

Community Mental Health Association of Michigan

# Purposes and roles within Michigan's public mental health system: State of Michigan and the state's CMHSPs and PIHPs

May 2024

## PURPOSE OF THIS DOCUMENT

---

Key to sound policy making relative to Michigan's public mental health system<sup>1</sup> is a clear understanding of the roles played by the State of Michigan, the state's Community Mental Health Service Programs (CMHSPs) and Prepaid Inpatient Health Plans (PIHPs).

This document outlines these roles and will serve as a foundational document for dialogue and advocacy around statutory, policy, contract, and practice issues (in whole or as a source for relevant excerpts) with MDHHS, other executive branch offices, the State Legislature, the federal Centers for Medicare and Medicaid Services, CMHA members, advocacy organizations, persons served, local government officials, and other stakeholders.

## A. ROLES AND RESPONSIBILITIES IMBEDDED IN STATUTE

---

The State of Michigan has a direct role in financially supporting and partnering with the state's CMHSPs and, by extension, entities created by the state's CMHSPs. Michigan's CMHSPs have been designed, with that design imbedded in Michigan's Mental Health Code, as **public comprehensive mental/behavioral health services providers, directly tied to county government**. Parallel to this, Michigan's PIHPs have been designed to be either **CMHSPs holding the dual role of PIHP and CMHSP or entities created by the CMHSPs in a region defined by those CMHSPs**.

Relevant sections of Michigan law are provided below. All excerpts are from the Michigan Mental Health Code (330.xxx) and the Michigan Social Welfare Act (400.xxx).

### Role of the state

---

#### **State transfers responsibility for the delivery of public mental health services to the state's CMHSPs:**

Michigan Mental Health Code

Sec. 116. Powers and duties of department

(b) Administer the provisions of chapter 2 so as to promote and maintain an adequate and appropriate system of community mental health services programs throughout the state. In the administration of chapter 2, it shall be the objective of the department to **shift primary responsibility for the direct delivery of public mental health services from the state to a community mental health services program** whenever the community mental health services program has demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of that service area.

#### **State obligation to financially support the state's CMHSPs:**

Michigan Mental Health Code

Sec. 202.

(1) The **state shall financially support**, in accordance with chapter 3, **community mental health services programs** that have been established and that are administered according to the provisions of this chapter.

---

<sup>1</sup> For the sake of simplicity, the terms "mental health" and "behavioral health" are used, in this document, to refer to services to persons with mental illness, emotional disturbance, intellectual/developmental disabilities, and/or substance use disorders.

Michigan Mental Health Code  
Sec. 308. Financial liability of state

(1) Except as otherwise provided in this chapter and subsections (2) and (3), and subject to the constraint of funds actually appropriated by the legislature for such purpose, the state shall pay 90% of the annual net cost of a community mental health services program that is established and administered in accordance with chapter 2.

## Role of county government as foundation and funder of CMHSP system

---

### Counties establish Michigan's CMHSPs:

Michigan Mental Health Code  
Sec. 210. Community mental health services program; election to establish; coordination of services

(1) **Any single county or any combination of adjoining counties may elect to establish a community mental health services program** by a majority vote of each county board of commissioners.

Michigan Mental Health Code  
Sec. 212. Board; establishment; appointment of members

(1) Upon electing to establish a community mental health services program, the county or combination of counties shall establish a 12-member community mental health services board, except as provided in section 214, 219, or 222(2) or (5). Except as provided in subsection (2), each board of commissioners shall by a majority vote appoint the board members from its county. Recommended appointments to the board shall be made annually following the organizational meeting of the board of commissioners.

Michigan Mental Health Code  
Sec. 226. Board; powers and duties

(1) The board of a community mental health services program shall do all of the following:

(c) In the case of a county community mental health agency, obtain approval of its needs assessment, annual plan and budget, and request for new funds from the board of commissioners of each participating county before submission of the plan to the department. In the case of a community mental health organization, provide a copy of its needs assessment, annual plan, request for new funds, and any other document specified in accordance with the terms and conditions of the organization's inter-local agreement to the board of commissioners of each county creating the organization. In the case of a community mental health authority, provide a copy of its needs assessment, annual plan, and request for new funds to the board of commissioners of each county creating the authority.

(f) Submit to each board of commissioners for their approval an annual request for county funds to support the program. The request shall be in the form and at the time determined by the board or boards of commissioners.

(2) A community mental health services program may do all of the following:

(a) Establish demonstration projects allowing the executive director to do 1 or both of the following:

(i) Issue a voucher to a recipient in accordance with the recipient's plan of services developed by the community mental health services program.

(ii) Provide funding for the purpose of establishing revolving loans to assist recipients of public mental health services to acquire or maintain affordable housing. Funding under this subparagraph shall only be provided through an agreement with a nonprofit fiduciary.

(b) Carry forward any surplus of revenue over expenditures under a capitated managed care system. Capitated payments under a managed care system are not subject to cost settlement provisions of section 236.

