

STATE OF MICHIGAN

Request For Information No. [RFI-180000000003]

298 Pilot(s) – Medicaid Physical-Behavioral Health Full Financial Integration

1. Genesee Health System
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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.

See page 3 for the Genesee Health System Proposed Organization Structure diagram supporting implementation of the pilot.

(1) Genesee Health System’s proposed role as the Community Mental Health Service Provider (CMHSP) in this delivery model would be as a fully integrated Physical and Behavioral Health (SMI, I/DD, SUD) Specialty Care Coordination Managed Care Organization. Genesee Health System (GHS) shall work with the Medicaid Health Plans to develop a shared care and coordination of integrated services model, based on overall physical and behavioral health care performance measures. It will produce improved integration of care while sustaining the existing behavioral health safety net which the CMHSP has always provided to the local community. Under this model, we envision a seamless behavioral and physical health care system to reduce consumer access to care barriers and enhance health outcomes. Furthermore, this design will incorporate measures of integration to address the opioid addiction crisis that is facing our county.

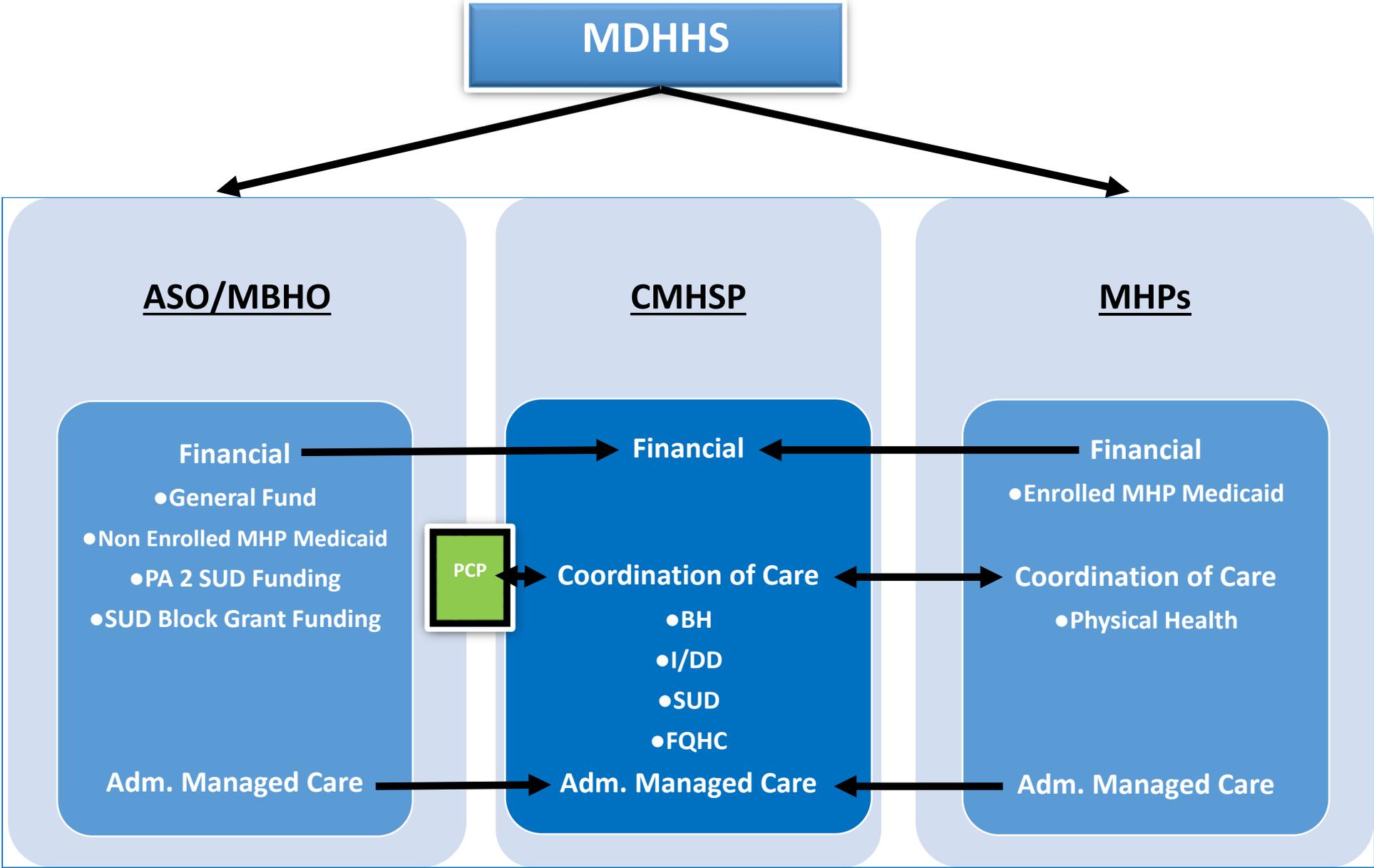
As a former standalone Prepaid Inpatient Health Plan (PIHP), GHS is uniquely positioned to effectively develop and implement this integrative care model as we have the proven experience and current administrative capacity to perform all of the managed care functions required. GHS has a comprehensive directly operated provider network and has also continued to maintain a large contracted external provider network, which combined delivers all of the required Medicaid mental health specialty supports and services to Genesee County residents. In addition, GHS’s strong commitment to providing for the physical health care needs of our consumers is evident through our development and operation of a Federally Qualified Health Center (FQHC). Through this coordinated care model of directly operating both behavioral and physical health services, GHS has led the way in integrated health care organizational design and innovation. These efforts render GHS to be uniquely poised to fully engage in this integrated care pilot and the organizational capacity to deliver the full array of behavioral health services, including the SUD treatment as the former coordinating agency. In addition, GHS has established relationships with the Medicaid Health Plans, having been greatly fostered in the last few

years through coordination efforts around implementation of the Expanded Flint Water Medicaid Waiver. As the Designated Provider Organization, GHS provides Targeted Case Management for children potentially affected by lead contained within our water system. This newly created relationship between the MHP organizations and GHS has led to a coordinated effort to provide wraparound care and services to this expanded population.

(2) It is recognized that this pilot represents a commitment to support a significant model change in physical and behavioral health integration that is yet to be fully planned and designed, and therefore; a detailed organizational structure cannot yet be offered. However, on a conceptual level, the model would consist of a shared coordination of care responsibility between the CMHSP and the MHPs, with defined structures developed to reduce consumer barriers to care, to provide seamless access to health care, to share information across agencies, and for the creation of coordinated service/care navigation to and from the primary provider level. Financially, a pass through of the current capitated rates as set by MDHHS would flow from the MHPs to GHS under a contract directly with the MHPs, for shared coordination of care service delivery model. GHS could provide and report to the MHP for all managed care functions, including the Coordinating Agency for Substance Use Disorder services. GHS's current service model would remain in place to ensure access to the full array of Medicaid services. In addition, GHS can quickly re-establish the SUD provider network as we were the coordinating agency prior to the Regional PIHP model.

(3) GHS currently has a relationship with MDHHS not only as the General Fund CMHSP, but also as the Designated Provider Organization for the Expanded Flint Water Medicaid Waiver, as well as through multiple grants and contracts to service individuals within Genesee County. Depending on the design that MDHHS may wish to implement (MBHO/ASO), GHS would have a contractual relationship through this entity while maintaining other contractual and grant associations with MDHHS. GHS is the safety net provider for all behavioral health services, and as such is viewed as the crisis services provider for Genesee County residents. In addition, GHS provides expanded services to include behavioral health, SUD, housing and homeless resources, primary health care, and provider participation in the State Innovation Model, MICare, and a host of other services. GHS will work jointly with MDHHS to develop a reimbursement model for the non-enrolled Medicaid Health Plan beneficiaries as well as the General Fund behavioral health services provided in Genesee County.

Genesee Health System Proposed Organization Structure



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

To ensure success with this pilot, not only will integration be required for behavioral and physical health providers, but also with social service program providers within Genesee County. Integration will need to be supported through already established, as well as expanded and redefined structural and relational mechanisms between these partners. Pilot participants will need to jointly explore and identify opportunities for both increased integration and efficiencies, across administrative, service delivery, and managed care processes. Perhaps unique to Genesee County and certainly considered to be a significant asset relative to this pilot, is the Greater Flint Health Coalition, an organization that strives to improve the health status of our residents, as well as improve the quality and cost effectiveness of the health care system in our community. Its members are made up of representatives from the physical health care and social services community; and GHS is both an active partner member and Board Director of this organization. The Coalition has long been involved in community-wide health care improvement initiatives and is expected to play an integral role in supporting the initiatives of this pilot which align well with the Coalition. For example, GHS is a steering member of the State Innovation Model (SIM) project through the Coalition, with a focus on reduction of unnecessary emergency department visits and avoidable inpatient physical health related hospitalizations. We are a HUB within the Community Health Innovation Region (CHIR) for the SIM initiative and currently, GHS has SIM coordinator staff embedded within two of the county's hospital emergency rooms, as well as staff at our Federally Qualified Health Center, working to address chronic health conditions and social barriers. Along with our work in the MICare program and monthly meetings with the Medicaid Health Plans, we are starting to see reductions to these unnecessary emergency room visits to improve the overall health status of the consumers we service.

Genesee Health System (GHS) is a well-established and integral partner of Genesee County's health care and community social services network. GHS and our FQHC (which is currently an integrated behavioral and physical health care provider) have been involved in and are steering committee members of many county-wide initiatives, again providing a strong foundation for development of the pilot integrated care model. GHS has been involved from the start regarding the lead water issues affecting Flint residents. Our role as the Designated Provider Organization for Targeted Case Management under the Expanded Flint Water Medicaid Waiver and as a recipient of a number of water crisis related federal, state and private foundation grants has led to the establishment of many new partnerships. GHS has developed ongoing associations and service affiliations with many of the local physicians, the Genesee County Medical Society, homeless shelters and programs, as well as strengthened alliances with our local hospitals. These partnerships are considered to be a strong foundational asset to this pilot with the expectation that they will grow and be refined through this process.

GHS has had a long and continuing relationship with Genesee Health Plan (GHP), the County's millage operated physical health plan for under insured county residents. This relationship has created unique partnerships between GHS and GHP for the integration of health care for over a decade. GHS understands that to make significant improvement in our consumers' health, we must work closely with all of the primary care providers who touch the lives of the individuals we serve. This will be done not only at the organizational level with Physician Health Organizations, Medicaid Health Plans and Social Service Agencies, but we will also work with individual physicians by embedding services at the practice level of targeted case managers, assistant case managers, health coaches, RN care managers and navigators along with peer-delivered services. These individual relationships and this unique ability to

work with clients through community based in-home services will provide additional health supports and assist all clinical professions.

