Section 298 Barriers to Implementation Report

(FY2018 Appropriation Act - Public Act 107 of 2017)

November 1, 2017

Sec. 298. (1) Before implementing the pilot projects and demonstration models described in subsections (2) and (3), the department shall enter into an agreement with an independent project facilitator with at least 5 years of project management experience to establish performance outcome metrics of the pilot projects and demonstration models, finalize each pilot project's or demonstration model's implementation milestones, determine and manage the critical path to the pilot project's or demonstration model's completion, provide independent guidance on resolving conflicts between parties, and perform other necessary oversight and implementation functions as determined by the department. These performance metrics shall evaluate how the pilot projects and demonstration models impact, at a minimum, each of the following categories:

(a) Improvement of the coordination between behavioral health and physical health.

(b) Improvement of services available to individuals with mental illness, intellectual or developmental disabilities, or substance use disorders.

(c) Benefits associated with full access to community-based services and supports.

(d) Customer health status.

(e) Customer satisfaction.

(f) Provider network stability.

(g) Treatment and service efficacies before and after the pilot projects and demonstration models.

(h) Use of best practices.

(i) Financial efficiencies.

(j) Any other relevant categories.

(2) The department shall work with a willing CMHSP in Kent County and all willing Medicaid health plans in the county to pilot a full physical and behavioral health integrated service demonstration model. The department shall ensure that the pilot project described in this subsection is implemented in a manner that ensures at least all of the following:

(a) That any changes made to a Medicaid waiver or Medicaid state plan to implement the pilot project described in this subsection must only be in effect for the duration of the pilot project described in this subsection.

(b) That the project is consistent with the stated core values as identified in the final report of the workgroup established in section 298 of article X of 2016 PA 268.

(c) That updates are provided to the medical care advisory council, behavioral health advisory council, and developmental disabilities council.

(3) In addition to the pilot project described in subsection (2), the department shall implement up to 3 pilot projects to achieve fully financially integrated Medicaid behavioral health and physical health benefit and financial integration demonstration models. These demonstration models shall use single contracts between the state and each licensed Medicaid health plan that is currently contracted to provide Medicaid services in the geographic area of the pilot project. The department shall ensure that the pilot projects described in this subsection are implemented in a manner that ensures at least all of the following:

(a) That allows the CMHSP in the geographic area of the pilot project to be a provider of behavioral health supports and services.

(b) That any changes made to a Medicaid waiver or Medicaid state plan to implement the pilot projects described in this subsection must only be in effect for the duration of the pilot projects described in this subsection.

(c) That the project is consistent with the stated core values as identified in the final report of the workgroup described in subsection (2).

(d) That updates are provided to the medical care advisory council, behavioral health advisory council, and developmental disabilities council.

(4) The department shall begin to implement the pilot projects and demonstration models described in subsections (2) and (3) by no later than October 1, 2017 and shall work toward implementing the pilot projects and demonstration models described in subsections (2) and (3) by no later than March 1, 2018. Each pilot project shall be designed to last at least 2 years.

(5) 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.

(6) It is the intent of the legislature that the primary purpose of the pilot projects and demonstration models is to test how the state may better integrate behavioral and physical health delivery systems in order to improve behavioral and physical health outcomes, maximize efficiencies, minimize unnecessary costs, and achieve material increases in behavioral health services without increases in overall Medicaid spending.

(7) The department shall contract with 1 of the state's research universities at least 6 months before the completion of each pilot project or demonstration model to evaluate the pilot project or demonstration model. The evaluation shall include information on the pilot project's or demonstration model's success in meeting the performance metrics developed in subsection (1) and information on whether the pilot project could be replicated into other geographic areas with similar performance metric outcomes. The evaluation shall be completed within 6 months of the end of the pilot project or demonstration model and shall be provided to the department, the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office.

(8) From the funds appropriated in part 1, $3,088,200.00 shall support the implementation of the pilot projects and demonstration models described in this section, including funding for an independent project facilitator, evaluation of the pilot projects and demonstration models, modifications to state contracts, and the hiring of state staff to support the implementation of this section. By December 1 of the current fiscal year, the department shall provide a spending plan of these funds to the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office.

