## STATE OF MICHIGAN

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

**RESPONSE PREPARATION**

Please respond to the following topics and questions sequentially in a "Question and Answer" format, providing thorough information for each, when possible.

1. Applicant full name and address (The applicant must be a Michigan CMHSP in good standing).

Response:

Muskegon County CMH
dba HealthWest
376 East Apple Ave.
Muskegon MI 49442

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

Response:

Julia Rupp.
Executive Director
231-740-8764
Julia.Rupp@HealthWest.net

Please Note that HealthWest is submitting this RFI application as a single CMH but as you will note the proposed clinical and financing model are the same or very similar for West Michigan CMH, Saginaw CMH and HealthWest. As such we would consider being one 298 Pilot with all three CMH applicants or as West Michigan and HealthWest are geographically contiguous, a single pilot with HealthWest and West Michigan CMH.

HealthWest was prepared to submit its RFI on the evening of February 12th, when it received notice on Friday (February 9) afternoon that the date and the content of the RFI had changed significantly. As such, HealthWest's RFI response is specific to the original RFI specified Model elements (including the ASO). HealthWest did complete an additional response for the newly added 8e that is included in the RFI.

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.

Response:

See attachment B graphic (2 pages). Question 4 below describes the relationships between the entities on the graphic; please note that the graphic was developed using the original instruction of including the ASO for the unenrolled population.
HealthWest was prepared to submit its RFI on the evening of February 12th, when it received notice on Friday (February 9) afternoon that the date and the content of the RFI had changed significantly. As such, HealthWest's RFI response is specific to the original RFI specified Model elements (including the ASO). HealthWest did complete an additional response for the newly added 8e that is included in the RFI.

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.

Response:

**State to MHPs:** The state will pay a Medicaid capitation payment each for specialized behavioral health and also physical health to each of the 6 MHPs for the enrolled populations.

**State to ASO/MBHO:** PLEASE NOTE: HealthWest created its entire RFI under the assumption of the ASO as written in the original RFI. Because HealthWest and its CMH partners had extensive dialogs with the MHPs regarding that model, it continues to represent that model in this graphic and in the rest of the RFI. With the late notice of the change, even with the extension, there is not time to regather the MHPs and CMHSPs to address the conversation adequately or to adjust the RFI in a way that fairly reflects the conversations the CMHSPs and MHPs have had. Since the partner MHPs has indicated their support for the original discussion in their attestation, HealthWest did not believe it would be acting in good faith to change the proposal without adequate time to discuss. HealthWest anticipates that the specific mechanics of how the unenrolled population will be managed in a financial integration pilot will be discussed at length after the award of the RFI. HealthWest's ideas for this, albeit not entirely vetted with the MHPs, are presented in question 8e.

As the structure was originally proposed in the RFI, the state will pay a capitation payment to the ASO for behavioral health services for the unenrolled populations. The unenrolled population makes up as little as 30 and as much as 50% of the unenrolled population (depending upon the CMHSP). Therefore how this population is supported and managed in the context of a financial integration pilot is critical to the ultimate outcomes of the 298 Pilot process. Since the 298 Pilot is intended to be a full financial integration pilot, the ASO would ideally manage the physical health dollars for unenrolled population as well as other behavioral health dollars. Otherwise the addition of the ASO structure truly is duplicative of the PIHP structure and merely creates another management entity for the Pilot CMHSPs to manage and work with outside of the scope of financial integration.
HealthWest and its partner CMHSPs would expect in order to maximize efficiency that the delegation principles and care model proposed would be consistent across the MHPs and the ASO.

**MHPs to CMHSP**: MHPs will be payers for the Enrolled Medicaid and Healthy Michigan for persons with Substance Use Disorders (SUD), Persons with Mental Illness (MI), Serious Emotional Disabilities( SED) , and Intellectual/Developmental Disabilities (IDD), inclusive of the Mild-to-Moderate Population

currently managed by the MHPs. The services for these populations will be contracted to the CMHSP, who would continue in their roles as direct service providers and network managers of the specialty benefit. This payment structure will include a mixture of a PEPM and Value-based arrangement (more description on potential payment methodologies in question 8). PEPM will be paid for the traditional behavioral health services (including Mild-to-Moderate) and expanded CCBHC type services. The MHP and CMHSP may agree to additional value-based payment arrangements for either additional services the MHP selects to contract for with the CMHSP or for new service areas collectively identified and prioritized by the MHP/CMHSP partner. As delegation arrangements are established, the MHPs may add dollars to the capitation or set up additional value based payment mechanisms for functions delegated to the CMHSP. Additionally, for functions that the CMHSP performs locally on behalf of the MHP, additional funding mechanisms may be discussed either via Fee-for-service, value-based payment or, additional dollars in capitation.

