
Overview of the PIHP Model Used by the Community Mental Health Authority of Clinton, Eaton and Ingham Counties

CMHA of CEI is the hub in a hub and spoke affiliation, the **Community Mental Health Affiliation of Mid-Michigan**. The other Affiliates serve as Comprehensive Specialty Service Networks (CSSN)

Serving Benzie, Clinton, Eaton, Gratiot, Ingham, Ionia, Manistee, and Newaygo Counties
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I. PIHP Model in Brief

This PIHP uses a third generation managed care model, using subcapitated payments and delegated risk management and other care management functions to a number of comprehensive service providers. ¹ This model is a hybrid of: a locally-driven hub-and-spoke federation and the best of a provider-sponsored organization/plan (PSO, PSP), staff model HMO/PHP, and network model HMO/PHP. While the PIHP (hub) is solely responsible for use of the Medicaid funds allocated to its region, it draws upon the strengths and best practices of its members - strengths honed over three decades of community-based practice - to guide its work.

II. History

The CMH Affiliation of Mid-Michigan (CMHAMM) is made up of five CMHs, covering 8 counties, and has the responsibility for managing the Medicaid mental health, substance abuse, and developmental disability services for the 80,000 Medicaid lives in the region. The Affiliation, made up of the CMHs serving Gratiot, Ionia, Manistee, Benzie, Newaygo, Clinton, Eaton, and Ingham counties, was formally created in February 2002 to ensure that the members of the Affiliation, via joining together into an affiliation, would meet the size requirements of the Michigan Department of Community Health's (MDCH) AFP for consideration as the Medicaid Prepaid Health Plan (PHP) for the region.

While meeting the size requirement was the catalyst for the formation of the Affiliation, a much more aggressive and robust vision emerged and has driven the work of the Affiliation over the past eight years.

¹ This PIHP has elected to use third generation managed care approaches (subcapitated payments and delegation of risk management and other care management responsibilities to a set of comprehensive community-based providers) rather than start with first generation and evolve, over time to this third generation approach.

III. Vision and Values

The Affiliation's vision and values are central to its formation and day-to-day operation. The Affiliation's formation, in fact, was driven by the similarity of values among the Affiliation members. The Affiliation exists to ensure and promote:

- Consumer choice and empowerment
- High quality services and supports which promote community inclusion
- Sound care management systems and practices
- Management and clinical efficiencies
- Local community-driven control and responsiveness

IV. The Affiliation Model

The Affiliation fulfills these values - core to its approach and operations - by capitalizing on the strengths of its members; strengths honed over three decades of community-based practice. The integration of a set of responsive, nimble, locally-based CMHs into an efficient Affiliation, utilizing best practices, is made possible through the use of a number of design features, listed below.

- Locally-driven federation-style affiliation, which is virtually transparent to consumers and other stakeholders
- Integrated care manager and provider (using a "smart provider" model)
- Consumer involvement and focus at all levels
- Locally-responsive, community-based Boards of Directors
- Strategic and conscious use of centralization, standardization, and autonomy

This model results in: the ability to draw on the strengths of the affiliates, greater responsiveness to the needs and concerns of local communities and consumers, increased linkages to local governments and other human service providers, lower overhead costs, increased nimbleness and agility of response, and the continued application and growth of clinical and management expertise.

V. Discussion of the Five Key Components of the Affiliation Model

A. The use of a locally-driven federation-style affiliation: This model, virtually transparent to consumers and other stakeholders, retains the longstanding relationship of each CMH with its community, strong local participation and decision making, strong consumer and community stakeholder involvement, ability to rapidly respond to local community need and variations, alignment of interests of provider and care manager via its integration in each Affiliate.

To ensure the strong local ties and autonomy of each CMH, each affiliate retains its state General Fund and its local funds.

B. Integrated care manager and provider: All of the members of the Affiliation will fulfill "smart provider" roles - integrating key care manager and service provider roles - in the fulfillment of the contract with DCH. The care management model being used by this Affiliation is akin to provider sponsored plans/organizations, in that the five CMH affiliates:

Are responsible for managing, via "smart provider" methods, a population-based rate (the population being the Medicaid eligibles within the community served by each Affiliate)

Employ a range of risk management methods in managing the benefit to the Medicaid recipients in their community

Make decisions as to whether to directly provide or purchase services, for the Medicaid eligibles within its community, based upon consumer choice, quality, and cost considerations.

