State of Michigan, Michigan Department of Health and Human Services
Request for Information RFI No. 180000000003
298 Pilot – Physical Behavioral Health Full Financial Integration

Submitted by Saginaw County Community Mental Health Authority on **February 13, 2018**

1. Applicant full name and address.

Saginaw County Community Mental Health Authority
500 Hancock Street
Saginaw, MI 48602

2. The name, title, telephone number and email of the individuals who will serve as the applicant's authorized contact.

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3. Provide the proposed organizational structure (chart) to support the implementation of the pilot. The organizational structure should delineate (1) the role of the CMHSP; (2) the relationship of the CMHSP to all MHPs in the pilot region; and (3) the relationship of the CMHSP to MDHHS.

Please see Attachment B at the end of this document.

4. Describe the relationship of all the parties that are necessary to support successful pilot implementation including the regions approach to administrative simplification, consistency in service delivery, and managed care processes.

The *SCCMHA Organizational & Financial Structure to Support the Implementation of the 298 Pilot* chart (provided in response to Section 3 of the RFI and shown as Attachment B) was designed to comprehensively represent the parties participating in the Saginaw proposal and their relationship to one another. The chart represents a fully integrated financial model. The chart also incorporates two different financing options for the unenrolled.

Identified in the top band of the chart are the "payers." The center (red box) represents the Michigan Department of Health and Human Services (MDHHS) and its Per Member Per Month (PMPM) funding relationship to the four Medicaid Managed Health Plans (MHPs.) The Medicaid Health Plans include: McLaren Health Care, Meridian, Molina Healthcare and United Healthcare. The physical healthcare networks for these four MHP "payers" are symbolized by the purple arrow connecting the MHP box to their providers at the bottom.

The payor level of the chart also shows two options (gray arrows) for the financing of services for the unenrolled. Option one, which is our preferred option, is a direct capitation or sub-capitation to the CMHSPs as is described in Response 8.e to this RFI. Option Two is a sub-capitation to a contracted MHBO/ASO by MDHHs-- this was the original MDHHS proposal.

Note that because either MDHHS in Option One or the MBHO/ASO in Option Two would pay fee for service directly to providers for physical healthcare claims, no network appears on the chart. Though the arrows depicting these funding pathways are labeled Medicaid, they are intended to include: Healthy Michigan funding, HICA and Claims Taxes as well as all specialty Waiver funding to both downstream "payer" entities.

The Payer and Fund Source level of the chart also shows the County of Saginaw as the provider of PA2 funding from the state liquor tax and provider of local match to SCCCMHA. In turn, required Medicaid and local GF match payment from SCCMHA to MDHHS is shown at this level of the chart.

The second band of the Attachment B chart represents SCCMHA as the CMHSP/CMHE Healthcare System (green box). As a Healthcare System, SCCMHA includes its own service programs and administrative operations together with its provider network symbolized by the green provider boxes in the third band. The SCCMHA network in this proposal brings together the specialty network for behavioral health and intellectual and developmental disability services with the SUD provider network and the provider network for those with mild/moderate behavioral conditions. This new configuration will provide for improved efficiency in network management, workforce development and training, unified expansion of healthcare integration activity and administrative simplification solely focused on the interests of consumers/members, their families and the greater Saginaw Community.

The second band of the chart also depicts the existing SCCMHA co-located healthcare integration relationships with the Great Lakes Bay Health Centers (FQHC) that support our Health Home and our co-located presence for integration at the Central Michigan University (CMU) Health Clinics and Covenant HealthCare's Emergency Care Center.

The vertical bars to the left represent the many relationships we have with other key community partners and demonstrates our co-located placement of SCCMHA mental health clinicians in Saginaw City Schools, Saginaw Courts and our presence at our emergency shelters. The yellow box labeled Advocacy and Consumer Voice connected to SCCCMHA represents the many pathways for the voice of our customers and the community to inform our operations which will continue in a 298 Pilot.

The third band of the Attachment B chart includes the combined provider networks in our region, both physical health which is in purple and behavioral health which is in green.

Finally at the far right, are vertical bars from the top to the bottom of the page, depicting the managed care functions for 298 Pilots. SCCMHA's RFI submission provides our best thoughts on the sharing of these functions between the MHPs and either MDHHS or a MBHO/ASO to promote maximum efficiency as possible in delegated arrangements. However, these are proposed delegations and have not yet been approved by all parties.

This design introduces the concept of the CMHSP/CMHE as a Healthcare System through which administrative efficiencies are derived from the elimination of both vertical and horizontal redundancies. This design preserves the essential membership relationship between the four MHPs and their respective members, while leveraging the efficiencies of a single organization to manage and deliver services. A healthcare system approach stabilizes service

delivery across plans yet creates opportunity for both health improvement through population specific projects as well as savings through incentivized improvements in the interface of behavioral and physical healthcare systems.

Option One which addresses the financing for the unenrolled provides greater administrative efficiency than Option Two simply by reducing the redundant infrastructure for managed care functions which would be necessitated by introducing a second level payer and moving the CMHSP to third level. The CMHSP shared risk contract currently in place for General Fund could be adapted for limited risk for the unenrolled sub-capitation.

5. Describe in detail your prior experience with integrated physical and behavioral health financing and service delivery systems for the proposed pilot region (including summary of pre-planning and engagement efforts inclusive of the regions MHPs.)

SCCMHA has incrementally integrated physical and behavioral health in Saginaw for adults with SMI for over 5 years and refers to these services as “Health Home.” SCCMHA closely adheres to the State Plan Amendment 2703 Health Home project, which prescribed the 6 components of managing consumer health. SCCMHA has adopted these components as its framework for providing person-centered, integrated care services within the Health Home. These principles guide staffing and service delivery prioritization as well as quality and health outcome evaluation.

Since 2012, SCCMHA has held a memorandum of understanding with Great Lakes Bay Health Centers (GLBHC), the FQHC serving Saginaw County, to provide co-located health services 3 days per week to adults with severe mental illness. This integrated arrangement also allows SCCMHA direct access to GLBHC’s EHR to schedule primary care appointments; document prescribed psychotropic medications, lab results and other information to support coordination of care. SCCMHA has a fifteen-year history of co-location with a private pediatric clinic and more recently has co-located a Behavioral Health Consultant within CMU Health Center’s Pediatric Medical Clinic, providing on site behavioral health support to primary care providers. Current integration efforts supported by a four-year Physical and Behavioral Health Care Integration (PBHCI) grant awarded to SCCMHA in 2014, are focused on integrating care for adults with severe mental illness and one or more chronic health conditions. In 2017, SCCMHA was identified as one of three lead agencies by MDHHS as part of a five-year grant from SAMHSA, “Promoting Integration of Primary and Behavioral Health Care” (PIPBHC), which would have extended SCCMHA’s ongoing integrated care efforts to children with severe emotional disorders.

The proposed CCBHC-Plus model is a logical extension of our experience with SAMHSA PBHCI. The model serves as a central point of access, providing a comprehensive array of services, care coordination, prevention and treatment for all Medicaid eligible persons who present with behavioral and substance use disorders. The strength of the model is in its ability to promote a collaborative care approach that advances our efforts toward full behavioral health and primary care integration. SCCMHA has developed workflows that use CC360 to capture ADTs and ZENITH ICDP to assist in clinical decision-making and identification of consumers at high risk of hospital admissions, among other health indicators.

Our financing experience is a result of our PBHCI award. As a 2014 grantee, we have made significant advances toward a close collaboration approach with GLBHC. Since 2014, the

grant enrolled nearly 600 adult SMI consumers with a 79.4% reassessment rate. PBHCI funding has allowed SCCMHA to hire nontraditional resources such as medical assistants and to provide complex care and coordination services, which the Medicaid carve out does not reimburse.

SCCMHA has participated in individual meetings with each of the four MHPs who provide medical insurance to Saginaw County Medicaid eligible residents. Since the release of the RFI in January 2018, WMCMH, HealthWest, and SCCMHA held three joint meetings with at least one member of all six MHPs participating in all three of these meetings. Agendas, notes, and sign-in sheets are available upon request. The MHPs and CMHSPs discussed the need for the integration of clinical, business, and financial operations to achieve a successful model. The CMHPs proposed a care coordination and delivery model that builds on traditional CMHSP specialty services using the constructs of the Certified Community Behavioral Health Clinics (CCBHC). The CCBHC-Plus model would comprise all behavioral health populations including adults with mental illness, individuals with substance use disorders, children with severe emotional disturbance, and adults and children with intellectual and/or developmental disabilities. The mild/moderate population would also be included.

6.a Describe the pilot's planned approach for assuring compliance with established public policies.

The vision statement for SCCMHA is: *"A belief in potential, A right to dream, An opportunity to achieve."* The various public policies established by the State and referenced in the RFI are integral to making this vision a reality and to meeting our public mandate. SCCMHA has well-established audit tools designed to assure that our provider network is in full compliance with each of these standards. These audit tools were developed when SCCMHA was a PIHP and contractually required to assure that these policies were appropriately applied to the Medicaid benefits provided. Currently the contractual requirement for assuring compliance is with the PIHP, although SCCMHA through delegated responsibility from MSHN continues to monitor the entire network. During the 298 Pilot, this same approach would be used. SCCMHA would continue to monitor compliance with these public policy mandates through an internal auditing process while acknowledging the oversight responsibility of the MHP and ASO as the new MDHHS contract holders. Similar to the current practice between SCCMHA and the PIHP a parallel process would occur when SCCMHA, as a pilot site would report all findings to the MHPS as these arrangements are more specifically determined.

As these public policies are integral to achieving goals and outcomes for individuals and communities, this level of oversight is essential during the pilot phase. Efficiency and savings can be achieved through reciprocity arrangements similar to those existing within PIHP/CMHSP arrangements. Currently, CMHSPs agree to recognize the group home training successfully completed by staff at another CMHSP. This practice saves the expense of retraining staff. Similarly, under the pilot, it would be our plan to participate in oversight and monitoring of inpatient contracts with the rest of the PIHP/CMHSP system. With a common auditing tool the audit findings of the CMHSP where the hospital is located may be accepted. Multiple audits are avoided and savings are experienced by the hospitals and CMHSPs.

During the 7/27/17 MSHN Monitoring of Delegated Functions, SCCMHA was found in full compliance with the public policies reviewed. In fact, some practices were identified as "best practice" and "strengths" were called out in other areas. SCCMHA has policies to enforce each of these crucial public mandates and has demonstrated full compliance to the standards

as required. That being said, as an organization we closely reviewed the comments of the 298 work group and heard loud and clear the expectation that the system as a whole needed to demonstrate improvements in some specific areas of practice. SCCMHA initiated a "PCP Reboot" process based on recommendations 5.2 through 5.8 of the *Final Report of the 298 Facilitation Workgroup*.

The charge of the PCP reboot group was the review of our current policies, staff trainings, electronic medical record and evaluation process to determine what changes/modifications we might make to move us closer to the true spirit of person-centered planning. The group met for several months prior to kicking off several changes that will bring us in line with the recommendations of both the 298 Facilitation Work Group and the Home and Community-Based Service (HCBS) Final Rule. The PCP Reboot Work Group identified eleven different policy and practice changes that we believe would move us closer to the true spirit of person-centered planning. All case managers and support coordinators throughout the network were required to go through Person-Centered Planning 202 training in order to assure that they understand the new expectations.

Finally, it should be noted that SCCMHA has always embraced self-determination. SCCMHA currently has 137 individuals living self-determined lives. 104 of those individuals are persons with an intellectual or developmental disability and 33 are persons with a mental illness.

6.b Describe how consumer engagement will occur, including how feedback will be used to inform policy development and implementation, program performance review, recovery plan development, network adequacy, etc.

It is the policy of SCCMHA to include consumers in all areas that affect services. Consumer input is obtained through involvement with committee membership, customer satisfaction surveys, the quality improvement process, orientation to SCCMHA services, special work groups, bi-monthly meetings with peer support staff throughout the network, evidence based practices, the request for proposals process, and provider network audits.

Input relevant to this RFI was sought through letters of support from all major advocacy groups in Saginaw County as well as the February/2018 Citizen Advisory Committee. Letters of support were received from the following advocacy groups:

- SAID: Saginaw Advocacy for Individuals with Disabilities
- NAMI: National Alliance on Mental Illness-Saginaw Chapter
- ETRTFT: Empowering To Reach and Teach Family Team (Family advisory group of the Saginaw MAX System of Care)
- SOGI: Sexual Orientation Gender Identity Youth Advocacy Council

It is SCCMHA's policy to obtain information and feedback from consumers on an ongoing basis regarding the quality of services provided. This occurs through satisfaction questionnaires, input from committee members, and suggestion boxes.

SCCMHA has an active Citizens Advisory Committee. The purpose of this Advisory Committee is to provide citizen input to the SCCMHA Board. It serves to foster consumer, provider and citizen participation in the planning and implementation of mental health services through the collecting, coordinating, evaluating and disseminating of information and citizen

concerns to the SCCMHA Board. The CAC advocates for state and local funding and supports the highest standards of mental health service delivery. The SCCMHA Citizens Advisory Committee membership includes persons with lived experience for all population groups with additional diversity shaped by age, race ethnicity and sexual gender identity. Representation of persons with primary lived experience with substance use disorders in recovery will be added to the CAC.

Consumer input related to network adequacy is obtained in a variety of ways including a variety of consumer satisfaction questionnaires as well as the annual needs assessment process. The substance abuse system in Saginaw County also has venues to seek consumer input including:

- Saginaw Prevention Council
- Great Lakes Bay Regional Families Against Narcotics
- Alignment Saginaw's-Saginaw Community Health Improvement (CHIP) Sub-Committee on Behavioral Health
- Michigan Health Improvement Alliance
- Saginaw Great Start Collaborative

If selected as a 298 Pilot CMHSP, SCCMHA will utilize these well-established venues to both seek consumer input into the planning for 298 Pilot implementation and to review consumer experience feedback at regular intervals once pilot activity commences. These activities will be informed and implemented in concert with Medicaid Health Plans and build upon the best feedback loops and activities available from both systems in partnership with the University of Michigan evaluators engaged by MDHHS for the study of the 298 Pilots. How consumer and provider input collected locally will be reported to the MHPs and MBHO/ASO will need to be determined in future planning.

6.c Explain your plan to assure compliance with Section 330.1287 of the Michigan Mental Health Code (Public Act 258 of 1974 as amended) regarding MDHHS designated Community Mental Health Entities responsibilities for the implementation of SUD treatment and services.

Section 330.1287 of the Michigan Mental Health Code (Public Act 258 of 1974 as amended) describes the requirements for the composition of the board: use of funds; contracts; allocation formula; establishment of substance use disorder oversight policy board; report on redistricting of regions; administrative and reporting requirements; and entities as coordinating agencies. SCCMHA is familiar with and capable of assuring compliance with these standards as demonstrated by SCCMHA's previous role as a PIHP managing and providing oversite of the substance abuse network during 2014 and 2015. SCCMHA is also aware of the need to take immediate steps to plan to be in full compliance with this public act. SCCMHA is aware that the County of Saginaw will need to approve the movement of PA2 savings and ongoing PA2 revenue to SCCMHA as a CMHE should pilot status be awarded. We do not foresee any difficulties in achieving this approval.

Anticipating the full integration of mental health and substance use disorder treatment, SCCMHA continues to employ the previous Treatment and Prevention Services (TAPS) Director. The former Director has maintained an active role with the substance abuse network in Saginaw County and is able to play a key role in this transition. If selected as a pilot, a candidate

with lived SUD experience would be selected to fill this vacancy. It is recommended that for the term of the pilot, the SCCMHA Board of Directors serve as the SUD policy board.

SCCMHA is aware of the recommendations of the 298 Affinity Groups to improve access and enhance the delivery of substance use disorder services. Our activities over the last several years are aligned with key concepts identified by the Affinity Group participants, including: (1) the need for broader access for individuals with substance use disorders; (2) increased funding for prevention and treatment services; (3) broader access to medication assisted treatment; (4) campaigns aimed at workforce education and stigma reduction; (5) the use of Screening, Brief Intervention and Referral to Treatment (SBIRT) as an evidence-based practice across encounter points; (6) improved access for justice-involved individuals and veterans; and (7) the expansion of billable codes or other mechanisms for reimbursement.