**ASO/MBHO to CMHSP:** The ASO entity, as currently envisioned by MDHHS, will be a single payer for the Unenrolled Medicaid and Healthy Michigan SUD, MI, SED, and IDD populations. The services for these populations will be contracted to the CMHSP. In order to create consistency and manage demand burden on implementation for the CMHSPs (6 MHPs + 1 ASO vs. 1 PIHP), it is anticipated that the delegation arrangements and payment methodologies established for the MHPs and ASO will be parallel. [Please note: This diagram assumes the ASO moves into the Pilot as currently envisioned by MDHHS. If the ASO construct is re-envisioned as described above, additional dialogue will be necessary to describe flow of dollars and care around the ASO/CMHSP partnership.]

**County Government to CMHSP:** Muskegon County will make payments directly to the CMHSP for PA2 dollars for Substance Use Services (treatment and prevention) and for local match. The CMHSP will be accountable to the standards of CMHEs for the functions associated with the PA2 dollars.

**CMHSP to Local Care Networks (LCN):** As is currently the case, the CMHSP will retain necessary managed care functions to support the locally established systems of care and the specialty service delivery network for the MI, SED, IDD, and SUD populations. Additionally, HealthWest will assume necessary managed care functions for the locally established Mild-to-Moderate network. Specific managed care functions to be performed by WMCMH for the Local specialty services network will likely include access and eligibility, quality management, some utilization management functions and network relations.

HealthWest and the MHPs will work to identify and collectively support a collaborative model across the existing healthcare networks in the 298 Pilot areas. They will particularly explore mechanisms to support the CCBHC Plus collaborative care model for all populations served in the Pilot region but most especially relationships between the CMHSP specialty and community network and the local FQHCs, Physician Organizations and ACOs, primary care and specialty care providers, and hospital systems. The model described in CCBHC plus Collaborative Care model is consistent with the SIM practice/intervention model and our partners stand ready to help improve integration with the health plans as our partners.

Any delegation of functions from MHP to HealthWest will be done in accordance with MHP Standards and Accreditation Guidelines. This will include incorporating extensive standardization of functions and key elements of care models in alignment with MHP requirements and guidelines and best practice standards. A full functional and gap analysis will be conducted post-Pilot award to determine which specific functions will be performed by the CMHSP/CCBHC.

Again, it is anticipated that the contractual design, delegation of functions, and broad-stroke best practice of care standards will be consistent across the 6 MHPs and the ASO.

Mental Health Code defined Recipient Rights Functions for all behavioral health services including the behavioral health specialty services network will be retained by the CMHSP.

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).

Response:

**Direct Care Integration Experience:** HealthWest has a solid track record in the integration of behavioral health and physical health services. In this arena we have co-located behavioral health staff in primary care offices as well as run an onsite integrated health clinic. This integrated clinic has been operating for over 10 years; however due to a SAMSHA grant received on primary behavioral health care integration grant (PBHCI) we have greatly expanded the model. This is as a result of a partnership with one of our local FQHC's, Hackley Community Care (HCC). While in the beginning HCC provided primary care and HealthWest provided behavioral, health care in a co-located arrangement we have become far more sophisticated. HCC and HealthWest each employee primary care providers, HCC provides Primary Care Medical Co-Director and HealthWest provides Psychiatric Medical Co-Director, HealthWest provides nursing and other supports as well as an onsite pharmacy and lab services. This month we will be expanding the space to accommodate 3 dental operatory, HCC will hire and recruit the dentists and HealthWest is providing the equipment , space, and support staff. All psychiatrists are co-located in the integrated clinic. This allows for immediate consultation between primary care and psychiatry when indicated. While we have not yet integrated our health records all staff have access to the medical record of the other organization for shared clients. Our integrated clinic is a PCMH and is accredited as a Health Home through CARF. HCC is also accredited as a PCMH. In addition we are currently assisting HCC in writing a grant to offer Medication Assisted Treatment and substance use services. In addition we are partnering with HCC to provide an integrated solution in our local county jail. We are collectively working with a consultant to implement an integrated approach to jail medical services. While we currently provide behavioral health services in the jail we are proposing a model that would be integrated in the jail. We are also working with our other FQHC (Muskegon Family Care) to expand substance use services inclusive of medication assisted treatment. They have already become accredited and licensed and we will add them as a SUD provider in our network to support these efforts. We work with a third FQHC (Cherry Street) to provide Methadone treatment in our community.