(9) By November 1 of the current fiscal year, the department shall report to the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office on progress, a time frame for implementation, and any identified barriers to implementation and the remedies to address any identified barriers of the items described in subsections (2) and (3). The report shall also include information on policy changes and any other efforts made to improve the coordination of supports and services for individuals having or at risk of having a mental illness, an intellectual or developmental disability, a substance use disorder, or a physical health need.

(10) Upon completion of any pilot projects or demonstration models advanced under this section, the managing entity of the pilot project or demonstration model shall submit a report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office within 30 days of completion of that pilot project or demonstration model detailing their experience, lessons learned, efficiencies and savings revealed, increases in investment on behavioral health services, and recommendations for extending pilot projects to full implementation or discontinuation.

INTRODUCTION TO THE REPORT

The Section 298 Initiative is a statewide effort to improve the coordination of publicly-funded physical health and behavioral health services. Under Section 298 of FY 2018 Appropriations Act (PA 107 of 2017), the Michigan legislature directed the Michigan Department of Health and Human Services (MDHHS) to implement pilot projects and a demonstration model to test the integration of publicly-funded physical and behavioral health services. As part of the Section 298 Initiative, MDHHS will be working with the Kent County Community Mental Health Service Provider (CMHSP) and willing Medicaid Health Plans (MHP) within Kent County to pilot a full physical and behavioral health integrated service demonstration model. In addition to the demonstration model, MDHHS will implement up to three other pilot projects to achieve fully financially integrated Medicaid behavioral health and physical health benefit and financial integration demonstration models.

Prior to the implementation of the pilot and demonstration project(s), MDHHS is required under Sub-Section 9 of Section 298 to produce a report "…to the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office on progress, a time frame for implementation, and any identified barriers to implementation and the remedies to address any identified barriers…" of the demonstration model and pilot project(s).

This report includes:

- A summary of progress to date;
- A high-level timeline for the project;
- A chart of identified barriers and a corresponding set of solutions; and
- A preliminary summary of the analysis of the recommendations from the Final Report of the 298 Facilitation Workgroup.

PROGRESS TO DATE

MDHHS has made significant strides towards the implementation of the demonstration project and pilot projects. The following summary describes the progress that has been made to date:

- MDHHS selected the Michigan Public Health Institute (MPHI) as the project facilitator. MDHHS completed the contract with MPHI and onboarded the project facilitation team.

- MDHHS selected the Institute for Healthcare Policy and Innovation (IHPI) at the University of Michigan as the project evaluator. MDHHS is in the process of completing the contract with IHPI and onboarding the project evaluator.

- MDHHS and MPHI have completed the project initiation phase and developed a project charter, project plan, project environment and scope statements.

- MDHHS has initiated discussions with the Total Health Collaborative (Kent County CMHSP and other potential partners) in regards to the demonstration model under Subsection 2 of the boilerplate. MDHHS has also developed and transmitted a set of parameters for the Kent County demonstration project to the Total Health Collaborative.

- MDHHS with MPHI has completed discussions with current system representatives in regards to the pilots under Subsection 3 of the boilerplate. MDHHS is using the input from these meetings to refine the parameters for the pilots and develop a Request for Information, which will be used to select the pilot sites. The following meetings were held:

    - Meeting with consumer advocates on October 18, 2017.

    - Meeting with the Community Mental Health Association of Michigan on October 18, 2017.

    - Meeting with the Michigan Association of Health Plans on October 20, 2017.

    - Meeting with the Michigan Association of Counties on October 23, 2017.

    - Regional meetings with CMHSPs and other providers.

        - Traverse City on October 24, 2017.

        - Ann Arbor on October 25, 2017.

        - Grand Rapids on October 26, 2017.

    - Meeting with Prepaid Inpatient Health Plans (PIHP) on November 2, 2017.