SCCMHA strongly believes in the need to pursue and maximize funding for SUD prevention services. SCCMHA pursued support from our PIHP for the funding with PA2 funds of home visiting programs in Saginaw County that utilized Parent as Teachers which is an evidence -based home visiting model. The model emphasizes and addresses family well-being which can have a long term impact on a child's health well into adulthood. Additionally, due to SCCMHA's close ties to Covenant Hospital's neonatal unit and Saginaw's early childhood home visiting programs, SCCMHA was chosen as a local convener for a Neonatal Abstinence Syndrome grant. SCCMHA has also developed and implemented a successful mentoring program for children with SED and will continue to pursue funding to sustain and expand the program as we recognize the need to provide mentoring as a prevention activity. Finally, we see the need to expand after school programming, especially in the rural areas of Saginaw County, as yet another prevention service.

SCCMHA supports the need for broader access for individuals with substance use disorders. SCCMHA's Central Access and Intake Unit allows for same day or next day intake appointments when a person calls or walks in for services. The current system allows for a person to be referred for services 24 hours per day including the SCCMHA presence in the Covenant Hospital Emergency Department. SCCMHA is moving toward directly providing substance abuse services through the Health Home and Wellness Center so that a person can immediately be linked to brief interventions when the use of SBIRT suggests the need for an intervention. These services would also be made available to individuals served through Saginaw's specialty courts (Mental Health Court, Felony Treatment Drug Court, Veteran's Court and District Sobriety Court). We are also looking to contract with a physician in the area that specializes in medication-assisted treatment in order to expand this service in the Saginaw area.

7.a Describe the applicant's planned approach to ensuring access to the full array of specialty behavioral health services and supports.

SCCMHA, as the prior PIHP and currently delegated manager of the Specialty Benefit for this region, manages a network which provides the full array of services described in the Medicaid Specialty Supports and Services benefit and commits to provide the entirety of the benefit in a 298 pilot including the SUD and the Mild/Moderate benefit. With 15 years of experience, SCCMHA has successfully demonstrated this ability to ensure full access in consecutive external quality reviews by Health Service Advisory Group, MDHHS and Mid-state Health Network.

SCCMHA has pioneered a four-phase Access Management plan with an emphasis on increasing the Medicaid penetration rate and ensuring clinical outcomes. This "high touch" approach uses a six-week window to stabilize presenting crisis, assess needs and establish an active relationship with the consumer prior to the start of Person-Centered Planning. Services such as screening, peer supports, community health workers, health assessments as well as mental health and SUD assessments are authorized upon the initial request for services in order to facilitate stabilization and engagement according to the consumer's presenting needs. The emphasis is on the service delivery system's responsiveness to consumer's access needs. SCCMHA has trended eight quarters of increased Medicaid service rates as a result of these methods.

On March 12, 2018 SCCMHA will be live with the MiBridges portal as a Referral Partner. Direct electronic self-referrals through the MiBridges portal will be received in the SCCMHA Central Access office. The use of the MiBridges portal is one of many outreach methods currently employed by SCCMHA. Strong collaborative access relationships with community partners have been developed over many years and include SCCMHA membership in the HUD/MSHDA local Continuum of Care for outreach to the homeless; and co-located Behavioral Health in Saginaw City elementary and middle schools which reaches children who present with mental health needs at school; and similarly co-located staff at the Juvenile Detention Center who provide screening and assessment services.

A same day/next day access standard has been established in the Central Access and Intake (CAI) unit. The CAI unit is designed to provide Crisis Stabilization services on site and to follow up over a period of brief intervention with medical as well as social supports and guided entry to services. Removal of barriers to access whether time of day, transportation, location of services or other concern is measured by the rate at which service requests result in initial assessments.

Ensuring access to service includes assurance of engagement in services. We measure engagement by the rate at which consumers who are assessed as eligible for service, actually start services. Interventions to reduce withdrawal at transitions of care are an effective approach; i.e.: Crisis Intervention staff who are co-located in the Emergency Departments place follow up calls to all consumers served in the ED to ensure that they are engaged in follow up care and Central Access staff place follow up calls to persons discharged from inpatient care to ensure that they are seen within seven days of discharge.

7.b Describe how the applicant will assess and ensure adequacy of the specialty behavioral health provider network.

Provider Network capacity is monitored both through an annual review of the network and through continuous review of utilization using real time encounter data. This capacity to manage has been built on an integrated platform of information system applications. This process includes the collection and review of data for the MDHHS required annual submission, and culminates in the annual budget plan presentation in a local public hearing, open to all stakeholders. Each primary case management/clinical team of SCCMHA, both directly operated and those operated by providers under contract with SCCMHA, have set core staff expectations including but not limited to clinicians/therapists, case managers, nurses, peers and supervisors as well as sufficient availability of psychiatry. SCCMHA monitors the provision of services

included in the 1915(b), (b)(3), and (c) waivers as well as autism services. SCCMHA is prepared to continue this process as we work with MHPs --- as the 298 implementation contractor. SCCMHA employs peer specialists in various areas of the organization and specifically in the Access area to assist beneficiaries in the navigation of mental health and substance use services.

MSHN currently monitors the SUD benefit however, as noted earlier in this document, SCCMHA administered this benefit prior to 2016. We hired the previous Director of SUD services for Saginaw County as the SUD Coordinator for SCCMHA to help continue to monitor the needs of the beneficiaries in Saginaw County and assure adequacy of services within Saginaw. The SUD Coordinator is in frequent contact with SUD providers and works closely with the Saginaw County Felony Treatment Drug Court and the new Sobriety Court in Saginaw.

SCCMHA is prepared to reassume the oversight of SUD services in Saginaw County. We are working closely with law enforcement to help educate and combat the opioid epidemic in Saginaw. We would prefer to add additional resources to help the beneficiaries in Saginaw by adding additional Medication Assisted Treatment options; additional transportation options, and additional prevention services for SUD.

7.c The public mental health system has encouraged (and in some cases contractually required) the use of evidence-based practices. Describe your plan to maintain use and validation of specialty behavioral health evidence-based practices.

SCCMHA has invested extensively in the development of evidence-based practices (EBP) for at least 10 years, investing in grants and taking advantage of MDHHS opportunities to assure that the organization continues to support a workforce and network trained to provide evidence-based practices. SCCMHA has committed and continues to offer many resources (budget cost, time, and staffing) in assuring that the workforce is well trained, that refresher trainings are available as needed and that consumers' needs are met through a large and appropriate array of practices, aligned with the different developmental phases of consumers' lives and needs.

Very early on SCCMHA invested in the development of evidence-based practice guides to guide the work of clinicians looking to determine which practice might be most effective for the population(s) they serve. Eleven different evidence-based practice guides have been developed by SCCMHA and are disseminated widely, including being available on the SCCMHA website. The best utility of these guides is in their electronic formats which have hyperlinks to the research for the practice.

At the present time SCCMHA supports and oversees the delivery of services through a large variety of different evidence-based practices, including but not limited to MI, CBT, DBT, ACT, TF-CBT, MAT, and Wraparound services. SCCMHA requires that all clinic staff have foundational knowledge in motivational interviewing, positive behavioral supports, and trauma informed care, as well as recovery. SCCMHA provides ongoing EBP oversight through an EBP Coordinator as well as an EBP Leadership Team. An EBP privileging process was created by SCCMHA for therapists and supervisors to ensure proper training and consistent use of key practices. Staff providing evidence-based practices are trained, credentialed and privileged to do so and fidelity monitoring occurs to assure that there is not drift from the model. In

addition, SCCMHA recently developed a testing process to assure that case manager/support coordinators/therapist are proficient in motivational interviewing as a core practice.

SCCMHA also supports a number of evidence-based wellness programs and offers a variety of ongoing educational supports for consumers and families in these areas, including smoking cessation, healthy hearts and nutrition. In addition, when overseeing the substance abuse provider network in 2014 and 2015, SCCMHA encouraged and supported the use and development of evidence-based practices which continue to be used throughout the Saginaw SUD network.

7.d Describe current and planned activities to physically co-locate or otherwise integrate physical health and behavioral health services.

It is assumed that the MHPs and the CMSHPs participating in this project recognize that care coordination is bidirectional and that all initiatives to "integrate" care must include the MHP contracted physical healthcare providers to succeed. We have learned, through our close collaboration with the FQHC, Great Lakes Bay Health Centers (GLBHC), that sustaining indirect services, such as care coordination, which until now have relied solely on funds generated from a patchwork of State and federal grants, requires new and innovative reimbursement models. It is for this reason that SCCMHA would work in tandem with the MHPs to achieve a collaborative behavioral health treatment model, which would include reimbursement or alternative payment models for the delivery of care coordination by both physical and behavioral health providers for our shared population.

Our current interdisciplinary team-based approach focuses on reducing high cost services such as emergency room visits and hospital admissions; addressing excess morbidity and mortality; promoting independence and self-care; and supporting earlier intervention. SCCMHA continues to build upon the current SAMHSA Primary Behavioral Health Care Integration grant awarded to SCCMHA in October 2014 to integrate care to improve health outcomes for adults with severe mental illness (SMI) with multiple chronic health conditions. SCCMHA, under this project, would plan to expand care to address the unmet healthcare needs of children/youth with SED. Covenant Health System has hosted SCCMHA within its Emergency Room since 1992. Additionally, GLBHC has co-located primary care at SCCMHA's main site since 2012, providing medical services to primarily SCCMHA adult consumers. The co-located clinic includes a team of behavioral and physical healthcare providers. SCCMHA has developed a "Level 5 – Close Collaboration Approaching an Integrated Practice" model (SAMHSA - Six Levels of Collaboration/Integration Core Descriptions) with GLBHC. SCCMHA and GLBHC actively seek system solutions together, communicate frequently in person, collaborate by a shared desire to be a member of the care team, have regular team meetings to discuss overall patient care and specific patient issues and have an in-depth understanding of roles and culture of our organizations. This collaborative care model uses current MDHHS CC360 encounter data to stratify Medicaid eligible identified with multiple chronic health conditions within Saginaw County, which informs the prioritization of healthcare services to adults with SMI. SCCMHA's EHR vendor, PCE, possesses the technology to support the interoperability standards to support care coordination and integrated health. The use of ZENITH/ICDP clinical platform enhances SCCMHA clinical decision making. ZENITH/ICDP utilizes predictive modeling to profile at risk consumers as well as notification and tracking for required biometrics within a dashboard

format. SCCMHA is actively using this capability and will plan to purchase for use across all of its providers as part of a Pilot implementation. Additionally, SCCMHA accesses GLBHC's EHR to facilitate scheduling of SCCMHA consumers for primary care visits with GLBHC and documentation of SCCMHA prescribed psychotropic medications and lab orders to inform GLBHC clinical decision making.

We will also take lessons learned from the evidence-based care coordination model we implemented through the CMS-funded innovation grant for the Michigan Pathways to Better Health project where we served high-risk, high-utilizers with multiple comorbidities and apply that model to children with high needs. We have built and maintained the infrastructure of the Pathways Community HUB (which is operated by SCCMHA) and its linkages to Care Coordination Agencies (CCAs) which hire, train, supervise and deploy community health workers (CHWs). We are able to leverage that experience and utilize that evidence-based model for the target population of this project.

7.e Describe how care coordination will occur and be integrated for physical and behavioral health needs.

SCMHA will create a true medical/health home located in the community behavioral health setting through integrated team-based approaches to treatment plans and responsibilities. In addition to providing services to persons with Medicaid, SCCMHA will expand its services, including existing co-location sites to engage consumers, focusing on mental health and substance use prevention, consultation and brief screening and intervention to improve the overall health of the community. Care coordination, particularly targeted toward individuals with behavioral health needs and comorbid health conditions, will rely on our established collaborative care model developed with GLBHC currently focused on adults with severe mental illness. SCCMHA will plan to deliver care within the framework described in CCBHC Plus model and expand its delivery of service to all populations, including individuals with mild and moderate behavioral health issues, individuals with substance use disorders, developmental disabilities as well as children with severe emotional disorders.

SCCMHA's care coordination efforts include Integrated Care Nurses (ICNs) who will continue to work in close collaboration with GLBHC to ensure access to primary care within GLBHC's clinics, including the co-located clinic within SCCMHA. The ICN will coordinate transition of care from inpatient settings to home or community in addition to providing health promotion, individual and family support, and needed referrals to community resources and supports in conjunction with the integrated healthcare team. Integrated Care Nurses will continue to identify comorbidities using CC360 and ZENITH ICDP to prioritize interventions. GLBHC shares its EMR with SCCMHA to facilitate the scheduling of primary care appointments. Additionally, the shared EMR allows for the documentation of psychiatric services and medications by SCCMHA case managers. SCCMHA's Care Management model (Attachment C) is demonstrating measurable improvements in physical healthcare access to improve health and wellness and we anticipate that this model will have the same results for the expanded SUD, mild, moderate, DD and SED population. SCCMHA also has onsite staff (a reverse co-location model) at Central Michigan Health for pediatric behavioral health consultation services as well as in the emergency room of Covenant Hospital. SCCMHA provides behavioral health consultation in schools (and has a presence in a preponderance of the K-12 schools in the city of

Saginaw). These co-location efforts, supported by System of Care Grants, strategically placed behavioral health services at the point of service in primary care and school facilities to support at risk individuals and to secure timely access to community mental health services. SCCMHA is able to identify and link individuals in their homes, jails, emergency rooms, homeless shelters and other community locations. These initiatives have demonstrated the efficacy of integrating behavioral health services and consultation within the community, adhering to the "right service, at the right time, in the right place."

SCCMHA recognizes that successful coordination of physical and behavioral healthcare to advance healthcare integration also relies on the ability to leverage existing or developing technological platforms. SCCMHA is well positioned as a Meaningful Use 2 (MU2) certified organization, to share data and interface with information exchanges that will be requisite for effective care coordination. SCCMHA's EHR vendor, PCE, is actively engaged in moving its primarily behavioral health platform to a more fully integrated EHR that prompts providers to assess and act upon physical health metrics. PCE supports all Meaningful Use requirements for EHRs and has developed the ability to use EHR encounters to calculate national clinical quality measures and outcomes relevant to behavioral health service delivery that include physical health metrics i.e., BMI, blood pressure, A1c, etc. PCE is working toward a meaningful interface with Great Lakes Health Connect and MiHIN that will expand the current care coordination activities that SCCMHA is actively providing with community partners. SCCMHA will expand their partnership with ZENITH/ICDP and directly purchase access to their integrated care delivery platform to support complex care management activities including the identification of high risk consumers.

7.f Explain how the applicant will meet all capacity and competency requirements for care coordination and service delivery that are new to the pilot members (i.e. Substance Use Disorder Services, Services for Individuals with Intellectual or Developmental Disabilities, Services for Individuals with Severe and Persistent Mental Illness, Services for Children and Youth with Serious Emotional Disturbances).

In a 298 Pilot SCCMHA would need to address capacity requirements in the area of the Substance Use Disorder benefit. Saginaw would request to be designated as a Community Mental Health Entity by the department. The provider network currently under management by MSHN is adequate for the region and SCCMHA would need to review and issue new contracts as a CMHE. Most providers in the current MSHN SUD panel were under contract with SCCMHA as SUD providers during the 2013-2014 transition period prior to the change of CA. Contract language would require updating and as CMHE, SCCMHA would need to assess community need and network adequacy within the first year following start up.

Administrative efficiencies might be available with a transfer of business data facilitated by PCE which also provides the electronic management of the SUD benefit for MSHN. Current active consumer records, authorizations as well as provider data could possibly be transferred. Disruptions in business related to system change for the providers would be minimal.

New competency requirements for SCCMHA would occur in the area of Substance Use Disorder in a 298 Pilot as well. At SCCMHA competency management is supported in a number

of ways; Credentialing, Continuing Education and through competency requirements established in Provider contracts.

