

Report to the Affiliation's Stakeholders: Accomplishments to Date

September 2003

Now that the Community Mental Health Affiliation of Mid-Michigan (CMHAMM) has completed its first phase of development with the successful submission, in 2002, of the Application for Participation (AFP) - to serve as the Prepaid Health Plan (PHP) for the region - and initial phases of the related affiliation development work, it is appropriate to take stock of what the Affiliation has accomplished.

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 70,000 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 requirements 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 18 months.**

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
- Sound care management systems and practices
- Local community-driven control and responsiveness
- Outcome and data based decision making

- Public good, public equity, social justice

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, with is virtually transparent to consumers and other stakeholders
- Integrated care manager and provider (using a “smart provider” model)
- An active Affiliation-wide Consumer Advisory Council
- Locally-responsive 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.

Discussion of the Five Key Aspects 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. Affiliation-wide Consumer Advisory Council (discussed in depth, below) which, through monthly Affiliation-wide meetings, ensures that the work of the Affiliation is guided by the voice of the consumer.

D. Locally-responsive 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.

Accomplishments to Date

While structure and process are critical to the direction and the success of the Affiliation, its ability to apply its values is the true test of the Affiliation. Below is a status report on many of the Affiliation's accomplishments, to date.

Real Results: Consumer Choice and Empowerment
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A. Consumer Involvement 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
- **Dozens of primary and secondary consumers** are involved in the on-going oversight and advising of each of the five Affiliates
- **15 consumers** are on the Affiliation Consumer Advisory Council. The work of this council is discussed, in greater detail, below
- **Dozens of consumers** are employed as staff within the Affiliate CMHs

B. Affiliation Consumer Advisory Council: Primary consumers and family members have formed an affiliation advisory council with the following purposes:

- Guide and advise the Affiliation
- Review the Affiliation's progress in addressing consumers issues\
- Assist in the identification and development solutions to problems
- 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
- Generate ideas about how consumers can get jobs outside/inside of Community Mental Health
- Share information with consumers and/or staff at the home community
- Review and advise on affiliation policies

The council meets one time a month, the first Thursday of the month, and is made up of 15 representatives from the five Affiliate members. The list of Advisory Council members and recent meeting agenda are attached.

C. Customer Service Representatives: All five Affiliates created Customer Service Representative (CSR) positions that are reserved for persons who are or have been CMH consumers. These persons carry out a wide range of ombudsperson duties including:

1. Assisting consumers and their families in the completion of complaint forms and appeals
2. Acting as a consumer advocate
3. Receiving and addressing concerns of consumers and families, via telephone calls and walk-in visits
4. Preparing and distributing a wide variety of customer service materials
5. Preparing and/or distributing lists, tallies, data summaries, activity reports or other customer services reports
6. Assisting the Recipient Rights staff with the maintenance of recipient rights training materials inventory
7. Serving as a customer services representative on CMH committees, participates in the design and operation of the Mystery Shopper program
8. Providing person-centered planning training to consumers, families and staff
9. Participating in PCP meetings as consumer advocate

D. Consumer Empowerment Specialist: 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 very high profile position, reporting to the PHP'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.

Accomplishments, to date, by this staff person and the Affiliation's Self Determination (SD) Work Group, include:

1. Refined of role of Affiliation Consumer Empowerment Specialist
2. Defined the role and function of SD Workgroup (this workgroup consists of staff and consumers from each affiliate)
3. Developed the Self-Determination and Person-Centered Planning (SD/PCP) policy of the Affiliation
4. Completed and submitted a federal block grant proposal for SD/PCP
5. Increased the linkages between the Affiliates relative to SD/PCP
6. Fostered the sharing of resources and knowledge between the Affiliation agencies (each agency is giving a presentation about SD/PCP implementation and practices within their own agencies)
7. Ensured the representation of each Affiliate agency at SD conference in June 2003
8. Provided consultation to the QI workgroup on independent facilitation survey
9. Coordinated the Affiliation's efforts relative to SD/PCP in the DCH site review and completed the plan of correction relative to SD/PCP.

