COMMUNITY MENTAL HEALTH AUTHORITY OF CLINTON, EATON, AND INGHAM COUNTIES
In the Role as the Medicaid Prepaid Inpatient Health Plan for
THE COMMUNITY MENTAL HEALTH AFFILIATION OF MID-MICHIGAN:
BENZIE, CLINTON, EATON, GRATIOT, INGHAM, IONIA,
MANISTEE, AND NEWAYGO COUNTIES

RISK MANAGEMENT STRATEGY

Revised July 14, 2008

Below is the risk management strategy for the Community Mental Health Authority of Clinton-Eaton-Ingham Counties, in its role as the Medicaid Prepaid Inpatient Health Plan (PIHP) for the 8 county region which includes: Clinton, Eaton, Gratiot, Ingham, Ionia, Manistee, and Newaygo counties. This strategy reflects a multi-factor approach to estimating, reducing and managing risk as well as the maturation of the affiliation as it retains a strong local presence and continues to gain powerful regional capabilities. It forms the foundation for much of the organization's work, clinically, fiscally, and administratively, and is a companion to the organization's **Strategic Plan, 2005-2008 (See Attachment)**

Factor 1: The number of Medicaid eligibles as well as the total population of the PIHP service area as related to risk.

The Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI), in its role as the Prepaid Inpatient Health Plan for the eight county region, regularly monitors the size of the Medicaid population in these eight counties (through data provided it by the Michigan Department of Community Health), as well as the much slower changing population of the entire region (through the annual update of the 2000 census figures). Given that these figures are key variables in assessing the demand for mental health services from CMH and state general fund and Medicaid funding, the on-going monitoring of these populations is seen as key to the organization's operations.

Additionally, each affiliate, in their roles as providers, monitor Medicaid enrollment trends through a review of enrollment data for each of the eight counties.

Factor 2: The PIHP's penetration rates relative to expectations of penetration rates.

CMHA-CEI conducted a penetration rate analysis in 2008 looking at fiscal years 2006 and 2007 for the entire eight county region (**See Penetration Rate Data in Attachment**). This foundation analysis is updated regularly, specifically analyzing penetration by population and service level. This review examines trends in penetration rates and explores reasons for those trends. To date, the highest penetration rates occur in the age band of 50-64 years with the lowest penetration rates occurring in the age band of 0-17. Penetration rates have changed slightly within these two fiscal years in response to increased outreach activities of the PIHP and its affiliates.

Factor 3: Historical and present PIHP's ability to accurately (and with sound methodology) predict need.

Community need is assessed, by the PIHP and its affiliates, via a number of methods, including:

A. An annual survey of:
   1. Clients with currently open cases
   2. Clients with recently closed cases
   3. Human service providers and referral sources from throughout the covered region
   4. Appropriateness of level of care

B. Dialogue with representatives of advocacy groups, clients, client families, and representatives of community organizations via the Mental Health Partnership Council of the Capital Area Health Alliance

C. Annual public hearing, as part of the annual budget development process

D. Active involvement in Community Collaborations in each county

E. Active involvement with a wide range of community coalitions addressing issues such as: homelessness, child abuse and neglect, disaster response, grieving, employment and training, wrap-around services, Early-On, Strong Families / Safe Children, suicide prevention, juvenile justice, jail diversion, system of care, and health care access; and

F. Involvement, by CMH staff and board members at all levels within the organization, in regional, statewide, and national conferences, trainings, and professional organizations, to maintain a strong working knowledge of needs that have been identified in other communities - needs that may exist within these eight counties

G. Active involvement through the affiliation in steering committees and workgroups.

Additionally, all affiliates do this yearly through the PPG process. These methods have worked very well in guiding the continued development in this eight county CMH system. The information collected through these varied means is used to redesign this eight county region's service delivery system. The changes that have occurred as a result of this information, over the past several years, include: the establishment of a consumer-operated transitional living home for adults with mental illness (JIMHO), a great increase in home-based services to adolescents and youth with SED (through state and federal funding arrangements), the development of a co-occurring (MI – SUD) capability for services to adults, the conversion of day program operations to community-based inclusion "hubs" for persons with developmental disabilities, the elimination of day program waiting lists for persons with developmental disabilities (through a combination of a broader distribution of day program slots and increased supported employment initiatives), increases in the funding for respite services for families of persons with developmental disabilities, the development of increased supportive independent living opportunities for adults with mental illness, and the development of a common assessment approach (between CMH, DHS, and the Family Court) for use with children at risk of out-of-home placement.