SCCMHA's current policy and practice models for care coordination at transition of care address integrated behavioral health and primary care communication. We have been building both workforce and health information technology capacity for the past four years. The alignment of resources to do the job is pivotal to the capacity to perform care coordination. At SCCMHA, nursing services have been reorganized to support care coordination and positions have been equipped with access to the Zenith Integrated Care Data Platform and to CareConnect360. The electronic health record which is in use throughout the network is linked to the Zenith ICDP. ADTs are received in both the electronic health record and in Zenith. We attested to Meaningful Use of the electronic health record in 2017. Electronic prescribing, messaging, and lab orders are all in place. The SCCMHA MIS facilitates staff development in analytics are able to link consumers in risk categories to treatment teams, case holders, Managed Health Plans and primary care. SCCMHA uses the LACE predictive analytics which are a part of the Zenith ICDP.

Substance Use Disorder benefit management would be new to SCCMHA however; the workforce in Crisis, Access and UM departments was prepared over a period of several years prior to the 2014 move of the coordinating agency and have maintained SUD credentials and credential requirements in all these positions. The SCCMHA electronic health record currently incorporates all essential elements for SUD care coordination including the ability to collect and report BH-TEDS, standardized UM through use of the ASAM, and stages of change assessments. This depth of SUD knowledge and practice support is based on the SCCMHA business decision for universal adoption of the Integrated Dual Disorder evidence-based practice in behavioral health. SCCMHA would incorporate management of the SUD benefit into this existing infrastructure and add the existing SUD network to the platform.

Assurance of competency across all services is a twofold effort involving Continuing Education and Fidelity Auditing. The SCCMHA Continuing Education Unit supports the network with training across all aspects of compliance, program fidelity and evidence-based practice.

7.g Explain how principles of cultural competence will be used to support and inform integrated care (include current or proposed coordination with Michigan Tribal Nations).

SCCMHA uses a number of different processes and methods to support and inform integrated care in the principles of cultural competence. Cultural, linguistic and treatment needs are assessed on an ongoing basis. Supervisors through review of consumer assessments help to inform us of needs in the community. SCCMHA does outreach with cultural groups in the community. SCCMHA also employs routine administrative discussions with clinical supervisors about treatment needs of consumers which also can result in added training, reinforcement leading to improved knowledge of resources or other planning needed to enhance services to meet consumer needs. SCCMHA has policies that address cultural competency. All beneficiaries are assessed and monitored for any cultural values, beliefs, and practices to assure support individuals while receiving mental health treatment.

In the area of training, SCCMHA requires all providers to successfully complete cultural competency training. The SCCMHA system has adopted the California Brief Multicultural Competency Scale Training Program which addresses socio-cultural diversities including issues

of race, gender, gender identity, sexual orientation, aging, social class, and disability. SCCMHA providers also receive, as part of required cultural competency training, instruction in military culture with an emphasis on understanding the rank structure, warrior ethos, deployment cycle, stressors and supports available to veterans and their families, physical and psychological trauma (war wounds, MST, PTSD, etc.), value systems, barriers to seeking mental health services, etc. Recent system training enhancements have been made to improve staff knowledge and skills supporting individuals who are lesbian, gay, bisexual or transgender. SCCMHA also offered Deaf, Deaf-Blind and Hard of Hearing training to staff to help bring awareness to the culture of this population.

In the area of employment and staff, SCCMHA has chosen to hire staff to assist beneficiaries in the navigation of the mental health system. One such position is through the System of Care project, SCCMHA has employed a Cultural and Linguistic Competence Coordinator to ensure emphasis on meeting diverse local cultural needs of children and families served and another such position is an Intake Hospital Diversion Specialist who is a bilingual therapist located in our Central Access and Intake unit.

SCCMHA initiated a collaborative interagency agreement with the Saginaw Chippewa Indian Tribe of Michigan which is based in Mt. Pleasant in 2005 that is still in effect. The agreement addresses terms for the mutual sharing of service scope information, unique service eligibility conditions of each entity and interest in bi-directional referrals between the entities when appropriate. SCCMHA will reach out to the Saginaw Chippewa Indian Tribe relative to acceptance of this proposal to refresh the collaborative referral agreement between the organizations. Further, SCCMHA has embedded Native American culture information as part of the network cultural competency training and relevant policies and procedures. Last year SCCMHA was honored to be invited by Chippewa tribal leaders to provide Mental Health First Aid Training.

7.h Describe how the applicant plans to use CareConnect360 and other health information technology systems to improve care coordination.

SCCMHA would plan to enter into a direct Data Sharing agreement with MDHHS for use of the CC360 Web Application and the Data Extract. We would also plan to directly purchase from Zenith Analytics, continued use of the Integrated Care Data Platform and analytics tools developed collaboratively with Mid-State Health Network.

The SCCMHA UM division uses CC360 to assess the need for chronic condition care coordination at the point of access. The CC360 encounter data can be used to validate the co-morbidity subscale in LOCUS and allows us to direct the point of entry for consumers to the Health Home for more in depth assessment of biometrics and examination of care coordination needs which should be considered in the Person-Centered Planning process. Engagement with the consumer from the point of entry regarding health concerns establishes the expectation that successful treatment of mental health conditions is highly associated with successful management of overall health. CC360 provides information about all current Medicaid enrollees which allows for startup coordination prior to service start.

The SCCMHA Quality Program uses the Data Extract in the Zenith Integrated Care Data Platform (ICDP) to monitor Key Performance Indicators (KPI) in two categories: Utilization and Access to Care and Living with Illnesses. SCCMHA has worked with the Zenith to create a federated relationship which uses the appointment calendar from the electronic health record for prompting clinical teams with a daily roster of consumers who have Care Alerts derived from the KPIs which need to be addressed.

SCCMHA has three points of reception for Admission, Discharge and Transfer (ADT) messaging: 1) the SCCMHA electronic health record receives ADTs into the consumer record and messages the case holder when an ADT has been received for an active consumer, 2) ADTs can be viewed directly in CC360, and 3) ADTs are integrated with the Data Extract application in Zenith ICDP. SCCMHA has developed a preferred use of the ADT in the Zenith ICDP because the Zenith predictive analytics allows us to prioritize high risk consumers using the LACE risk algorithm. In any given fifteen-day period SCCMHA may have as many as 1,500 ADTs which require filtering for priority and routing to the appropriate level of care coordination response. This type of system interface requires alignment of staffing and technological resources. Additionally, the Zenith ICDP has built modules for care coordination which SCCMHA is scheduled to implement later in 2018.

SCCMHA has a registered secure Direct Email Address for the interface of our electronic health record with Great Lakes Health Connect and MiHIN for messaging referrals, laboratory orders and results. We are working on building local partnerships registration for specific interfaces such as referrals and transition of care communications.

7.i Describe how the applicant will promote interoperability in clinical processes through the use of common privacy standards.

Recent amendments to the Michigan Mental Health Code allow for HIPAA compliant sharing of information between behavioral health and other healthcare providers/payers (MCL 330.1748 of the Michigan Mental Health Code (Act 258 of 1974). The SCCMHA Compliance and Privacy Officer and the Chief Information and Security Officer stay abreast of the current legislative and technology developments.

SCCMHA is presently involved in the development of interoperable applications for connecting our electronic health record to CC360 and Zenith Technology Solutions which hosts the Data Extract for use in clinical applications. Mobilizing clinical information related to predictive analytics, key performance indicators, and population health is dependent on this interoperability.

The ability to perform care coordination through a network of CMHSP providers is imperative to the successful implementation of any performance project. We recognize the importance of pressing the technical and legal challenges for successful interoperability and are currently working with our IT partners to: 1) incorporate contractors and agents in the Data Use agreements, and 2) find a cost effective solution to multifactor authentication (PCE is currently exploring cost effective options.)

7.j Explain how the pilot region will improve coordination of care through health information exchange.

SCCMHA is committed to full participation in health information exchange(s) with the goal of effectively improving the coordination of care. SCCMHA has adopted an agency strategy that the electronic exchange of clinical information is essential to improve healthcare quality, safety and consumer outcomes. SCCMHA is actively receiving admissions, discharges and transfers (ADTs) twice daily, directly into our EHR and through ZENITH/ICDP. We are using this information to improve the transitions from hospital to home to avoid readmissions as well as clinical decision making.

Electronic exchange of clinical information is one of the core objectives of Meaningful Use), SCCMHA is now Meaningful Use (MU) 2 certified for 2016 and works in tandem with a MU3 certified EHR platform through our vendor. SCCMHA is preparing to pursue MU3 in 2019. SCCMHA, through its MU2 certification has achieved the capabilities reported in the chart below.

We are currently receiving SCCMHA ordered lab results directly into our EHR from hospital and commercial laboratories. Additionally, through a Direct Services Agreement with Great Lakes Health Connect (GLHC), we are awaiting final tests to implement direct messaging. Many CMHSPs, including SCCMHA, experience the exchange summaries of care as a hurdle to full MU compliance and it is a challenge to work with some Michigan psychiatric hospitals who are not utilizing HIEs. We hope that working in conjunction with MHPs in the 298 Pilot may present a new opportunity to improve this measure. SCCMHA is actively participating with MiHIN's project, "Coordinating the Care Coordinators" project and has contributed a CMHSP perspective to their recent white paper. SCCMHA will continue to acquire the capacity to participate in HIE development and intends to utilize HIE and our EHR to its fullest capacity, especially in advancing interoperability among EHRs held by our community healthcare partners.

MU Dashboard Modified Stage 2 for 10/1/2017 to 12/31/2017

Objective	Num.	Den.	Rate	Required
Objective 3, Measure 1: Computerized Provider Order Entry (CPOE)--Medication	2695	2695	100.00%	60%
Objective 3, Measure 2: Computerized Provider Order Entry (CPOE)--Lab Orders	240	240	100.00%	30%
Objective 3, Measure 3: Computerized Provider Order Entry (CPOE)--Radiology Orders	0	0	0.00%	30%
Objective 4: Electronic Prescribing (eRx)	2259	2563	88.14%	50%
Objective 5: Health Information Exchange (Summary of Care)	0	0	0.00%	10%
Objective 6: Patient-Specific Education Resources	172	287	59.93%	10%
Objective 7: Medication Reconciliation	5	5	100.00%	50%
Objective 8, Measure 1: View Online, Download, and Transmit--Access	286	287	99.65%	50%
Objective 8, Measure 2: View Online, Download, and Transmit--VDT	28	287	9.76%	5%
Objective 9: Secure Electronic Messaging	17	287	5.92%	5%

8. a Explain the proposed MHP to CMHSP payment model including any plans for shared-risk and value-based financing models (Any proposed financial arrangements that passes downside risk to a CMHSP must be approved by the Department

SCCMHA supports a full financial integration model for the 298 Pilot developments. Furthermore, SCCMHA sees the pilot opportunity as one that not only works toward financial integration and administrative efficiency but also attends to transformational opportunities for the local service networks and consumer experience at the points of service.

There have been individual and three group meetings with the MHPs that provide coverage to Medicaid and Healthy Michigan members in Saginaw County to inform this submission. Included in these meetings was the discussion of a desire for a sub-capitated funding arrangements to the CMHSP pilots all advancing the CCBHC Plus care and service model. It was explained that a sub-capitation model would work to stabilize the pilot's networks and to finally bring the SUD networks (treatment and prevention) and the network for mild/moderate mental health conditions presently managed by the MHPs into the CMHSP pilots. A sub-capitation arrangement would reflect an understanding that CMHSP infrastructure has matured over the last 20 years around sub-capitation and that we are not willing nor would it be affordable or in the best interest of providing the specialty benefit to return to a fee for service environment we left behind in the early 1990s. It is our understanding from MHP feedback at these meetings, that there has not been agreement to a sub-capitation but rather an understanding of the CMHSP rationale for such a funding model request.

SCCMHA would, in addition, welcome the additional element of a sub-capitation withhold that would be used to support an incentive payment. SCCMHA proposes the establishment of mutually negotiated incentive payments that are tied to MHP metrics and performance objectives, informed by MDHHS priorities. SCCMHA would also prefer the ability to eventually share such incentive payments with select contracted network providers that will need to be engaged to help achieve the incentive performance targets.

Less developed has been the discussion with the MHPs regarding the payment mechanics for healthcare coordination/care management for priority populations identified in partnership with the plans and ASO for high cost and high risk shared consumers/members with chronic co-morbid physical health conditions as well as healthcare integration at a provider point of service. This may be the space where value-based purchasing options could be developed initially although SCCMHA would also agree to begin with fee for service arrangements with MHPs as a starting place for these activities which are not a part of the specialty carve out benefit. This would necessitate the turning on of new billing codes for non-face-to-face care coordination activity, select patient education codes to promote consumer self-regulation and management of chronic disease and codes for the inclusion of new disciplines to our system like medical assistants for the cost effective collection of physical health biometrics not currently a part of the specialty carve out. Though there has been no commitment from the MHPs to this CMHSP Pilot management scope and construct for care coordination and point of service integration activity, there has been open discussion as to the merit of these recommendations and a willingness to continue discussions should SCCMHA be selected for pilot status. The MHP discussions in this area have revealed a fairly common understanding that there is a subpopulation of CMHSP served consumers that are difficult if not impossible for the plans to engage effectively and an appreciation for the CMHSPs mobile

"boots on the ground" workforce, strong treatment relationships and service benefits unique to our public CMHS system. This is the space in the 298 Pilot that is ripe for transformation to promote improved healthcare access, treatment adherence, improved health outcomes and reduced healthcare costs.

There could be significant variation in the CMHSP cost of serving consumers/members depending upon which MHPs members are enrolled in various waiver populations like HSW and ASD as an example, where expenses are just generally higher. Our history as CMHSPs has largely been blind to MHP enrollment. The PIHP/CMHSP system generally recognizes revenue in what we have now come to appreciate as simple delineations of Medicaid and Healthy Michigan (State Plan, b, b3) revenue and specific population Waivers (HSW and Autism) and cost alignment has had more recently the flexibility to move revenue assignment between sources. This kind of revenue flexibility will need to continue but this is a very new concept when we refer to similar arrangements between MHP and MBHO/ASO revenue and CMHSP pilots.

Another important consideration for the establishment of the funding model will be the challenge of funding the pilots at levels that promote success. The consideration for actuarially sound rates for the 298 pilot will be a very important endeavor. Then add the expectations of the State for administrative efficiency and the multitude of transitional start-up tasks across multiple MHPs and the MBHO/ASO as well as at the selected CMHSP Pilot sites collectively; and the result will prompt the need for start-up cost recognition and adequate funding for implementation. SCCMHA is up for the challenge, but funding for the model adequately and thoughtfulness concerning the start-up and transitional costs cannot be minimized. There was some limited discussion with the MHPs about their ability to advance payment for pilots which would be extremely helpful in this regard, but again will require much more discussion and creative planning. Pilot success will be dependent upon MHP investment at the start to reduce the costs later for targeted sub population members who we collectively know to be high cost outliers. However what remains to be seen is whether or not the final funding model has enough financial incentive and return on investment for the MHPs to make pilot participation worth their while.

8.b Describe your experience with value-based financing methods and models.

SCCMHA was the sub-recipient of a 3-year CMS CMMI grant, known as Michigan Pathways to Better Health, that tested an outcomes based, provider performance oriented, value-based payment model for addressing the social determinants of health through linking high-risk consumers to health and human service resources and helping those consumers adopt healthy lifestyles.

The primary goals achieved by using this payment model were rewarding (i.e., incentivizing) the successful recruitment and retention of high-risk and high healthcare utilizer consumers as well as to reward the successful completion of goals leading to health improvements using the nationally recognized and evidence-based Pathways Community HUB model in which care coordination pathways are used to track and document the confirmed delivery of health, social and educational services to at-risk consumers, document processes and outcomes, and track reimbursement. Secondary goals achieved included improvements in

the timeliness and completeness of documentation (since payment was predicated on documented evidence of the impact of intervention on consumer outcomes).

This value-based payment model, which also includes a system for measuring and monitoring performance at both individual provider and agency levels, offered SCCMHA opportunities to provide incentives to contract agencies that reward performance (i.e., achieve a range of initial, intermediate and final outcomes) as well as to develop value-based contracts with third party payers (e.g., Medicaid health plans) that are interested in focusing on outcomes rather than encounters. In sum, SCCMHA gained experience in funding services based on outcomes, which differs from standard models that rely on encounters or time spent with MHPs and MHBO/ASO, regardless of the success in obtaining needed resources or affecting behavior change.

8.c Describe how the pilot will track Savings and develop a reinvestment plan in accordance with the 298 boilerplate.