By working with consumers on behavioral and physical health conditions and other social determinants (linking to other needed health care services and referrals, nutrition/diet, housing, coordinated medication management through our contracted, onsite pharmacy, etc.), a clearer understanding of barriers to clients' health care will be identified. A coordinated holistic approach to individuals' complete health care needs and determining barriers to an improved overall lifestyle will reduce duplication of care monitoring, improve information sharing, promote care coordination among multiple providers, reduce unnecessary repeating of services and tests, reduce health care costs and enhance administrative simplification. Consistent coordinated and informed service delivery will not only produce improved overall health conditions and status for the population served, but will ultimately reduce costs for unnecessary services and duplications within our current health service delivery model.

GHS's former role as the PIHP gives us the proven capability to provide all of the managed care functions to achieve these outcomes under this pilot project. Furthermore, as the maturity of this model develops, GHS is in a position to take on potential primary care functions to further the coordination of health care and produce overall health status improvement. As a current manager of a primary health center, we possess this ability and professional skill set.

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

Genesee Health System (GHS) has long recognized the need and value of improved care coordination and integration and has a unique and extensive history of successfully engaging in systems of care initiatives to promote physical and behavioral health integration in Genesee County. In 2005, GHS funded and co-located a primary care clinic within the Community Mental Health Center, in partnership with Hamilton Community Health Network, the Genesee County Federally Qualified Health Center. As GHS recognized the need to move beyond a co-location model to further advance physical and behavioral health integration efforts, a HRSA Health Center Planning Grant was sought and in 2011 was awarded to GHS, subsequently leading GHS to establish a new FQHC in Genesee County (Genesee Community Health Center). GHS was the first CMHSP to open an FQHC, a model that has proven to be both challenging and highly beneficial. This primary care resource is strategically situated on the GHS main campus in downtown Flint, greatly increasing the accessibility of primary care services for both the community at large, as well as for those individuals receiving mental health services through GHS. Later, a second primary health care location was opened in a public housing complex in Genesee County and then in 2016, GHS received a FQHC expansion grant to assist with physical facility growth and enhancement, a project that was completed in 2017. Though the primary target populations served by the Health Centers are the homeless and public housing recipients, a significant portion of the primary health care in these settings is delivered to individuals with co-occurring and substance use disorders, including providing integrated care for opiate dependent individuals.

There are numerous other examples of ways in which GHS has engaged in initiatives to promote wellness as well as to support health care integration. Since 1992, Genesee County has had an active coalition of healthcare providers, insurers, and other stakeholders, named the Greater Flint Health Coalition. GHS has been involved in the coalition for a number of years and on many levels, including board and committee membership. The coalition heads the current State Innovation Model (SIM) project, in which GHS is a partner and sub-contract participant by providing mental health support in an emergency room

setting to address social determinants of inappropriate and excessive emergency room utilization. This coalition forum provides GHS regular and ongoing opportunities to interface with the medical community on relevant topics and projects around healthcare, ensuring that behavioral health is represented and leading to well established working relationships.

GHS has played a primary role in the Flint Water Crisis response, leading to many opportunities to coordinate with the medical community in Genesee County. As the Designated Provider Organization for the new Targeted Case Management service, the Flint Medicaid Water Waiver expansion resulted in numerous coordination meetings between GHS and many state, federal and community partners, as well as with the Medicaid Health Plans (MHP), resulting in a successful and rapid start-up of this service. In addition, as a prior Pre-paid Inpatient Health Plan (PIHP), GHS had a long history of working with the MHPs to coordinate care for high risk cases, a model we successfully continue to engage in today.

There are many other examples of GHS's engagement in care integration initiatives. To name a few, GHS was an early adopter of the use of health and recovery coaches, a model that continues to be widely used in GHS's directly operated mental health and primary care (FQHC) settings today. Another example is a recently formed partnership in which GHS co-located children's specialty mental health services at Mott Children's Health Center's primary care physical health setting, affording both organizations an opportunity to expand in facilitating coordinated health referrals. Further, GHS is the recipient of a multi-year University of Michigan subcontract under the Michigan Child Collaborative Care Program (MC3) where we embed mental health workers in primary physical care clinics to provide behavioral health screening, consultation and referrals. These exemplars demonstrate GHS's long standing commitment and strong capability to engage in progressive, effective care integration initiatives.

Through the above initiatives, GHS developed a specialty regarding physical health financing and billing. GHS's management of our Federally Qualified Health Center requires unique skills to bill each health plan, work directly with the State of Michigan for the fee for services of physical health care billing, as well as submit specific financial reporting to the Center for Medicare and Medicaid, the State of Michigan and HRSA for cost settlement, and quarterly and annual status reporting. Additional financing expertise exists within GHS for dental/oral health billing and specialty financial reporting on our 340b medication/pharmacy program. In 2017, GHS was required to change to institutional billing methods, which was successfully accomplished. It is also important to mention the financial reporting requirements of HRSA and many of the health related water grants that GHS is currently performing for many different state, federal and local funders utilized by GHS. This experience positions GHS to meet the specialty guidelines which may be required under this new model of financing.

Genesee Health System and our committed Medicaid Health Plan partners have started discussions for the development of a unified financial system for funding, billing and reporting. These are complicated conversations and will take time to identify and develop the best possible model to use for ensuring the success of this pilot and the provision of the best possible care delivery to our mutual clients. It is the understanding of all involved that meetings will continue and discussions will move toward refining the process, and outlining the guidelines for developing a cohesive financial method for funding to meet MDHHS's stated objectives and goals of this pilot program.

6. Public Policy: The public behavioral health system has been designed and modified to meet a number of public policy requirements which have continued to expand over time. These various policies and the resulting community and service structures are integral to achieving goals and outcomes for individuals and communities. The current Prepaid Inpatient Health Plan (PIHP) contracts include a number of attachments detailing these policies, which include:

- Technical Requirement for Behavior Treatment Plans
- Person-Centered Planning Policy
- Self Determination Practice & Fiscal Intermediary Guideline
- Technical Requirement for SED Children
- Recovery Policy & Practice Advisory
- Reciprocity Standards
- Inclusion Practice Guideline
- Housing Practice Guideline
- Consumerism Practice Guideline
- Personal Care in Non-Specialized Residential Settings
- Family-Driven and Youth-Guided Policy & Practice Guideline
- Employment Works! Policy
- Jail Diversion Practice Guidelines
- School to Community Transition Planning

MDHHS has contractually required the PIHPs to ensure that these policies are appropriately applied to the Medicaid benefits provided. In the pilot locations, this responsibility will fall to the MHPs as the new contract holder. CMHSPs that apply to be pilot sites must demonstrate pre-planning with all MHPs in their geographic area to determine how ongoing implementation and compliance will be monitored and verified.

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

Genesee Health System (GHS) has continued to maintain a commitment to all of the above listed public policies and practices. The ideals described within these policies were not merely contractual requirements but a path to quality improved services, self-determination, and consumer centered service and choice. These policies were held by GHS as standards built into our everyday delivery care model and has a long history of demonstrated compliance and excellence in these areas. GHS has never wavered from these policies or the implementation of the standards. Though GHS is no longer the stand alone PIHP, we continue the implementation and the updating of these policies, to ensure that all requirements are maintained, in every level of services and program delivery. GHS will engage the Medicaid Health Plans in discussions and education on the content of these standards and associated policies, and on the reasons and history that led to the development of the policies and practices. GHS will establish technical training to and for the MHP staff. These trainings will be developed in conjunction with the MHP organizations and distributed in a variety of methods offering access to all levels of the staff. GHS will ensure continued compliance with the public policies and will work to include that all public policies are contained as contractual compliance, within the agreements, which shall be developed between the MHPs and GHS. Policy compliance related to these standards will be performance indicators held within all contracts between GHS and the MHPs.

The current GHS Policy Manual is inclusive of all public standards listed in this RFI.

- 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.

One demonstration of GHS's deep commitment to consumer engagement and input is the fact that it was the first CMH in Michigan to have a consumer chair its Board of Directors. GHS engages consumers in a number of ways, which we will continue and expand in the pilot. Welcoming begins at the front door, where a staff person, usually a peer, is present to greet incoming individuals in our lobby. Our Customer Services Department is active in soliciting involvement in psychoeducational groups and other activities. GHS's Consumer Council meets regularly and receives information on a number of activities and findings, for example performance improvement projects, MMBPIS performance indicators, and information about new or special programs. The Council's input is incorporated as programs and systems are reviewed.

As a prior PIHP, GHS convened a Consumer Advisory Group, which worked with the Quality Management Department to review PIHP data and reports, and provide input. Returning to a care manager role through this pilot, we will reinstate this group and propose expansion to include physical health care consumer membership.

Broader consumer input is gathered through several processes. First, annual surveys are conducted, both per MDHHS requirements, and also to gather data from a broader population using Region 10 PIHP's standard tool. After consumers leave all GHS services, GHS's Customer Services contacts them to conduct a brief phone survey and ensure their needs were met.

Through this pilot, we anticipate building on the Region 10 PIHP tool, the MHSIP, and other sources to develop a tool and process that meet our and our consumers' needs – for example, perhaps inquiring about Flint water issues and other factors applicable to our specific community and consumers. We will also institute a formal system of focus groups to gather input in an alternative format. In the past, as the PIHP, we included consumer interviews by a peer concurrent with our provider audits. We are exploring opportunities to recreate this system.

GHS Customer Services tracks and categorizes consumer grievances and other interactions that are in our data system. Customer Services also conducts monthly "secret shopper" calls to staff and departments. This information is reported directly to executive leadership, and passed along to management and supervisors to address any concerns. GHS participates in a similar process where, statewide, CMHSPs mutually "secret shop" each other.

The above data, integrated, inform general and provider-level analysis of consumer experience and concerns. Consumer satisfaction findings are included in our annual consumer satisfaction report and our provider report card. Beyond reporting, the information has proven useful in quality and process improvement at both the system and provider level. In the past, consumers have, for example, identified concerns with front-door access procedures, which provided valuable input as access processes were reviewed and updated.

- 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.

As a prior Prepaid Inpatient Health Plan (PIHP) and Coordinating Agency (CA), GHS has significant experiential knowledge in the successful management of prevention and treatment service provision for individuals with, or at risk of, developing substance use disorders in Genesee County, placing us in a unique position to resume this role. GHS was the CA from April 1, 2006 to January 1, 2014 when Region 10 became the PIHP for our county and assumed the CA responsibilities. GHS administered and coordinated state administered funds for substance use disorder (SUD) treatment and prevention services and developed and managed the contracts for provision of SUD services with 12 different providers. Through these contracts, GHS served over 4,000 clients annually receiving substance use disorder services during this period. We are prepared to resume this responsibility, ensuring that these funds are retained for SUD services and not diverted to fund services other than SUD. We will work with the Department utilizing the allocation formula based on federal and state data sources to allocate and distribute nonmedical assistance substance use disorder services funds.

GHS's current board composition includes representatives of substance use disorders as well as mental health and intellectual/developmental disabilities. When GHS was the CA, we established a substance use disorder oversight policy board, which in 2014, was moved under the regional entity. Currently two of GHS's board members sit on the Region 10 PIHP oversight board. If GHS were to resume the CA role through this pilot, we would re-establish a SUD oversight board, ensuring that one of the members was appointed by the Genesee County Board of Commissioners. This SUD oversight policy board would perform all assigned functions and terms agreed to by the participating parties consistent with the authorizing legislation, including compliance with all reporting requirements. The board would advise, recommend and approve any budget containing local or nonlocal funds for treatment or prevention of substance use disorders and advise and make recommendations regarding contracts with SUD or prevention providers.