(c) Carry forward the operating margin up to 5% of the community mental health services program's state share of the operating budget for the fiscal years ending September 30, 2009, 2010, and 2011. As used in this subdivision, "operating margin" means the excess of state revenue over state expenditures for a single fiscal year exclusive of capitated payments under a managed care system. In the case of a community mental health authority, this carryforward is in addition to the reserve accounts described in section 205(4)(h).

(d) Pursue, develop, and establish partnerships with private individuals or organizations to provide mental health services.

(e) Share the costs or risks, or both, of managing and providing publicly funded mental health services with other community mental health services programs through participation in risk pooling arrangements, reinsurance agreements, and other joint or cooperative arrangements as permitted by law.

(f) Enter into agreements with other providers or managers of health care or rehabilitative services to foster interagency communication, cooperation, coordination, and consultation. A community mental health services program's activities under an agreement under this subdivision shall be consistent with the provisions of section 206.

#### Michigan Mental Health Code Sec. 204.

(1) Except as provided in subsection (4), a community mental health services program established under this chapter shall be a county community mental health agency, a community mental health organization, or a community mental health authority. A county community mental health agency is an official county agency. A community mental health organization or a community mental health authority is a public governmental entity separate from the county or counties that establish it.

#### **Financial obligation of Michigan's counties for support of CMHSPs:**

#### Michigan Mental Health Code Sec. 302. Financial liability of county

(1) Except as otherwise provided in this chapter and in subsection (2), **a county is financially liable for 10% of the net cost of any service that is provided by the department, directly or by contract, to a resident of that county.**

(2) This section does not apply to the following:

(a) Family support subsidies established under section 156.

(b) A service provided to any of the following:

(i) An individual under a criminal sentence to a state prison.

(ii) A criminal defendant determined incompetent to stand trial under section 1032.

(iii) An individual acquitted of a criminal charge by reason of insanity, during the initial 60-day period of evaluation provided for in section 1050.

#### Purposes of CMHSPs

---

#### Michigan Mental Health Code Sec. 206.

(1) The purpose of a community mental health services program **shall be to provide a comprehensive array of mental health services** appropriate to conditions of individuals who are located within its geographic service area, regardless of an individual's ability to pay. The array of mental health services shall include, at a minimum, all of the following:

- (a) **Crisis stabilization and response including a 24-hour, 7-day per week, crisis emergency service** that is prepared to respond to persons experiencing acute emotional, behavioral, or social dysfunctions, and the provision of inpatient or other protective environment for treatment.
- (b) **Identification, assessment, and diagnosis** to determine the specific needs of the recipient and to develop an individual plan of services.
- (c) **Planning, linking, coordinating, follow-up, and monitoring** to assist the recipient in gaining access to services.
- (d) **Specialized mental health recipient training, treatment, and support**, including therapeutic clinical interactions, socialization and adaptive skill and coping skill training, health and rehabilitative services, and pre-vocational and vocational services.
- (e) Recipient rights services.
- (f) Mental health advocacy.
- (g) **Prevention activities** that serve to inform and educate with the intent of reducing the risk of severe recipient dysfunction.
- (h) **Any other service approved by the department.**

Michigan Administrative Rules

### **SUBPART 1. COMMUNITY MENTAL HEALTH SERVICES**

#### **R 330.2005 Minimum services to be provided.**

Rule 2005. A community mental health board shall ensure that the following minimum types and scopes of mental health services are provided to all age groups directly by the board, by contract, or by formal agreement with public or private agencies or individuals contingent on legislative appropriation of matching funds for provision of these services:

- (a) Emergency intervention services.
- (b) Prevention services.
- (c) Outpatient services.
- (d) Aftercare services.
- (e) Day program and activity services.
- (f) Public information services.
- (g) Inpatient services.
- (h) Community/caregiver services.

#### **R 330.2006 Emergency intervention services.**

Rule 2006. (1) "Emergency intervention services" means those outpatient services provided to a person suffering from an acute problem of disturbed thought, behavior, mood, or social relationship which requires immediate intervention as defined by the client or the client's family or social unit.

(2) Emergency intervention services include all the following:

- (a) A telephone that is answered 24 hours a day for dealing with mental health emergencies. The number for this telephone shall be advertised through the telephone book, public information efforts, and by notifying the appropriate agencies of the telephone number and the services provided.
- (b) Provision for face-to-face services to persons in valuation, intervention, and disposition. the areas of crisis
- (c) A manual on emergency care protocols for use by the emergency services unit staff.

(3) The community mental health services provider shall assign mental health professionals or trained mental health workers for telephone and walk-in services.