SCCMHA agrees that the tracking of savings and the development of a Reinvestment Plan is critical to 298 Pilot successes. The legislative boilerplate is clear in Section 298 (5) stating that "*For the duration of any pilot projects demonstration models, any and all realized benefits and cost saving of integrating the physical and behavioral health systems shall be reinvested in services and supports for individuals having or at risk of having a mental illness, an intellectual or developmental disability, or a substance use disorder. Any and all realized benefits and cost savings shall be specifically reinvested in the counties where the savings occurred.*" Therefore, the definition of what constitutes savings and from what system; the specialty PIHP/CMHSP carve out system or from the MHP physical health system including their management of the mild/moderate behavioral health benefit matters. The nature of where saving may be derived from in the pilot demonstration is also critical to informing this process. The boilerplate language calls out administrative efficiencies but there could also be savings derived from changes to service utilization patterns in both systems. The savings definition is also dependent upon the identification of costs at the start of the pilot especially in sorting out the costs between the CMHSP pilot's former PIHP including their unique responsibilities for Substance Use Disorder treatment and prevention networks, and those delegated to their participant CMHSPs as a starting place or baseline.

The proposed financial model suggests the MHPs and the MBHO/ASO pay a sub-capitation to the CMHSP pilot networks to continue to provide the current specialty carve out benefit including services for SUD and add the inclusion of the benefit for mild/moderate BH conditions and its provider network as indicated in the response to 8.a. The tracking of savings once managed care functional delegations are determined will allow cost projections that can then be compared to current PIHP/ CMHSP costs and select mild/moderate benefit costs net the MHPs and MBHO/ASO costs for their share of this responsibility as a first step. The proposed model also suggests that the CMHSP Pilots will also provide specific care coordination and related integration activities at the point of service that would produce reduced physical healthcare costs for the MHPs. To calculate saving in this area would suggest the negotiation of the defining characteristics of these targeted subpopulations of shared consumers/members; likely those with high ED utilization and readmission rates, with multiple chronic health conditions and those that may have been difficult for MHPS to engage and who have not had

consistent access to needed primary and even specialty care as examples. Once defined, historic paid claims data should help to determine the baseline cost from which cost reductions may be determined such that potential "savings" could be quantified and tracked over time. Because the suggested 298 Pilot financial model would for the first time consolidate at the local CMHSP pilot, all of the Medicaid and Healthy Michigan Plan behavioral health funding and the other public funding sources for SUDs, and funds for the mild/moderate benefit, it is likely that there are still other efficiencies we cannot yet imagine especially in areas like workforce training, network management, data collection and information technology just to name a few.

As to the considerations for the Reinvestment Plan for Savings, there will need to be processes in place to ensure all service and administrative costs are covered first, especially in transition to pilot status. A new challenge for the SCCMHA as a pilot will be the recognition and sorting of revenue from 4 new MHP payers and the MBHO/ASO needing to be "federated" or pooled to support the cost of service and administration. This construct of the paid revenue to the CMHSP for each of the MHPs in particular, not being exclusively directed to their members cost of care alone (PMPM vs. PEPM), is surely a new and unique arrangement that will require much more conversation and planning. It may be possible to assign administrative cost proportional to MHPs member enrollment and MBHO/ASO PEPM funds but even this notion will be challenged by how costs are experienced for consumers enrolled in each plan and consumer services funded by the MBHO/ASO for the unenrolled population.

The CCBHC Plus model we are proposing has as a core value the desire to use "savings" at the CMHSP level which would have a "local identity" to expand services to persons who are uninsured or underinsured which is a priority for the Saginaw community. Every week we meet or hear from such citizens that are not Medicaid or Healthy Michigan eligible and that have real time treatment needs that we have no way to address because State General funding is so limited and who have no interest in being on a waiting list. Among this group is a small population of eligible youth that we can seek SED waiver enrollment for, but that is really about the only situation where we have the means to provide treatment and supports. That said though, we think it will take some time to get to this level of savings to truly be able to meet the needs of all uninsured or underinsured comers to our front door.

In addition, we also have had a steady increase in penetration rates in each of the last three years in the provision of the specialty benefit to eligible Medicaid and Healthy Michigan enrollees. The related costs have been exceeding PEPM funding for Saginaw County enrollment. Therefore we have several cost reduction strategies already underway to contain expenses. This is an important context not only for the initial adequacy of 298 Pilot rate development, but also for the consideration for 298 Pilot savings and a reinvestment plan development. We think the pace of the increased access demand from eligible Medicaid and Healthy Michigan enrollees for the specialty benefit will continue into the pilot period. Therefore reinvestment plans as per the 298 boiler plate language that directs any 298 Pilot savings to be reinvested into services for treatment and supports to persons with behavioral health and intellectual disabilities or at risk of such, are in alignment with our current experience and efforts. Our early thinking, informed by the need of those new consumers coming into service and the needs of the most expensive to serve persons in our system, would begin with reinvestment plans that include strategies to create new residential services and shoring up existing residential options as well as creating and piloting additional alternatives to inpatient care that we have not had the resources to develop to generate even greater savings.

How much saving can be realized in the life of the pilot and when it can be made available, will help to shape the Reinvestment Plan details. Reinvestment of saving generated from integration activities is discussed in Section 10.c.

8.d Specify how the financial arrangements of a pilot will address the various "community benefit" functions of the CMHSP such as various pooled funding arrangements, social services collaborative agreements, and other relevant community activities.

The long standing behavioral health leadership role and the community benefit offered by the public mental health system not only sets it apart from other states, but also from other public service delivery systems in Michigan. We know that our local community contributions have been game changers to local communities. These important contributions to the communities where CMHSPs are located has been supported and legitimized by the PEPM capitation and now sub-capitation from the current PIHP. Had we still been working in the fee for service environment of the early 1990s with the huge reductions of State General Fund appropriations over this same time period, we could simply not financially support the community benefit work we do in local communities.

Over the last two decades the largest financial support to the CMHSPs has come in some form of sub-capitation which has permitted CMHSPs to use the Medicaid and now Healthy Michigan funds to not only support the specialty carve out benefit to eligible consumers, but to also work in the important community spaces between direct consumer service and system innovation. There is respected and purposeful variation between CMHSPS and their home communities in this space, unique to the make-up, resources and needs in local communities. SCCMHA and Saginaw County are no different in this regard.

SCCMHA like many CMHSPs is generally regarded as a skilled, reliable leadership organization in the community, known for innovation and creative problem solving and as a trusted partner for other systems. This experience and skill comes from decades of improved understanding and navigation of other local systems whether they be law enforcement systems, judicial and forensic systems, educational systems, employment systems, housing and homeless systems, transportation systems, entitlement systems, child welfare systems, juvenile detention and probation systems, adult parole or probation systems, faith community systems, advocacy systems, self-help and recovery systems, tribal community systems, veteran's systems, healthcare systems and other human service systems. The motivation to understand and develop mastery over the navigation of such systems has been to improve access and resources for consumers with disabilities who could not navigate them on their own. Good collaborative partners respect each other, learn from each other and help each other, often without a single dollar for anything passing between them. The fact of the matter is that the needs of our consumers are deep and wide and for many span a life time. While for others their needs will be met in these other systems well after their treatment and recovery time with us is over. They and we as CMHSPs, are bottom line, working with these other systems every day to help the consumers we serve not just navigate them but to maximize what they have to offer, to create for themselves, meaningful quality lives of their choosing. That means a place to live, work, learn, recreate, worship and yes get physical healthcare, while partnering with us to assist with their mental illness, substance use disorders and intellectual/developmental

disability needs. We could simply not carry out our CMHSP mission without help from other systems.

In the case of SCCMHA, in addition we are known for our sophisticated administrative infrastructure; our ability to convene and lead stakeholders on a wide variety to subjects; our ability to write grants for initiatives in partnership with other organizations for a specific need and to implement well such awards if funded; our willingness to share what we know and teach this content to others. We are even asked to fill some unique roles as we are perceived to be a "neutral party" when projects bring together organizations that may be in competition with each other for funding, market share or some other consideration. Though asked often to fill such roles, we generally accept only when the project or endeavor will benefit those we serve and their families, the request is in alignment with our mission and values, we have staff experts available or the role is short term and there are funds to pay for our leadership. In other cases we see a problem bigger than our ability to address on our own and will initiate projects ourselves.

We have many staff that sit on the boards of other local agencies outside our network and sometimes hold leadership positions there, still others are not in leadership but are members because they are technical experts. SCCMHA leadership and staff members participate in the following local groups; the Children's Mental Health System of Care Executive Committee, Child Abuse and Neglect Council Board, the Saginaw Health Plan Board, the Great Start Collaborative Executive Committee, the Saginaw Crime Prevention Council, the Saginaw team for the *First Responder's Guide to Behavioral Health Interventions*, Alignment Saginaw our community collaborative and its Community Health Improvement Plan Steering Team, and the related Emerging Health Care Models and Behavioral Health sub committees where our senior staff serve as chair persons, the Children's Health Access Program, the Sexual Orientation and Gender Identity Council, the Mexican American Council, the Community Corrections Advisory Board where we have chaired for 17 years, the Michigan Health Improvement Alliance Board, Open Table- a faith communities initiative, the Executive Planning Committees of all of the specialty treatment courts in Saginaw (Mental Health Court, Felony Treatment Drug Court, Sobriety Court), the Saginaw Psychiatric Inpatient Advisory Group, the Saginaw County (SUD) Prevention Council, the Saginaw County Suicide Prevention Council, the Saginaw County Consortium for Homeless Assistance Providers, the Saginaw Hoarding Task Force and most recently, the Neonatal Abstinence Initiative.

At other times our community benefit work is described in Memorandums of Understanding to describe specific activities like training, staff crisis debriefing, screening and referrals and so on. At present, we have MOUs with the following Saginaw organizations; the Saginaw Community Foundation for the Community Health needs Assessment, Partners in Pediatrics, Saginaw County Sheriff's Office, Saginaw Commission on Aging, Child Abuse & Neglect Council, Early On Saginaw, Great Lakes Bay Health Clinics, Mexican American Council, Saginaw Chippewa Indian Tribe of Michigan, CMU Partners in Health, City of Saginaw Public School District, Legal Services of Eastern Michigan, Michigan Youth Treatment Infrastructure Enhancement and, the MDHHS for the MI Bridges Benefit Portal.

Still other local partnerships have actual contracts that delineate something we are being paid to do like the 20 year contract with Covenant Health System for our presence in the Emergency Care Center for psychiatric prescreening of commercially insured and Medicare patients, with the Family Court for MAYSI screening of all youth with family court involvement,

mental health treatment to Saginaw Mental Health Court participants that are not Medicaid or Health Michigan Plan enrolled. SCCMHA also holds a contract with the Saginaw Family Court to define the pooled funding arrangements for our combined SCCMHA GF and the Child Care fund for the SED Waiver and other projects.

In addition to the responsibilities we have for providing the Specialty Carve-Out benefit and our service to uninsured, commercially underinsured and Medicare consumers, the community benefits we provide to Saginaw County defines who we are as a CMHSP and why a sub-capitated funding arrangement is being recommended to the MHPs for the 298 Pilot. Assuming this is acceptable, there would be no plans to change these efforts or our approach to community benefit offerings in the future. It is in this critical spirit of community partnership, that we plan to post our RFI response on our website along with the 20 plus letters of support that our partners including our three state legislators have offered to us for this RFI, but for which space constraints will not permit inclusion as a part of our submission.

NEW Section 8. e Provide a description of how the specialty behavioral health benefit for the fee for service population could be best managed in the pilot region.

In offering the response to this NEW question, we wish to point out that the responses throughout our RFI submission are largely unchanged and that the review team can surely consider that the specified MBHO/ASO “payer” for the fee for service (unenrolled with a MHP) population can be replaced with any of the first two options below, which are listed in order of our preference.

Option 1. MDHHS to pay a capitation or sub-capitation for the unenrolled to the CMHSP Pilots individually or through a single pilot with sub-capitaion or sub distribution to the other pilot participants. MDHHS could withhold the HICAA tax and either direct the pilots to pay the hospital the HRA payments and or the HICAA tax or do so themselves. MDHHS would also maintain the oversight and as such join the pilots and the involved MHPs in planning for implementation as described throughout the SCCMHA RFI submission. MDHHS in so doing would work with the pilots as we will need to work with the MHPs to determine the criteria for care coordination by the pilot CMHSP sites in order to facilitate integration activities up to and including the addition of necessary HCPC/CPT codes to either fund this work on a fee for service basis or through other value based purchasing options with dollars from the fund paying physical health care claims to providers currently serving the population.

Option 2. MDHHS to procure an MBHO or ASO to pay the CMHSP Pilots a sub-capitation for the population for behavioral health services and this organization would join in pilot planning as described in this RFI. Again, specifically with regard to care coordination and integration activities, fee for service or other value based purchasing options would be acceptable. SCCMHA appreciated that such procurement would be a large undertaking for MDHHS and the time limited duration of the pilot and necessity for quick start-up may prohibit qualified applicants from participating.

PIHP to retain the payer role for this population is not preferred, largely because it will be challenging enough to plan and move through transitional activity with the MHPs without the confusion and misaligned interests between the MHPs and PIHPs. This option is also from our discussions with the MHPs not their preference and for some may be a deal breaker to pilot participation. Furthermore, to ask the CMHSP pilots to maintain their responsibilities for our

delegated managed care functions from our PIHP, shared governance role there and respect for the regional interests of other non-pilot CMHSP partners in the PIHP affiliation does everyone involved a disservice. In the case of our current region, there would be a One PIHP and 11 CMHSP partner interests out of alignment with our own.

9.a.i Describe the applicant's plan for specialty behavioral health access including any delegated activities.

SCCMHA would recommend shared access responsibility with the MHPs and MBHO/ASO. SCCMHA has a well-established system of access as evidenced both in the access services which we provide and in our history of administrative compliance with Access standards. However, we recognize the importance of the MHPs and MBHO/ASO to attend to access standards from a Member Services perspective as well as their capacity to strengthen access through provider network referral agreements. Thus we would recommend partial delegation of this function. SCCMHA is able to provide eligibility and level of care assessments which require the face-to-face assessment of consumers requesting service.

Ensuring access can be accomplished by monitoring a number of different aspects of performance:

- Desk audit of documents which demonstrate compliance in policy and publications;
- Demonstrated availability of the service array in a provider network adequacy reports;
- Demonstrated use of the service array as evidenced in encounter data across all categories of service;
- Through consumer self-report as measured through survey (CAHPS) or similar member input;
- Through focused access performance indicators such as HEDIS, MIPS or other National Quality Measures;
- Through analysis of Medicaid penetration rates which demonstrate if the plan is reaching enrollees in a given region at a comparable rate to other plans or the state average;
- Performance Improvement Projects (PIPs) specifically related to Access performance improvement;
- The MDHHS Michigan Mission-Based Performance Indicator System (MMBPIS) to measure access timeliness;
- MDHHS summary encounter data analysis using the annual MUNC and Sub-element Reports comparing service use patterns across the state;
- The three-year Certification of CMHSPs by MDHHS, which also demonstrates the requirement of the CMHSP to provide the full array of services.

SCCMHA would be prepared to work with MDHHS and the 298 Implementation contractor, MPHI, to identify methods of access performance monitoring which would exist in the current MHP Compliance Plan which would also have applicability in the monitoring of access to the Specialty Benefit. Our assumption is that the integration of the Specialty Benefit into the MHP would include the transfer of monitoring of benefit access, along with all other

dimensions of compliance, to the MHP. The MHP could demonstrate compliance with access assurance as a function delegated to the CMHSP or as a direct provided function.

Our capacity to monitor access performance has been built on an integrated platform of information system applications. The platform is fourfold, including: 1) a fully automated financial system, 2) a fully automated electronic health record which is in use throughout the network, 3) a federated health record for care coordination using the CC360 Data Extract in the Zenith Integrated Care Data Platform, and 4) a mature data warehouse which uses SQL server ETL based OLAP technology.

SCCMHA has taken collaborative leadership for health insurance enrollment in the community with two campaigns: the Saginaw County Enrollment Advocacy Network, which is a learning community for advocacy staff supporting Medicaid enrollment; and the *"Get it; Keep it; Use it"* public information campaign which was launched in 2015 to message the importance of health insurance enrollment.