Current and future projects include:

1. The development of guidelines for trainings and implementation for SD/PCP
2. The development of a resource bank to be shared throughout the Affiliation
3. The development of a range of methods to foster SD/PCP networking among staff and consumers within the Affiliation
4. The standardization of forms
5. The formation of an external facilitation panel
6. The development of a system for completing individual budgets throughout Affiliation
7. The examination of fiscal intermediary options
8. The exploration of the choice voucher system
9. Examination of the liability-related and legal implications of Self Determination practices

E. Consumer Satisfaction: The Affiliation continually assesses the views of consumers, via dialogue at the local level, at the Affiliation level (through the Advisory Council, described above, and through the annual surveying of consumers of services. In 2002 – the most recent survey year - over 1,800 consumers were surveyed as to their satisfaction with services. The findings of the survey are provided below:

Persons with Mental Illness

Dimension of quality and satisfaction	Percentage of respondents who were satisfied with the performance of the Affiliation along this dimension
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Quality of Care

- | | |
|--|-----|
| • Prompt response for services | 93% |
| • Courteous and respectful treatment | 96% |
| • Help in obtaining the right type of services | 92% |
| • General satisfaction with services | 93% |
| • Staff understands needs and situation | 89% |
| • Staff have knowledge and skills to serve consumers well | 92% |
| • Would refer friend or family member, in need of services, to CMH | 91% |

Person-Centered (or Family Centered) Plan

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|--|-----|
| • CMH staff follows Person Centered Plan or Family Centered Plan | 87% |
| • CMH helped to identify natural supports | 85% |

Improved Functioning

- | | |
|--|-----|
| • CMH services helped consumer function better in life | 90% |
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Persons with Developmental Disabilities

Dimension of quality and satisfaction Percentage of respondents who were satisfied with the performance of the Affiliation along this dimension

Quality of Care

- Prompt response for services 85%
- Courteous and respectful treatment 96%
- Help in obtaining the right type of services 91%
- General satisfaction with services 93%
- Staff understands needs and situation 88%
- Staff have knowledge and skills to serve consumers well 90%
- Would refer friend or family member, in need of services, to CMH 89%

Person-Centered (or Family Centered) Plan

- CMH staff follows Person Centered Plan or Family Centered Plan 90%
- CMH helped to identify natural supports 79%

Improved Functioning

- CMH services helped consumer function better in life 91%

Real Results: High Quality Services and Supports

The Affiliation's performance in the dimensions of quality established by the Michigan Department of Community Health is very strong.

A. Meeting State-Established Standards of Quality: The Affiliation is consistently at or above the established thresholds for quality in the following areas:

Access and Timeliness

- Completion of psychiatric inpatient screening, within 3 hours, for person with Medicaid for:
 1. Children and adolescents with emotional disturbance
 2. Adults with mental illness(This item is not measured for persons with developmental disabilities)
- Providing face-to-face assessment within 14 days of request for non-emergency service
 1. Children and adolescents with emotional disturbance
 2. Adults with mental illness
 3. Persons with developmental disabilities
- Starting services within 14 days of the non-emergency assessment
 1. Children and adolescents with emotional disturbance
 2. Adults with mental illness
 3. Persons with developmental disabilities

Preventing Unnecessary Hospitalizations

- Prevention of readmission, to an inpatient psychiatric unit, within 30 days of discharge
 1. Children and adolescents with emotional disturbance
 2. Adults with mental illness

B. Surpassing State Averages: Additionally, the Affiliation performs better than state averages in the following areas

Outreach and Penetration

- Reaching a higher proportion of children and adolescents than the state average
- Reaching a higher proportion of seniors (age 65 years and older) than the state average
- Reaching a higher proportion of Medicaid enrollees than the state average

Employment

- More of the Affiliation's consumers, in supported employment, receive minimum wage than the state average

Real Results: Sound Care Management Systems and Practices

The Affiliation applies cutting edge care management approaches to its efforts to manage the \$70 million Medicaid mental health benefit for the Medicaid recipients in its eight county region. The Affiliation, through the use of two key concepts, has been very successful in improving care management systems and practices, across the Affiliation. These two concepts are:

1. Cross-affiliate Work Groups, which guide the Affiliation, through applying the collective expertise of the staff of the Affiliate CMHs.
2. The strategic and conscious use of centralization, standardization, and autonomy across the Affiliation

The use of these two concepts has resulted in a large number of substantial accomplishments, across the Affiliation. A sample of these accomplishments are listed below.