- (4) Emergency care includes all the following:
- (a) Evaluation, which means arrangements for determining the client's mental status, medical status and need for treatment, and, when indicated, medication status and family, job, or housing situations.
  - (b) Intervention, which means face-to-face counseling and initiation and monitoring of medication when indicated.
  - (c) Disposition, which means the ability to provide or make referral for all the following:
    - (i) Hospital emergency department services.
    - (ii) Psychiatric inpatient services.
    - (iii) Specific community-based services, such as the following examples:
      - (A) Respite care placement.
      - (B) Outpatient care.
      - (C) Home visits.
      - (D) Aftercare.
      - (E) Day treatment/care.
      - (F) Drug or alcohol programming.
      - (G) Problem pregnancy help.
      - (H) Spouse and child abuse help.
      - (I) Children's services.
      - (J) Adolescent services.
      - (K) Geriatric services.
      - (L) Services for persons with intellectual and developmental disabilities.
      - (M) Social services.
- (5) For the disposition of emergency intervention matters, the community mental health services provider shall provide all the following:
- (a) Written referral procedures, available to the staff, for emergency care and voluntary and involuntary psychiatric hospitalization.
  - (b) Documented efforts to arrange for the transportation of the client, when necessary.
  - (c) A list of available dispositions within the community mental health area of service with special notations for those dispositions having 24-hour accessibility.
  - (6) In the administration of the emergency services, the community mental health services provider shall provide evidence of all of the following:
    - (a) Periodic testing with regard to the accessibility, availability, and effectiveness, of those emergency intervention services.
    - (b) Regular meetings of staff involved in emergency services to discuss administrative, supervisory, training, programmatic, and client management issues.
    - (c) Confidential records of all mental health emergency contacts, whether the contacts are by telephone or walk-in contact.
    - (d) Training or experience of the emergency intervention staff using such factors as professional credentials, licensure, descriptions of training experiences, in-service orientation, in-service education, and continuing education.

**R 330.2007 Prevention services.**

Rule 2007. (1) Prevention services are those services of the county program directed to at-risk populations and designed to reduce the incidence of behavioral, emotional, or cognitive dysfunction and the need for individuals to become mental health recipients of treatment services.

(2) Prevention services may be provided through individualized services, time-

limited recipient training, or community/caregiver services.

(3) Prevention services shall include both of the following:

(a) Provision for responding to the mental health dimensions of community catastrophes.

(b) Attention to the needs of children living with severely mentally impaired adult recipients.

(4) Prevention services shall also include 1 of the following:

(a) Infant mental health services.

(b) Services to increase life-coping skills of children and adolescents.

(c) Services to increase life-coping skills of adults.

(d) Services to reduce the stressful impact of life crises.

### R 330.2008 **Outpatient services.**

Rule 2008. (1) Outpatient services include all the following:

(a) Diagnostic and evaluation service.

(b) Referral service.

(c) Counseling service by arrangement at scheduled nonscheduled visits at times of increased stress.

(d) Service to families of individuals in mental facilities, as appropriate and as requested.

intervals and in hospitals or residential

(e) Life consultation and planning for the persons with intellectual disabilities, and persons with developmental disabilities as defined in section 100a of the act.

(f) Treatment service to individuals in mental hospitals or residential facilities when appropriate with the consent of the individual and the hospital or facility staff person in charge of the individual's plan of service.

(2) The community mental health services provider outpatient services shall be made available at times of the day and week appropriate to meet the needs of the population served.

(3) Outpatient services shall be accessible to the population served.

(4) Provision for adequate and appropriate space to deliver services, including provision for privacy and the special needs of children, adolescents, and physically handicapped persons shall be provided by the community mental health services provider.

### R 330.2009 **Aftercare services.**

Rule 2009. (1) Aftercare services shall only be provided with prior consent of an individual over the age of 18, a parent if the individual is under 18, or a legally empowered guardian.

(2) These aftercare services shall include both of the following:

(a) Follow-up services to assist individuals released from a hospital or facility or who have received other services from a community mental health program.

(b) Mental health services for individuals placed in foster care, family care, or community placement in the service area, unless otherwise provided. Collaborative programming and planning for provision of services shall take place before the time of placement.

(3) Aftercare services shall be available to individuals located within the service area regardless of whether or not the individual was a resident of the county or counties of the service area prior to admission to a hospital or facility.

(4) A county may be billed for services rendered to its residents pursuant to

section 306 of the act.

(5) Aftercare services shall be offered by a community mental health agency without a request for service by a released individual, when authorized by the individual, and upon notification from a hospital or facility.

**R 330.2010 Day program and activity services.**

Rule 2010. Day program and activity services shall include providing habilitative and rehabilitative treatment and training activity for mentally ill children, mentally ill adults, children with intellectual disabilities, adults with intellectual disabilities, and persons with a developmental disability requiring services similar to those provided persons with intellectual disabilities.

**SUBPART 7. CERTIFICATION PROCESS**

**R 330.2701 Application process.**

Rule 2701. (1) As a condition of state funding, a single overall certification is required for each community mental health services program.

(2) The certification process shall include a review of agencies or organizations that are under contract to provide mental health services on behalf of the mental health services program.