7. Service Array and Delivery: A strength of Michigan's Specialty Behavioral Health systems is the comprehensive range of services and supports that have been made available to eligible consumers. It is the department's expectation that pilots will assure access to the required service array as defined in current contracts, applicable waivers, and the Medicaid Provider Manual.

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

Genesee Health System (GHS) currently provides a full array of Medicaid services via directly operated and contracted provider networks. These services can be viewed on our website. GHS has been a leader in development of specialty evidence based programs to meet the needs of consumers served. Some examples are Multisystemic Therapy (MST), Dialectical Behavior Therapy (DBT), Assertive Community Treatment (ACT), Home based, Wraparound, and Intensive Care Management programs. GHS also ensures we remain the safety net for all crisis services, most recently the response to the Flint water crisis. We have also been involved in the development of new programs through the partnerships with MDHHS and other federal and local funders to ensure that community behavioral needs are met now and in the future.

GHS has set an organizational goal of achieving and maintaining excellence in our responsiveness to ensure service capacity within our network and offer a full array of specialty behavioral health services and supports to our community. Through the strategic planning development process, GHS uses

community needs assessments, local and national healthcare data, community forums, community and consumer input and other resources to ensure adequate behavioral health services are offered in our community. Examples are medication assisted treatment programs for individuals addicted to opioids (through our Federally Qualified Health Center (FQHC)), veteran services programs, and specialty services programs with Genesee Health Plan (county funded health plan) to serve the mild and moderate and uninsured population. As new services are added, either through new contracts or applicable waivers, GHS will manage service availability through the development of planning tools, review, and analysis of various data reports and audits. By determining utilization, service usage, population specific data, and penetration rates, we can better react to changes effecting capacity, reduce risk of under provided services and comply with contractual obligation with the Region 10 PIHP/State of Michigan, and CMS regulatory requirements.

GHS, through different standing committee meetings, as well as ongoing discussions with contract agencies, will collect key information to assist with evaluations of network wide service gaps, capacity and provider specialties and resources. By gathering data from these sources, the following will be determined;

- Emerging service practices (evidence-based practices) to better service the clients of Genesee County
- Best practice guidelines which can be implemented through the network of providers
- Opportunities for improvement
- Consumer demand
- Changes in population demographic
- Resource challenges
- Areas of efficiency or conflict

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

GHS's Provider Relations Department will monitor the network capacity to verify service/provider capacity shortage and excess. Provider Relations will publish provider capacity census, identify current capacity available by service and provider. Tracking of provider staffing will offer Provider Relations the ability to conduct clinical provider ratio analysis and ensuring qualified clinical staff meet the service needs of our clientele.

Furthermore, Provider Relations will evaluate and analyze selected reports to recognize network trends. The reports used in this analysis will consist of:

- Staff to Client Ratio
- Census Report by Program
- Census Report by Service
- Utilization Trends by Service Units
- Utilization Trends by Service Reimbursement
- Population Growth or Reduction
- Service usage by population (SED, SMI, DD)
- Medicaid Covered Lives
- Penetration Rates
- Quality Reports by Penetration Rates
- Performance Indicator Compliance/Achievement by Provider

- Clients Served by Funding Source
- Clients Served by Service, by Funding Source
- Complaints and Grievance Reports
- Provider Survey
- Demographic Reports
- Client Satisfaction Survey Reports
- Outlier Reports
- Stockholder Input
- Medicaid Claims Verification Audit Reports

GHS will strive to foster the needed infrastructure to ensure the sufficiency of service available and contract provider capacity. By meeting this organizational goal, we will help to advance the quality of behavioral healthcare in Genesee County.

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.

GHS currently offers a full array of well-established, evidence based practices (EBP), as well as supports several EBPs in initial implementation phases. Considered by GHS to be essential and integral to meeting the care needs of those served through specialty supports, GHS is fully committed to sustaining and ideally increasing access to a full array of EBPs under the 298 Pilot. As a large service provider, as well as a previous Prepaid Inpatient Health Plan (PIHP) and Substance Use Disorder Coordinating Agency, GHS has extensive experience in both initial implementation and ongoing fidelity maintenance of a full range of EBP's. These specialty services have been initially supported in a number of ways, for example through application to block grants, participation in Learning Collaboratives and MIFAST reviews, application to EBP Cohorts, and through community partnerships such as with the judicial system. Over time, the array of available EBPs and emerging/promising practices offered by GHS has grown significantly and today include, among others, Assertive Community Treatment, Family Psychoeducation, Motivational Interviewing, Dialectical Behavior Therapy, Applied Behavior Analysis, Trauma Focused Cognitive Behavior Therapy, Parent Child Interaction Therapy, Parent Management Training, Multi-Systemic Therapy, Jail Diversion Mental Health Courts, Crisis Intervention and Recovery Team, Veteran's Navigator Services, Recovery and Health Navigator Coaches, Peer Support Services, and the Psychosocial Rehabilitation Clubhouse. Additionally, with GHS's long history of focusing on integrated health and wellness, we have experience in developing collaborative EBPs/promising practices with community partners, such as the opening of the Sobering Facility, the establishment of the SBIRT (Screening, Brief Intervention, Referral and Treatment) model in a primary care setting, and implementation of the InSHAPE EBP in coordination with a community fitness center. Through ongoing participation in required EBP monitoring and mentoring, external consultations and validation activities, and internal quality assurance and improvement efforts, GHS is experienced in both sustaining and growing EBP resources, all methods that would be continued under the 298 Pilot to assure continuation of these essential resources.

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

GHS is currently engaged in a number of physical and behavioral health integration initiatives with plans to both continue and enhance these initiatives. GHS widely utilizes a health and recovery coach model,

both in GHS's directly operated mental health services and GHS's primary care (FQHC) setting. Further, the recently formed partnership of GHS and Mott Children's Health Center represents a co-location model of primary care physical health and specialty mental health services, affording both organizations an opportunity to expand in facilitating coordinated health referrals. In addition, GHS is the recipient of a multi-year University of Michigan subcontract under the Michigan Child Collaborative Care Program (MC3) where we embed mental health workers in primary physical care clinics to provide behavioral health screening, consultation, and referrals.

Genesee Health System (GHS) has a long history of developing and operating co-location and full integration models of behavioral, substance use disorder and physical health services. In addition, GHS has extensive and effective experience in all areas of behavioral health managed care operations as a previous PIHP and Coordinating Agency, uniquely positioning us as a strong 298 Pilot participant.

In 2005, GHS embedded Hamilton Community Health Network to deliver physical health care services within our Psychiatric Medication Clinic. GHS has also provided peer delivered services located at our local emergency departments. GHS also operates and manages a fully integrated Federally Qualified Health Center, called Genesee Community Health Center (GCHC). GCHC provides primary health care, psychiatric medication evaluations/medication monitoring, outpatient therapy, crisis intervention and SBIRT, peer delivered services, medication assisted treatment programs (Suboxone and Vivitrol) and health coach navigation. Our health center is currently delivering this fully integrated health care to 4,500 patients and is designated as a health care clinic for the homeless and public housing population. It is a project site for the State Innovation Model (SIM) and MICare programs. It was recognized as a Patient Center Medical Home by NCQA in 2016.

GHS has been at the forefront of Integrated Physical and Behavioral Health Care and will expand its integration and co-locations under this pilot project by ensuring access to care coordination by (*see page 14-Genesee Health System Integrated Model of Care diagram*):

- Developing a shared, integrated, coordinated treatment plan between the CMHSP and the primary care physician, the targeted case manager will attend appointments, support medication management and medication assistance programs, coordinate transportation, health service navigation, PCP appointment schedule management, housing, nutrition/diet, and other social determinants of health care.
- Provide High Intensity Care Coordination Services (*see page 15-GHS High Intensity Behavioral Health/Physical Health Programs diagram*). GHS has an established and successful history of providing services to high intensity behavioral health need individuals. Evidence Based Practices like ACT, MST, DBT, home-based, wraparound and intensive case management programs have produced positive outcomes in reduction of psychiatric inpatient hospitalization, increased jail diversion, maintenance of stable housing, and engagement in SUD detox and residential treatment programs. GHS will further develop and design these resources to service beneficiaries to meet the high intensity of their health care needs. These programs will have team members or direct access to behavioral and physical health care staff who will ensure referrals and access to specialty health care services, coordinated medication monitoring and medication assistance programs, health care staff, navigation to health care service, PCP appointment schedule management, housing, nutrition/diet, and reduction of other social barriers to health care.

- Further develop expanded co-location at county Physician Health Organization, multi-Primary Care Physician practices, as well as at our local hospital emergency departments. Because of GHS's firsthand experience in managing a primary care health center, we will consider expansion of our Health Center and the primary care functions under direct contract with the Medicaid Health Plans. We propose in another section potential reimbursement and financing models which offer the possible development of a fully integrated model of care (offer primary care health services), which GHS is currently operating and managing with our Federally Qualified Health Center.
- GHS has an existing, effective model of addressing inpatient psychiatric admissions and jail diversion opportunities (*see page 16-Service Utilization diagram*). We embed liaison's working directly with local hospital ED/inpatient psychiatric units and in the jails and court system. GHS receives downloaded reports from the hospitals and jail which are electronically crossed referenced to any prior or currently open individual within our services. This immediately starts a process of re-admission for the individuals, linking to currently open programs and clinical staff or a re-evaluation for a high level of care. By using this same design, we propose to receive all emergency department and/or medical inpatient admission information and the liaison shall implement the same process to ensure immediate linking to current open programs, re-evaluation for services, and/or an increase in the level of care services. Within 24 hours, contact will be made for consumers in our high intensive service programs as described above, and within 72 hours for individuals in lower intensity programs. A further step would be to refer and link with the primary care physician within 3 to 7 days, following some of the same guidelines used for the SIM and MICare programs, as well as develop coordinated relapse prevention plans.
- Potential expansion of services for coordinated integrated services to the mild and moderate population for treatment and prevention.

Genesee Health System Proposed Integrated Model of Care

**Coordination
Primary Care/Behavioral
Health**

Case/Care Management

- Expansion of current Case Management program to include physical health.
- Utilize concepts from the State Innovation Model (SIM) and MICare model to develop Care Teams.
- Access to RNs, Social Workers, Case Management Assistants, Peer Supports.
- Attendance to PCP appt.
- Share communication between PCP/BH.
- Management of Social Determinants of Health via Peer Supports.
- Monitors Service Utilization (see Service Utilization diagram).
- Integrated Treatment and Relapse Prevention care plans.

