COMMUNITY MENTAL HEALTH AUTHORITY
CLINTON • EATON • INGHAM

# Overview and History of the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties 2012

## I. Overview of CMH

The Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMH) serves in two related, but distinct roles – both designed to ensure that Michigan's citizens, especially the most vulnerable, have access to full citizenship and to high quality mental health and substance abuse services and supports. These two roles are:

- As a three county Community Mental Health Services Program (CMHSP) - the local public mental health and substance abuse service provider, serving the citizens of Clinton, Eaton, and Ingham Counties.

- As an eight county Medicaid Prepaid Inpatient Health Plan (PIHP) – managing the Medicaid funded mental health and substance abuse services for the citizens of Benzie, Clinton, Eaton, Gratiot, Ingham, Ionia, Manistee, and Newaygo Counties. This organization carries out its PIHP role through the Community Mental Health Affiliation of Mid-Michigan via subcontracts with the CMHs and the substance abuse coordinating agencies serving these counties.

CMH is a public governmental body, formed by the County Commissions of Clinton, Eaton, and Ingham Counties, with a 12 member board of directors appointed by the County Commissions of all three counties.

In its CMHSP role, CMH serves, through the work of its staff (over 800 employees) and its contractual providers (over 600 employees of these providers), the mental health and related needs of approximately 10,000 persons in four populations:

- Children and adolescents with emotional disturbance
- Adults with mental illness
- Adults, children, and adolescents with developmental disabilities
- Persons with substance abuse disorders

## II. History

**A. State facilities:** Through the early 1960s, state psychiatric hospitals and developmental disability centers were the first line of treatment and supports for serious mental illness and developmental disabilities. Community treatment services were rare.

**B. CMH movement begins and CMH is formed:** in the early 1960s, the U.S. Congress and the President supported legislation enabling states to initiate and strengthen community programs with federal grants. Emphasis was on the formation of a network of complementary state and local services, to make mental health services accessible to all community residents. As a result, Michigan adopted legislation, Public Act 54, permitting counties to form mental health boards and to receive state grants to help finance services. This new philosophy stimulated the development of Michigan's Community Mental Health Boards to plan and develop local services.

The Community Mental Health Board of Clinton-Eaton-Ingham Counties was formed in 1964, initially as a federally funded community mental health center, serving Lansing.

The organization moved towards its current legal structure, when the Community Mental Health Board of Clinton-Eaton-Ingham Counties was created, under the authority of Public Act 54 and the Urban Cooperation Act. PA 54 was superseded in 1974 when the Michigan legislature enacted Public Act 258, the new Michigan Mental Health Code. This state legislation transferred greater levels of responsibility for mental health services from state to local government. The Mental Health Code, the law which governs all state and local mental health programs in Michigan, was most recently revised in late 1995 (and is continually revised) and has moved even more responsibility from the state to the local level.

**C. De-institutionalization**: Starting in the 1970s, the major theme that drove Michigan's CMH system was de-institutionalization – allowing persons who formerly lived in state hospitals and DD centers, to live in the community. This theme provided the impetus for the transfer of thousands of Michigan residents from treatment in state facilities to treatment in their home communities, by the CMH system.

**D. Substance abuse services**: During the 1970s, CMH also added substance abuse services to the range of services that it offers, becoming one of the first and one of the few CMHs which offers substance abuse services.

**E. Full management**: CMH became a managed care organization (before we called what we were doing managed care) with the advent of Afull-management@ in the early 1980s. Full management is the arrangement by which a CMH takes on the clinical and financial responsibility for care for a person who leaves a state hospital or DD center. When this CMH became a Afull management CMH@, in the early 1980s, we took on our first managed care role. As a full management Board, CMH:

- receives additional state funding for placing persons, from state hospitals and DD centers, into the community
- is responsible for providing the community-based care for persons formerly in state hospitals and DD centers
- is responsible for paying for the consumer=s care in the community and in the state hospital or DD center if he or she returned to those facilities
- uses any savings that were generated by providing community-based care rather than care in state facilities.

As a part of full management, CMHs assumed a number of managed care functions, in addition to those associated with our role as provider. These functions include: making determinations about the package of services that a consumer receives, resolving complaints and disputes, contracting with and paying contractors, ensuring compliance with federal and state requirements, making decisions as to how use funds that are saved by serving persons in more cost effective ways, and measuring and ensuring the performance of the system in a wide range of areas. We (typically CMH managers) have assumed these tasks, while often not recognizing them as managed care functions.