(3) The governing body of a community mental health services program shall request certification by submitting a completed application to the department. If the department is already in receipt of information required for application, then submission of that information may be waived by the department. The application shall be submitted in the format specified by the department and shall include all of the following information:

- (a) The legal name of the community mental health services program.
- (b) The address for legal notice and correspondence.
- (c) The governing structure of the community mental health services program.
- (d) The current annual budget, including all sources of revenue, of the community mental health services program.
- (e) The organizational chart of the community mental health services program.
- (f) The name of the executive director of the community mental health services program.
- (g) A list of all contracts with other agencies or organizations that provide mental health services under the auspices of the community mental health services program.
- (h) A description of the services provided by the community mental health services program, including any services provided by contract with another agency or organization.
- (i) If applicable, documentation of the community mental health services program's accreditation, including accreditation of any contract agency or organization, by an accrediting body deemed acceptable by the department as specified in R 330.2702(2).

(4) Upon receipt of an application, the department shall determine if the application is complete. The department shall acknowledge receipt of an application. If an application is incomplete, the department shall notify the applicant within 30 days from date of receipt of any corrections or additions needed, may return the materials to the applicant, or both. An incomplete application shall not be regarded as an application for certification. Return of the application materials or failure to take further action to issue a certificate shall not constitute denial of an application for

certification.

(5) After the department's acceptance of a complete application, the department shall determine whether the applicant meets certification standards. The certification process may include conducting an on-site review.

(6) Failure of the community mental health services program to comply with the requirements of the certification process shall be grounds for the department to deny, suspend, revoke, or refuse to renew a program's certification.

### **R 330.2805 Improvement of program quality.**

Rule 2805. (1) A community mental health services program shall continuously evaluate and improve organizational processes and performance.

(2) A program shall continually solicit customer feedback on the quality of services and utilize this information to improve service delivery.

(3) A program shall compile, analyze, and use data on service outcomes to improve performance.

(4) A program shall promote consumer and family member participation in the design of programs and services.

(5) A program shall promote consumer and family member participation in the evaluation of programs and services.

---

## Identity and roles of the state's PIHPs as CMHSPs or Regional Entities formed by CMHSPs

---

### **Role of Michigan's PIHPs:**

Michigan Social Welfare Act:

Sec. 109f Medicaid-covered specialty services and supports; management and delivery; specialty prepaid health plans

(1) The department shall support the use of Medicaid funds for specialty services and supports for eligible Medicaid beneficiaries with a serious mental illness, developmental disability, serious emotional disturbance, or substance use disorder. **Medicaid-covered specialty services and supports shall be managed and delivered by specialty prepaid health plans chosen by the department. The specialty services and supports shall be carved out from the basic Medicaid health care benefits package.**

(2) **Specialty prepaid health plans** are Medicaid managed care organizations as described in section 1903(m)(1)(A) of title XIX, 42 USC 1396b, and are responsible for providing defined inpatient services, outpatient hospital services, physician services, other specified Medicaid state plan services, and additional services approved by the Centers for Medicare and Medicaid Services under section 1915(b)(3) of title XIX, 42 USC 1396n.

### **Standards for Michigan PIHPs:**

Michigan Mental Health Code

Sec. 232b. Specialty prepaid health plans

(1) The department shall establish standards **for community mental health services programs designated as specialty prepaid health plans under the Medicaid managed care program** described in section 109f of the social welfare act, 1939 PA 280, MCL 400.109f. The standards established under this section shall reference applicable federal regulations related to Medicaid managed care programs and specify additional state requirements for specialty prepaid health plans.

**Creation of regional entities (as the regional organizations that will serve as PIHPs for the CMHSPs in the region):**

Michigan Mental Health Code  
Sec. 204b. Regional entity

**(1) A combination of community mental health organizations or authorities may establish a regional entity by adopting bylaws that satisfy the requirements of this section. A community mental health agency may combine with a community mental health organization or authority to establish a regional entity if the board of commissioners of the county or counties represented by the community mental health agency adopts bylaws that satisfy the requirements of this section.** All of the following shall be stated in the bylaws establishing the regional entity:

(a) The purpose and power to be exercised by the regional entity to carry out the provisions of this act, including the manner by which the purpose shall be accomplished or the power shall be exercised.

(b) The manner in which a community mental health services program will participate in governing the regional entity, including, but not limited to, all of the following:

(i) Whether a community mental health services program that subsequently participates in the regional entity may participate in governing activities.

(ii) The circumstances under which a participating community mental health services program may withdraw from the regional entity and the notice required for that withdrawal.

(iii) The process for designating the regional entity's officers and the method of selecting the officers. This process shall include appointing a fiscal officer who shall receive, deposit, invest, and disburse the regional entity's funds in the manner authorized by the bylaws or the regional entity's governing body. A fiscal officer may hold another office or other employment with the regional entity or a participating community mental health services program.