**Co-Location
Physical/Behavioral Health
Services**

**Mott Children's Health Center
(MCHC)**

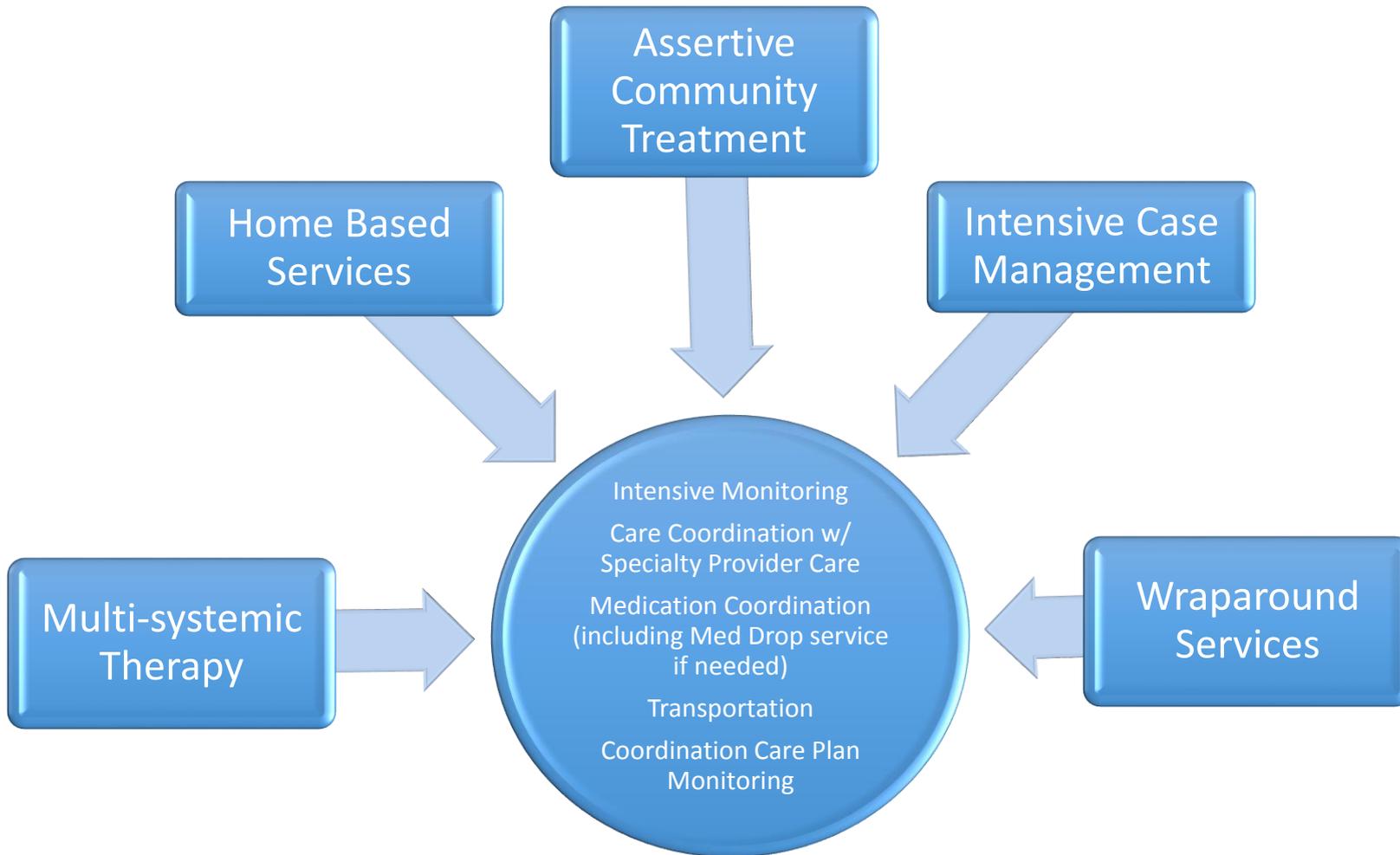
- GHS currently co-located with MCHC.
- MCHC provides primary care services.
- GHS provides behavioral health services on site.
- Psychiatric medication management services on site.
- Monitors Service Utilization (see Service Utilization diagram).
- Discussion of future expansion of co-located sites with Physician Health Organizations and other practices.

**Integrated
Physical/Behavioral Health
Services**

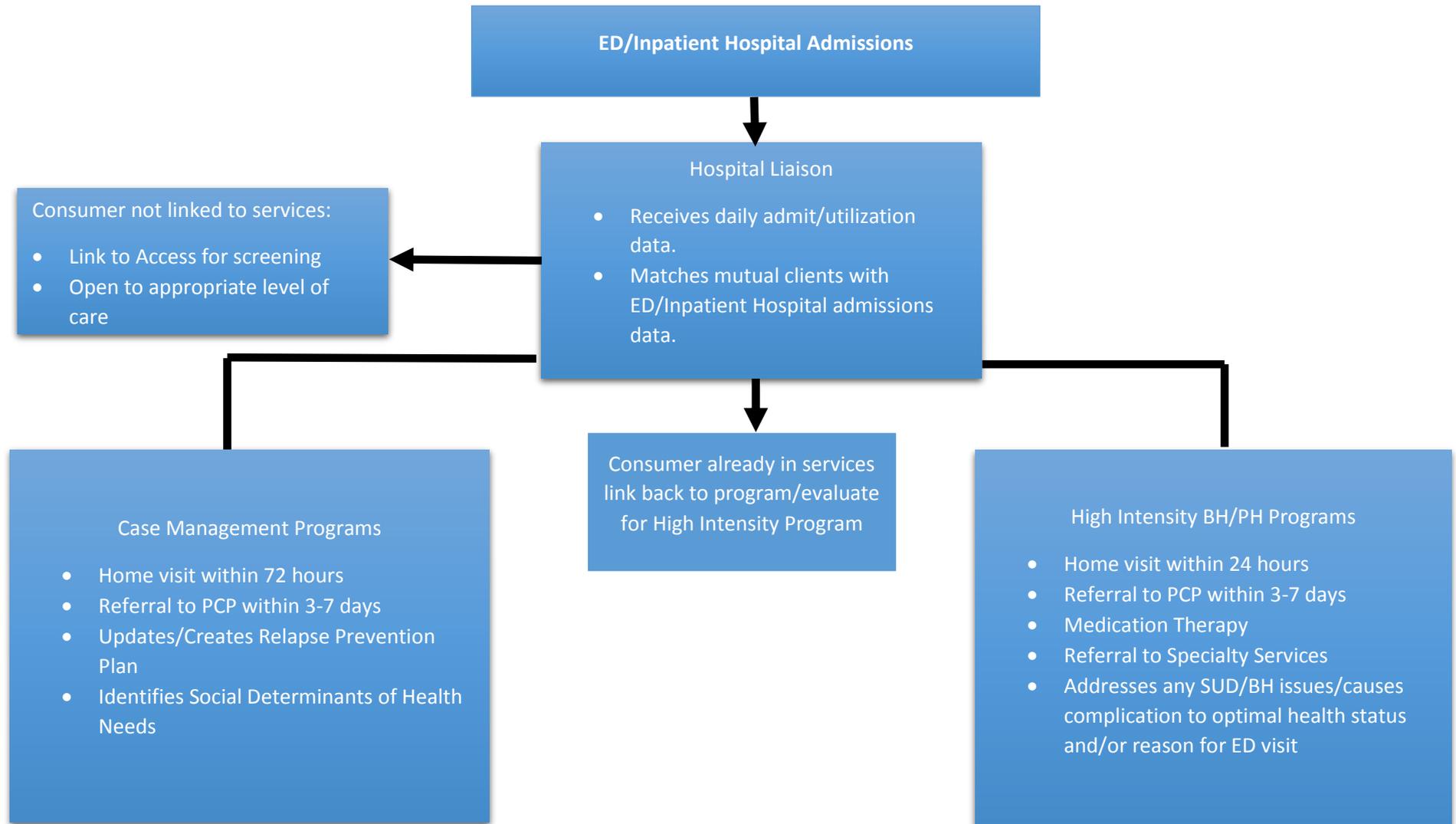
**Genesee Community Health Center
(GCHC)**

- GHS was awarded the grant to open a Federally Qualified Health Center in 2012.
- Currently two locations.
- Fully integrated model includes on site: Primary Care Providers, both MH and SUD Social Works, Psychiatric Support, Community Health Works/Peer Support.
- Offers SUD Medication Assisted Treatment (Suboxone, Vivatrol).
- PCMH recognized by NCQA since 2016.
- Monitors Service Utilization (see Service Utilization diagram).
- Potential expansion of model to target population.

GHS Proposed High Intensity Behavioral Health/Physical Health Programs



GHS Proposed Service Utilization



e. Describe how care coordination will occur within the pilot region and specifically address how coordination will be integrated for physical and behavioral health needs.

GHS is currently actively engaged in many processes for care coordination and continues to develop innovative approaches with multiple community care providers and the MHPs to better coordinate, inform and direct both behavioral and physical health care for the individuals we serve. In regards to this pilot, GHS expects to continue to engage in already established coordination of care methods, as well as to expand and innovate new methods with MHP and health care partners. One current example involves regularly occurring individual meetings with the six Medicaid Health Plans (MHP) in our county to collaborate and intervene regarding high-risk, shared patients/consumers. These monthly meetings involve the MHP, PIHP, GHS Risk Coordinator, and the provider team members of the individuals receiving services at GHS. The consumers identified have frequent emergency room visits, hospital admissions or chronic health conditions for which they are not filling prescriptions or seeing their primary care doctor and/or specialist. Armed with this knowledge and consultation, the team works with these individuals to address treatment needs and other social determinants of health that may be preventing them from accessing preventative and primary care; to enhance their compliance with treatment; implement and link them to relevant interventions and services; and improve their overall health.

GHS uses CareConnect 360 as a means of gathering data regarding chronic health conditions and diagnoses, treatment history and compliance of consumers we serve. We are currently evaluating the best use of CareConnect 360 to coordinate with and link to primary care and to better assess, diagnose and develop relevant integrated treatment plan goals at the Access, Intake, and Medication Clinic and program levels. We are particularly focused on consumers with the most complex health conditions that may not be engaged in treatment with the physicians and specialists required to effectively manage their care and are developing an organized process of identification with effective strategies to employ that may assist these individuals in improving their health outcomes.

As another example, GHS's FQHC (Genesee Community Health Center) is one of approximately a dozen primary care entities to recently partner with Greater Flint Health Coalition (GFHC) to participate in the State Innovation Model (SIM) pilot through MDHHS. The project entails identifying patients with frequent emergency room visits, preventative emergency room visits and/or inappropriate emergency room visits. The hospital, through GHS SIM grant positions, or primary care completes a social determinants of care survey with the patient and enters the data into a secure software platform which is received by Greater Flint Health Coalition (GFHC). Patients may have barriers such as mental health and substance use disorder symptoms, transportation, childcare, housing, food, utilities or other aspects that pose challenges in accessing annual or other preventative health care services. GFHC notifies the participating primary care and makes a prompt electronic referral to the most appropriate entity in the community. GHS has two staff working at both local hospitals and in the community to connect these patients to all needed resources and to provide feedback as to the status of the referrals.