    - Meeting with the Medicaid Health Plans (MHP) on November 3, 2017.

    - Meeting with other providers on November 7, 2017.

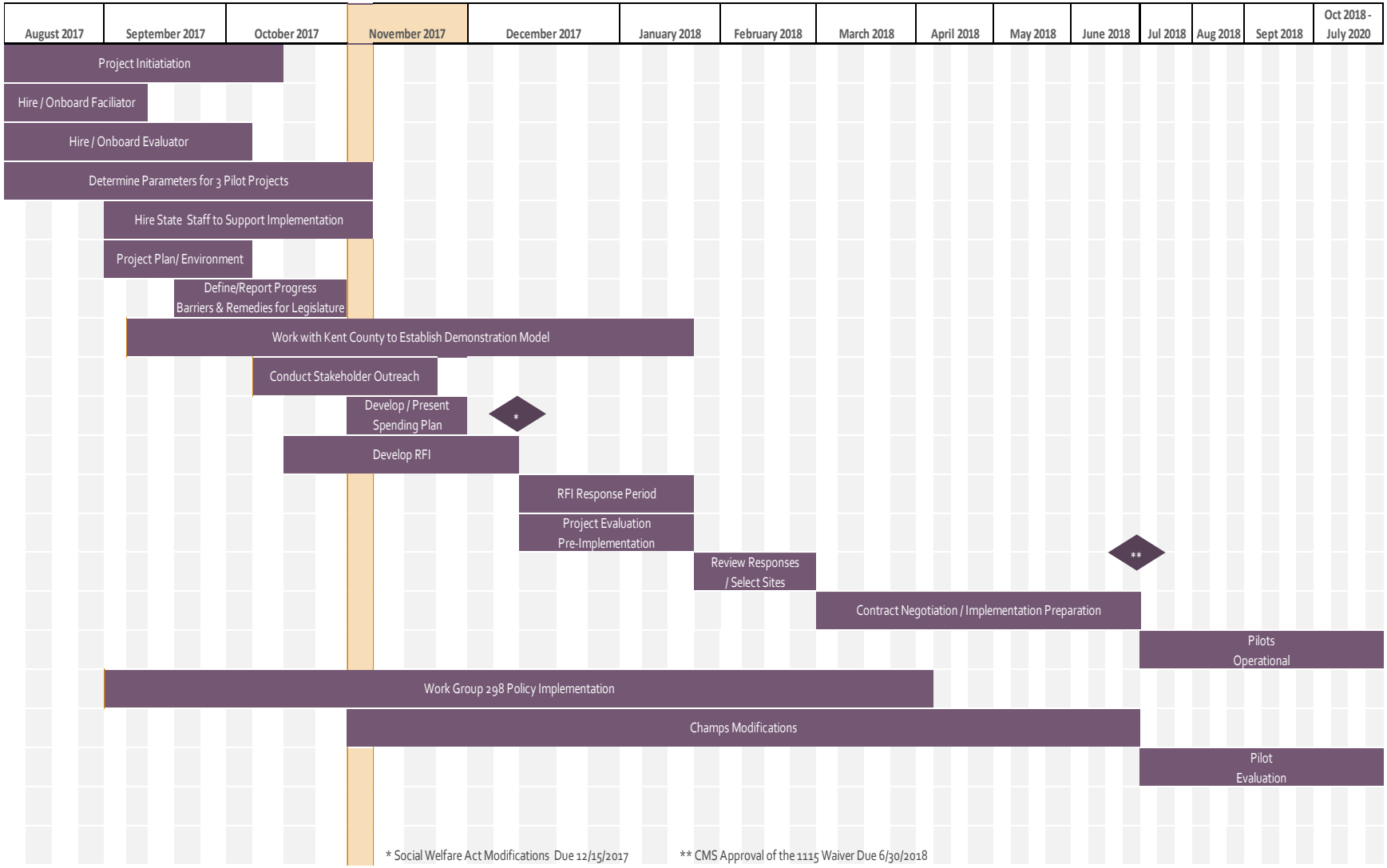
- Under Subsection 2 and 3, the Legislature requires MDHHS to provide updates to three state-level councils. MDHHS and MPHI met with the Developmental Disabilities Council in the beginning of October. MDHHS and MPHI are also developing plans to conduct similar outreach to the Behavioral Health Advisory Council and the Medical Care Advisory Council at their upcoming meetings.