(c) The manner in which the regional entity's assets and liabilities shall be allocated to each participating community mental health services program, including, at a minimum, all of the following:

(i) The manner for equitably providing for, obtaining, and allocating revenues derived from a federal or state grant or loan, a gift, bequest, grant, or loan from a private source, or an insurance payment or service fee.

(ii) The method or formula for equitably allocating and financing the regional entity's capital and operating costs, payments to reserve funds authorized by law, and payments of principal and interest on obligations.

(iii) The method for allocating any of the regional entity's other assets.

(iv) The manner in which, after the completion of its purpose as specified in the regional entity's bylaws, any surplus funds shall be returned to the participating community mental health services programs.

(d) The manner in which a participating community mental health services program's special fund account created under section 226a shall be allocated.

(e) A process providing for strict accountability of all funds and the manner in which reports, including an annual independent audit of all the regional entity's receipts and disbursements, shall be prepared and presented.

(f) The manner in which the regional entity shall enter into contracts including a contract involving the acquisition, ownership, custody, operation, maintenance, lease, or sale of real or personal property and the disposition, division, or distribution of property acquired through the execution of the contract.

(g) The manner for adjudicating a dispute or disagreement among participating community mental health services programs.

(h) The effect of a participating community mental health service program's failure to pay its designated share of the regional entity's costs and expenses, and the rights of the other participating community mental health services programs as a result of that failure.

(i) The process and vote required to amend the bylaws.

- (j) Any other necessary and proper matter agreed to by the participating community mental health services programs.
- (2) Except as otherwise stated in the bylaws, a regional entity has all of the following powers:
- (a) The power, privilege, or authority that the participating community mental health services programs share in common and may exercise separately under this act, whether or not that power, privilege, or authority is specified in the bylaws establishing the regional entity.
- (b) The power to contract with the state to serve as the Medicaid specialty service prepaid health plan for the designated service areas of the participating community mental health services programs.
- (c) The power to accept funds, grants, gifts, or services from the federal government or a federal agency, the state or a state department, agency, instrumentality, or political subdivision, or any other governmental unit whether or not that governmental unit participates in the regional entity, and from a private or civic source.
- (d) The power to enter into a contract with a participating community mental health service program for any service to be performed for, by, or from the participating community mental health services program.
- (e) The power to create a risk pool and take other action as necessary to reduce the risk that a participating community mental health services program otherwise bears individually.
- (3) A regional entity established under this section is a public governmental entity separate from the county, authority, or organization that establishes it.
- (4) All the privileges and immunity from liability and exemptions from laws, ordinances, and rules provided under section 205(3)(b) to county community mental health service programs and their board members, officers, and administrators, and county elected officials and employees of county government are retained by a regional entity created under this section and the regional entity's board members, officers, agents, and employees.
- (5) A regional entity shall provide an annual report of its activities to each participating community mental health services program.
- (6) The regional entity's bylaws shall be filed with the clerk of each county in which a participating community mental health services program is located and with the secretary of state, before the bylaws take effect.
- (7) If a regional entity assumes the duties of a participating community mental health services program or contracts with a private individual or entity to assume the duties of a participating community mental health services program, the regional entity shall comply with all of the following:
- (a) The manner of employing, compensating, transferring, or discharging necessary personnel is subject to the provisions of the applicable civil service and merit systems and the following restrictions:
- (i) An employee of a regional entity is a public employee.
- (ii) A regional entity and its employees are subject to 1947 PA 336, MCL 423.201 to 423.217.
- (b) At the time a regional entity is established under this section, the employees of the participating community mental health services program who are transferred to the regional entity and appointed as employees shall retain all the rights and benefits for 1 year. If at the time a regional entity is established under this section a participating community mental health services program ceases to operate, the employees of the participating community mental health services program shall be transferred to the regional entity and appointed as employees who shall retain all the rights and benefits for 1 year. An employee of the regional entity shall not, by reason of the transfer, be placed in a worse position for a period of 1 year with respect to worker's compensation, pension, seniority, wages, sick leave, vacation, health and welfare insurance, or another benefit that the employee had as an employee of the participating community mental health services program. A transferred employee's accrued benefits or credits shall not be diminished by reason of the transfer.
- (c) If a participating community mental health services program was the designated employer or participated in the development of a collective bargaining agreement, the regional entity assumes and is bound by the existing collective bargaining agreement. Establishing a regional entity does not adversely affect existing rights or obligations contained in the existing collective bargaining agreement. For the purposes of this subsection, "participation in the development of a collective bargaining agreement" means that a

representative of the participating community mental health services program actively participated in bargaining sessions with the employer representative and union or was consulted during the bargaining process.

## **PIHPs as public substance use disorder coordinating organization:**

Michigan Mental Health Code  
Sec. 210.

(1) Any single county or any combination of adjoining counties may elect to establish a community mental health services program by a majority vote of each county board of commissioners.

(2) A **department-designated community mental health entity** shall coordinate the provision of **substance use disorder services in its region** and shall ensure services are available for individuals with substance use disorder.