There are a number of other current examples of GHS taking a lead role in care coordination that would be maintained and expanded through the pilot. For example, in response to the increased needs of those affected by the Flint Water Crisis, GHS engages in comprehensive coordination of the physical and behavioral health needs for the children, pregnant adults, elderly and others we serve. MDHHS approved

a Medicaid waiver program and contracted with GHS to provide targeted case management for the children and pregnant women receiving this expanded Medicaid benefit. GHS performs comprehensive assessments and links and coordinates these individuals and families to all needed services including counseling and medication through the MHPs, specialty mental health services through GHS; primary care through Genesee Community Health Center and other primary care providers; lead testing; immunizations; water resources and testing and more. GHS also operates a mobile unit that goes into the community and local neighborhoods; complete with clinicians providing therapy, education and information and linkage to needed resources. GHS has a team of community-based Family Navigators and Parent Support Partners with lived experiences that serve families, coordinating all aspects of their health care and other needs; and providing them with support and guidance along the way.

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).

GHS is currently meeting all capacity and competency requirements for care coordination and service delivery for individuals with intellectual or development disabilities, adults with severe and persistent mental illness and children and youth with serious emotional disturbances with a vast network of specialty providers and a full array of specialty services including numerous evidence based practices.

Although GHS is not currently functioning as the Coordinating Agency (CA), care coordination and service delivery for individuals with co-occurring and substance use disorders (SUD) are not new to GHS. Most of Region 10 PIHP SUD contracts are ones that GHS formerly held and are agencies we still partner with in various community initiatives. As a part of a recovery-oriented system of care that works to combat stigma and increase accessibility for those with substance use and co-occurring disorders, GHS will assume responsibility for contracting with these SUD providers, as well as others as needed, to resume authorizing substance use services of sub-acute detox, residential, day treatment, intensive outpatient, enhanced outpatient, methadone, and recovery housing; and partner with these providers to enhance their competencies in assisting individuals and families with co-occurring and substance disorders achieve recovery and wellness.

Currently, GHS Access, under lease of Region 10 PIHP, utilizes ASAM (American Society for Addiction Medicine) for initial level of care placement and will continue under the pilot. In addition, when GHS was the former PIHP/CA, GHS's electronic medical record authorization system had ASAM built into the electronic authorization request and is poised to re-instate this authorization system so that ASAM is reviewed with each ongoing substance use authorization request. Priority populations are supported and managed according to all federal, state and local requirements.

Genesee Health System has maintained effective and comprehensive network capacity for specialty mental health services and will be able to do the same when adding substance use disorder services. GHS's Provider Relations Department obtains monthly capacity reports from providers. In addition, GHS has a committee that reviews monthly data, such as number served by providers and service type, service utilization, and monitor trends over time to identify in advance, potential capacity issues, or need for specific service expansion. This infrastructure is currently in place and will continue to be leveraged in the pilot.

GHS has a robust training department that ensures core training requirements are met, but also provides additional trainings in behavioral health, physical health, trauma, and substance use disorders to enhance

staff skills. GHS Quality Management audits programs and providers at least once annually, during which time QM auditors review staff human resource files, to ensure appropriate trainings have been completed for continued credentialing and privileging. GHS currently employs numerous clinicians who possess substance use disorder credentials through the Michigan Certification Board for Addiction Professionals and would continue to support and enhance this effort, ensuring compliance with all credentialing requirements.

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).

Genesee Health System (GHS) has a well-established comprehensive training curriculum, which all GHS staff are mandated to attend, and has access to continuing education opportunities. Trainings are also offered to other community agencies, including providers of mental health services, law enforcement agencies and support groups, through the GHS Speaker Bureau and participation in local health fairs and events.

Newly hired staff are required to attend the New Employee Orientation, a weeklong training with classes covering topics such as welcome and overviews, human resource matters (payroll, benefits, and retirement), HIPAA, Ethics, Cultural Competency, Blood Borne Pathogens, health and safety, and many others. GHS has had experience providing specific training on cultural competency including classes covering topics on culture, age, race, gender, sexual orientation, spiritual beliefs, socio-economic status, language, stigma and military culture. Through continued assessments of community needs, staff feedback and training requests, and other community input, GHS's training curriculum has and will continue to provide education to professionals in order to provide the best of care.

By training and educating staff on cultural competency, a foundation will be built that could be used in both mental health and physical health caregiving. GHS believes cultural competence is just good healthcare. Under the 298 pilot, GHS will continue to provide comprehensive and up to date training and education.

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

Genesee Health System (GHS) currently uses CareConnect 360 (CC360), as well as other information technology tools, as a means of gathering data regarding chronic health conditions and diagnoses, treatment history and compliance of consumers we serve. These tools are used to coordinate with and link to primary care and to better assess, diagnosis and develop relevant integrated treatment plan goals at the access, intake, medication clinic and other program levels. GHS plans to continue to leverage the use of these tools during the pilot, as well as to expand opportunities for use. Using CC360, GHS is currently particularly focused on consumers with the most complex health conditions that may not be engaged in treatment with the physicians and specialists required to effectively manage their care and are developing an organized process of identification with effective strategies to employ that may assist these individuals in improving their health outcomes. In addition to the above, GHS Quality Management compares a sample of audited cases with health diagnosis in CC360 to ensure they are identified and appropriately assessed and addressed in the mental health record. If new information is found in CC360 that is not found in the clinical record, the information is provided to the program management for it to be appropriately assessed and addressed in the individual plan of service.

GHS also utilizes the Great Lakes Health Connect referral platform to link and coordinate with primary care offices and community partners that are participating in the State Innovation Model pilot, through

Greater Flint Health Coalition. In addition to receiving and making electronic referrals, there is a secured messaging system to communicate with the primary care office and other agencies concerning consumer referrals and status.

Genesee Health System also receives Admission, Discharge, and Transfer (ADT) feeds, which automatically populate for the assigned primary case manager in the GHS electronic medical record, CHIP. Case managers follow up with consumers and healthcare providers on the information from the ADT feeds, such as emergency department or hospital admissions, medical and psychiatric, to ensure consumer needs are met, and to prevent worsening of symptoms/issues and future emergency department and hospital admissions.

As these information technology tools evolve, GHS will continue to develop additional and more effective methods of utilization to improve care coordination, outcomes, and risk management. Policies and procedures, staff trainings, electronic medical record upgrades, and other adoption and expansion efforts will be made to maximize use of these tools, both routinely and as part of the pilot efforts.

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

GHS possesses robust and effective resources, policies, and procedures to ensure healthcare interoperability of its information technology systems and software applications to communicate, exchange data, and use the information that has been exchanged. All computer users at GHS must sign the Computer Acceptable Use Agreement annually, attesting to confidentiality and credentialing, before being allowed access. Each login and all client record access is recorded and monitored. GHS's information system security policy requires each user to have a unique User ID and password that is not shared. Passwords are required to be complex (8 characters or more, and at least 3 from the following categories: uppercase letter, lowercase letter, number, symbol) and changed every 3 months.

Access to our electronic medical record (EMR) is restricted based on user training, licensing and job function, and controlled via login ID. Staff have access to information only for clients that are authorized to their providers. They are also subject to a time-based auto-logout for periods of inactivity. Each time a user logs into the EMR, they must agree to a confidentiality statement and attest to their credentials. All access is logged and monitored.

GHS computer facilities are all in access controlled buildings with badge readers to restrict access. Network hardware is physically secured in a locked and monitored room, with access limited to IT personnel, and secured by both network and software security. The GHS data center is a secure room with logged badge access, climate control with redundant air conditioners, backup generator power, with water lines removed from the room. There is a 24/7 alarm service notification of physical security breaches, and extreme temperatures. GHS virtualizes all of our servers for high availability, better performance, and more efficiency to administer the network resources. Daily backups, which include the NextGen GHS FQHC EMR since we host it on premise, are replicated from the main appliance to an identical one stored at an external location. We use industry standard controls, including firewalls, intrusion detection/prevention system, and anti-virus software, to prevent unauthorized access via public networks. To safeguard against Protected Health Information (PHI) being transmitted over the Internet unprotected, we have equipment in place to encrypt the message to make it more difficult for an unauthorized person to view it.

Our EMR (CHIP) data center is located at the vendor's (PCE) data center in Farmington Hills, MI in an access controlled building. To prevent the loss of any transactions, the application software commits all transactions to disk when the user saves the record. A system failure will not cause any loss of data already stored on disk. Disk failure is prevented by RAID-5 protection where any failed disk can be reconstructed by the operating system without losing any data. The AS/400 operating system continuously monitors the error rates of all disks; when error rate on any disk reaches predetermined threshold, the operating system automatically notifies IBM Rochester Support Center where an IBM customer engineer will be dispatched with the replacement disk to replace the failing disk on site at PCE. All equipment in the data center is supported by uninterruptible power supply and a natural gas backup generator to provide maximum system availability. The entire network is protected by firewall software (Check-Point) to prevent unauthorized access and intrusion. All access to the system functions are logged for auditing purpose. In addition, PCE contracts with a data center in Chicago which hosts an identical copy of all of the data and can utilize it as a hot-site in case of an emergency or maintenance, so the downtime would be minimal.

Paper medical records are secured in a locked room with access limited to Health Information Department (HID) staff. Record shelving is rolled shut and locked each night. Staff must submit an electronic request for records, which is logged, and records are checked out/in. Records from storage are requested by faxing or emailing list to storage facility. Once record is received in HID, it is logged in and when record is ready to return to storage, it is logged out.

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

GHS will contribute to a community health record or participate in certain health information exchanges whereby we may disclose health information, as permitted by law, to other health care providers or entities for treatment, payment, or health care operations purposes. Currently, we have a relationship with Michigan Health Information Network (MiHIN) and Great Lakes Health Connect (GLHC) where we actively participate in sending and receiving health information to increase efficiency and quality, while reducing cost and time. Admission, Discharge, and Transfer (ADT) notifications received are paramount in improving patient care coordination and identifying high utilizers of health care. GHS also collaborates with Mott Children's Health Center and shares data with our common patients. We have two electronic medical records (EMR), one for behavioral health (CHIP) and one for our FQHC health center (NextGen Healthcare) which are capable of exchanging HL7 standard messaging so we anticipate no problems interfacing with new entities.

8. Financing Model and Considerations:

Consistent with the requirements of Sec 298 of PA 107 of 2017, the pilots will integrate physical health and behavioral health funding in a single contract with each licensed Medicaid managed care entity that is currently contracted to provide Medicaid services in the geographic area of the pilot.

Approximately forty-percent of the behavioral health expenditures are directed to individuals who are not enrolled in a Medicaid Health Plan. This specific population includes a higher percentage of individuals with significant behavioral health needs receiving multiple services. MDHHS is currently analyzing multiple options for the management of specialty behavioral health benefits for this population during the pilot(s).