    - MDHHS and MPHI will meet with the Behavioral Health Advisory Council on November 17, 2017.

    - MDHHS and MPHI will meet with the Medical Care Advisory Council on December 6, 2017.

- MDHHS has started to identify barriers to the pilot implementation and has incorporated these barriers and their related solutions into this report.

Current Timeline for the Section 298 Initiative



NOTE: This timeline is premised upon the assumptions that (1) MDHHS will be using a RFI process instead of a RFP process and (2) all barriers related to federal waivers, state statutes, and changes to state systems, contracts and rate structures are resolved.

Barriers and Proposed Solutions

MDHHS has identified the following barriers to the implementation of the pilot(s) and demonstration model to date. As stakeholder discussions continue, MDHHS may identify additional barriers to implementation. MDHHS also included corresponding solutions for each of these barriers below. The recommendations are only applicable to participants in the pilot(s) and demonstration model.

TYPE OF BARRIER	DESCRIPTION OF BARRIER	DESCRIPTION OF SOLUTION
Statutory	The Section 298 boilerplate does not explicitly identify who the applicant is for participation in the pilots.	Absent changes to the Mental Health Code, the CMHSP is the specialty provider and must be involved in the provision and management of services, and therefore the CMSHP is the primary applicant for participant in the pilot.
Policy	The implementation of the pilots under Subsection 3 is contingent on the identification of a willing CMHSP.	MDHHS is working with CMHSPs to identify barriers to pilot participation, and the RFI will be developed in a way that mitigates their concerns.
Statutory	The current structure within the Social Welfare Act requires MDHHS to contract with "specialty prepaid health plans" for the management and delivery of Medicaid-covered specialty services and supports. MHPs do not qualify as specialty prepaid health plans. Therefore, MDHHS cannot implement pilots where MHPs have a single contract for the management of Medicaid-funded physical health and behavioral health services unless the Social Welfare Act is amended. Social Welfare Act (Sec. 400.109F) – "The department of community health shall support the use of Medicaid funds for specialty services and supports for eligible Medicaid beneficiaries with a serious mental illness, developmental disability, serious emotional disturbance, or substance abuse disorder. Medicaid-covered specialty services and supports shall be managed and delivered by specialty prepaid health plans chosen by the department of community health with advice and recommendations from the specialty services panel created in section 109g. The specialty services and supports shall be carved out from the basic Medicaid health care benefits package."	The Michigan Legislature must amend the Social Welfare Act to allow for the implementation of the pilots as defined under Public Act 107 of 2017.