**F. Medicaid funding of the CMH system**: Parallel to full management efforts, in the early 1980s, this CMH, and others, became a Medicaid fee-for-service provider (what is known as a Type 21 provider), under a sole source contract with the Michigan Department of Community Health. Under this contract with the state, no other provider could receive Medicaid funding for the range of community-based care that we provide. As a Type 21 provider, CMH is also required to do many administrative functions that typical fee-for-service Medicaid providers do not need to fulfill. These functions mirrored many of those that CMH assumed when the organization assumed the full management role, listed above. Type 21 provider status was the precursor to the sole source Medicaid managed care contract that CMH signed in 1998.

During the 1970s, 1980s, and most of the 1990s, the growth in the CMH system was the result, almost exclusively, of:

- the transfer of funds from state institutions to the CMH system, as a result of de-institutionalization and full management
- the transfer of responsibilities, formerly held by the state, to CMH (payment for inpatient care, for Medicaid recipients, in community hospitals; operation of AIS homes)
- the CMH system's participation in the federal Medicaid program
- the expansion of CMH's substance abuse and corrections initiatives
- the acquisition of Medicaid waiver payments
- the receipt of a number of federal and state grants and earned contracts

**G. Managed care**: In 1998, CMH took on the care management role for the mental health component of the Medicaid program in addition to its "safety net" role in serving non-Medicaid consumers. In this care manager role, as a Prepaid Inpatient Health Plan (PIHP), CMH could no longer bill Medicaid for services provided. Rather, CMH receives

a monthly pre-payment for each Medicaid recipient living in this community. The monthly payment, known as the Per Enrollee Per Month payment (PEPM) differs by the age, gender, and Medicaid enrollment type of each enrollee. In this PIHP role, CMH must serve the mental health needs, above those of mild severity (which are served by Medicaid HMO's), of any and all Medicaid recipients living in the tri-county region. No new Medicaid funds are provided to the CMH if demand for services increases. Under such an arrangement, the CMH system serves, in many ways, as a staff model HMO for mental health and developmental disability services.

While these services were funded via this capitation model (as in "per capita"), substance abuse services continue to be funded on a fee-for-service method, through the Mid-South Substance Abuse Commission.

**H. Affiliation**: In 2002, a number of smaller CMHSPs were required to either affiliate or merge with other CMHSPs to form PIHPs which covered at least 20,000 Medicaid enrollees. As a result of this mandate, and in fulfillment of a number of strategic goals of this CMH, CEI formed the CMH Affiliation of Mid-Michigan, with the CMHs of Gratiot, Ionia, Newaygo, and Manistee-Benzie Counties. The strategic goals include:

- Foster the CEI hybrid model of a provider/care manager by ensuring the survival and health of CMHs which have retained this dual role
- Be proactive relative to size, regionalization, local control, and efficiency
- Ensure that CEI was a key player in the development of policies that impact the state=s CMH system
- Provide for pooled expertise and staff to allow CEI and its affiliates to rapidly meet increased federal and state requirements
- Bring in revenue to share the costs of required PIHP administrative functions to CEI
- Allow CEI to stabilize its funding

CEI's success in achieving these goals is discussed in the February 2007 document "Status Report on the Benefits Resulting from the Formation of the CMH Affiliation of Mid-Michigan".

**I. Increased federal and state requirements**: in the early 2000s, simultaneous with the formation of the Affiliation, the managed care-related compliance demands placed on this CMH increased dramatically. These demands include those related to:

- the integrity of encounter and demographic data
- site visits, by MDCH, the federal Centers for Medicaid and Medicare Services, and the external quality review organization.
- Medicaid fair hearings and the appeal and grievance rights of consumers
- clinical record compliance
- medical necessity, utilization review, and authorizations
- fiscal accountability

The most recent set of demands are due, in the main, to the additional reporting and compliance requirements that were added to our PIHP role by the 1997 Balanced Budget Act (BBA), the rules of which went into place in 2002 and 2003.

It is important to differentiate the impact of two simultaneous events on the added demands on this CMH. These two events are:

1. the changes in federal statute, federal regulation, and state contractual requirements that have come with CEI becoming a PIHP under the state=s Medicaid waiver

2. the formation of the eight county Affiliation, of which CEI is the hub.

The bulk of the demands that CMH has encountered are due to the former cause: changes in federal statute, federal regulation, and state contractual requirements that have come with CEI becoming a PIHP.

This CMH, as a PIHP, is mandated to meet these federal requirements regardless of whether this CMH had formed the Affiliation.

**J. Authority status**: In 2002, CMH was designated as the Community Mental Health Authority of Clinton-Eaton-Ingham Counties. As an authority, CMH can employ staff, take on debt, and act in many of the ways that an autonomous governmental body can, except for the levying of taxes and the selection of its governing body. These two powers are retained by the counties.