Are able to capture and reinvest savings created by sound clinical, fiscal and risk management approaches

This model is a **hybrid of the best of provider-sponsored organizations/plans (PSO, PSP), staff model HMOs/PHPs, and network model HMOs/PHPs** (sometimes known as social HMOs). It applies a growing body of research, by the Robert Wood Johnson Foundation and others, regarding the use of tight-knit provider and payer/care manager systems to ensure the highest total quality care at the lowest total cost for persons suffering from chronic health conditions, such as serious mental illness and developmental disabilities. See endnote 1 for a representative sample of this RWJ Foundation research.

C. Consumer involvement and focus at all levels: The locally-driven approach of the Affiliation ensures that consumers have a strong role in the operation of the Affiliation and its members. As a result of the structure:

20 primary and secondary consumers are directly involved in the governance of the Affiliations member organizations, via membership on the Boards of Directors of the five Affiliates

10 primary consumers are directly involved in the governance of the Affiliations member organizations, via membership on the Boards of Directors of the five Affiliates

20 consumers are on the Affiliation Consumer Advisory Council. The work of this council is discussed, in greater detail, below

Dozens of primary and secondary consumers are involved in the on-going oversight and advising of each of the five Affiliates

Dozens of consumers are employed as staff within the Affiliate CMHs

Primary consumers have formed an **Affiliation Consumer Advisory Council** which meets months to carry out the following purposes: guide and advise the Affiliation, review the Affiliation's progress in addressing consumers issues, participate in training of consumers, monitor performance of providers (mental health staff and contractor's), assist in selection of contractual network providers and hiring key staff, share information with consumers and/or staff at the home community, review and advise on affiliation policies

All five Affiliates created **Customer Service Representative (CSR)** positions that are reserved for persons who are or have been CMH consumers. These persons, collectively (across the Affiliation) and individually, carry out a wide range of ombudsperson duties including: assisting consumers and their families in the completion of complaint forms and appeals, acting as a consumer advocate, receiving and addressing concerns of consumers and families, via telephone calls and walk-in visits, preparing and distributing a wide variety of customer service materials, preparing and/or distributing lists, tallies, data summaries, activity reports or other customer services reports, assisting the Recipient Rights staff with the maintenance of recipient rights training materials inventory, serving as a customer services representative on CMH committees, participates in the design and operation of the Mystery Shopper program, providing person-centered planning training to consumers, families and staff, participating in Person Centered Planning meetings as consumer advocate.

To foster the on-going development of strong consumer-oriented organizations and practices, the Affiliation has, on staff, a **Consumer Empowerment Specialist**. This Specialist, a high profile position, reporting to the PIHP's Deputy Executive Director, promotes and coordinates the design, development, and implementation of a range of initiatives related to consumer empowerment. Consumer empowerment efforts may relate to: consumer and stakeholder involvement in governance and organizational guidance, person centered planning, self-determination, consumer-run services, and other similar efforts.

D. Locally-responsive, community-based Boards of Directors: Each CMH continually communicates, and seeks guidance, about the work of itself and the Affiliation via a number of locally-based venues: its local Board of Directors (consisting of 1/3 consumers; all of the members of which are appointed by the local county commissioners), local consumer advisory councils, and the on-going, day-to-day dialogue with local consumers, local community collaborative partners, and stakeholders.

E. Strategic and conscious use of centralization, standardization, and autonomy in the carrying out of PHP and provider functions and to ensure that all Affiliation members meet industry standards and achieve functional integration. The Affiliation, through the operation of cross-affiliate work groups, draws on the best of what each Affiliate has to offer by determining the best course of action to achieve integration:

- Centralization of function and responsibility

- Standardization via the application of affiliation-wide best practices and standards

or

- Autonomous functions, carried out locally, by each Affiliate

The decision as to which approach to pursue is made on the basis of:

- Effectiveness

- Efficiencies and total cost (via an analysis of economies of scale or economies of autonomous parties/small scale)

- Capacity for synergy

- Nimbleness of action

- Value of a uniform approach

- Existence of unique local characteristics.