TYPE OF BARRIER	DESCRIPTION OF BARRIER	DESCRIPTION OF SOLUTION
Population	Approximately one quarter of Michigan's Medicaid Behavioral Health population is Fee For Service (FFS) and not enrolled in a MHP. This population also represents up to 40 percent of the Medicaid Behavioral Health spending. MDHHS must identify a mechanism for providing coverage for this population during the implementation of the pilots.	MDHHS will be looking for ways to address this issue and will continue to research approaches in other states and make a recommendation related to the pilot.
Statutory	The Mental Health Code contains multiple sections that require publicly-funded substance use disorder (SUD) services to be managed by department-designated community mental health entities. The Mental Health Code identifies several responsibilities for the PIHPs in regards to SUD services. These sections include: - Mental Health Code 330.1100a - Mental Health Code 330.1210 - Mental Health Code 330.127 - Mental Health Code 330.1281 Mental Health Code 330.1287	There are two possible solutions to this barrier. The first option is that the SUD funding, inclusive of Medicaid, could go directly to the CMHSP, which can be a department designated community mental health entity as defined in the Mental Health Code. In this option, the Medicaid funding would first go to the MHP and then to the CMHSP. The other option is to amend the Mental Health Code to allow the Medicaid funding for SUD, for the duration of the pilot, to go to the MHPs with contracts in the geographic area of the pilot.
Policy	The CMHSPs have not historically had the capacity or the experience in providing oversight of the SUD benefit. The pilot specifically positions CMHSPs to be responsible for this activity.	MDHHS will develop appropriate technical assistance for SUD oversight. Additionally, and if necessary, CMHSPs can purchase SUD administrative and clinical capacity/competency from the existing PIHPs.
Regulatory	MDHHS does not have the ability to amend the 1915(b)(c) waiver combination while operating under an extension. The 1915(b)(c) and the 1115 Waiver application specifically identify the current PIHPs and service delivery structure.	MDHHS is waiting for approval from the Centers for Medicare & Medicaid Services (CMS) for an 1115 Waiver. Once the waiver has been approved, MDHHS will need to request an amendment.
Policy	The implementation of the demonstration model under Subsection 2 is dependent upon the ability of Kent County CMHSP and other potential partners to achieve an agreement on the structure of the demonstration model.	MDHHS is working with the Kent County and other potential partners to develop the parameters for the demonstration model.

TYPE OF BARRIER	DESCRIPTION OF BARRIER	DESCRIPTION OF SOLUTION
Regulatory	It is expected that integration of behavioral health and physical health funding and service delivery will result in both administrative and medical cost savings. However, there are several structural factors for the pilots that may have an impact on the ability to achieve administrative efficiencies in the short run. First, as the pilot is required to be implemented in a way that all changes may be "undone" at the conclusion of the pilot period, it is not possible to "disassemble" various administrative structures currently in place. Additionally, each pilot CMHSP will transition from one Medicaid funding source to multiple Medicaid funding sources. Under federal regulation, this change will result in additional administrative requirements for delegated functions and reporting requirements. Finally, in addition to the Medicaid requirements as noted above in the SUD Oversight discussion, it may be necessary for CMHSP participant(s) to develop necessary administrative capacity to adequately manage the non-Medicaid SUD funding.	The Request for Information for the pilot will require applicants to describe their approach to achieving administrative efficiency across the region. Approaches may include: • Consistent utilization management practices; • Reciprocity and coordination in network management and related functions (including credentialing); • Streamlined and uniform reporting; and • Coordinated quality management activities. MDHHS is also working internally to integrate and simplify reporting requirements.
Operational	In order to implement the pilots, MDHHS must make several changes to state systems, contracts and rate structures to realign payment methodologies. Specifications for these changes cannot be defined until pilot sites are identified. System changes, contract changes and rate development also typically take six to nine months. Due to the sequential nature of the changes, the pilots cannot be implemented by March 1, 2018. The timeline for these changes will also be impacted if the department is required to use a competitive bidding process to select the pilot sites. This schedule is also contingent upon the completion of changes to federal waivers and state statutes.	MDHHS will need to extend the timeline for implementation.
Operational	PIHPs, MHPs and CMHSPs expressed substantial concerns about starting pilots in mid-fiscal year. Initiating implementation mid-fiscal year could have adverse impacts on rate development, budgeting and reporting.	MDHHS will need to account for these challenges when developing the timeline for implementation.