Factor 4: The PIHP's ability to competently and comprehensively maintain a system of access, authorization, claims management, utilization management, real time data collection and analysis, and QI practices.

Over the past several years, CMH has developed an integrated set of components designed to provide for effective and efficient care management. These components are addressed below:

A. Each affiliate within this eight-county CMH system has established a toll-free telephone based **Access Center** to provide telephone screening and scheduling for face-to-face assessments for residents throughout the region. Assessment appointments at CMH's assessment centers, throughout the eight-county region, can be accessed through this Center. This Access Center complements the organization's Emergency Services Center, which provides telephone and face-to-care crisis intervention, assessment, and inpatient screening to residents 24-hours a day. **Initial authorization** for routine assessments is provided by the Access Center with authorization for inpatient, partial, and crisis residential

services provided by Emergency Services. **(See Affiliation Customer Services Handbook in Attachment)**

B. Each affiliates' **authorization and utilization management** system is well developed for all of its services. A **prospective (pre-authorization)** process is used for high cost and high risk services: inpatient, partial hospitalization, and crisis residential services. **Concurrent and retrospective review** is done for all other services (case management/supports coordination, psychiatry, residential) using a statistical process control method, wherein the direct line supervisors review all cases for appropriateness, using a standardized set of review criteria. A sample of these cases, randomly selected, is then reviewed by the organization's central utilization review/management unit. Disputes as to the appropriateness of care, between these two parties are resolved via dialogue between the parties and, when and if this fails to resolve the disagreement, the use of a clinical UM resolution panel.

C. The PIHP and its affiliates have many years of **claims management** experience, paying over $60 million in claims annually. This system is being upgraded to handle the payment, to outside providers, for inpatient and outpatient services, provided to Medicaid recipients.

D. Each affiliates' **information system** allows staff to collect and retrieve a wide range of client, treatment/service, financial, and cost data at over 400 PCs throughout this eight county CMH system. Examples of the data that is routinely retrieved by staff include: information on each day's hospital admissions (reviewed by the next morning); a record of the treatment episodes of any of over 45,000 clients served by CMH over the past several years; client demographics (including those required by the Department); utilization patterns of each of CMH's program components and clinical staff; insurance coverage of clients; penetration and client flow (case open and close patterns); hospital admissions and diversion patterns; length of stay pattern for all levels of care.

E. The organization's **Quality Improvement** system, restructured several year's ago, is described in depth in the organization's QI plan. This system is critical to each affiliates' ability to monitor penetration rates, access timeliness, recidivism, UM compliance, and dozens of other performance indicators that are key to the organization's ability to manage risk.

Factor 5: The PIHP developed, implemented, and maintained a strategic plan consistent with the vision and mission of the organization.

Annually, the PIHP and its affiliates revise the strategic plan - a three year plan, which serves as the basis of the organization's strategic initiatives. Over the past several years, managed care readiness (including many of the issues discussed in this risk management strategy) and responding to community needs have many of the vectors driving this plan. **(See Strategic Plan 2005-2008 in Attachment)**

Each affiliates' progress in carrying out the strategies outlined in the plan are monitored through the regular review of the status of the strategies by the Leadership Group (made up of senior management) and Leadership Group Plus (senior management are joined by the leaders of strategy-specific initiatives). Barriers to completion, for any strategic initiative, are identified through these discussions, and approaches to overcoming them are developed at these meetings and in meetings of cross - department / program / discipline teams with insight into the initiative. **(See Strategic Plan Status Report 2006 in Attachment)**

The plan is revised annually through the budget development process - a process that is strategically, not fiscally, driven.