Finance

Accomplishments to date:

1. Established common costing practices
2. Shared expertise related to financial practices and interpretation of Affiliation agreement, Medicaid sub-capitation agreement, MDCH General Fund and Medicaid contracts, Mental Health Code, Medicaid Chapter III, Code of Federal Regulations (42 & 45), OMB A87, GASB 10, GASB 34, and GAAP that have enabled us to better manage our individual and group resources
3. Developed financial strategies for risk management, Internal Service Funds, long-term financial health of affiliates, sub-capitation financing, and joint reporting for MDCH contracts.

Provider Network Management

Accomplishments to date:

1. Developed Affiliation policies and procedures for network management
2. Created central file for Affiliation contract documents, meeting minutes and other materials
3. Developed standardized tools and practices:
 - For performing provider background checks
 - For provider credentialing
 - For network application process
4. Developed inventory of services provided across the affiliation
5. Created Affiliation-wide Provider Manuals as resource for providers

Quality Improvement

Accomplishments to date:

1. Revised and implemented FY 2002-2003 QI Plan and FY2002-2003 Corporate Compliance Plan
2. Developed definitions, indicators, quarterly reporting process to affiliation and annual reporting process to DCH for the Medicaid Claims Verification Process
3. Initiated development, jointly with the Customer Service Representatives, of the Mystery Shopper Program
4. Developed and implemented a uniform record review tool and process including the periodic review of data collection, tool/criteria and the distribution of quarterly results to affiliates
5. Developed and implemented a uniform sentinel event policy
6. Developed and distributed quarterly, graphic representation of MMBPIS (MHQMS 5.0) data (data is reviewed locally first with recommendations for improvement going to local quality councils)
7. Piloted a PC-based HIPAA training module
8. Conducted affiliation-wide customer satisfaction surveys of consumers, guardians, and network providers
9. Developed a standard “Members Guide to Services” developed regular meetings of Customer Service Representatives (CSRs) and Affiliation-wide job description developed in conjunction with CSRs
10. Developed indicators for “PCP – Natural Supports” indicators for “Coordination of Care with Primary Care Physician”, consumer survey for “Independent Facilitation” process and identified Community
11. Education and Marketing” as the alternative project – all of which were QISMC projects.

Utilization Management

Accomplishments to date:

1. Developed affiliation service authorization policy and procedure
2. Continued on-going monitoring of MMBPIS indicators
3. Developed additional inpatient hospital utilization indicators with continued monitoring
4. Initial review and development of affiliation-wide service selection guidelines.

Information Services

Accomplishments to date:

To meet DCH requirements, three IS indicators were created and defined across the Affiliation:

1. Availability of the data system, computer orientation of new employees within 30 days
2. Timeliness of reporting submissions
3. Regularly reviewed these indicators and worked for

consistency of definition.

The IS Work Group focused the majority of its attention on creation, modification and review of procedures for the collection and tracking of QI (demographic) and encounter data. Precise procedures were created for each Affiliate to test, encrypt and send information, and for CEI to decrypt, store, combine and process the information. This procedure has been used successfully for the better part of a year, and is regularly modified to remain current. All Boards have been successfully submitting QI data.

The PHP created software which each Board runs to error-check its QI (demographic) data prior to submission. This software takes the place of the error checking that was previously done manually, saving substantial time and significantly increasing accuracy. Five reports can be run by each affiliate: Demographic Field Detail, Demographic Client Detail by Client (a list of errors sorted by Client ID), Demographic Client Detail by Error (a list of errors sorted by the error message), Demographic Summary Report (total count of blank, invalid and valid elements), Demographic Inclusive Check.

The Work Group devoted substantial time to dealing with DCH's change from the previous encounter reporting mechanism to the new 837 format. These efforts included:

- Successful completion of B2B testing for the 837 format
- Each Affiliate (except CEI) decided to leverage resources by contracting with the same individual to write the software to convert its data into the 837 format. Although still an expensive process, this allowed R&D costs to be shared.
- The PHP regularly shared information about requirements and specifications with each Board, and provided substantial technical assistance to the contractor writing the new 837 format for each Board.