TYPE OF BARRIER	DESCRIPTION OF BARRIER	DESCRIPTION OF SOLUTION
Policy	The PIHPs are responsible for ensuring CMHSP compliance with various public policy requirements (e.g. person-centered planning, self-determination, consumerism, recovery-oriented systems of care, peer supports, etc.). MHPs have not historically had expertise in these public policy requirements.	MHPs will need to develop technical expertise regarding public policy requirements related to publicly-funded behavioral health services. MDHHS will develop appropriate technical assistance for compliance with the public policy requirements in a similar way to the technical assistance that is already being provided for the PIHPs and CMHSPs. Pilot CMHSPs will provide input and guidance on the development of technical assistance to MHPs.
Regulatory	By participating in the pilot, the MHPs will need to be in compliance with the Home and Community Based Services (HCBS) final rule.	MHPs will be responsible for compliance with the rule. MDHHS will develop appropriate technical assistance for HCBS compliance for the MHPs in a similar way to the technical assistance that is already being provided for the PIHPs and the CMHSPs. Pilot CMHSPs will provide input and guidance on the development of technical assistance to MHPs.
Evaluation	A key part of the implementation of the pilots and demonstration model is assessing the performance of these new models against the performance of the current system. However, some of the variance in performance between the pilot regions and comparison sites may be due to variables that are unrelated to the system changes that are being tested as part of the pilots and demonstration model. If these confounding variables are not appropriately controlled within the evaluation, they could impact the comparability of performance across the pilot sites and comparison sites.	The evaluator will use available resources from the MDHHS data warehouse and other programmatic data sets to select comparison regions.

Recommendations from the 298 Facilitation Workgroup

MDHHS is currently working to analyze and act upon the recommendations that were identified in the final report of the workgroup established in section 298 of article X of 2016 PA 268. MDHHS is currently undertaking the following steps as part of this process:

- Determining the relationship of recommendations to the demonstration projects and pilots established under section 298 of PA 107 of 2017.
- Setting policy action priorities.
- Identifying subject matter experts to analyze the various recommendations.
- Assessing the recommendations against the current state of state programs and policies.
- Defining barriers to implementing the recommendation.
- Clarifying the action that must be taken to enact the recommendations, including legislative and public policy changes.
- Assigning responsibility and setting due dates for action.

MDHHS has identified 23 of the 76 recommendations as being pertinent to the planning and development of the pilot(s) and demonstration projects. The other recommendations contained in the final report are being reviewed separate from the pilot process. The recommendations that impact the pilots and demonstration model include:

Recommendations	Barriers	Proposed Solution/Action
The workgroup recommends that MDHHS should develop a process for evaluating model concepts that do not require policy or statutory changes for implementation.	Identifying willing MHP and CMHSP participants.	Please see the planned action under the section of this report that focuses on barriers to the implementation of the pilots and demonstration model (pages eight through eleven).
For inclusion among models to be tested, the workgroup recommends the expansion and broadening of jointly funded, staffed and operated programs between MHPs and the local public behavioral health system for coordinating services to shared enrollees.	No barriers identified.	Pilots are expected to define their financing model with consideration of jointly funded/risk-sharing efforts for coordinating services to share enrollees.

Recommendations	Barriers	Proposed Solution/Action
The workgroup recommends the development of consistent statewide contract provisions to encourage the integration of physical health, behavioral health and intellectual/developmental disability services and supports for all populations at the point of service, which should be driven by local coordination between providers rather than statewide integration of financing.	Billing for co-located services.	MDHHS will work with pilots to identify and resolve billing issues that are raised for concurrent and/or co-located services. Once resolutions are identified, MDHHS will enact necessary policy, contract and reporting changes. Pilots will be required to define their plan for integrated care and supports coordination.
The workgroup recommends the use of models which improve the coordination of physical health and behavioral health services and supports through the local public behavioral health network for individuals with a mental illness, serious emotional disturbances, and substance use disorders. Within that population, the focus should be on individuals who are vulnerable and at risk for issues of increased morbidity and premature death as well as persons who are high utilizers of emergency services and hospitalization services.	No barrier.	Pilot applicants will be required to specifically address how they intend to integrate care including integration of care and supports coordination. The pilot will also be required to assure they meet competency and capacity requirements for care coordination that are new to the pilot members (e.g. substance use disorder services and supports)