9.a.ii Explain the processes for assessing and ensuring adequate access to appropriate specialty behavioral health screening, assessment, and ongoing service (including but not limited Native Americans, children and adolescents, and persons with substance use disorders).

Ensuring adequate access for special populations is accomplished through policy, practice guidelines, the use evidence-based practice models and through service delivery system design. Performance is monitored through quality improvement workgroups and projects.

For individuals who are American Indian or Alaska Native services would generally be provided by formal arrangements with tribal providers; SCCMHA includes American Indian cultural information in SCCMHA training programs and has developed policy to support knowledge of specific culture needs. Person-centered and family-centered care includes care which recognizes the particular cultural and other needs of the individual. This includes but is not limited to services for consumers who are American Indian or Alaska Native (AI/AN), for whom access to traditional approaches or medicines may be part of CCBHC Plus services. For consumers who are AI/AN, these services may be provided either directly or by formal arrangement with tribal providers.

SCCMHA initiated a collaborative interagency agreement with the Saginaw Chippewa Indian Tribe of Michigan based in Mt. Pleasant in 2005 that is still in effect. The agreement addresses terms for the mutual sharing of service scope information, unique service eligibility conditions of each entity and interest in bi-directional referrals between the entities when appropriate. SCCMHA has reached out to the Saginaw Chippewa Indian Tribe at this time to refresh the collaborative referral agreement between the organizations. Further, SCCMHA has embedded Native American culture information as part of the network cultural competency training and relevant policies and procedures.

In regard to access for children, adolescents/youth and families, SCCMHA adheres to person and family-centered planning and youth-guided treatment to deliver services and supports that are recovery oriented, culturally and linguistically responsive to meet consumer needs, preferences, choices and values. Additionally, SCCMHA conducted a yearlong assessment of the access experience for children and as a result has designed new process which opens families directly into a period of crisis stabilization with the Mobile Urgent

Treatment Team with an intensive period of assessment, family education and matching of families with appropriate EBPs as a part of the Person-Centered Planning process following stabilization.

Access for persons presenting with SUD concerns has been a part of the CMHSP access design both directly and as a delegated access site for MSHN. The Access and Crisis Intervention Staff are trained in the SUD access screening and level of care criteria and are enrolled as users in the MSHN REMI SUD access program. SCCMHA establishes through policy the expectation that care coordination is a critical expectation of service delivery throughout the SCCMHA network in order to promote positive outcomes and improve the experience of consumers.

9.b.i Explain the planned process for customer service under the pilot including delegated activities.

SCCMHA would expect that the MHPs and MBHO/ASO would retain the preponderance of Customer Service functions and partially delegate certain tasks to the CMHSP. There would be a comparable level of Customer Service required of the CMHSP in order to meet Recipient Rights duties and to respond to and coordinate response to any communication from the MHP or MBHO/ASO. Functions such as: maintaining a designated unit, phone access with toll free and live response, posted hours of operations, publication of a customer handbook, provider listing, information about the MHP and the benefit, assistance with grievance and appeals and customer service staff training are all elements that SCCMHA could assist with but they would be an excellent starting point for the MHPs and MBHO/ASO to demonstrate an integrated benefit to the members and a touch point for member and service communications between SCCMHA and the MHP.

Presently at SCCMHA, information about how to access the benefit is provided to consumers at the point of entry. Consumers receive the Consumer Handbook which informs them of the array of services included in the benefit and following determination of eligibility. An individual orientation session is provided at the start of services and it expands on the explanation of services and how to request them. SCCMHA would be able to distribute MHP specific member handbooks.

SCCMHA has also created an Entitlements Office which is collaboratively staffed with outstation workers from the local DHHS office. This partnership of several years duration focuses on removing barriers to access by ensuring that consumers are assisted with Medicaid applications, with monitoring their continuous enrollment, and with ensuring that all deductibles are reported.

A chartered quality committee at SCCMHA, the Access Management Group, reviews five measures of access performance including: outreach, access, engagement, activation and retention. The overarching goal of this workgroup is to improve the Medicaid Penetration Rate by improving the access experience for consumers. SCCMHA increased the Medicaid penetration rate an average of 15% per month from the previous year at the same month, over the last three quarters of FY 17 per MSHN reports.

SCCMHA maintains a website which meets the Customer Services requirements for access to information about the PIHP and capacity would be available to incorporate pages for affiliated MHPs and the ASO if they wished to delegate this function or provide links from their website. The handbook and detailed information about the benefit is available on the website.

We are assessing the new regulations requiring us to address the new managed care standard for machine readable content. The SCCMHA website also serves as the interface for public education, access information, hours of operation, provider listing and other obligations of public governance. SCCMHA also uses a Facebook page for public service announcements.

9.b.ii If the function of customer services as defined by contracts is retained by the MHP, explain how the MHP will demonstrate competency to administer customer services functions for the specialty behavioral health population.

SCCMHA is recommending that Customer Service be partially delegated by the MHPs and MBHO/ASO. The HSAG 2017 technical report on compliance across MHPs and PIHPs shows a high degree of performance in these functions. We would assume that the External Quality Review Organization (EQRO) would continue to monitor compliance. SCCMHA would be prepared to submit the following to each MHP and MHBO/ASO in order to assist them in meeting these requirements if retained.

Hours of operation: SCCMHA as a provider network would need to provide hours of operation for all sites or for a subset of sites as required. Services are provided in over 200 contracted locations.

Provider listing: SCCMHA publishes a provider listing by category and would submit this to the MHP for customer services purposes. The listing is also available on the SCCMHA website.

Phone Access: SCCMHA could provide toll free phone with live answer 24/7/365 for second level response if the MHP retains customer service functions.

Information about CMHSP/CMHE: The managed care rules require information about the plan itself be available for members. SCCMHA would provide this information for all delegated functions to the MHPs and MBHO/ASO to include in their member handbooks and related publications.

Customer Service Staff Training: SCCMHA would be prepared to provide periodic training to the MHP Customer Service staff about the specialty benefit, relevant public policy and health integration practices within the region.

9.c.i Describe the applicant's IT capacity to interface with various MHP systems including the ability to submit Behavioral Health Treatment Episode Data Set (BH TEDS) and encounter data to the appropriate MHP for submission to MDHHS.

SCCMHA has the ability to interface with Secure FTP sites for transfer of the BH-TEDS and Encounter data to specified recipients according to contract. In a 298 Pilot, this reporting could be done by submission to a single site which would distribute the data to the MHPS and MHBO/ASO following confirmation of enrollment in CHAMPs or SCCMHA could use our 834/271 enrollment/eligibility files to identify the MHPS and MHBO/ASO and send files to multiple sites. The name of the MHPS and MHBO/ASO is not a data element in either the BH-TEDS file or the Encounter Data file and so the programming for batches if done by SCCMHA or PCE would require some development to accomplish that parsing by plan.

SCCMHA would need to have continued access to the 834/271 files for all enrollees. These are presently sent by MSHN to PCE and will need to be sent directly to PCE for 298

operations and reporting. It would be preferable to continue to receive a single county wide file rather than a file from each MHP and the MBHO/ASO. A single file would be more efficient to work with and would reduce the risk of enrollment/eligibility data integrity errors throughout all operations.

The MDHHS specifications for the structure of all reporting files are published on the MDHHS reporting requirements web page. SCCMHA begins construction of batch files in the PCE reporting service and prior to submission reviews and addresses errors. Our quality metric report for reporting performance shows zero errors per month over the past twelve months. SCCMHA submits an average of 11,500 encounters per month in three batches. With an average of ten pre-submission errors per month which are resolved prior to submission. A similar batch process is used for BH-TEDS submissions with validation audits identifying errors prior to submission.

PCE submits incident reports to MSHN from modules within the electronic health record. These incident reports are submitted nightly and not by batch. The MHPS and MHBO/ASO contract would need to specify a secure address for submission of incident data.

Other non-batch reporting is done directly to MDHHS which maintains a variety of secure web based sites for reporting various special funding including the WSA portal for waivers and the OBRA Application. The PIHP/MHP MDHHS Systems List users are managed through the SCCMHA Security Management quality workgroup.

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9.c.ii Describe how you will track data by distinct funding sources (i.e. separate MHPs.)

SCCMHA has submitted to Health Services Advisory Group (HSAG) and to MSHN an annual Information System Capability and Assessment Tool (ISCAT) for the validation of performance measures for over 15 years with consistent exemplary audit reports. The ISCAT points to our ability to demonstrate data integrity in administrative processes which begin with the accurate identification of the Medicaid consumer and the Medicaid payment. The SCCMHA Revenue Cycle Critical Path is documented and monitored by several operations work groups which verify fund source applications monthly. The SCCMHA electronic claims processing and fund source allocation is fully automated and linked with the CHAMPs 834 Enrollment and the MPHI 271 Eligibility files. The 837 Encounter Reports are consistently submitted successfully by SCCMHA and coupled with the year-end Medicaid Utilization Net Cost Report (MUNC) demonstrate our ability to identify consumers and encounters by fund source. In the 298 pilot, the MHP payer information would be readily integrated into the consumer insurance record as an automated system linked to the 834 file. This demonstrated capacity is at the core of our automated revenue management system. (See the sample Chart of Accounts which follows in Section 9.d.ii.) Additionally, the SCCMHA system continuously checks and reassigns fund sources using the 271 file which more accurately establishes eligibility and enrollment at date of service.

9.c.iii Describe your current capacity and readiness to report required substance use disorder data and information to meet current SUD reporting requirements as specified in the PIHP contract.

SCCMHA served as the PIHP with coordinating agency oversight for Saginaw County in FY 2014 and 2015. During that period all aspects of SUD reporting were incorporated into the business platform. SCCMHA delegated CA functions to the former entity, the Saginaw County Department of Public Health, but all administrative services were performed by SCCMHA including network management, encounter and quality reporting, claims payment and customer service during that period. The SCCMHA data warehouse imported 837 encounter files which were generated in the CareNet electronic managed care software used by the CA at the time and made that encounter data available to support our administrative service's needs.

The SCCMHA electronic health record is capable of collecting and reporting the BH-TEDS and encounter data with minimal required adaptations of existing processes. All SUD HCPC/CPT codes which were added to the system have been updated to ICD10 and are ready for use in contract set up, authorization, and claims adjudication.

Other required SUD reporting for Prevention, Annual Plan and similar MDHHS ad hoc reporting requests can be met through existing experience and capacity. The former Saginaw CA director was retained by SCCMHA as an SUD program coordinator. This position has served as the PIHP liaison for delegated SUD managed care functions and provided leadership in locally retained functions related to the management of the SUD benefit.

The SCCMHA data warehouse provides real time (claims paid within the past 24 hours) data for comparison by any service/demographic or period of time. The 298 Pilot Project would need to address the availability of the SUD encounter data for Access Monitoring at the MHP level, but SCCMHA would be prepared to report on SUD encounter utilization by plan if needed once encounter data was moving through Saginaw as CMHE. We would require at least two prior years SUD data from the MSHN PIHP for the purpose of benchmarking.

9.c.iv Address the applicant's capacity and competency requirements for any reporting that is new to the pilot members (i.e. BH-TEDS.)

PCE Systems, the EHR vendor for SCCMHA, currently has a number of PIHPs and CMHSPs who serve as CAs using their electronic health record and associated managed care functionality. SCCMHA will work with PCE to select the right configuration for the Saginaw application based on our existing platform and to expand reporting services accordingly.

Our vision for SUD operations is consistent with the CCBHC Plus model of integrated mental health/substance use disorder treatment. We would design an integrated business and clinical record platform with minimum necessary segregation of operations to address the requirements for protection for categorical fund source management and reporting. The SCCMHA EHR has multilayered Access and Identity Management security mechanisms which will support the SUD 42CFR provisions as well as the categorical program financing and UM tools which are unique to the SUD benefit.

SCCMHA has the ability to generate the BH-TEDS files. The Department has provided technical documents and training through the EDIT workgroup. The BH-TEDS files for SUD have minor differences from the BH files other than the distinction of the type of episode. The

SCCMHA BH-TEDS administrator is the Quality Supervisor who works closely with the IS staff to troubleshoot any BH-TEDS data errors. Additionally, BH-TEDS data integrity is monitored by the SCCMHA State Reporting workgroup which prepares a monthly metric report documenting encounter, BH-TEDS and Performance Monitoring submissions for volume and errors.

9.d.i Describe the planned process for Claims Management including delegated activities.

In meetings with the MHPs there have been productive discussions surrounding SCCMHA's experience in claims payment activity and its complexity with regard to the current specialty service benefit. Discussions have touched on topics such as: the volume of contracts, the unique nature of the services, additional responsibilities for SUD network and CMHE status, and considerations for efficiency. SCCMHA is recommending that these responsibilities be delegated to SCCMHA. The response to this recommendation from the MHPs would be characterized as under advisement with their final decision pending.

SCCMHA claims management systems (current MH & addition of SUD with pilot/CMHE status) will operate through fully integrated clinical and financial HIPAA compliant web-based software ensuring medical necessity through managed care prior-authorization number approval. Provider fee schedule setup is coordinated and entered by the SCCMHA Network Services Department ensuring checks and balance in delegation of duties from the SCCMHA Finance Department claims processors in efforts of ensuring effective financial controls. The SCCMHA Network Services Department procures standardized service contracts based upon MDHHS HCPCS and revenue coding and staffing qualification guidelines. Furthermore, all competitive market service contract rates are standardized by service category and require coordination of benefits (COB) billing through primary insurers where applicable ensuring the use of Medicaid funding as payer of last resort. Service contracts and fee schedule setups include all appropriate coding and State reporting fields such as tax identification number (TIN), national provider identification (NPI), and any applicable coding and location specific modifiers. Provider network demographics are updated at least annually via a standardized provider application submission process for contract initiation, continuation or revision.

The SCCMHA claim adjudication recognizes the fund source that will cover the cost of the service at the time of either claims submission or board operated billing. External providers submit both professional and institutional claims through the EHR via paper claims, direct claims entry into the EHR, or an 837P/837I electronic claims compliant format, which identifies the eligibility of the consumer on the date of service, captures the contracted rate, and applies the appropriate general ledger account number, in addition to other edits applied at the time of adjudication. If the fund source recognized is capitated, a journal entry is posted to recognize the correct funding to cover the cost of service. If the fund source identified needs to be billed to a third party payer, the required information is captured and becomes part of the billing/COB process.

Board Operated services are provided by employees of SCCMHA. Employees that are clinical staff enter service activity logs (SALs) into the PCE electronic health record, which captures all required billing information. The EHR likewise identifies the eligibility/COB of the consumer on date of service, applies the standard billing rate, and applies the appropriate general ledger account number. The plan for the 298 pilot is to create additional fund sources in the general ledger that are specific to each of the MHPs and the MBHO/ASO. What will still

need to be determined is the way revenue from all MHPs and the MBHO/ASO will be "federated" to be sure that there is adequate revenue to match to service claims, service activity logs from the SCCMHA Board operated programs and related administrative costs no matter which payer is involved. Historically, the CMHSP system has been blind to specific MHP member enrollment and unenrolled Medicaid populations. Instead, we only had to assign service costs to BH Medicaid, Healthy Michigan Program, SUD Medicaid, SUD Block Grant, SUD Pa2 and so on. 298 Pilot status will require changes in the chart of accounts to track revenue by specific MHP and the MBHO/ ASO. The system can readily handle these changes with the implementation of the Revenue Recognition plan for MHPs and MBHO/ASO Revenue.

SCCMHA makes timely payments to all providers for covered services provided under a signed contract with defined claims submission terms. Claims are paid within 30 days of receipt for 90% of all "clean" claims and within 90 days of receipt for 99% of all "clean" claims. A clean claim is defined as having all Claims Criteria accurately supplied. A letter of authorization is distributed by SCCMHA to providers, which includes the assigned authorization number for delivery of the appropriate service. Every claim must contain this authorization number in order to be considered a clean claim. If a claim submitted by the provider is paid by SCCMHA, but is subsequently determined to be a false claim (i.e., improper or unsubstantiated), SCCMHA is entitled to recover its costs by deducting the amount of the false claim from the provider's future claims or requiring reimbursement by the provider. In addition to the amount of the false claim, SCCMHA costs may include, but are not limited to, associated administrative costs and expenses. SCCMHA also reserves the right to seek any other remedies available at law and/or in equity in remedying a provider claims dispute. Every claim payment includes the identification of the fund source number of the benefit plan that will cover the cost of the claim. This information is integrated into our general ledger system, which allows for routine reporting.