Of note, Muskegon is also a SIM (State Innovation Model) pilot and the FQHC's, Mercy Health (Pathways) and Health West is very involved in this effort. Our Operations plan for the SIM recognizes

the work our community has already done with community health workers, complex care, and integration and care coordination with social determinants and strives to integrate into one community wide system that "catches" the high emergency room utilizers and connects them to the appropriate level of care coordination. The SIM needs assessment identified that those Medicaid individuals that most often used the Emergency room included persons with substance use and/or pain management issues, youth, and persons with developmental disabilities and co-occurring medical and substance use disorders. This is consistent with the model described within this pilot. This SIM model screens for social determinant of health needs as well as behavioral health and physical health needs and has a referral system in place to ensure that our identified population is connected with a care manager and connected to a PCMH. HealthWest is a member of the SIM steering committee, chairs the clinical and community linkages committee and is intimately involved in this project. Affinia, the ACO for physician practices associated with this project, has experience in value based purchasing and is willing to explore with us in the development of integrated models and associated alternative payment methodologies.

Another integration project is specific to children. HealthWest on behalf of the community received a SAMSHA Children's Mental Health Grant for systems of care. The result is that we are coordinating services with the school as the base utilizing the Pathways to Potential model. HCC has several health clinics in the schools and are part of this initiative. Through the SIM project we identified that we have a child population that are high utilizers of the Emergency room. While the goals/outcomes of the SOC grant are much broader we are also implementing strategies to improve access to Behavioral health services for children and add community health workers specifically dedicate to youth who use Emergency rooms 5 or more times per year. HealthWest also has a team dedicated to juvenile justice involved youth which is funded by both Medicaid (for medically necessary services for youth) and by the family court for services and supports for the family.

HealthWest established an MOU with the Battle Creek VAMC for coordination of care for veterans. In addition we have our own VA navigator that actively recruits and supports veterans (with and without VA benefits) ; trains community on how to work with veterans, help access VA services when appropriate and helps to access VA benefits.

HealthWest has staff with lived experience (peer support and recovery coaches) trained on wellness coaching, specifically the WHAM model. In partnership with the Pathways Community Health Worker (CHW) Program for CHW's placed in Mercy Life Counseling SUD program HealthWest provided supervision and cross trained the CHW's as Recovery Coaches. The Red Project is co-located in the HealthWest program to provide training and distribution of Narcan to our consumers. We worked with them to provide training to the community inclusive of the local sheriff and police departments.

**Financial Integration Practice**: HealthWest's experience in financial integration is described throughout this document. Examples include our Integrated Health Clinic, our Juvenile court team, our various specialty courts, our jail diversion services, our school based services (a joint project with health care,

family court, and DHHS), and our SIM efforts. These are all examples of creative and innovative integrating funding Non Medicaid Health Care, child care funds, local funds and others with the Medicaid Specialty Behavioral Health benefit.

**MHP Preplanning and Engagement Efforts:**

HealthWest and WMCMH began meeting with the MHPs in July, 2017. We met with Priority Health and Meridian on July 21, 2017. WMCMH and HW have continued this partnership to explore relationships with the plans. Dates of subsequent meetings by plan are provided below:

- Meridian (September 6, 2017; September 18, 2017; October 5, 2017; December 5, 2017)
- Optum (September 6, 2017; October 23, 2017)
- United (October 23, 2017; December 18, 2017)
- Blue Cross Complete (October 31, 2017)
- McLaren (November 10, 2017)—NOTE: also included Saginaw County CMH (SCCMH)
- Molina (November 20, 2017)—NOTE: also included SCCMH

(Emails and notes documenting all of the meetings referenced above are available upon request.)