Recommendations	Barriers	Proposed Solution/Action
The State of Michigan should retain system structures for Medicaid funding with (1) separate funding for and management of physical health flowing through the MHP system and (2) separate funding for and management of specialty behavioral health and intellectual/developmental disabilities flowing through the public PIHP/CMHSP system. Michigan should retain a public separately funded and managed system for non-Medicaid specialty behavioral health and intellectual/developmental disability services. CMHSPs should continue to play the central role in the delivery of Medicaid and non-Medicaid specialty behavioral health and intellectual/developmental disabilities services. The recommendation does not preclude the consideration of models of other competent, public, risk-based configurations.	Some stakeholders see the implementation of the pilots as defined in 298 as a deviation from this policy recommendation and are opposed to financial integration.	The planned 298 pilots and demonstration project will operate concurrent to the existing financing system, which continue to use the remainder of Medicaid and non-Medicaid funding to deliver services to individuals outside of the pilot regions. Pilot CMHSPs will retain their contractual and statutory role as the safety-net behavioral health provider. The 298 Action Team will include ongoing opportunities for stakeholder input during planning implementation and evaluation of the 298 pilot(s) and demonstration projects.
Through the use of consistent language in state contracts with payers, MDHHS should create standards that require contracted providers to follow the wishes of the person and/or family members for the coordination of services at the point of service delivery. Each individual should have the ability to choose where services are coordinated at the point of service delivery (e.g. health home, patient-centered medical home, etc.). This choice is not a choice of payer but rather a choice of the party that will coordinate services for the individual at the point of service. These standards should also include the opportunity for the person and/or family member to coordinate services for himself or herself.	No barriers are identified.	Pilots will be required to adhere to all current contractual, statutory, and public policy requirements (e.g. Person-Centered Planning, Self-Determination, etc.).

Recommendations	Barriers	Proposed Solution/Action
MDHHS should ensure that citizens are universally screened for substance use disorders problems at all points of health care system encounters using a consistent battery of state-defined screening instruments.	Available funding. Competency assessment and readiness. Network adequacy.	Pilots will have the opportunity to expand substance use disorder screening through their financing model including reinvestment of savings. Pilots will be required to demonstrate they meet network adequacy and competency requirements to assure provision of required substance use disorder services and supports.
MDHHS should ensure that citizens have on-demand access to the full array of substance use disorder services, supports, and/or treatment delineated in the American Society for Addiction Medicine criteria regardless of where they live in Michigan.	Available funding. Competency assessment and readiness. Network adequacy.	Pilots will have the opportunity to expand substance use disorder services and supports (consistent with American Society for Addiction Medicine criteria) through their financing model including reinvestment of savings. Pilots will be required to demonstrate they meet network adequacy and competency requirements to assure provision of required substance use disorder services and supports.
MDHHS should expand and promote the role(s) of recovery coaches and other peers across service delivery systems to improve consumer engagement and retention in services.	Available funding. Uncertainty around the federal policy position under the new administration.	Pilots will have the opportunity to expand use of recovery coaches and peer services through their financing model including reinvestment of savings. Expansion of recovery coach and peer support services will be in accordance with federal guidance and evidence-based practices.
The Michigan Legislature and MDHHS should increase the investment in community-based prevention activities.	Available funding.	Pilots will have the opportunity to expand prevention services through their financing model including reinvestment of savings.
MDHHS should pilot value-based payment models that incentivize harm reduction and long-term recovery outcomes and adopt successful models statewide.	No barriers.	Pilots are required to define their financing model including any risk sharing. Value-based payment models are permissible with prior MDHHS approval. Pilots will have the opportunity to incentivize harm reduction and long-term recovery outcomes.