---

## **B. ROLES AND RESPONSIBILITIES OF CMHSPS AND PIHPs IN MICHIGAN'S MEDICAID WAIVERS**

**CMHSPs as Comprehensive Specialty Services Networks (CSSN):** Michigan's managed behavioral health Medicaid program is built on a structure that designates Michigan's CMHSPs as comprehensive providers receiving sub-capitation payments.

Since the 1998 implementation of the Michigan Medicaid Managed Specialty Supports and Services Program and subsequent federal waiver authorities, CMHSPs were designated as Comprehensive Specialty Services Networks (CSSNs) and are expected to create and maintain Provider Specialty Services Networks (PSSNs). This has been the state's expectations for all CMHSPs and is the very foundation for Michigan's unique managed care "carve-out" sole source contractual arrangement with the public community mental health system.

These roles are outlined in a number of foundational documents of Michigan's behavioral health Medicaid program, excerpts of which are provided below:

Michigan Department of Community Health; [Revised Plan for Procurement](#) of Medicaid Specialty Prepaid Health Plans; Final Version; September 2000

... CMHSPs in the affiliation would be eligible for a special provider designation – that of **"Comprehensive Specialty Service Network" (CSSN)** – that affords them special consideration in the provider network and qualifies them to receive a sub-capitation from the PHP or hub-CMHSP.

**In practice - CMHSPs as core providers in PIHP network with variation for SUD services:** The state's CMHSPs are the prime mental health service providers funded by the PIHPs in their regions (where regional entity PIHPs exist), with the exception of substance use disorder services. Substance use disorder services are managed and purchased, by the state's PIHPs, in their SUD coordination role from a variety of providers, some of whom may be CMHSPs.

**Sub-capitation with risk sharing as an allowable form of financing:** Subcapitation between the state's PIHPs and the CMHSPs in their region (for PIHPs that are regional entities of CMHSPs) is allowed form of financing of the state's CMHSPs. This form of financing is the most advanced form of value-based healthcare financing.

Michigan Department of Community Health; Specialty Pre-Paid Health Plan 2002 application for participation; January 2002

Sub-capitation: An applicant **may sub-capitate for shared risk with affiliates** or established risk-sharing entities.

**Responsibilities of PIHPs:** The functions for which the current PIHPs are responsible, whether directly carried out by the PIHPs or by their member CMHSPs, are spelled out in the Michigan Department of Community Health; [Application for Participation](#) for Specialty Prepaid Inpatient Health Plans; February 2013 (AFP) and in the MDHHS contract with the state's PIHPs. The AFP and contract outline the following administrative functions and requirements for Michigan's PIHPs:

Administrative Responsibilities:

- General Management
- Financial Management
- Information Systems Management
- Provider Network Management
- Utilization Management
- Customer Services
- Quality Management
- Accreditation Status
- External Quality Review

Public Policy Initiatives

- Regional Crisis Response Capacity
- Health and Welfare
- Olmstead Compliance
- Substance Use Disorder Prevention & Treatment
- Recovery

The right to delegate and rescind delegation of these functions to the CMHSPs in a PIHP's region is outlined in the MDHHS contract with the state's CMHSPs.

**CMHSPs' central role in the governance of the state's PIHPs:** In citing state law, the 2013 [Application for Participation](#) (AFP) outlined the need for and value of CMHSPs have a central role in the governance of the state's PIHPs. The relevant citations are provided below:

The AFP affords initial consideration for specialty prepaid inpatient health plan designation to qualified single county or regional entities (organized under Section 1204b of the Mental Health Code or Urban Cooperation Act). Therefore, the first and most basic requirement is that the organization submitting an application, be comprised of and jointly, representatively governed.

The only acceptable legal arrangements for affiliation going forward will be either UCA agreements or creation of a regional entity under Section 1204b of the Mental Health Code. In either case, such intergovernmental affiliation formations result in the creation of a new legal entity jointly "owned" and governed by the sponsoring CMHSPs. It is this entity that will be considered, recognized, and designated as the PIHP (for a region consisting of more than one CMHSP).

## C. ROLES AND RESPONSIBILITIES OF MICHIGAN’S CMHSPS AND PIHPS IN FEDERAL LAW AND REGULATIONS

---

The clear interpretation of the federal regulations guiding cost allocation is that CMHSPs within Regional Entity PIHPs serve in two distinct roles – primarily, as the chief network provider within the community served by the CMH (in the CSSN role described above), providing Medicaid services, and, at times, as a subcontractor of the PIHP, carrying out managed care functions.

To obtain legal guidance on this issue, CMHA obtained the [legal opinion of Adam Falcone](#) (with the firm of Feldesman Tucker Leifer Fidell), one of the nation’s leading legal experts on Medicaid managed care for a legal opinion on this issue.

Below are the key excerpts from Mr. Falcone’s opinion that provide the necessary clarity in separating the provider roles of CMHs from the managed care subcontractor roles (of which there are few if any) and the related cost allocation principles that apply. (Boldface added for emphasis.)