Recently, CMHA-CEI revised its mission and vision to encompass a broader range of services and supports through four key functions. The mission and vision always forms the basis on which each strategic plan is built. **(See Vision and Mission of CMHA-CEI in Attachment)**

Factor 6:	**The PIHP's provider network competencies and sufficient resources to ensure choice, quality, and market competition.**

The PIHP and its affiliates maintain a significant provider network, allowing for a number of choices in provider from throughout the eight-county region, for virtually all levels of care. This network is managed through Medicaid contracts of over $80 million annually. The organization's network development and management system is described, in depth, in the organization's **network development and management plan.**

The eight county CMH system utilizes a procurement process to ensure that prospective contractors are carefully evaluated prior to being credentialed as a participating provider. Prospective providers must complete and submit a Network Provider application detailing their professional history and experience, and background checks and verification of credentials are performed to ensure providers meet Medicaid and state-mandated standards and criteria. (The Credentialing process is described in the agency's Credentialing Procedure). Following acceptance on the provider panel, the PIHP and its affiliates perform periodic quality monitoring to ensure performance standards and contract obligations are being met. Consumer and staff feedback and input from other sources are considered as part of the ongoing process of provider monitoring and re-credentialing.

In determining sufficiency of the provider network, this eight county CMH system considers data elements such as anticipated Medicaid enrollment, expected utilization, numbers and types of providers required, number of providers not accepting new patients, distance and travel time, and transportation availability. If the programs identify the need for a new service provider, the need is met either through the development of an RFP or through direct contracting. The decision to develop a specific contract with a provider is often dictated by the wishes of the parents or guardians of consumers or by the consumers themselves.

Factor 7:	**The PIHP's relationship with other community organizations and resources to promote efficiencies, and access to consumer entitled and/or naturally available resources.**

As noted in the discussion of factor 3, the PIHP and its affiliates are well integrated into a network of community organizations. To reiterate, this integration includes the active involvement in:

A. The Community Collaboratives in all eight counties
B. A wide range of community coalitions addressing issues such as homelessness, child abuse and neglect, disaster response, grieving, employment and training, wrap-around services, Early-On, Strong Families / Safe children, and health care access.

Through participation in and leadership of these local collaboratives and partnerships, each affiliate greatly broadens the resources available to those served by the organization.

Factor 8:	**Historical and present financial performance and viability as evidenced in routine fiscal practices including the timeliness and accuracy of tracking revenues and expenditures, and in projections of revenues and expenditures.**

The organization's fiscal management system maintains three main areas of focus: 1) focus on the PIHP, 2) focus on the provider's role, and 3) focus on the financial statements of each affiliate.

This eight county CMH system maintains a sound fiscal system that ensures **strong budget control and revenue projection**. The organization's strong fiscal controls permit its management and Board of Directors to continually monitor the fiscal health of the organization and make adjustments, throughout the fiscal year, to maintain that health. This fiscal control system, with a well-oiled payables and claims payment system, makes it possible for the organization to efficiently carry out its **fiduciary role in the receipt and transfer of Medicaid substance abuse funds** to the local coordinating agencies, Mid-South Substance Abuse Commission and Northern Michigan Substance Abuse Services and four affiliate CMHSPs.

The organization examines the traditional components of a financial reporting system: **revenue and expense statements** (at a number of detailed levels, tailored to the needs of the user: direct line manages review component-specific budgets, line item by line item; senior management reviews program specific budgets; the Board of Directors review expenditures and revenues by major line item and funding source); **balance sheets; cash reports**. The solvency of the organization is monitored using these three fundamental building blocks and analysis provided by program and central-office management.

The organization's **reinvestment plan** calls for the use of Medicaid savings to be used for several purposes:

A. Contribution to risk reserve/internal service fund, until the estimated risk level is reached. This level was reached in 1999.

B. New treatment or support modalities, including primary and secondary prevention efforts; and

C. Expansion of existing treatment modalities to address unmet need, including primary and secondary prevention efforts.

This eight county CMH system annually **contracts** for over $80 million in Medicaid services from a wide range of providers. The organization's contract management system is operated under the direction of the Contract Network Administrator and is staffed by a set of trained contract managers, each with expertise in the service modality provided and population served by the contractor. Contract development and negotiations are handled by the Contract Network Administrator and a team of management staff with expertise in the service modality being purchased. Contracts with the providers address the following conditions: referral, access, and treatment requirements; prior authorization requirements; reporting; recipient rights, and QI requirements; relationships with other providers and CMH; payment requirements and procedures; and anti-delegation provision.