The PHP instituted site visits to help ensure that each member is meeting the Information Management terms of the AFP. Each affiliate Board received a 4-6 hour visit to review data security (physical, backups, network protection, documentation) and methods of collecting IS indicators. Written analysis and recommendations were provided to each Board. Additional site visits will be scheduled to review other areas.

The Affiliation created a sophisticated "data warehouse" to store, process, submit and track Affiliation-wide QI and Encounter data. This software is used by PHP to convert 837 submissions, test them for accuracy, combine files, submit to DCH and store status information on all files. This software was necessary due to the complexities of the DCH process and the requirement for error-free information. Approximately 12 months of programmer time went into the creation of this software.

Real Results: Gaining Efficiencies and Maintaining Low Overhead Costs
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A. Cost Savings through Shared Expertise and Resources: The affiliation's efforts, to date, have resulted in over \$550,000 in efficiencies to the Affiliation - efficiencies that have resulted in the ability to meet or surpass industry standards in care management and service provision, while maximizing the funds available to serve consumers. Efficiencies gained by the Affiliation through the synergy of the affiliates and standardization and integration of operations are listed below.

Through the combined efforts of the Affiliates, the Affiliation was able to meet AFP and industry standards in the following areas, at a considerable savings over what it would have cost each Affiliate to meet these standards on their own. The dollar figures, presented below, represent savings over the eighteen month period of February 2002 through July 2003.

Dimension of Operation	Sample Activities	Savings over 18 month life of Affiliation
Finance	Standard policies; common costing methods; research and staff development in OMB A-87, GASB 34, GASB 10, GAAP, Medicaid Chapter III.	\$41,600
Provider Network Management	Uniform policies and procedures; standardized tools and practices for: provider background checks, provider credentialing, network application process; Affiliation-wide Provider Manuals as resource for providers	\$31,000
Quality Improvement	Unified QI plan; Medicaid claims verification system; sentinel event policy; HIPAA training module; Mystery Shopper program development	\$84,000
Information Services	Conversion of data systems to HIPAA 837 formats; policies and procedures related to data security and integrity; uniform error checking software; joint purchase of consumer data and billing software	\$412,000
Total Savings		\$568,600

B. Low Overhead Costs

The total administrative overhead spent by the Affiliation and its affiliates equals **11% of its revenue**. This overhead represents **both the Managed Care Organization/PHP overhead and provider overhead, combined** – a very low figure and far below national averages for administrative overhead. The details behind this administrative rate is presented below:

Annual administrative costs of Prepaid Health Plan (PHP) and Affiliation providers (FY 2003):	\$ 12,114,230
Total Annual Revenues for the PHP and its Affiliates (FY 2003):	\$110,096,394
Administrative costs as % of total Revenues:	11%

End Notes

Below is a representative listing of Robert Wood Johnson Foundation sponsored research underscoring the value of **tight-knit multi-disciplinary 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. The core principles of these models have been incorporated into the structure of the Affiliation and its affiliate members, in the application of these components in the treatment of chronic mental health conditions such as serious mental illness and developmental disabilities.

Chronic Care Initiatives in HMOs: Care Coordination Programs for Working-Age Adults with Multiple Chronic Medical Conditions; Douglas W. Roblin, PhD, Kaiser Foundation Hospitals Research Institute, Portland, OR; ID 026938

Management of Chronic Disease in the Employed Population; Christopher D. Saudek, MD, The Johns Hopkins Hospital, Baltimore, MD; ID 019665

Chronic Care Initiatives in HMOs: Conference on the Requirements for Effective Chronic Disease Management and Planning for Programs of Chronic Disease Management in Organized Health Systems; Edward H. Wagner, MD, MPH, Group Health Cooperative of Puget Sound, Seattle, WA; ID 028681, 030104, and 033712

Chronic Care Initiatives in HMOs: Case Management for Chronically Ill HMO Enrollees; Ronnie Grower, Sierra Health Services, Las Vegas, NV; ID 024898

Chronic Care Initiatives in HMOs: Integrated Services for Children with Chronic Illnesses and Disabilities; Barbara E. Straub, MD, Group Health Foundation, Minneapolis, MN; ID 026523