WMCMH, HW, and SCCMH have partnered with Michigan Association of Health Plans to convene three additional meetings since the RFI was released. At least one member of all six MHPs participated in all three of these meetings. The dates of these additional meetings were:

- January 5, 2018
- January 19, 2018
- January 26, 2018

(Agendas, notes, and sign in sheets are available upon request).

During these meetings, the MHPs and CMHSPs discussed the need for Clinical, Business Operations, and Financial Integration for a model to be successful. The CMHPs proposed a care delivery and care coordination model which builds on traditional CMHSP specialty services, via the constructs of the Certified Community Behavioral Health Clinics (CCBHC). The CCBHC-Plus model would comprise all behavioral health populations including adults with mental illness, individuals with substance use disorders, children with severe emotional disturbance, and adults and children with intellectual and/or developmental disabilities. The CMHSPs would also, as part of the 298 Pilot, assume responsibility for the mild-to-moderate population, currently managed by the MHPs. The CMHSP and/or its provider network would continue to provide the comprehensive array of services that are necessary to create access, stabilize people in crisis, convene social supports in the community, and provide early intervention and the necessary treatment for those with the most serious, complex mental illnesses and addictions. The CMHSP would also integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration.

Direct care coordination in the pilot for individuals with (or at risk for) behavioral health conditions, inclusive of all current populations served with the addition of the mild-to-moderate population, would be the responsibility of the CMHSP, where individuals could be offered a range of supports from brief interventions to very intensive daily contact. CMHSPs use a multidisciplinary team approach; those

teams addressing the highest level of need include psychiatrist, nurse, master's level clinician, case manager, peer/recovery support coach, and employment specialist. Far beyond integrating funding, the CMHSPs believe that care coordination, particularly for those with behavioral health needs and co-morbid chronic health conditions, is critical to success in this model. The proposed models of care coordination are "boots on the ground", often seeking out and engaging individuals in the home, emergency room, in jails, homeless shelters and/or other community locations.

Additional dialog with MHPs is needed to ensure that the care management functions required of the MHPs as a managed care entity provide support and oversight (but not redundancy) to the care coordinators providing direct support to individuals in the community. The MHPs would retain their obligation to provide risk stratification and identification and complex care management to those identified as high risk.

An attestation signed by five of the six MHPs in Muskegon County, the HealthWest service area demonstrating their participation in the RFI process are presented in Attachment A.

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.

Response:

During meetings with the MHPs beginning in July 2017, the HealthWest and partner CMHs have repeatedly called attention to these key public policies as well as specific operational requirements inured in current PIHP contracts and federal waivers. HealthWest is currently in compliance with these policies and has offered technical assistance to the MHPs to support understanding and compliance in their oversight/monitoring responsibilities. The MHPs have additionally sought technical assistance and education from MDHHS related to their responsibilities under these policies. In some instances (i.e. Reciprocity), certain conflicts with current accreditation requirements have been identified. MHPs/CMHSPs will need to continue to work collaboratively to resolve discrepancies and/or conflicting requirements.

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.

Response:

HealthWest has multiple mechanisms in place to engage consumer input and guidance in policy development, program and service development, quality improvement, and network adequacy. HealthWest exceeds the Mental Health Code requirements and meets the CCBHC requirements for Consumer and Family Member representation on the HealthWest Board, persons with lived experience in all populations served are represented on the HealthWest board. As we currently do now, we will use our existing structure of consumer input to inform policy and implementation, program performance review, network adequacy etc. Some examples of this structure include a consumer advisory panel, involvement of consumers on quality improvement processes using the NIATx process, Meeting with ARC Muskegon, Quarterly Meeting co-hosted with ARC Muskegon for families of and persons with Developmental Disabilities, Contract with Disability Network for consumer input, input from System of Care for Intellectual and Developmental Disability organizations, and Good For Youth, an organization of young people .

HealthWest employs persons with lived experience on each of its team including youth peers, parent support partners; certified youth support specialists, and SUD Peer Recovery Coaches. HealthWest peers are embedded members of organizational teams who support consumers, the organizational team, and decision-making. HealthWest regularly engages consumer feedback from all populations via Recovery Surveys, Consumer Satisfaction Surveys, and target focus groups.