Recommendations	Barriers	Proposed Solution/Action
MDHHS should address service gaps and geographic inconsistencies in supporting children, youth and families. These gaps include shortages of pre-crisis intervention, crisis response (including mobile response and crisis residential services), child psychiatry, respite and peer supports for children, youth and parents. MDHHS should establish clear access guidelines for each support and standards for sufficient capacity to ensure a full array of services is available.	Available funding. Recruitment of providers to rural areas and with a child/youth focus or competency.	Pilots will have the opportunity to address inconsistencies and expand services and supports for children, youth and families through their financing model including reinvestment of savings. Pilots will be required to demonstrate they meet network adequacy and competency requirements to assure provision of required child, youth and family services and supports.
MDHHS should fund and provide opportunities in all communities for support groups, family education and family empowerment to improve systems navigation and access to resource information.	Available funding.	Pilots will have the opportunity to provide and expand provision of support groups, family education and family empowerment through their financing model including reinvestment of savings.
MDHHS and the Michigan Department of Education should improve collaboration and communication with schools to better provide mental health screening, early intervention, and services to children with mental health needs.	Available funding.	Pilots will be required to maintain contractually specified coordination agreements with schools including practices to support transition planning.
Every effort should be made by MDHHS, payers and providers to maintain existing provider and support relationships as long as the supported person desires or needs. Policy should be designed with a primary goal of maintaining existing relationships.	No barriers.	Pilot applicants are required to address to what extent they will maintain the current specialty behavioral health provider network; and to address how they will coordinate regional network management activities to achieve efficiencies.

Recommendations	Barriers	Proposed Solution/Action
The Michigan Legislature should require at least a third of all members of boards of directors for organizations managing Medicaid benefits to be primary consumers (persons who have or currently receive services from providers managed by the organization) or secondary consumers (families of persons who have or currently do receive services from these providers). Among the primary and secondary consumers on these boards, at least half should be primary consumers.	Willingness of pilot MHP partner(s) to change their governance composition.	Pilots are required to stipulate how they will include primary and secondary consumer input (including policy and planning). The pilots are also expected to describe how they will meet Substance Use Oversight Policy Board requirements.
The State of Michigan should develop and implement a statewide strategy for aligning policy, regulatory, statutory and contractual requirements to enable the sharing of behavioral health information.	Concern about breaches of confidentiality for persons with behavioral health conditions; and more restrictive requirements for privacy protection for persons with substance use disorders.	Pilots will be expected to meet current health information exchange requirements and may serve as a test site for improved information exchange, infrastructure and consumer education efforts.
MDHHS should conduct education and outreach efforts to inform individuals, families, providers and payers about the importance and value of health information sharing.		
MDHHS should support local and statewide efforts to build infrastructure that will enable the secure sharing of behavioral health information across health care organizations.		
MDHHS should create a common culture of collaboration where stakeholders can identify, discuss, and overcome statewide barriers to health information sharing on an ongoing basis.		

Recommendations	Barriers	Proposed Solution/Action
MDHHS should develop a core set of quality metrics that are standardized across systems and consistent with national standards and federal requirements, including but not limited to the State Innovation Model (SIM), and 2703 Health Home initiative.	No barriers.	MDHHS and the project evaluator will identify standard measures for the pilots and demonstration project, which will be included in an independent third-party evaluation.
MDHHS should convene a workgroup to evaluate existing performance metrics and eliminate metrics that do not align with state and national practice and performance guidelines. Increased emphasis should move to measurement of outcomes from measurement of compliance.	No barriers.	MDHHS has established a workgroup to integrate and streamline reporting for pilot sites. Pilot and demonstration projects will work with a third-party evaluator to identify key measures and required reports that can be modeled to demonstrate improved efficiency and increased emphasis on outcome assessment.
MDHHS should complete an assessment of the existing administrative layers in the public behavioral health and physical health system to identify redundancies and duplication of oversight in the administration of Medicaid services. The assessment will serve as the basis for developing an administrative model that provides a service system that is person-centered, effective and efficient; reduces redundancy; and supports coordination across all layers of the behavioral and physical health system including regulatory requirements from the consumers to the providers, payers and up to the state level.	Increased administrative burden for pilot CMHSPs is likely given they are moving from a single Medicaid payer to multiple payers.	Pilots are required to (1) address administrative efficiencies as part of their application and (2) establish a plan for tracking savings and subsequent reinvestment into behavioral health services and supports.

Note: The other recommendations from the 298 Facilitation Workgroup have applications beyond the pilots and are being considered on a statewide level. MDHHS may address the other recommendations through general contract or public policy requirements.