Three aspects of the above regulatory definitions (42 CFR Part 438) bear on the issues presented. First, the definition of a network provider contains two requirements: (1) the provider or entity must have a network provider agreement with a MCO, PIHP or PAHP, or a subcontractor and (2) the entity must receive Medicaid funding to order, refer or render covered services. **Applied here, that means that a CMHSP should be considered to be a network provider if it holds a network provider agreement and receives funds to order, refer or render services. CMHSPs undisputedly meet both of those requirements.**

**Second, nothing in the definition of network provider above requires a provider to furnish services directly to patients.** The Medicaid managed care regulations define a “provider” as “any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services.” 42 C.F.R. § 438.2. Many providers engage in the delivery of services by purchasing services of other providers through professional services agreements. Because CMHSPs are entities engaged in the delivery of services and are legally authorized to do so by the State of Michigan, CMHSPs continue to meet the definition of a provider even when they purchase services from other direct care providers.

Federal Medicaid managed care regulations state clearly that providers are not subcontractors by virtue of having a network provider agreement.

## D. STANDARD CLINICAL AND FINANCIAL RISK-MANAGEMENT PRACTICES FOR SUB-CAPITATED ORGANIZATIONS, SUCH AS MICHIGAN’S CMHSPS

---

Michigan’s CMHSPs receive their Medicaid funding via a capitation method directly from MDHS for those CMHSPs who also serve as PIHPs, and via a sub-capitation or global budget, from their Regional Entity PIHPs for those CMHSPs working within Regional PIHPs. These capitation and sub-capitation financing methods are outlined in the MDHHS contract with the state’s PIHPs and in the contracts that the regional entity PIHPs have with their CMHSPs.

CMHSPs in these advance alternative payment methods (APMs), as with all providers receiving funding through such methods, take on a number of clinical and fiscal functions that are core to their work as advanced APM providers. These functions include:

- Utilization management (including eligibility determination, level of care determination, authorization, Utilization review)
- Network management (including staff/provider credentialing, network development, contract management)
- Quality Improvement (including standard setting, performance assessment, corporate and regulatory compliance, evaluation, and provider training)
- Financial management (including claims payment, fiscal risk management, and organizational fiscal management)
- Customer services (including complaints, grievances and appeals)
- Information services (including data aggregation and reporting)

As with all MCO-to- provider relations, the **PIHP retains the responsibility for ensuring that these functions are carried out by the comprehensive service provider** – by the receipt of reports from the comprehensive advanced ABP provider, reviews of samples of work products and processes, audits, and the implementation of corrective action plans as needed.

**The responsibility for fulfilling the functions contained in the document are those already (for decades) held by the state’s CMHSPs. These responsibilities are at the core of what defines a CMHSP in Michigan, as a comprehensive specialty services network – responsibilities held long before the advent of managed care in Michigan’s Medicaid program.**

As noted over the last several years, to mislabel these functions as managed care functions that can be delegated to, or their delegation withheld, from a CMHSP is:

- Is in **contradiction of the core elements required of Michigan’s CMHSPs**. This mislabeling is in violation of the state statutes and rules that define the state’s CMHSPs and their work,
- All of the work of the CMHSP in fulfilling this role, including staff credentialing, contract management, quality improvement, claims payment, customer services and recipient rights, is **related to the CMHSP role as a comprehensive services provider as it has been for decades long prior to the advent of managed care in Michigan’s Medicaid program.**

**These functions are those of a comprehensive APM-financed provider, such as Michigan’s CMHSPs, and not those of a managed care subcontractor.**

One of the clearest descriptions of the roles that sub-capitated comprehensive provider networks is provided by the [United Hospital Fund in its report, “Capitation and the Evolving Roles of Providers and Payers in New York”](#). The most relevant segments of the roles that provider organizations take on to fulfill their obligations under a sub-capitated payment arrangement are included in **Appendix A**.

## **E. ROLES AND RESPONSIBILITIES OF CMHSPS AND PIHPS AS OUTLINED IN MDHHS CONTRACTS**

---

A wide range of roles for both CMHSPs and PIHPs are outlined in their contracts with MDHHS. **These roles and responsibilities are so numerous that they will not be spelled out here.**

Additionally, through negotiations and the impact of changes in federal and state statutes and regulations and in other environmental factors, **these contracts change throughout the terms of the contracts.**

Because confusion exists relative to the **roles of CMHSPs as safety net organizations** fulfilling a number of community benefit functions outside of their work as comprehensive behavioral health networks, **those responsibilities are the focus of the following segment of this analysis.**

## F. CONTRACT REQUIREMENTS UNDERSCORING COMMUNITY BENEFIT AND SAFETY NET RESPONSIBILITY OF MICHIGAN'S CMHSPS

---

The recognition of the fact that “**community benefit**” and “**safety net**” functions are core requirements of Michigan’s CMHSPs and are required as part of the [MDHHS contract with the state’s CMHSPs](#). These functions represent a range of responsibilities far beyond traditional direct service delivery – far beyond those expected of a service delivery that would be expected of a private sector provider - and include:

- Ensuring that persons with mental health needs have opportunities to be active members of their communities – often by breaking down barriers to such opportunities
- Addressing homelessness and ensuring sound, safe, and affordable housing in the local community
- Fostering employment opportunities and economic opportunities in the local community
- Ensuring access to income support systems (entitlements)
- Actively lead and participate in community collaboratives
- Ensure a sound law enforcement, judiciary, and mental health partnership, including jail diversion, mental health courts, training of law enforcement personnel
- Ensure a system of care including schools, child welfare, juvenile justice, and mental health systems
- Serve as the community’s information source for a wide variety of mental health issues
- Serve as the community’s navigator for persons seeking mental health services and other, ancillary services (food, clothing, housing, utility assistance)

## Appendix A:

### Excerpts from the United Hospital Fund report: Capitation and the Evolving Roles of Providers and Payers in New York <sup>2</sup>

Through our interviews with the outside experts, we developed a framework that identifies some of functions provided by payers under traditional payment schemes. In Table 1, we grouped those functions into four broad categories. **The experts whom we interviewed suggested that a (comprehensive provider) operating under a capitation contract would likely want to control or strongly influence those functions that have the greatest impact on the measures of the (comprehensive provider's) success: whether it improves quality, provider experience, and member experience, and whether it controls costs. They suggested that (comprehensive providers) themselves might want to assume responsibility for these functions, indicated by the areas (boxed) in the table.**

#### **Table 1. Migrating (Comprehensive Provider) Administrative Functions from Payers**

Boxed areas indicate functions for which (Comprehensive Providers) might assume responsibility.

#### **Product design, sales, and regulatory compliance**

##### **Product Design**

Actuarial soundness  
Network design  
Co-insurance and deductibles  
Premium rate-setting

##### **Marketing**

Specify population covered  
Purchaser relations  
Advertising and sales

##### **Compliance & Risk Management**

Insurance rules, regulations  
Policies and procedures  
Risk management

#### **Provider-facing functions**

##### **Provider Relations**

Network management  
Credentialing  
Provider contracting  
Provider communications

##### **Medical Management**

Quality reporting and improvement  
Utilization management

<sup>2</sup> [Capitation and the Evolving Roles of Providers and Payers in New York](#); United Hospital Fund; Burke, Gregory C.; Brundage, Suzanne C; Myers, Nathan; May 5, 2016

Disease management  
Care management  
Care coordination

### **Member-facing functions**

#### **Customer Service**

Member communications  
Call center and member services  
Health education  
Track and report on member experience  
Appeals and grievances

### **Finance, Planning, and Analysis**

#### **Finance**

Pricing services  
Receive, adjudicate, pay claims  
Tracking expenditures  
Monthly, regular reports to providers  
Monitor and report to plan / purchaser  
Reinsurance and stop-loss

#### **Planning and Analytics**

Planning  
Claims data and analytics  
Monitor, report on quality  
Monitor utilization, expenses, costs  
Track provider and network performance

(Underlining, in the following excerpt, is provided for emphasis)

**Provider-Facing Functions.** (Comprehensive providers) are responsible for the performance of an entire provider network in caring for their attributed population. To do so effectively, they must be prepared to assume or oversee a series of new functions that affect their relationships with participating providers, including credentialing, contracting, communications, and network management. Most important, they will need to control processes for medical management, including care management, quality improvement (identifying and spreading best practices and reducing variation), and sensitive functions like pre-authorization and utilization management, which can greatly influence both costs of care and provider satisfaction.

**Member-Facing Functions.** (Comprehensive providers) will also want to control (or strongly influence) functions that affect their relationships with members. They will need to develop or enhance member services, supported by 24-hour call centers to handle patient questions and complaints, and to organize and deliver programs of health education to engage and support patients and their caregivers. Their performance in these areas can influence patient engagement (which contributes to improved outcomes), member satisfaction (a measure on which (comprehensive providers) are generally graded), and member retention (which is key to attribution).

**Finance, Planning, and Analytics.** Perhaps the greatest challenge facing (comprehensive providers) under capitation is in the broad category of finance, planning, and analytics. Under shared savings and shared risk arrangements, (comprehensive providers) need to develop basic capabilities in some of these areas; but since most of their provider payments are still tied to fee-for-service billing (and only a small portion to the year-end bonuses based on the shared savings they may generate), their performance in these areas may not be perceived as critical.

Under capitation, however, (comprehensive providers) need robust health information and planning capacities, including the ability to assess and adjust for risk, to promptly produce clinical and claims data analytics needed to support quality improvement, to track performance against budget, and to mitigate the potential impact of the increased risk they are assuming. (Comprehensive providers) will also need to develop or acquire new financial, actuarial, and accounting systems, including the capacity to negotiate payment rates, and pay bills received from providers.