HealthWest has shared educational information and sought input from above identified groups on strategic plan of the organization. Consumers as well as community stakeholders are kept informed and feedback is solicited on strategic direction. Specifically education sessions have been held on the 298 pilot for consumers, as well as other major initiatives such as CCBHC status and the Transition plan for home and community based waiver. Questions and Answers are posted on our web site after each

session. In addition to our formal structure we have begun to use social media and email to improve communication with persons served. Should HealthWest be awarded a Pilot opportunity, we anticipate significant consumer participation in the integration of care design and on the enhanced coordination of care model between the MHPs and the CMHP. We would also seek input from our network of providers and their consumers.

HealthWest and its CMH partners have reiterated in meetings with MHPs the importance of the consumer voice at every level of CMH operations, from Board leadership to policy and practice implementation, performance reviews, network adequacy, quality oversight, and member services. While the MHPs do have structures in place to solicit consumer input, and we can likely use these structures to solicit input, HealthWest believes this must be strengthened in the Pilot to ensure that any new policies or protocols are fully vetted with consumer and stakeholder input. HealthWest and its CMH partners have proposed an oversight committee which includes representatives from consumers/family members/advocates be formed as part of the pilot process to ensure that consumer voices remain a priority. HealthWest also believes that this pilot provides unique opportunities for increased use of peer supports, recovery coaches and family advocates to support care integration across physical and behavioral healthcare systems.

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.

Response:

Lakeshore Regional Entity (LRE; the PIHP for HealthWest), currently maintains the SUD Advisory Board and retains prevention functions. Under the 298 Pilot, HealthWest would continue performance of the SUD HealthWest is currently delegated to perform managed care functions for substance use services from the managed care functions and would also manage substance use prevention services.. HealthWest is actively engaged in all prevention activities for Muskegon County, and would continue to rely on the Muskegon County Drug Free coalition for strategic planning inclusive of community needs assessment and identification of community priorities. While recently the Drug Free coalition has expanded its role to include community planning for SUD treatment, historically it has been and will continue to be the leader in developing prevention strategies. In addition to managing the community Network of SUD providers HealthWest also provides Substance Use services. HealthWest has established a full Substance Use Disorder delivery team. The multidisciplinary team includes Masters level therapists, Peer Recovery Coach, and care management. In addition we have wide array of groups both professional lead and peer support. Our clinic offers Medication Assisted Treatment (Suboxone and Naloxone). Since taking over the SUD network management we have added many evidenced based community practices, many supporting specialty populations. HealthWest has leveraged the Medicaid benefit by applying for grants and coordinating with others in the community to expand the service array in both treatment and prevention.

HealthWest anticipates establishing a subcommittee of the Board to perform the functions of the SUD Advisory Board. That SUD Advisory Board would consist of appointees representing the SUD provider

community, consumers, and other stakeholders including potentially MHP representation.. Depending on the location and philosophical alignment of other 298 Pilot sites, HealthWest would consider co-developing this SUD Advisory Board function with another Pilot Site.

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.

Response:

HealthWest has been managing the full array of specialty behavior supports through network management or direct provision of services for many years. Currently network management is delegated, and prior to our membership in the Lakeshore Regional Entity, HealthWest was a PIHP. HealthWest is proposing a CCBHC Plus model for this pilot, designed to provide a comprehensive range of mental health and substance use disorder services, particularly to vulnerable individuals with the most complex needs. HealthWest will offer the following services either directly or through a formal contract with a designated collaborating organization (DCO). In addition to the full array of Medicaid-funded behavioral health specialty services provided through the CMHSP and/or its provider network as defined by the Michigan Medicaid Provider Manual, HealthWest will provide the following services for ALL behavioral health populations:

- Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization
- Screening, assessment and diagnosis including risk management
- Patient-centered treatment planning
- Outpatient mental health and substance use services
- Primary care screening and monitoring
- Targeted case-management
- Psychiatric rehabilitation services
- Peer support, counseling services, and family support services
- Services for members of the armed services and veterans
- Connections with other providers and systems (criminal justice, foster care, child welfare, education, primary care, hospitals, etc.)