The PIHP and its affiliates have a well developed **costing system** that integrates the acumen of the finance staff with that of the information services staff and clinical management. This team-based approach provides both validity and reliability to the costing figures derived by the system. CMH is also involved in the end stages of the development of a fully automated costing system - a system that will provide the organization with the ability to determine unit costs at any point in time, reflecting changes in aggregate fixed and variable costs, and productivity. The beta testing of this system is slated for the next several months.

As outlined above, the organization's ability to serve as the **fiduciary for the Medicaid substance abuse funds** for the eight county region served by the local coordinating agencies, Mid-South Substance Abuse Commission and Northern Michigan Substance Abuse Services, is ensured through the depth of experience that it has in operating a payables and claims payment system. Additionally, the PIHP and its affiliates have a long standing relationship with the coordinating agencies - spanning two decades - that forms the foundation for this fiduciary relationship.

Factor 9:	Financial risk protections sufficient to protect the PIHP and consumer interests with regard to appropriately determined risk levels

The PIHP has developed a methodology by which the PIHP will make straight capitated payments to affiliates, identify the conditions for using Medicaid Savings and/or ISF to ensure benefit stabilization throughout the Affiliation, and to outline the steps that the PIHP and affiliates will take to ensure fiscal stewardship across the Affiliation. This methodology is based upon the following **Guiding Principles:**

Each process takes into account the commitment by the PIHP to adhere to the following principles:

1. Autonomy is retained by each CMHSP within uniform standards and statutory and regulatory requirements.
2. The PIHP will confirm that each CMHSP demonstrates financial stewardship through the use of a transparent system of on-going reporting, including reviews of actual to projected Medicaid expenditures, including projected lapse.
3. The PIHP will ensure that the Affiliation has sufficient Risk Reserve.
4. The PIHP is responsible for ensuring that Medicaid recipients, within the PIHP region, have access to medically necessary Medicaid services as indicated in 42CFR Sec. 438.206 (see attachment A)
5. All current year Medicaid revenues and Medicaid savings as well as the Medicaid ISF must be projected to be spent before State General Funds (GF) are used to cover the costs of Medicaid services.

These guiding principles are evident throughout our procedure for **Capitation Payments and Budget Development Attachment.**

Factor 10:	Role of the Regulatory Management system in reducing risk

The PIHP and its affiliates, serving the counties of Benzie, Clinton, Eaton, Gratiot, Ingham, Ionia, Manistee, and Newaygo) is committed to consumers, employees, contractual providers, and the community to ensure business is conducted with integrity, in compliance with the requirements of applicable laws and sound business practices, and with the highest standards of excellence. As such, the PIHP has established a Compliance Procedure requiring the **Attached Compliance Plan and Standards of Conduct.**

The Compliance Plan is prepared as a good-faith effort to summarize our rules, policies and procedures. To the extent that the Plan conflicts with, or misstates any applicable law, the law takes precedence.

The purpose of the Compliance Plan is to provide the framework for the PIHP and its affiliates to comply with applicable laws, regulations and program requirements. The overall key intentions of the Compliance Plan are to:

- Minimize organizational risk and improve compliance with billing requirements of Medicare, Medicaid, and all other applicable federal health programs.
- Maintain adequate internal controls (paying special attention to identified areas of risk).
- Reduce the possibility of misconduct and violations through early detection.
- Reduce exposure to civil and criminal sanctions.
- Encourage the highest level of ethical and legal behavior from all employees, contractual providers, and board members.
- Educate employees, contractual providers, board members and stakeholders of their

responsibilities and obligations to comply with applicable local, state, and federal laws and regulations including licensure requirements, as well as accreditation standards.

- Promote a clear commitment to compliance by taking actions to uphold such laws, regulations, and standards.