SCCMHA's accounting practices have been developed to provide stability for the entire system, as well as accommodation for the ever changing CMH financial environment. The general ledger account structure has been created to allow for monitoring of consumer eligibility by service, effective date, and payer. The account structure also allows for integrated cost reporting for both summarized and detailed analysis of billing and claims activity. The structure's flexibility allowed by this automation impacts both fee for service billing and claims adjudication processes.

By using system edits within provider contract setup already described, we are able to create efficiencies during claims processing by eliminating claims submission if they are not in accordance with provider contracts. Providers submit their claims online, which are then adjudicated based on the edits applied to individual provider contracts and setup, which is monitored and maintained by provider management. Although the concept seems quite simple – the structure is extremely complex as it relates to the software and programming developed to insure accuracy in routine claims payment, upstream billing, and reporting.

SCCMHA's general ledger uses a five-segment- thirteen-digit chart of accounts number (0.00.000.0000.000), to capture the detail for individual transactions. The system is programmed to automate population of each of the digits within these five segments based on the provider setup, consumer population, business unit, and fund source effective on the date of service. The five segment structure also allows detailed information to be sorted and analyzed based on each of the segments. When new segments are needed to report new fund

sources, providers, business units, etc., additional account combinations are created and linked to complete the automated processes. This functionality lends itself to creation of new funding streams that will be required as part of the 298 Pilot. It will allow transactional detail to be captured for reporting and costing purposes using the flexibility already built into the system. *See the SCCMHA Chart of Accounts illustration below for recognition of MPHs and MBHO/ASO revenue.*

SCCMHA Chart of Accounts Format in Sentri/GreatPlains				
Agency Number	Population Number	BU-Business Unit Number (Range)	Account Number (Range)	Payer - Fund Source Number (Range) * Expanded for 298
0.	00.	000.	0000.	000
0 = Total	10 = SED Child	100 = Hospitalization	1000 = Cash Accounts	001 = Private Pay
2 = Board	20 = MI Adult	200 = Crisis/Emergency	1100 = Insurance & Other Receivables	*200 = 298 Medicaid Health Plan
3 = Contract	30 = DD Adult	300 = Clinic Health Pharm	1200 = Grant Receivables	*210 = MBHO/ASO
7 = Unearned	40 = DD Child	310 = Physician Services	1901 = Prepaid Expense	*220 = McLaren HP
	60 = SUD Adult	333 = Enhanced Health Services	2600 = Deferred Revenue	* 221 = Waiver
	70 = SUD Child	380 = Pharmacy	5890 = Capitated Revenue	*223 = Fee For Service
	90 = Allocated	400 = Case Mgmt/Supports	5000 = Revenue Recognized	*225 = Sub Capitation MH/DD
		421 = Case Management Services	5100 = Revenue Adjustments	*227 = Sub Capitation SUD
		435 = Support Coordination Services	6000 = Wages & Benefits Expense	*229 = Allocations
		453 = Family Support Services	7000 = Other Operating Expense	*230 = Meridian HP
		500 = Clubhouse/Drop In	8100 = Contract Expense	*240 = Molina HP
		600 = Residential/CLS	8200 = Accrual IBNR Expense	*250 = United HP
		700 = Employment/Skill		300 = Commericial Fee for Service
		800 = Prevention		400 = Medicaid Fee for Service
		900 = Allocated		500 = Grant Funding
				528 = Community Block Grant
				700 = Capitated General Fund
				710 = PA2 Funding
				740 = General Fund
				800 = Capitated Other Waiver
				900 = Capitated Medicaid
Example Account Combination Number =		**3. 60. 421. 8100. 210**		
3 = Contract Provider	60 = SUD Adult	421 = Case Management Services	8100 = Contract Expense	210 = MBHO/ASO
Note - This list is not all inclusive, rather it is a tool to illustrate the chart of accounts format				
Date - January 2018				

9.d.ii Explain the partner CMHSP's capacity and competency (including electronic infrastructure to manage substance use disorder (SUD) services claims consistent with the following SUD financing arrangement.

During FY14 & 15, SCCMHA provided service contract procurement, network management and claims management for all SUD functions for Saginaw County and still retains these FY14-15 SUD provider setups of the Saginaw SUD network in our electronic health record in an inactive status that could be easily updated and reinstated at minimal administrative expense. In this prior role, the SUD network claims were submitted to SCCMHA for adjudication and payment using a similar process as all other managed network service providers. External providers submitted claims, which checked eligibility of the consumer on the date of service, captured the standardized contracted rate, and applied the appropriate general ledger account number, in addition to other edits applied at the time of adjudication. Even though the electronic medical record was maintained in the CareNet system, the claims data was captured in the EHR. Likewise during the adjudication process, similar to all other claims submitted for CMH services, if the fund source recognized was capitated, a journal entry would be posted to recognize the correct funding to cover the cost of service, with the business unit (BU) that captured the cost. If the services delivered are to be charged to the Block Grant or PA2 revenue, the specific fund sources for this revenue would be identified. The

methodology currently used at SCCMHA for payment of claims allows for the flexibility to add additional payers, which are monitored by the internal controls/edits that have been developed within the provider management system. These internal controls/edits have been developed to capture the allowable service array, correct fund source based on eligibility, and pay the allowable contracted/standard rate based on the date of service delivery.

9.e.i Explain the applicant's plan for ensuring all required quality management functions (as defined by current contracts) are met including delegated activities.

SCCMHA would recommend that certain Medicaid quality management functions be, partially delegated to SCCMHA; SCCMHA would expect to participate in a pre-delegation review of capacity by the MHPs and MHBO/ASO. The pre-delegation review of performance capacity would be most efficiently done by a single audit, but if necessary SCCMHA could be prepared to respond to five audits for this region. This will also apply to our readiness to participate in the required External Quality Review of Compliance on behalf of the MHPs and MBHO/ASO which addresses quality management inclusive of: Performance Measure Validation, Information System Capability Assessment, Event Verification, PIP participation and any select HEDIS measures.

There are four areas of Quality Management which will require attention during the 298 Pilot operational discussions: 1) the clarification of the denominator in quality measures; 2) a decision regarding how to identify specialty benefit members in the Consumer Assessment of Health Care Provider Systems (CAHPS®) reporting or whether to select an alternative tool designed for the specialty population (e.g. the MHSIP which is currently used by MDHHS as well as by SCCMHA); 3) a selection of HEDIS measures which the MHPs and MBHO/ASO would want to extend to include the CMHSP; and 4) a decision about whether the MHPs and MBHO/ASO selection of a PIP can incorporate reporting for specialty members or if a unique PIP would be chosen by each of the MHP and MBHO/ASO or if a single PIP would be selected for all participants. The 298 call for administrative efficiencies would suggest that the selection of HEDIS and PIP projects would be project wide for the region and that would be our preference.

SCCMHA has experience, competency and capacity in demonstrating the above described dimensions of quality management with high scores from HSAG and MSHN reviews. The SCCMHA EHR was recently certified for Stage 3 Meaningful Use and we are preparing to attest in 2019. The progressive development of HIE capacity with health partners in the region is an important component of health outcomes through care coordination. SCCMHA is working with Covenant Health System, CMU Health and Great Lakes Bay Regional Health Centers in a variety of projects involving HIE applications.

SCCMHA has also participated in population health leadership in two venues, the Michigan Health Improvement Alliance (MiHIA) and through Alignment Saginaw with its Community Health Needs Assessment and planning processes, working to address community wide approaches to health outcomes. Alignment Saginaw partners include the Saginaw Community Foundation, Saginaw ISD, Saginaw Department of Public Health, Covenant Health Systems, St Mary's of Michigan (affiliated with Ascension), and Great Lakes Bay Health Clinics (FQHC).

9.e.ii The applicant should describe how the CMHSP, as a provider, fits into the MHP quality management requirements and plan.

SCCMHA would not define itself as merely a provider but more on par with the relationship that MHPs have with healthcare systems. We would be prepared to adopt an array of quality measures negotiated with the MHPs and MBHO/ASO. Ideally, the quality measures would be derived from those which are foundational to the demonstration of the core managed care functions but also include certain measures which would demonstrate the unique capacity of the Integrated Pilot. We would also encourage MDHHS to select a common set of measures to be demonstrated across all participating MHPs/ASO/CMHSP Pilots.

SCCMHA is not just a provider but a healthcare system with over 250 providers and we would be prepared to accept delegated quality management duties for the network. The pairing of our Meaningful Use electronic health record with the Zenith Integrated Care Data Platform, supported by a strong Information Management System, would facilitate most HEDIS and Process Improvement Project activities as well as Performance Measure Validation.

The SCCMHA attestation to Stage 2 Meaningful Use and the Medicare CQM submission in 2017 was based on performance by physicians who are directly or contractually employed in the Board operated program. The SCCMHA Director of Health Home and Integrated Care and the Medical Director meet with all physicians in the SCCMHA Network to ensure that Meaningful Use protocols are uniformly implemented. This medical leadership would serve the pilot well for network wide quality improvement projects.

9.f.i Describe the proposed plan for utilization management including delegated activities.

SCCMHA proposes that Utilization Management be a fully delegated function consistent with the plan for sub-capitated funding. Utilization Management incorporates the essential business controls to manage risk. With the risk for the region being divided to five participating plans ranging in membership from less than 800 to more than 1,500, it would be important for SCCMHA it have a single strategic plan for risk management with performance monitoring reported to the constituent MHPs and MBHO/ASO. The demonstration of performance would require the MHPs and MBHO/ASO to establish a utilization risk management plan which would guide the delegated functions for the CMHSP.

SCCMHA will build on the administrative capacity developed from our over 10 years of direct experience as a PIHP and from the experience delegated by MSHN since 2014. The essential elements including: written program description, review of scope, and procedures for prospective, concurrent and retrospective authorization are in place and have met both HSAG and MSHN auditing standards.

SCCMHA places a strong emphasis on integrity of the business controls which are embedded in the Utilization Management design. The authorization which is issued is contingent on confirmation of consumer enrollment and eligibility, demographic record completeness, provider eligibility, current contract and rates, appropriate use of HCPC/CPT codes, completeness of required assessments and service plans as well as medical necessity. With these essential business controls in place the authorization allows for electronic claims adjudication. The resulting business platform is highly integrated and automated. In the 2017

mini-ISCAT submitted to MSHN for HSAG Compliance review, SCCMHA reported that 75% of network professional claims from contracted providers and 65% of hospital institutional claims are processed electronically. The resulting efficiency is evident in the SCCMHA administrative rate.

The SCCMHA Utilization Management Plan incorporates a description of the UM operational practice and capacity as well as an analysis of utilization patterns by service category. The semi-annual analysis of utilization compares SCCMHA to its regional partners in MSHN as well as to the state at large using the Sub-element data in order to identify areas of risk in over or under utilization. The degree of control is based on the degree of risk. The UM plan may increase or decrease the frequency of review or reduce prior authorization requirements to encourage use of a benefit which is under-utilized, such a Peer Support Specialist during the period of access/engagement with new consumers. In the table of organization the UM Director and the UM division report directly to the Chief Executive Officer separately from Network Services and Clinical Program divisions in order to comply with the federal Managed Care rules and conflict free case management regulations.

9.f.ii Explain the degree to which consistent utilization management criteria will be developed for the pilot region.

Consistency in the application of Utilization Management (UM) criteria would be best served in a delegated approach to UM. SCCMHA has had a single UM division in place for 15 years and it is the single point of eligibility and authorization decision making. If the UM functions were distributed to five entities, the MHPs and MBHP/ASO, the consistency in UM decision making would erode.

The Person-Centered Plan is the primary device used for UM review of medical necessity in the specialty benefit. The use of scored measures applied as UM criteria beyond initial determination of eligibility is very limited. There is no level of care tool for the IDD benefit with the exception of the Autism and Child Waiver where level of care is determined by MDHHS and in the case of the Child Waiver the department prior authorizes services for FFS reimbursement. The use of the ASAM for the SUD benefit is the most prescriptive, but even that tool is coupled with qualifying assessments of the consumer’s motivation to change and treatment experience.

The level of care assessments which have been adopted by MDHHS include the CAFAS, PECFAS, DECA, LOCUS and ASAM. In order to establish inter-rater reliability, training is provided to all network staff with responsibility for scoring level of care assessments. The tools are useful for establishing normal utilization patterns and for the identification of outlier ranges of service use. SCCMHA UM practice policy strictly adheres to the prohibition of a single measure determinant of medical necessity. Level of care scores are analyzed in conjunction with encounter utilization data to inform the overall UM plan. SCCMHA uses similar analysis of scores to profile providers for service intensity and program fidelity. Further, in the SCCMHA UM plan the use of tools such as these is limited to point of access and not to the prior authorization of services after the start of care. The SCCMHA assurance in the consistency of application in these tools is housed in policy, staff training and data analysis applied to program compliance and overall analysis of benefit utilization. UM makes recommendations to case

holders when under use of the benefit is apparent and encourages case holders to consider additional or alternative services when unmet consumer needs are identified.

9.f.iii Describe how service continuity will be maintained through transition to the pilot including active service authorizations, person-centered plans, and self-determination arrangements.

Under a delegated arrangement for utilization management service continuity would readily be addressed through continued use of the SCCMHA electronic health record (EHR) which holds the Individual Plan of Service (IPOS.) In the EHR the IPOS is associated with the authorizations and the authorizations are specific in amount, scope and duration to specific providers. All SD agreements are integrated in this current model including individual SD budgets and service array.

As described above, all necessary business elements of a managed benefit are in place in the SCCMHA electronic health record and the ability to assign membership and fund source to specific MHP enrollments is readily incorporated as described in Section 9.d. These four business operations--eligibility/provider/UM/claims--are interlocking and are embedded in the authorization for services.

Continuity of SUD would require some amount of set up in the business platform but a transfer of consumer records and authorization tables could also be readily achieved with MSHN and PCE facilitating data transfers.

In the SCCMHA electronic record, the request for authorization is attached to the IPOS which is facilitated by the Person-Centered Planning process. This contiguous relationship of the IPOS to the authorization request facilitates the UM review of PCP based authorization. Over time the ability to move the IPOS through HIE Continuity of Care messaging might be developed which would make it possible to ensure PCP continuity between providers and managers. This is an optimistic projection; implementation would require significant reduction of the PCP as a document itself. As it exists now, the IPOS is heavily weighted with compliance narrative as required by MDHHS and often exceeds 15 pages.

SCCMHA holds 43 contracts for psychiatric inpatient care and uses web based continuing stay reviews where inpatient providers log directly into the consumer record to request additional days of care. Level of care determination is according to the MDHHS criteria described in the Medicaid manual. Inpatient UM is provided 24/7/365 with face to face preadmission screening provided by the Crisis Intervention Services which is co-located in the Covenant Emergency Care Center. SCCMHA inpatient UM staff capacity to work on site at all local hospitals as needed to facilitate discharge planning if needed.

9.f.iv Address how physical health and behavioral health parity compliance will be maintained for the pilot region.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires insurers to attest that there are no greater restrictions on behavioral health benefits than physical health. The realm of “limits” includes financial requirements, quantitative treatment limits as well and non-quantitative treatment limits (NQTLs).

Our understanding is that MDHHS has developed a workgroup to oversee the implementation of this regulation in the administration of the new 1115 Medicaid Waiver. The work of MDHHS has been initiated and will continue into FY 18 with their review of policy and contracts and the implementation of a survey which will be completed by the MHPs and PIHPs. We would assume that survey would extend to the 298 Pilot participants and we would be informed and prepared to respond to questions about our UM practices.

Informed by the survey responses MDHHS will develop a plan for corrective action which will likely become contractual obligations of the plans and delegated to CMHSP/CMHEs for implementation.

9.g.i Explain your planned approach to network management including delegated activities. Describe how the network management approach will address access and availability standards defined in current contracts.