HealthWest will provide a comprehensive array of services necessary to create access, stabilize people in crisis, and provide the necessary treatment for those with the most serious, complex mental illnesses and addictions. HealthWest will also integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration. The CCBHC-Plus model proposed for this pilot includes all behavioral health populations including adults

with mental illness, Substance Use Disorders, children with severe emotional disturbance, and adults and children with intellectual and/or developmental disabilities. Under the 298 Pilot, HealthWest would also receive capitation and have management responsibility for the mild-to-moderate population and its network that is currently served under the MHPs. The expansion of the specialty services network to include the mild-to-moderate population and those at risk for serious behavioral health conditions is critical to the integration pilot and to efforts to improve long-term outcomes for individuals with behavioral health conditions. This is critical in our integration model.

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

Response:

HealthWest is a direct provider of most specialty behavioral health and substance use disorder services, while also managing a large provider network. It is the intent of the HealthWest to maintain responsibility of its current network management responsibilities as well as workforce development and continuing education for the specialty behavioral health network. To ensure consistency in care delivery during the pilot period, HealthWest will provide fidelity oversight and credentialing in evidence based practices. The MHPs would have a critical role in developing network capacity for key services including Medication Assisted Treatment and Psychiatry, improving and expanding provider relations with primary care and hospitals, and leveraging their network adequacy and contract management expertise to develop and improve the CMHSP provider network.

While it is currently the PIHP's responsibility to develop a network adequacy plan, HealthWest has continued this practice as part of our strategic planning. While this plan is consistent with the PIHP plan it is updated more frequently and goes to our board for approval and guidance in approving network contracts. This plan is based on input from existing community input/planning processes (CHNA and SIM for example but also include input from our consumers and stakeholders). HealthWest will continue to ensure access to the full range of specialty behavioral health services and supports in the local community, either via direct service provision or contract with its local network of providers.

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.

Response:

Below is a list of the Evidence Based Practices currently being practiced at HealthWest. Where appropriate and available we conduct fidelity reviews to ensure conformance to practice models. We have established internal review process to ensure fidelity to the models. When required we provide continued education and supervision to maintain these practices.

| |
|---|
| PMTO - Parent Management Treatment – Oregon Model – |
| FPE - Family Psycho Education – training hours maintained; level 4 supervisor on site |
| CBT - Cognitive Behavioral Therapy – individual supervision |
| SFBT - Solution Focused Brief Therapy |
| DBT - Dialectical Behavioral Treatment – no certification; Supervision |

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|---|
| ACT - Assertive Community Treatment – recertified every three years by the state; required trainings, including the doctors |
| IMH – Infant Mental Health – Certification |
| Individual Placement and Supports-fidelity reviews by the state |
| Medication Assisted Treatment -certification |
| Motivational Interviewing – trainers on staff, supervision |
| TREM – trauma recovery and empowerment (for women) – training and following protocols of the program |
| |
| TIP , Transition to Independence Model –Certified |
| WRAP, Wellness Action Recovery Planning, Trainer on site |
| WHAM – wellness, health and Medical –Trainer on site |
| MRSS-Mobile Response Stabilization Services (New Jersey Model) – training |
| TF-CBT – Certification |

HealthWest consistently evaluates new evidence based practices and requires training and certification; where appropriate of staff and teams as appropriate to meet the needs of the consumers and communities we serve. In addition to the list of EBPs implemented, HealthWest also provides training to providers in the community and support to implement evidenced based practices.

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

Response:

Much has already been described throughout this document regarding our current efforts regarding integration of physical health and behavioral health services. While some of our efforts are well established many are still evolving. For example while we currently provide behavioral health services in the jail and collaborate with the contracted medical services provider; we are working with a consultant to implement a fully integrated clinic operated by HealthWest in both the jail and the juvenile transition center. The efforts in the SIM project have additional planned services to address integration. While we have not yet worked through all the technology issues we are working towards having available a shared care plan available for all involved in a person's care inclusive of social service agencies, primary and behavioral health care providers and health plans. We intend on building on existing efforts specifically the new "My Bridges Integrated Service Delivery (ISD) System". Another effort not referenced yet is the ACES (Adverse Child Events) project. Through HealthWest leadership we completed a county wide ACES survey, published the results, developed a community wide action plan and have begun implementation. For example we are currently working with primary health providers in implementing the ACES survey into their assessment process.