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

GHS proposes payment at the current BH/SUD capitated rates developed by Milliman and passed through MDHHS in order to fund coordination of care. In subsequent years, potential co-location and embedded integration of behavioral, SUD and physical health models between GHS and the MHP whereby the MHP designates GHS as a specialty Primary Care Provider. GHS is open for discussion with the MHP in the development to a shared-risk model. This could include modified PMPM rates with the further development of a co-location and embedded PCP integrated model. These modified PMPM rates might include a percentage withhold which could be earned back based on performance. Initially, a negotiated risk reserve earmarked is a necessity, especially under a full-risk contract. The current regional entity holds all of the risk reserves and savings which have been produced.

Currently, our FQHC (which is currently an integrated Behavioral/SUD and Physical Health Care provider) has several value-based financing models for enhanced payment which could be used as a platform for a fully integrated physical and behavioral health financing model. These include payments for MHP HEDIS quality incentive programs as well as MDHHS sponsored programs such as MICare and SIM. These program's common goals are:

- Improving clinical quality outcomes (i.e. HEDIS)
- Emergency room readmissions cost reductions
- Hospital cost reductions related to length of stay

From a primary care standpoint, our FQHC is already working with one of our MHPs regarding the implementation of a value-based program ACO (Accountable Care Organization) contract with the underlying premise of a patient-centered medical home patient care continuum of care. Key elements include focus opportunity initiatives (FOI) related to measurement of post discharge follow up care, PCP/Membership accuracy and physician visit frequency for hypertension. All key elements entail development of processes to accurately track patient data through the continuum of care in a shared-risk arrangement leading to positive clinical outcomes. These particular clinical quality outcomes were partly chosen because from a financial standpoint, they are a significant component of the new Medicare Part B payment system (MACRA), slated to begin on January 1, 2019. Under the premise of a co-location and embedded PCP integrated behavioral/SUD and physical health model between GHS and the MHP, the above mentioned three primary care goals would be aligned with our behavioral health population with the ultimate financial model goal of maximizing reimbursement.

GHS will work jointly with MDHHS to develop a reimbursement model for the non-enrolled Medicaid Health Plan beneficiaries as well as the General Fund behavioral health services provided in Genesee County.

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

GHS was formerly a PIHP until recent years with the formulation of the Region 10 PIHP. Similar to today's Region 10 structure, MDHHS has a shared risk contract for the management of the behavioral health population. Due to GHS's past history as the PIHP, we are familiar with this shared risk arrangement and would be poised to enter into the same agreement moving forward under this pilot project. In addition, see above response to question #8A regarding our value-based financing models experience under our current FQHC.

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

“For the duration of any pilot projects and demonstration models, any and all realized benefits and cost savings of integrating the physical health 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.”

GHS is open to discussions with the MHP regarding various methods to track savings. The following are proposed savings tracking methods aligned with the common program clinical outcomes as described in question #8a above:

- Improving clinical quality outcomes (i.e. HEDIS): Through our FQHC, our MHPs track certain HEDIS data such as depression screenings, A1C counts, etc. on a monthly basis. This same program can be applied to our behavioral health consumers based on the various behavioral health quality indicators available. Based on actual results versus target results an enhanced incentive payment is computed.
- Emergency room readmissions cost reductions: Through our FQHC’s SIM program we will have the capability to monitor our consumer’s emergency room admissions. This allows the ability to track costs comparing an established baseline target to actual cost on an established time interval report out basis, such as monthly. This same program can be applied to our behavioral health consumers.
- Hospital cost reductions related to length of stay: Same as above. We will have access to our consumer’s data.

From the savings derived from the methodology described above, a reinvestment plan will be developed where necessary to invest in the pooled funding and collaborative relationships as described in question #8d below. Therefore compliance with the requirement of the Section 298 boilerplate of reinvesting all funds back into our consumer population within Genesee County is met.

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 surpluses generated from the shared-risk arrangement will be reinvested back into the entities with a collaborative dollar sharing and/or pooled risk arrangement very similar to our current agreements:

- Homeless Shelters
- Alliances with our local hospitals such as Hurley Hospital-various health fair offerings. In addition, there is a pooled funding arrangement for psychiatric crises referrals leading to the development of a crises center.
- Genesee Health Plan-current collaborative arrangement to service uninsured consumers seeking behavioral health services.
- Genesee Intermediate School District (GISD)-continue child screenings and other collaborative services.
- Social Service Agencies-MOUs currently exist to provide services at various agencies.
- Food banks
- Transportation services
- Expansion of Prevention Services for the treatment of the Opioid Epidemic.

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

Genesee Health System (GHS) is currently providing services for the State of Michigan under a fee for services contract. We have been identified as the Designated Provider Organization in regards to the Expanded Flint Water Medicaid Waiver for the targeted case management services for the water related crisis in Flint, Michigan. As the targeted case manager provider under this special waiver, it is GHS's responsibility to monitor children potentially affected by the lead contained within the water system in Flint, Michigan. GHS provides all of the linking and coordination for these special populations and works closely on all behavioral and physical health issues with the primary care providers. GHS has also provided services under the fee for service model for children open to our SED waiver program. These children require high-intensity services and are often provided wraparound services in which GHS staff coordinates care with multiple behavioral and physical health providers and service agencies.

Through our FQHC-Genesee Community Health Center, GHS also provides services under the fee for service model. This includes physical health, SUD, and behavioral health services for the homeless population with chronic diseases such as diabetes and heart disease to go along with mental illness. GHS recently moved to an institutional billing model which entails full wraparound payment for services at the time of the visit. Per GHS's RFI as shown in the Proposed Organization Structure diagram on page three, consists of a direct working relationship with the primary care providers for these populations. All care will be coordinated with the PCP and built into the individual's plan of service. This will include a care plan for all health related services and treatments.

GHS will provide the full array of Medicaid behavioral and SUD services for this population with the additional care coordination as identified within other sections of this proposal. GHS will provide the services under the same proposed financial model described with this RFI per question 8. GHS will use the Medicaid capitated funding as set by MDHHS using the current Milliman calculation rates for Genesee County.

GHS is very capable of submitting any data requirements directly to MDHHS, if contractually required under this pilot project. As a former PIHP, GHS submitted all required data to MDHHS per the contract requirements.

9. Managed Care Functions: Federal regulations set specific requirements for the performance of most managed care functions. In the PIHP system, performance of many of the managed care functions are delegated to the CMHSPs within the region. This delegation is intended to support the community behavioral health management role of the public behavioral health system. In the physical health delivery system, the MHPs have well developed systems and structures for performing the required managed care functions in a way that is consistent with both regulatory and accreditation requirements. It will be important, as part of administering managed care functions, that pilots balance community presence, compliance, and administrative efficiency in the performance of required managed functions.

a. Access

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

Prior to 2015 and for many years as a stand-alone PIHP, GHS successfully operated a fully functioning Access Center compliant with all Access standards, federal and state regulations. Once Region 10 became the PIHP, it pursued a centralization of the Access function for the four counties of the Region which meant the PIHP assumed day time operations of the existing GHS Access Center with the ongoing support of GHS through use of building space, leased employees as well as administrative and other

operational supports. Before and since the transition, GHS continues to offer “no wrong-door” access to adults and children with mental illness, serious emotional disorders, intellectual/developmental disability (I/DD), substance use disorders, and co-occurring mental health and substance use disorders including but not limited to Native Americans and those with Limited English Proficiency and mobility changes. Our policies and processes promote an unconditional Culture of Gentleness wherein positive supports and approaches are the norm regardless of the challenges with which individuals may present; a trauma-informed system of care which significantly improves outcomes for persons served; and pathways to recovery that reduce stigma and recognize resiliency and the strengths of persons served and their natural supports. If GHS were to be selected for the pilot, we would be poised to resume the Access screening function for Genesee County and see this as an opportunity for increased administrative efficiencies since much of the required structures are in place.

- 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).

Eligibility screening for serious mental illness (SMI), serious emotional disturbance (SED), intellectual/developmental disability (I/DD) and substance use disorders (SUD) for Medicaid recipients as well as uninsured and under-insured individuals would be available both telephonically and face to face via a walk-in model during the 8 am to 5 pm business hours in a welcoming and responsive environment. Maintaining mechanisms to prevent conflict of interest between the coverage determination function and access to or authorization of services, referrals for eligible individuals would be made to GHS and its network of providers through GHS’s existing Centralized Intake Department where a comprehensive biopsychosocial assessment is completed to determine medical necessity for supports and services and commence treatment planning and coordination of behavioral and physical health services. GHS currently manages a wait list for those without Medicaid but who meet severity of illness and places eligible individuals on a priority basis of severity into services as alternative funding allows. Those individuals assessed to not meet eligibility requirements would be provided information about community resources and due process rights including second opinion and appropriate fair hearing options. In addition, GHS would implant a clinician to function as a Navigator, linking individuals to both behavioral and physical health services, including scheduling and coordinating appointments as necessary. GHS currently provides, directly or indirectly via contracts, the full array of person and family-centered, culturally competent specialty mental health services including numerous Evidence Based Practices; and based on a long-standing relationship with network SUD providers could resume those contracts as well. Through a delegation relationship with the Region 10 PIHP, GHS currently provides a 24 hour/ 7 day/ 365 day crisis call center and crisis response with authorization of the full array of crisis services including inpatient, partial hospitalization, CRU, Crisis Stabilization, as well as a Crisis Intervention and Recovery Team (CIRT), sub-delegating the after-hour crisis line and authorization. GHS believes individuals seeking services should have a positive experience that minimizes barriers to access and conveys the willingness of the provider to address both mental health and substance use disorder clinical needs in an accepting manner. In this spirit, GHS has actively pursued ways to support individuals with co-occurring mental health and substance use disorders. Some examples include GHS developing a Sobering Facility to serve as a diversion for individuals who do not meet criteria for crisis services but are under the influence of substances and in need of a safe place to go for 23 hours and after-hour residential admission arrangement for pregnant women using substances.

b. Customer Service

- Explain the planned process for customer service under the pilot including delegated activities.

Genesee Health System (GHS) has an established dedicated unit called the Customer Service Department. The unit is comprised of a supervisor, coordinators, an ombudsman, and support staff. This unit has experience and knowledge of customer service activities from previous status as a PIHP, but also recently from a delegated setting. GHS would continue to ensure the staff within this unit have the most current training and working knowledge of populations served by the agency, eligibility criteria for various benefit plans, service array (including substance use disorder treatment), the grievance and appeal system, and Michigan Recipient Rights protections. The staff would also continue to have the knowledge of where to obtain information, including but not limited to person-centered planning, self-determination, recovery and resiliency, peer specialists, limited English proficiency, cultural competency, the organization of the public health system, community resources, and the public health code.

Under the 298 Pilot project, this dedicated unit would continue to act accordingly with the delegated functions of Customer Services such as ensuring enrollee rights, information sharing, assistance with the appeal and grievance system, and other identified functions recognized from state and federal regulations.

GHS has and will continue to abide by policy and procedures designated around delegated activities identified through a delegation agreement. Specific activities would include but not limited to, ensuring enrollee rights to receive information as appropriate, the right to be treated with dignity and respect, receive information regarding treatment options, the right to participate in decisions regarding healthcare, the right to be free from restraint or seclusion, and the right to confidentiality.