Provider Network Management typically includes the functions of 1) network development and procurement (and re-procurement), 2) provider contract management (including oversight), 3) network policy development, 4) credentialing, privileging and primary source verification of professional staff, and 5) background checks and qualifications of non-credentialed staff. It is SCCMHA’s intent to maintain these responsibilities as a delegated function.

Under SCCMHA’s current network development and procurement process we monitor both through an annual review of the network and through continuous review of utilization using real time encounter data. SCCMHA has policies and procedures that address network management and development, as well as network procurement. SCCMHA contracts include a provider manual as an attachment that outlines all policies and procedures required for each contracted entity to abide by as a provider of services to consumers of SCCMHA. In addition to the contract, SCCMHA has a Provider Network Auditing Team that reviews compliance standards to the delegated activities and other SCCMHA and MDHHS policies at annual site reviews with providers. Performance deficits are reported in writing to the provider with an expectation for the development, submission and SCCMHA approval of Plans of Correction. SCCMHA routinely communicates with the provider network through a provider newsletter for clinical teams and a residential newsletter to keep the network informed of policy and/or procedural changes, performance coaching and other information critical to inform and improve consumer care. SCCMHA has routine meetings with adult and children's case management team supervisors for both behavioral health and intellectual and developmental disability providers. The children's case management team includes a member of the local DHHS to pull in community resources and ideas. It is our intent to continue with these activities as we move forward into this new pilot project to inform them of related changes that may result.

SCCMHA has network capacity that is within the 30-minute/ 30-mile range of all areas within Saginaw County to provide services to consumer/members within the county. SCCMHA reviews all provider activity to assure consumers served are integrated in the community. All contracted residential providers are required by SCCMHA to have a van to transport consumers to physician services, outings in the community as well as other community integration activities at each of their facility sites. We continue to demonstrate our ability to stay within

the 14 day timeliness standards between first request and initial intake assessment and within 14 days between intake and first face-to-face contact as outlined by MDHHS. SCCMHA continues to strive for same day next day services to all consumer/members seeking services.

We will continue to collaborate and assure provider competencies and skill sets through mandatory trainings provided by our Continuing Education Unit and the training resources we have developed within the community. SCCMHA will plan to continue to retain the responsibility for fidelity reviews and oversight as well as credentialing in EBPs through our current EBP Coordinator and Evidence Based Practices Leadership Team.

SCCMHA will continue as a delegated function the oversight of provider network management credentialing functions including as a CMHE our re-assumption of the same responsibilities for the SUD network of providers. We will continue to monitor and evaluate providers in our network annually at a minimum and more frequently if there are performance deficits through onsite visits and desk audits. SCCMHA delegates background checks of all staff to the provider network, and monitors their compliance through an annual quality review to assure adherence to the requirements for credentialing. Credentialing of professional staff is completed by SCCMHA of all contracted providers to assure compliance at hire. Re-credentialing is delegated to the provider with annual quality reviews to assure adherence.

9.g.ii Retention of the provider network is a priority for consumers and advocates. Describe how the applicant will preserve the current network and how contracting, credentialing, and provider readiness review will be managed during the pilot transition.

SCCMHA anticipates no disruptions to its current provider network. The functions of contracting, credentialing and provider readiness review would remain the responsibility of the SCCMHA, with oversight and monitoring by the MHPs to ensure compliance with managed care requirements and accreditation standards. SCCMHA has a readiness review process to ensure provider performance including: the partial delegation of some select responsibilities such as BH-TEDS data, staff credentialing which SCCMHA verifies and some customer service tasks.

SCCMHA is proud of the strong working relationships built with our network of providers. Most of the members in the current provider network have worked with SCCMHA since 2002. SCCMHA as a prior PIHP and currently delegated manager of specialty benefit for Saginaw County has decades of experience managing the contracting, credentialing, and provider readiness review process. SCCMHA is recommending that these responsibilities be delegated to SCCMHA. We would like to retain network contracts management through this pilot project in part due to the fact contracts are often amended mid-year and we need quick informed turnaround time.

As part of the SCCMHA contracting process, every current provider is annually required to complete an application of intent to continue contracting with SCCMHA. This application includes information necessary to complete background and sanction checks of the provider organizations including their board members, type of accreditation, licensure of the program, and conflict of interest attestations. SCCMHA has a procurement policy to guide the addition of any new providers to our network. After selection, new providers attend an orientation with SCCMHA Contracts and Properties Manager. After this, the provider attends meetings with the Director of Network Services and Public Policy and other key members of the Management Team to address delegated areas and service delivery expectations. Provider will have a quality

review completed by SCCMHA Provider Network Auditing Team to assure the provider is performing the delegated tasks as outlined in the contract. Any provider not performing delegated tasks will be offered the opportunity to discuss deficiencies and determine a plan of corrective action to assure compliance. Additional training will be offered where necessary. SCCMHA would plan as a pilot to continue this process as we have developed a quality network oversite and monitoring process that has been so well regarded it has been borrowed by other PIHP and CMHSP organizations across the state.

SCCMHA has a credentialing policy and procedure that is attached to the provider contract each year. Any updates to policies/procedures are communicated to providers both in writing and at regular meetings. This policy and contract language partially delegates to the contracted providers. The SCCMHA Provider Network Auditing Team annually reviews all credentials for staff to assure providers are vetting their staff according to the requirements set by Medicaid and Medicare standards.

SCCMHA expects to bring the entire SCCMHA network of providers forward with us into the 298 pilot and as well as welcome into our network providers of SUD treatment and prevention services and those qualified to provide services to persons with mild/moderate services through our regular processes.

Through the 298 pilot we hope to be able to leverage the provider network expertise of the MHPs and MBHO/ASP to enhance the current SCCMHA provider network in areas such as psychiatry and Medication Assisted Treatment (MAT).

9 g.iii. To achieve administrative efficiency, describe the degree to which consistent network management practices will be developed and adopted for the pilot region (including reciprocity for credentialing, training, site reviews, etc.).

The issues of administrative efficiency and the need for reciprocity related to training, contracting, site visits, and credentialing per MDHHS policy have been highlighted in dialog with the MHPs. Initial discussion identified a potential barrier with accreditation standards which will need to be addressed during the pilot planning period. SCCMHA is recommending that these functions be performed by one entity (preferably SCCMHA) and that the other parties accept the results of those findings, to the extent that this is permissible under current accreditation standards.

SCCMHA has a comprehensive provider manual that has been in existence since 2004. This manual is attached to the provider contract to create a consistent message to all providers about the expectations of SCCMHA, Medicaid and MDHHS. This manual is reviewed regularly as new MDHHS directives are issued to the PIHP/CMHSPs and a new complete electronic copy is sent to providers every other year. Updates are published on our website to keep providers informed of any mandated state or federal policy changes. SCCMHA also publishes a provider newsletter and residential newsletter alternating every other month to communicate with providers about changes and to provide clarification of areas that may not be consistently implemented. As we move into the pilot program we will discuss how to incorporate these messages across all providers. We anticipate that many intricate details will need to be discussed further as we integrate services with the MHPs.

SCCMHA has created efficiency in using a single EHR. This allows for HIPAA compliant messaging to all providers. All providers including internal and external staff have access for

consumers that they serve including read only access by the residential providers in our network to be able to view consumer Individual Plans of Service (IPOS). We have read-only access available to Community Living Support providers as well. We continue to work with our EHR provider to create additional reports for all providers from the electronic health record to inform their service management performance and promote efficiency. Our current EHR is MU-2 certified this allows the capacity and ability to improve care coordination through the EHR.

We are prepared to grant access with security identification provisions to SUD providers and mild/moderate providers as they join our network as new members and complete EMR training.

SCCMHA has been working with our PIHP and other CMHSPs in our region to develop efficiencies across the state of Michigan. The PIHP's across the state are working toward a single inpatient monitoring tool to use for audits with our contracted hospitals. We have begun the execution of this model this contract year. In addition the work to develop a single set of inpatient psychiatric hospital oversight standards has also been completed. It would be our intention to participate in any state-wide standardization process with reciprocity by contributing our use of the new standard tool for the hospital located in our county. We would share the results with other PIHPs and CMHSPs in the state who would do the same for facilities in their counties; thus no hospital would have to manage multiple site review processes from the public mental health system. We hope this work will create efficiencies in the area of travel and less burden on the various hospitals with whom we have contracts. SCCMHA has worked in the last year with MSHN and other CMHSP partners in the region to create a single contract and monitoring tool for Fiscal Intermediary services as well with reciprocity expectations not unlike the new changes with hospital oversight. This will also create efficiencies in that reports will be shared with the network and others outside the region when requested. Currently SCCMHA whenever possible will obtain provider monitoring site reviews from other counties around the state to alleviate the necessity to visit providers who may contract with multiple counties. This process is true for residential facilities. SCCMHA shares reports with other counties in the state of Michigan to assist other counties with administrative efficiencies. Whenever possible the SCCMHA auditing team has coordinated efforts with other CMHSPs to visit providers jointly for annual oversite visits to create fewer burdens for providers. SCCMHA has developed monitoring tools and processes to create fewer burdens on providers by completing a shortened version of a site review for providers who have performed well in previous site reviews.

SCCMHA accepts training records and credentialing information from other CMHSPs whenever possible. We anticipate the partnership with the MHPs will allow efficiencies in our acceptance of credentialing and other provider specific information for their mild/moderate behavioral health providers and will have similar plans for SUD network providers for Saginaw from our PIHP.

The extension of the SCCMHA EHR to an expanded provider network--inclusive of providers of SUD and Mild/Moderate services—will generate additional efficiencies. The integrated functions of the PCE system provides the capacity for secure communications within the network, as well as authorization, claims management and reporting functionality.

9.h. For all delegated activities, describe the planned approach for pre-delegation review and ongoing monitoring.

To the extent SCCMHA is already performing many managed care functions for the specialty services and supports that they currently manage, the recommendation is that the MHPs accept the pre-delegation review that was previously conducted by the PIHPs. In any instance where a new delegation is being considered, it is recommended that one entity perform the pre-delegation review and that the results of that review are accepted by the other parties, to the extent that this is possible under current accreditation standards. We ask that any ongoing monitoring is performed in the same way. SCCMHA is proud to present the MHPs with the written reports from HSAG outlining our exemplary performance of such functions upon request.

Moving into the 298 pilot we anticipate pre-delegation review will be required at two levels; from the MHP to SCCMHA and from SCCMHA to its contracted providers as needed. At the first level, SCCMHA would expect to have any new pre-delegation activity reviewed from the MHPs and the MBHO/ASO. Each entity that delegates to SCCMHA will need to demonstrate that it has assessed our capacity to perform delegated activities prior to executing a contract. SCCMHA is experienced with these types of reviews and can be ready to participate in desk audit, site visit or both to demonstrate performance capacity for any delegated managed care function. At the second level, SCCMHA conducts pre-delegation reviews for activities which are delegated to our provider network; e.g. credentialing and quality data as described earlier in this section of the RFI. We would be prepared to share this information with the MHPS and MBHO/ASO as requested.

10. a Broadly describe your approach for measuring the performance of the pilot.

SCCMHA would be prepared to work with MDHHS and the University of Michigan as the 298 Implementation contractors to establish consultation with the evaluators for performance outcome metrics and implementation milestones that measure the impact of the pilot project and create the path to achieve the pilot's completion. At a minimum, SCCMHA will support and collaborate as requested with the evaluators to establish the following performance metrics outlined in the 298 Pilot boilerplate language to measure the impact of the following categories:

a) improvement of the coordination between behavioral health and physical health
b) improvement of services available to individuals with mental illness, intellectual or developmental disabilities or substance use disorders
c) benefits associated with full access to community-based services and supports
d) consumer health status
e) consumer satisfaction
f) provider network stability
g) treatment and service efficacies before and after the pilot project
h) use of best practices
i) financial efficiencies

SCCMHA has four years of experience participating with the SAMHSA PBHCI (Primary and Behavioral Health Care Integration) grant and has reported best practices and metric data on a quarterly basis into a series of SAMHSA operated databases, intended to track and report performance data across the United States. SCCMHA also chose to back its own PBHCI data during these platform changes and has the ability to extract and evaluate this data to drive SCCMHA health metrics. SCCMHA has worked more recently with our EHR vendor, PCE, to expand the collection of health metrics contained within the EHR for exportation and to include required PBHCI grant metrics, making those measures available to all users of our EHR.

10.b Describe your approach to developing organizational and technical capacity to participate in evaluation-related activities.

As a former PIHP, SCCMHA has successfully submitted demographic and encounter data to the state since 2002 and has passed all External Quality Reviews for data integrity. SCCMHA currently submits data to Mid-State Health Network which contracts with ZENITH Solutions for data analytics. Consumer's Medicaid pharmacy encounter data has been successfully linked in the Zenith Integrated Care Data Platform and the ICDP is in active use for Care Coordination at SCCMHA. SCCMHA has also demonstrated capacity to collect and report the BH-TEDS data set to Mid-State Health Network. These reporting capacities are supplemented by the SCCMHA data warehouse which is used in daily operations throughout the organization for business functions, ad hoc reporting, and quality assurance. SCCMHA is prepared to participate fully with the evaluation team.

SCCMHA has both internal and external analytics capacity to support evaluation-related activities related to this pilot project. External capacity is purchased from a number of sources. Mid-State Health Network provides two sources: the ZENITH Data Analytics Integrated Care Data Platform which uses several John's Hopkins predictive algorithms. Additionally, SCCMHA participates in the Mid-State Health Network (MSHN) Utilization Management Committee and associated Data Analytics and Data Lab workgroups. MSHN purchases supportive technical assistance from TBD Solutions for calculation of key performance indicators such as Plan All-Cause Readmission rates. These MSHN analytics venues provide external benchmark information for SCCMHA. SCCMHA contracts with APPRECOTS, a professional psychological consultation provider for analysis of clinical outcome tools such as the CAFAS, PECFAS and ANSA measures. Internally, the SCCMHA Quality Improvement department oversees internal management of quality assurance metric reporting and quality improvement management projects. This department is supported by Database Administrators and Data Analysts in the Information Services department who manage the SCCMHA data warehouse. SCCMHA also participates on two state level workgroups related to industry wide data management: the MDHHS EDIT Electronic Data Integrity Team and the MACHMHB Core Team. Participation in these groups supports integrity of in house analytics particularly in the areas of analytics based on costing and coding.

SCCMHA utilizes a range of reports both in the EHR as well as the Data Warehouse which includes both demographic and encounter data. The SCCMHA Electronic Health Record has been in place since 2006. SCCMHA has a mature health information system. There are four major components to the system: 1) Electronic Health Record which is a PCE Meaningful Use ready system. SCCMHA has used a PCE system since 2006 and upgraded to the MU certified

version in 2016 and will be attesting to MU3 in February 2018. The EHR is used by all clinicians, including all SCCMHA contracted providers; 2) the ZENITH Integrated Care Data Platform available to SCCMHA through Mid-State Health Network provides patient level integrated care encounter analytics and population analytics and is the service through which SCCMHA receives Admission Discharge Transfer from MiHIN; 3) CareConnect360 which provides integrated patient-level data on all Medicaid enrollees; and 4) the SCCMHA data warehouse, which is 24 hour current data from the SCCMHA electronic health records and which can accommodate large data interface with both secure and open data sets available for analytics.

SCCMHA is able to stratify risk, identify under and over utilization, facilitate focused outreach and conduct outcome evaluation. In addition SCCMHA uses the Mid-State Health Network data analytics service provided by ZENITH Solutions to import physical health encounter data and daily Admission Discharge and Transfer (ADTs) from area hospitals. Data interface with all of these sources is a desktop capacity for Quality and UM staff as well as the Integrated Health Team which provides outreach to at risk persons identified with the predictive analytics capacity available in ZENITH/ICDP. ZENITH/ICDP also provides predictive modeling reports that project the potential of hospital readmission based on the LACE model.

The underpinning of SCCMHA's combined population health initiatives, the implementation and use of data analytics and the deployment of trained clinical staff is for the purpose of reducing health disparities in the populations served and will serve to support the pilot's project evaluation.

10.c Specifically explain the method you will use to (1) measure savings as defined in the 298 boilerplate, and (2) assuring any savings are reinvested in services and supports for individuals having or at risk of having a mental illness, intellectual or developmental disability, or a substance use disorder. Please also address services and supports for children with serious emotional disturbance as a part of your response.

