in the work of the Affiliation and in the work of the Affiliation with MACMHB and MDCH

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1. Promote the State's pursuit of Health Homes for enrollees with chronic medical conditions, as described in the correspondence from the Centers for Medicare & Medicaid Services (November 16, 2010 SMDL# 10-024 ACA# 12)

D. Leading political advocacy

Our message, to public policy makers, on the role of the public mental health system in the emerging Affordable Care Act -influenced health care system

1. CMHs and PIHPs have a long track record in applying a rich array of community-based services and supports – many non-traditional (supported employment, housing assistance, transportation, peer support, even case management is non-traditional from a healthcare standpoint)
2. The work that the CMH and PIHP system do, to foster the health of persons with SPMI, SED, DD and those with even mild forms of MI, ED, DD reduce the overall health care costs of these patients. Research shows a \$2.07 return on investment for every \$1.00 invested in alcohol/drug prevention services (Mancuso & Felver, 2010).
3. CMHs/PIHPs have a strong track record of performance against the Michigan Mission-Based Performance Indicator System. Refer to following link for details:
http://www.michigan.gov/mdch/0,1607,7-132-2941_4868_4902-90608--,00.html
4. CMHs/PIHPs have, over the past several decades, taken a system that was heavily hospital based and made it almost entirely community-based (cite % of CMH/PIHP budgets spent on inpatient versus all other/community-based care)
5. CMH/PIHPs have many of the components of an ACO, including:
 - A. Integration of primary and behavioral care:
 - (a) Co-location
CMH behavioral care provider at a primary care site
Primary care providers at a CMH behavioral care site
 - (b) Joint educational efforts of behavioral and primary care providers
 - (c) Assistance for CMH consumers, by CMH, in connecting with primary care providers
 - (d) Healthy lifestyles education, by consumers, with consumers
 - (e) Health checks, by CMH staff or contractors, within the behavioral health care visit
 - (f) Coordination of care between emergency departments within local hospitals and the CMH system
 - (g) Addressing the needs of high utilizers of health care resources
 - (h) Use of an in-house pharmacy to foster the coordinated management of physical health and mental health medications
 - (i) Active involvement in state and local electronic medical record technology initiatives.
 - (j) Community health care coalitions

B. a full array of mental health and substance use services,

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- C. rapid access to care,
 - D. evidence based practices and programs,
 - E. consumer engagement and person centered planning,
 - F. care management of high need consumers
 - G. high performing mental health/substance use providers,
6. CMH/PIHPs provide many of the components of a Healthcare Neighborhood:
- A. community based evidenced based practices
 - B. help accessing community resources and supports needed to maintain wellness and participate in social, educational and vocational activities
 - C. housing assistance
 - D. transportation assistance (for non-medical Medicaid covered service
 - E. in-home private duty nursing for special health needs (HSW enrollees)
 - F. sub-acute detoxification
 - G. wraparound services
 - H. jail diversion
 - I. jail services
- E. Identifying training topics and methods
- F. Oversee and approve work of all workgroups with special guidance to and from the clinical, business, and financing practices group

REFERENCES

Institute of Medicine. (2003). *Health professions education: A bridge to quality* (A. C. Greiner & E. Knebel, Eds.). Washington, DC: The National Academies Press.

Mancuso, D. & Felver, B.E.M. (2010, October). Washington State Department of Social and Health Services Research and Data Analysis Division. *Health Care Reform, Medicaid Expansion and Access to Alcohol/Drug Treatment: Opportunities for Disability Prevention*. Retrieved November 23, 2010, from <http://www.dshs.wa.gov/pdf/ms/rda/research/4/84.pdf>

Shortell, S.M., Caslino, L.P., and Fisher, E.S. "How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations," *Health Affairs* 29, no. 7 (2010): 1293-98.