GHS has experience with the development and maintenance of a grievance and appeal system consistent with federal and state regulations. Under the pilot, all grievances and appeals will be delegated to GHS for processing with monitoring by the MHP.

- If the function of customer service (as defined by current contracts) is retained by the MHP, explain how the MHP will demonstrate competency to administer customer service functions for the specialty behavioral health population.

Under the 298 Pilot project, the customer service functions for the specialty behavioral health population will be delegated to Genesee Health System (GHS). GHS has the experience and knowledge of the specialty behavioral health population and their specific needs, from the previous PIHP status and the current delegated setting.

GHS has an established Customer Service department with the working knowledge of customer service functions, as identified in the current Code of Federal Regulations and current and previous State contracts.

Through a delegation agreement between the MHP and GHS, GHS will perform these delegated functions and the MHP will monitor for compliance.

c. Reporting

- 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.

GHS currently uses CHIP, a PCE Systems Electronic Medical Record product. CHIP currently has functionality to record and maintain BH-TEDS and encounter related data, and generate the necessary data files (837 and BH-TEDS) for submission. The generation of encounter data and BH TEDS data is a current responsibility of GHS. This data is then submitted to Region 10 PIHP who forwards the data to MDHHS. This data can be submitted to any system that accepts the MDHHS standard file format and coding.

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

Tracking data by distinct funding sources will be done by using consumer eligibility and payment data (270/271, 834 and 820) received from the State. Mechanisms are already in place to import that data into GHS's electronic medical record (CHIP). IT, enrollment and finance staff are very familiar with the data. In addition to using consumer eligibility and payment data, GHS tracks multiple other funding sources. This data includes grants managed through EGrAMS, Flint Water (Medicaid, General Fund and Grants), Genesee Health Plan Millage Grant, and others. IT staff are also ready and able to accept additional enrollment/payment data formats if needed.

- 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.

GHS managed the substance use disorder data and contracts in our current system, CHIP, for over 6 years prior to Region 10 PIHP taking over the administration of the Coordinating Agency on 10/1/2015. All of the mechanisms necessary for SUD reporting are currently installed and ready to use in CHIP.

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

GHS has four full-time IT staff who each have over 15 years of experience working with MDHHS reporting requirements. Those staff have assisted with the transition to a stand-alone PIHP, including the implementation of encounter/QI reporting as well as the transition from PIHP to a CMHSP in the current regional model.

d. Claims Management

- Describe the planned process for claims management including delegated activities.
- 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.

“The Michigan Mental Health Code requires that publicly funded substance use disorder services be managed by a “department designated community mental health entity” (department designated CMHE). The Mental Health Code also defines certain requirements that a department designated CMHE must meet. MHPs do not meet the definition of an entity that qualifies to be a department

designated CMHE. Consequently, MHPs in the pilot region must sub-contract with their CMHSP for the management of Medicaid funding for SUD services.

The non-Medicaid SUD funding (i.e., community block grant and liquor tax funds), will be transmitted directly to the CMHSP in the pilot. The CMHSP will then be required to (1) meet the Mental Health Code requirements for the department designated CMHE and (2) manage the SUD service array. The CMHSP is expected to be able to demonstrate the necessary capacity and competency to provide the necessary SUD benefits management.”

Genesee Health System (GHS) continues to maintain a comprehensive network of providers and maintains, via delegation from Region 10 PIHP, the claims management functions. Contracted providers submit fee for service claims via either direct data entry or electronically (via 837) to our electronic claims management system. GHS contracts with PCE systems to maintain this electronic claims management system. This system assigns funding sources at the time of adjudication based on such things as the PHIP/CMHSP Encounter Reporting Cost Per Code and Code Chart and consumer eligibility. The claims management system includes a sophisticated set of claims adjudication rules tied to provider contracts and when possible uses industry standards such as Washington Publishing Company denial codes. During the time GHS was the designated Coordinating Agency in Genesee County (2005-2014), the SUD funding sources were embedded into the claims management system. In fiscal year 2017, GHS’s claims management system paid approximately \$80 million dollars in claims.

e. Quality Management

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

Genesee Health System, formerly a PIHP, has maintained a fully functioning quality management (QM) department, which will continue QM activities in the pilot under the Medicaid Health Plan delegation. The QM Department maintains a schedule for provider audits using a structured tool to review staff credentialing and privileging, perform a physical site review to ensure sites are warm and welcoming and that there are no health and safety issues, and to conduct a random sample record review of open and closed cases.

Record audits consist of review of assessments for thoroughness and accuracy, including that substance use, health issues, needs, and risks are identified and comprehensively evaluated. The quality management auditor looks for coordination of care with primary care, schools, and other agencies involved with the consumer and that identified needs are being appropriately addressed in the individual plan of service. Adequacy of person and family centered planning and individual plans of services are reviewed and determined to reflect movement toward community engagement, and that natural supports are comprehensively addressed or reflect plans to increase natural supports, health related goals are reviewed and adjusted to meet changing needs, and safety is reviewed and addressed, among other indicators. The auditors also review for fidelity in Assertive Community Treatment, Home-based, and Wraparound programs, among others. Any program or provider performance falling below 95% on any indicator is required to complete corrective action plans that are reviewed and monitored by QM. GHS also solicits consumer feedback on quality of services and providers, through the GHS Consumer Council and consumer surveys, to identify weaknesses and quality improvement opportunities.

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

Genesee Health System has a robust IT Department capable of generating reports for Medicaid Health Plan monitoring. GHS can assist the Medicaid Health Plans with data towards various HEDIS monitoring, such as antidepressant medication management, diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications, and diabetes monitoring for people with diabetes and schizophrenia.

Currently, Genesee Health System has two performance improvement projects (PIP) with Region 10 PIHP that are in line with Medicaid Health Plan's monitoring needs. For one PIP, GHS is working towards increasing the number of individuals with serious mental illness that are identified with select cardiovascular risk conditions and that had at least one reported encounter for medical services to treat a cardiovascular condition. The second PIP focuses on increasing the percentage of consumers diagnosed with Bipolar or Schizophrenia and who are prescribed an antipsychotic medication and also have an annual glucose or HbA1c diabetes screening. Genesee Health System will continue with these two performance improvement projects as well as any future ones that are aligned with the Medicaid Health Plans quality improvement plans and monitoring.

f. Utilization Management

- Describe the proposed plan for utilization management including delegated activities.

Genesee Health System has had a robust, highly effective, and well established Utilization Management Department as the former PIHP that continues in full operation as a delegation from Region 10 PIHP. Genesee Health System Utilization Management (GHS-UM) is independent of all clinical services, continues to meet all State contracted requirements, and is poised to continue to provide this function, under delegation by the Medicaid Health Plans, if selected for the pilot.

Genesee Health System Utilization Management prior authorizes medically necessary services through application of criteria outlined in the Michigan Medicaid Provider Manual: Behavioral Health and Intellectual and Developmental Disability Supports and Services. Service authorizations are requested by providers through the GHS Electronic Medical Record (CHIP) *vis-à-vis* development of the individual plan of service, plan addendums, and treatment plans. Prior authorizations are not required to access emergent or non-emergent eligibility screening, or crisis services.

Utilization management processes for mental health services are based on three determinations:

- 1) Eligibility Determination – a) initial, non-emergent eligibility is determined through the Access screening process; b) initial, emergent eligibility is determined through UM, and after-hour delegation to Common Ground Crisis Intervention Recovery Team (C.I.R.T.), pre-admission reviews and; c) ongoing eligibility determination through provider clinical reviews and/or UM reviews.
- 2) Level of Care Determination - established initially and re-evaluated annually, as well as any time there is a significant change in clinical status, based on clinical and demographic information entered in the EMR and updated during person-centered planning.
- 3) Service Selection Determination – providers utilize established Benefit Plans to determine expected service utilization at the assessed level of care. Services authorized are a) identified through the person centered planning process; b) medically necessary as defined by the Michigan

Medicaid Provider Manual; c) based on Best Practice and Evidence Based Practice guidelines; and d) monitored via prospective, concurrent, and retrospective review processes by the UM Department.

Health care professionals who have the appropriate clinical expertise to treat the conditions under review conduct utilization management service authorization reviews, denials, and reductions.

During normal business hours, GHS-UM authorizes crisis services (inpatient, crisis residential, partial hospital, and crisis stabilization) through preadmission review to determine eligibility and medical necessity, ensuring that beneficiaries access the least restrictive medically necessary level of care in an expeditious manner. After-hours is delegated to Common Ground C.I.R.T. for pre-admission review coverage, 24 hours per day, 7 days per week. C.I.R.T. provides detailed activity to GHS-UM on a daily basis and is audited at least quarterly to ensure all standards are met, including HSAG standards, requiring corrective action for any composite or sub-score falling below 95%.

On-going concurrent reviews for all crisis service occur during normal business hours by GHS-UM to evaluate ongoing medical necessity, including to review appropriates of lower level of care service options.

The UM continued stay review will result in one of the following outcomes:

- 1) The continued stay is certified and the authorization is extended until the next concurrent review date, as determined and scheduled by UM.
- 2) The review is pended for GHS physician review due to identified issues in services, discharge plan progress, or quality of care, which may result in a GHS physician initiation of consultation with the provider physician.
- 3) The continued stay is denied and no further authorization is approved. GHS has provider appeal processes in place for any negative action.

Genesee Health System was previously the Coordinating Agency for substance use services for Genesee County, prior to Region 10 PIHP assuming this responsibility. Genesee Health System is poised to reassume substance use UM functions as a MHP delegation if selected for the pilot. Initial eligibility, level of determination, and initial services authorization, will be completed by GHS Access, and ongoing authorizations and requests for change in level of care would be made directly to GHS UM, via the electronic medical record. Both authorization requests and level of care requests have ASAM (American Society of Addiction Medicine) built into the request as part of the GHS-UM review process in determining medical necessity. Genesee Health System will not sub-delegate any utilization management functions for substance use services.

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

Genesee Health System Utilization Management has established, comprehensive procedures to direct review processes for all services and on which all UM staff are trained. Furthermore, GHS-UM follows criteria outlined in the Michigan Medicaid Provider Manual, including ASAM for substance use services. Inter-rater reliability reviews are routinely completed to identify need for staff training and procedural clarification which are reviewed in staff meetings. Except for after-hours crisis preadmission review, there are no other UM functions sub-delegated; all other UM functions are completed by one department directly operated by GHS. The afterhour's pre-admission sub-delegation is continuously monitored by GHS-UM to ensure all contract requirements are adhered to. Additionally, GHS-UM uses a variety of utilization reports to monitor trends, risk factors, consistency and compliance. These existing

utilization management structures and resources will be leveraged in the 298 Pilot to provide a consistent and effective UM process.

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

Genesee Health System continues to complete all utilization management functions for behavioral health services in Genesee County under delegation from Region 10 PIHP, including all services authorizations. All specialty behavioral health authorizations are currently maintained in the GHS electronic medical record (CHIP) therefore, if GHS were selected as a pilot, there would be no interruptions to current services, active service authorizations, person-centered plans, or self-determination arrangements. The transition would be seamless for providers and consumers.