SCCMHA looks forward to the collaboration with the team from the University of Michigan on all elements of the 298 Pilot evaluation. The RFI document itself has already described the broad parameters, scope and their planed methods for the evaluation process. A significant element of the evaluation planning will include the definition and establishment of baseline administrative and claims data and we think significant effort should also go into determining biometrics to measure health improvements and outcomes and we look forward to the opportunity to inform this process further as a pilot site.

The 298 Pilot model parameters direct the selected sites to engage in care coordination and related integration activities at the point of service that will produce improved health trajectory and outcomes as well as reduce physical healthcare costs for the MHPs. Further, the legislative expectation is that savings will be used to expand treatment services and prevention activity. SCCMHA welcomes the opportunity to contribute to the planning and defining of sanctioned activities and the metrics that will measure the results. We have been engaged in these activities for well over five years now as described in earlier sections of the RFI. Which consumer/members are prioritized will matter as their needs will inform 298 intervention strategies to determine actionable activities, related metrics and outcomes; including "savings."

To calculate healthcare savings for the MHPs, SCCMHA would suggest the negotiation with the plans in the defining of characteristics for targeted subpopulations of shared consumers/members: i.e those persons with high ED utilization, high inpatient readmission rates, multiple chronic health conditions, or those that may have been difficult for MHPs to engage who have not had consistent access to needed primary or even specialty care. Activities that impact these circumstances can really work to reduce healthcare expense for the MHPs and generate “savings.” Once defined, historic paid claims data should help to determine the baseline cost. The characteristics and needs of this subpopulation for which we share treatment responsibility with the MHPs, will help determine activities and interventions to improve access and utilization of outpatient care and reductions in unnecessary high priced emergency department and inpatient care, and hence the promotion of total healthcare “savings.” The next step will be to negotiate with the MHPs and MDHHS as to what percentage of the realized “savings” will be shared with the CMHSP pilots and when. Because SCCMHA has no new source of pilot funding at the onset and will experience new costs in providing and expanding the new care coordination and integrated services, very prescribed well defined interval measures that result in smaller short term incentives that are a part of longer term strategies and system changes and that compel greater savings shared later will probably work best.

Once an amount of savings can be quantified and projected the development of a Reinvestment Plan for savings becomes possible. A preliminary consideration before the CMHSP pilots can count such cost savings from the MHPs as savings available for reinvestment, all related SCCMHA costs to provide the related activities must be covered first. In any case, because SCCMHA is so tied into the local healthcare landscape and the community health needs assessment process, we are uniquely positioned to inform the use of savings for reinvestment in Saginaw to both enhance existing service delivery, expand access and perhaps finally be able to deliver prevention services. This is especially true with our proposed plan for 298 to finally bring all of the resources for mental health including mild/moderate populations for adults and children/youth; all persons with intellectual and developmental disabilities; and all persons with substance use disorders including prevention funding into a single network focused on the needs of Saginaw County.

The strategy for measuring and determining “savings” for children and youth however, will need to be defined in unique and separate ways from the adult strategy. Generally the total healthcare cost for children /youth is not of the same concern to MHPs compared to adult populations, with some key exceptions and their challenges for healthcare access are different. SCCMHA is prepared to work with the MHPs to define sub-populations of children and youth for 298 integration activity and to address social determinate challenges they may be experiencing with the use of case management, parent support partners, transition age youth peer supports, community health workers and recovery coaches. Parents with mental illness, those with substance use disorders and other disabilities themselves, may also be MHP members to include in SCCMHA interventions for obvious reasons. What will be important though is to align the needs of children, youth and families for intervention activities from SCCMHA with the treatment and financial interests of the MHPs and MBHP/ASO.

SCCMHA is also interested if possible, in using the pilot opportunity work with the MHPS to begin to address the asthma burden of children and youth in Saginaw which is a large negative outlier in the state. Asthma is a chronic condition impacted by the social emotional health of

children and has been on our radar for some time now. Another area of particular interest is pregnant women and those with young children that have substance use disorders. As the local convener of stakeholders in Saginaw for the new Neonatal Abstinence Initiative, we would use this community collaboration to inform intervention activity for this group. We are also keenly aware that children and youth with obesity challenges and prediabetes conditions in our community are the harbingers of large healthcare expenditures in the near future and this may be a good space to invest in collaborative ways with the MHPS to invest "savings." SCCMHA also believes that the screening for substance use disorders for children and youth in Saginaw is greatly under reported. However, our current co-located presence of mental health clinicians inside a local pediatric practice for BH and trauma screening could include SUD screening with a small investment and these activities with the assistance of MHPs and MDHHS could absolutely be tied to EPSDT encounters at well child medical visits especially for latency aged children and adolescents where encounters generally are fewer and more challenged. SCCMHA also has mental health clinicians co-located inside Saginaw City Schools and at the Saginaw Family Court and Detention Center that could provide additional SUD screening activity as we do for serious emotional disorders and trauma to inform and drive future interventions and savings reinvestment. The intervention strategies and related metrics for measuring the impact of screening interventions will require separate planning. None the less, all of these areas would be a great use of 298 "savings."

11 Specify identified barriers and requirements for training and/or technical assistance that the applicant may need to fully and successfully implement the proposed pilot.

In meeting with the involved MHPs it has become apparent that we will need Technical Assistance (TA) from an NCQA expert to sort through how much flexibility there is in the ability of the MHPs to delegate Managed Care functions. The MDHHS Q & A for the RFI provided clarification that delegations were permissible but there are concerns from the MHPs about the risk exposure to their accreditation status should they delegate functions. In addition, the MHPS will need technical assistance in the Home and Community-Based Services Rule not mentioned in the RFI and in their understanding of the Public Policy requirements called out in the RFI. The MAHPs has reported that there has already been an overview presentation by MDHHS staff to their members of this material and plans to continue this education to their members which is helpful. The MHPs however may also need TA to understand what compliance with these policies looks like at the provider level. SCCMHA would reassume the responsibilities as a CMHE for SUD networks for both treatment and prevention services as a pilot and will need TA to get up to speed on changes to network management expectations and MDHHS reporting in the system since 2016 when this responsibility was last held.

Another important area where technical assistance will be needed is in the financial arrangements for the pilot. As already mentioned, SCCMHA recommends a sub-capitation for the specialty benefit but whether or not there should be a percentage withhold associated with bonus payments for performance to certain metrics needs to be determined. Then there are the financial arrangements to consider with regard to compensation for care coordination activities by the CMHSP and financial support at the point of serve for actual treatment integration activity that characterize 298. At a minimum will be the need to consider turning on new codes for care coordination services which are not face-to-face as well as codes for

select patient education activities for chronic disease management and codes for extenders like medical assistants for the efficient collection of biometric data from individual consumers that do not exist in the carve-out and would require MHP sources of financial support, all of which would be greatly informed by technical assistance. It is in this area that value-based purchasing options might best serve the pilot. Further with regard to TA, would be the need for help with any changes to financial reporting for the MHPs to MDHHS with downstream implications to the pilots for quality and financial reporting (SECR, MUNC, and FSR). SCCMHA overall would be interested in MDHHS securing a behavioral health and physical healthcare integration expert that would work with SCCMHA and other pilot sites to provide TA in identifying the following:

1. Start-up and development cost considerations for implementation of the CCBHC-Plus Clinical Model.
2. Costs to support changes in process and IT systems to meet the intentions of the 298 Pilot in achieving integration of fiduciary and care responsibilities for CMHSPs, MHPs and MHBO/ASO.
3. Rate-setting for care coordination and care management functions that are new to CMHSPs, including identification of corresponding billing/reporting (HCPCS) codes.
4. Fiscally-sound formularies to calculate shared savings (or loss) through 298 Pilot care integration activities, clearly articulating that return of all resulting savings (not loss) are made to the corresponding CMHSPs.
5. Consideration and methods for CMHSPs to pass on savings directly to their provider networks based on treatment-level shared savings models.
6. Development of a sub-capitated model of Medicaid financing for traditional Medicaid specialty behavioral health services during the 298 Pilot period, similar to current funding arrangements with their PIHPs, that protects both CMHSPs and MHPs from unnecessary risk.
7. During the pilot, CMHSPs would like to partner with MHPs to consider value-based purchasing opportunities that are data driven and informed by evidence-based practices. The VBP development cycle would provide CMHSPs and providers with pay for planning, pay for participation, and ultimately, pay for outcomes/performance. The goal would be to develop replicable, state-wide behavioral and physical healthcare models for care and financing integration.
8. Still other TA will be needed in the area of technology and data. Whether or not the following list rises to the level of TA or it is just a request for information/data from MDHHS, we will leave to the 298 Pilot Team at the state to parse out. At a minimum however, assistance will be needed with the following:
    a. How will we receive the Saginaw County EDI eligibility & payment files to send to our IT vendor PCE (834, 820, 207 and 271)? We have noted the need for a single file for the county.
    b. Will we be able to receive written approval from MDHHS for access to the CC360 Data Extract by all SCCMHA contracted clinical team providers? SCCMHA will in turn submit a related plan for Access and Identity Management with role-based security specifications.

c. Will MDHHS support us in a request to our PIHP for 2 years of Saginaw SUD encounter data and all active files, closed files and open authorizations and similar files for prevention data?
d. CMHSPs can currently identify the mild/moderate claims for behavioral health in Zenith ICDP analytics and as a result have some insights into costs for service to these consumers/members. However, we are blind to the related administrative MHP costs for this benefit. It would be helpful if MDHHS would request this cost reporting for each plan to establish baseline costs pre pilot initiation to inform planning.
e. Will MDHHS provide clarification on the chain of authority concerning state web-based reporting for waivers and other program specific reporting into state or state contracted vendor portals?

Lastly, again whether or not this rises to the level of TA, the pilot CMHSPs, MHPs and MDHHS need to work out a communication plan and structure not just for the pilot implementation, though this is key, but also to ensure that the CMHSP pilots will continue to connect to MDHHS for traditional CMHSP business like policy changes and reporting clarifications, requests for specific topical information, and communication exchanges to inform policy and processes. An example of this would be how will the pilot stay connected to the current discussion for encounter reporting for monetary amounts? Will the pilots still be welcome at Edit or will this participation invitation move to the MHPs?

Attachment A: Attestation

STATE OF MICHIGAN

Request For Information No. RFI – 180000000003
298 Pilot(s) – Medicaid Physical-Behavioral Health Full Financial Integration

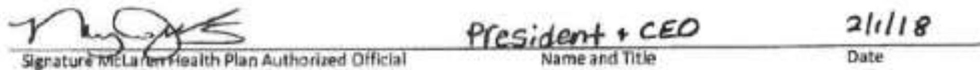
ATTACHMENT A

298 Pilot Request for Information
Memorandum of Support

The following Medicaid Health Plans: Meridian Health Plan, McLaren Health Plan, Molina Healthcare, and UnitedHealthcare have participated in substantive discussions with Saginaw County CMHA regarding a proposed Section 298 Pilot. Discussions have included considerations for financing models, performance of managed care activities, and various public policy requirements relating to the delivery of required Medicaid funded specialty behavioral health services. The MHPs listed below are committed to continuing discussions with Saginaw County CMHA to reach a final agreement regarding a proposed 298 pilot in the Saginaw County CMHA region. This is not a binding agreement.

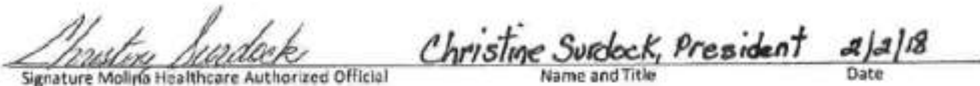
Sean Kendall President — 2-2-18

Signature Meridian Health Plan Authorized Official — Name and Title — Date



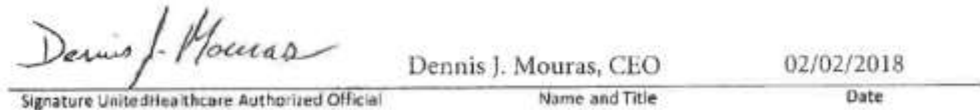
President + CEO — 2/1/18

Signature McLaren Health Plan Authorized Official — Name and Title — Date



Christine Surdock, President — 2/2/18

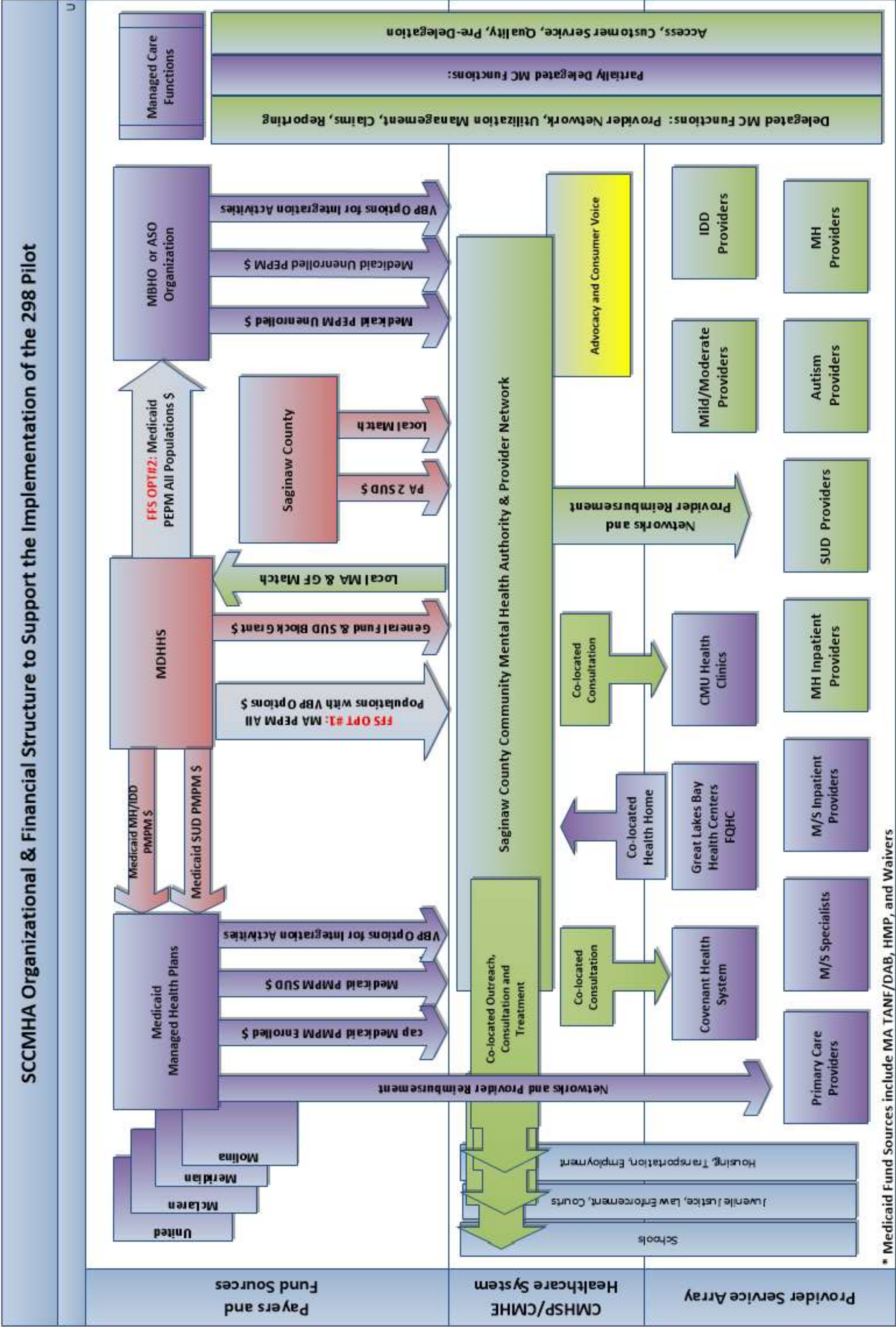
Signature Molina Healthcare Authorized Official — Name and Title — Date



Dennis J. Mouras, CEO — 02/02/2018

Signature UnitedHealthcare Authorized Official — Name and Title — Date

Attachment B: Organization Chart



Attachment C: SCCMHA Care Management Model