For substance use services that are currently directly authorized by Region 10 PIHP, GHS will work with Region 10 to have active authorizations transferred to the GHS CHIP system; both authorization systems are based on a PCE systems platform which will facilitate seamless transferability. GHS will honor active authorizations and would seamlessly assume on-going authorization and level of care reviews, without disruptions to consumer services.

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

Genesee Health System completes comprehensive assessments of mental health, substance use, and physical healthcare needs for individuals who enter services. Under this pilot, GHS would authorize mental health and substance use services that are medically necessary and provide close coordination with primary care physicians. Also, consumers without a current medical health home may elect to receive primary care services through Genesee Community Health Center that is located on campus, which provides a robust array of physical health, mental health, and substance use services. Services are coordinated so that there is not duplication and all consumer needs are met. Mental health, substance use, and physical health services would be provided based on medical necessity in accordance with Michigan Medicaid Manual, without any preset limits. Furthermore, GHS and the Medicaid Health Plans will share data in identifying individuals who have either mental health, physical health, and/or substance use needs that are unmet, and coordinate efforts to engage the individual into appropriate services, for which CareConnect 360 will also be utilized, in addition to support from GHS and Medicaid Health Plan IT resources.

Genesee Health System is also participating in the State Innovation Model as a specialty hub through Greater Flint Health Coalition. Medicaid beneficiaries identified as having, or at risk of having, frequent, inappropriate, or preventable emergency department visits by Medicaid Health Plans and primary care physicians, result in a referral to GHS via Great Lakes referral platform, for GHS to work with individuals to address various social determinates of health (coordinating, linking, and follow-up for behavioral, physical, substance use, and other needs such as food, clean water, housing, transportation, and utilities).

•Describe how the applicant will address capacity and competency requirements for any utilization management activities that are new to the pilot members (i.e. substance use disorder services).

GHS was the former PIHP/CA for Genesee County and successfully provided all utilization management functions for both specialty mental health and substance use services. Today, under a delegation from Region 10 PIHP, GHS maintains a fully functional UM Department of nine Masters prepared licensed mental health and substance use disorder or registered nurse credentialed coordinators, a UM Manager,

and a UM Director. The department currently has staff capacity and expertise to re-assume substance use utilization management functions. GHS has a well-developed training department that will provide ongoing trainings as well as seeking external trainings to maintain staff competency.

g. Network Management

• 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.

As the former PIHP, Genesee Health System (GHS) maintained and managed a large network of provider services and contracts. GHS continued in this role for the current PIHP, Region 10. GHS has in place a provider network, contract, finance, and claims payable department to support the provider panel. GHS also maintains an internal provider, which offers high level more intensive care services. GHS's Provider Relations Department has a monitoring system to verify services array, capacity at the individual provider level and program level, conducts quality audits of every provider and produces a Provider Report Card for consumers to review and use for informed choice when deciding on provider selection. GHS has operated a provider network panel since the start of the State's change from a fee for services to a Managed Care Model.

GHS's Provider Relations Department is responsible for the planning, development, monitoring, evaluation and network management of clinical behavioral services for Genesee County. Provider Relations manages a network of diverse programs, services, hospitals and grant-funded services that treat individuals suffering from developmental disabilities, severe mental illness, serious emotional disturbance and substance use disorders. These programs include outpatient, case management, support coordination, psychiatric services, medication management, supportive employment, community living supports and personal care in a residential setting. Other programs managed by GHS's Provider Relations Department include providers of intensive mental health and substance use disorders such as ACT, psychiatric inpatient, crisis residential, crisis stabilization and formerly when GHS was the CA sub-acute detox and IOP, OP, residential and the full array of SUD services.

Provider Relations serves to ensure that an array of behavioral health care is available to eligible recipients. As the single point responsible for the entire provider network management, Provider Relations functions include:

- Provider network development and management.
- Provider performance review and sanctioning.
- Coordination of network-wide training.
- Monitoring of credentialing and privileging policies.
- Publication and updating the Provider Directory.
- Coordination of the Provider Network application process.
- Provide recommendations for initial and renewal of contracts.
- Provide orientation and training to new and existing network providers.
- Monitoring of capacity and program/services in regards to planning and development for expansion and reduction.
- Publication of network updates, changes, policies, census, trainings, etc.
- Track the provider profile, including performance, rating, contractual and regulatory compliance, and geographic site location.

- Coordination of Quality Oversight Council meetings.
- Tracking and distribution of network capacity and accessibility.

Provider Relations is responsible for the systems and services necessary to manage the provider and developing the infrastructure of providers for services to ensure access to care. Provider Relations also is responsible to review data collection, analyses and reports to determine performance standards, quality of services, effectiveness, provider availability, and accessibility to ensure member satisfaction and contractual requirements are met. Other responsibilities of the Provider Relations Department include, but are not limited to; maintaining regular means of communication, providing information to improve the provision of services, address provider grievances and resolve disputes, ensure the development of a service delivery system and the establishment of administrative capabilities to carry the requirement of GHS's obligations as the County's Behavioral Health Organization.

•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.

GHS has a long and extensive history managing our provider panel. Most contractors have been on our external provider panel for many years.

GHS's Provider Relations Department has retention plans and practices which includes: provider meetings, training sessions and programs, communications of changes, state and federal initiatives and other topics as needed. Provider relations staff meets and reviews service expectations and provides technical assistance to all providers.

GHS's staff operating this panel are experienced and long term employees. They have developed strong relationships with our provider panel and there is every expectation that there will be no changes to the current external service provider panel or to any internal provide services.

•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.).

GHS strives to reduce administrative duplications and barriers. GHS currently reciprocates several training requirements such as recipient rights training with other CMHSPs and regional entities. We continue to review and accept credentialing and site reviews practices and other network management activities with other CMHSP and/or Regions. See the previous responses regarding network management for information on administrative efficiencies and activities.

h. Managed Care Oversight and Performance Monitoring

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

The MHP will provide a pre-delegation evaluation tool, with the identified potential delegated functions and interpretive guidelines. Genesee Health System (GHS) will complete the evaluation tool and provide documentation as evidence that will satisfy the requirements for delegation. Evidence may include policies, procedures, written narratives, and other written materials.

Upon review and approval, of the evaluation tool, the MHP will enter into a delegation agreement with GHS. This agreement will contain the specific delegated functions, the expectation of these functions, and the monitoring process with timeframes.

Ongoing monitoring activities by the MHP will be determined by the specific delegated function.

During the ongoing monitoring, if discovered non-compliant items, a corrective action plan process will be utilized. Continued monitoring of any correction action plans, showing evidence of improvements, will be completed and provided to the Medicaid Health Plan on a quarterly basis, or other frequency as identified with the Medicaid Health Plan.

GHS will, for all delegated functions that may be contracted, complete a pre-audit of the potential contractor's ability to perform the delegated function(s). This will include review of staffing to complete the function(s), policies and procedures regarding the delivery of the functions, monitoring and observation of the specific tasks. GHS will perform ongoing monitoring of the operations of the provider through data review, reports, and direct contact with the provider and stakeholders.

If any non-compliant items are discovered pre-contract, GHS will work with the provider to correct or issue an additional Request for Proposal to seek an alternate provider. If non-compliance is discovered through the contract monitoring process, a corrective action plan process will be utilized.

10. PILOT PROJECT EVALUATION: (The applicant must work cooperatively with the MDHHS designated evaluator and are required to participate in all activities related to the pilot project evaluation summarized in Attachment C)

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

GHS has a well-established and robust infrastructure, systems and resources to provide the foundational support for full participation in the pre and post 298 Pilot evaluation. GHS recognizes that along with many of the existing data resources and processes already in place, there will be additional data collection and reporting needs to ensure effective pilot measurement. However, with a more than 10 year history as the PIHP for Genesee County, and now through continued delegations from the Region10 PIHP, GHS retains the systems necessary to manage, monitor, and report service utilization detail and trends, expenditures, and outcomes. Further, there is existing capability to measure indicators related to specialty services penetration rate per MHP, access rates and timeliness, inpatient utilization, and annual costs, among other potential areas of interest. Using these existing resources, GHS would work closely with both the Institute for Healthcare Policy and Innovation (IHPI) evaluators and the MHPs to develop data collection and reporting protocols to ensure effective measurement and reporting capabilities under the pilot.

b. Describe your approach as a pilot site to developing the organizational and technical capacity to participate in evaluation-related activities.

GHS will assess the utilization of the EMR systems for behavioral health, physical health, and SUD to improve efficiency and productivity of clinical staff, supervisors and administration. On-demand, web-based reports and dashboards to evaluate the data both clinically and administratively will be provided. Other automation, such as a help request system, payroll system, and other customized web-based applications will be further developed as needed to improve productivity. Telemedicine will be utilized to improve availability and serve more clients more efficiently. Virtualization will be used to increase performance, save on energy use, making backups more efficient, and making restores more reliable.

Virtual Desktop Infrastructure will be deployed to centrally manage laptops and computers while protecting the data from being viewed by an unauthorized person by not having any data, including PHI, to reside on the actual device. We will continue to analyze how to utilize technology to improve our web site and increase visibility and availability to our stakeholders, explore using new mobile technologies to increase efficiency, serve more clients in more settings, lower costs, and evaluate ways to increase efficient methods to support our systems users, including on-line training modules.

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 disabilities, or a substance use disorder. Please also address services and supports for children with serious emotional disturbances as part of your response.

GHS is open to discussions with the MHPs regarding various methods to track savings. The following are proposed savings tracking methods aligned with the common program clinical outcomes as described in question #8a:

- Improving clinical quality outcomes (i.e. HEDIS): Through our FQHC, our MHPs track certain HEDIS data such as depression screenings, A1C counts, etc. on a monthly basis. This same program can be applied to our behavioral health consumers based on the various behavioral health quality indicators available. Based on actual results versus target results an enhanced incentive payment is computed.
- Emergency room readmissions cost reductions: Through our FQHC's SIM program we will have the capability to monitor our consumer's emergency room admissions. This allows the ability to track costs comparing an established baseline target to actual cost on an established time interval report out basis, such as monthly. This same program can be applied to our behavioral health consumers.
- Hospital cost reductions related to length of stay: Same as above. We will have access to our consumer's data.

From the savings derived from the methodology described above, a reinvestment plan will be developed where necessary to invest in the pooled funding and collaborative relationships as described in question #8d. Therefore, compliance with the requirement of the Section 298 boilerplate of reinvesting all funds back into our consumer population within Genesee County is met.

GHS has a full array for children services including a successful MST program. GHS also provides a Juvenile Mental Health Court and as described in other sections a co-located behavioral and physical health collaboration with Mott's Children Health Center. Additionally as stated in prior sections as well, GHS has been identified as the Designated Provider Organization for the lead related services in Genesee County. These along with new developing children services will continue to be a focus to services for the children of Genesee County.

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

At this time GHS has not identified any barriers to implementing this pilot. As discussions progress and any barriers are identified, GHS will work with MDHHS and the Medicaid Health Plans to resolve.