Other community wide efforts lead by HealthWest includes our efforts regarding prevention. HealthWest provides leadership roles and is an active participant on the Drug Free Coalition, the Opiate Taskforce, the Suicide Coalition, Healthy Babies Committee, and Safer Suicide implementation in our Health System.

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.

Response:

In the pilot, direct care coordination for individuals with (or at risk for) behavioral health conditions would be the responsibility of HealthWest, where individuals could be offered a range of supports from brief interventions to very intensive daily contact. HealthWest uses a multidisciplinary team approach; those teams addressing the highest level of need include psychiatrist, nurse, master's level clinician, case manager, peer/recovery support coach, employment specialist. Care coordination, particularly for those with behavioral health needs and co-morbid chronic health conditions, is critical to success in this model. The proposed models of care coordination are "boots on the ground" often seeking out and engaging individuals in the home, emergency room, in jails, homeless shelters and/or other community locations.

With that said however, we must ensure that the care coordination model is aligned with the Muskegon County SIM project. This model is similar to the CCBHC plus model and discussion with the Health Plans thus far that we will use " coordinator of the coordinators" model, this is consistent with a health home model. Just as there has been some confusion in discussion regarding terminology and what we mean by care management we had similar issues in coordination with health care providers in Muskegon. Both landed on the concept that there are many kinds and types of care coordination however our model would identify a Coordinator of the Coordinators and have primary responsibility to communicate individual care summary across provider types including the social determinants of health agencies as well as Primary care. Care managers must ensure that persons are connected to a primary care provider. This is essentially how CMH's care management has been working for some time but recognizes the need to break down silos and improve communication to payers and health providers. In the SIM model HealthWest is one of the identified sites (along with FQHC's) that uses the COMPASS framework to work with persons who have multiple chronic conditions including mental health and substance use disorders. This intervention focuses specifically on the population that use the emergency room frequently. This is the most intense level of care coordination and has a nurse providing the care coordination with a one to ten caseload ratio. (we refer to as collaborative complex care). We also provide care management at various levels of intensity based on needs, including high intensity Substance Use Team and ACT. For children we utilize WRAP model for those with most intense needs. We also provide care coordination (1 to 40 ratio) and have specialized Community Health Workers that are part of the Pathways program in Muskegon County. In all levels of care coordination physical health care coordination must be part of the individual plan.

The common goals of all the health information technology we apply are to 1) simplify and support the clinical care that is provided, and 2) enhance that care by putting increasingly accessible and actionable pieces of information in the hands of decision-makers and those delivering care.

HealthWest selected Core Solutions, Inc. to implement its electronic health record system, Cx360, with the goals of utilizing the technology to improve workflows and increase the transparency, accuracy, and

completeness of the organization's data. Used by customers in a number of states across the country, Cx360 is ONC-ATCB certified as a Complete Electronic Health Record Software and is designed to satisfy the data collection requirements and support the reporting needs of organizations pursuing criteria for both meaningful use and CCBHC certification. Cx360 also reflects a seamless integration of financial operations, documentation of clinical care and service delivery, and the ability to manage and monitor the performance of required tasks/functions with fidelity to standards and expectations. The higher-quality data will also enable enhanced care coordination, increase capacity for making informed decisions during treatment planning, service delivery, performance management, and program development, and will the organization the ability to exchange data with a variety of networks, health information exchanges (HIEs), and providers in the community. Because of its design as a web-based application, Cx360 can be available to our network of subcontracted external providers in the community and can be used to populate a patient portal accessed by individuals receiving services, regardless of location.

In addition HealthWest participates on the SIM data committee and is exploring opportunities for sharing information. We will be using both Great Lakes Health Connect and the new ISD (Integrated Service Delivery) application currently being piloted in Muskegon.

In our own onsite integrated Clinic while we do not have a shared record at this time, Hackley Community Care (FQHC) has access to our records and we have access to their medical record. We are able to get Admission Discharge and Transfer Data daily as well as Labs electronically to facilitate coordination.

Additional dialog with MHPs is needed to ensure that the care management functions required of the MHPs as a managed care entity provide support and oversight (but not redundancy) to the care coordinators providing direct support to individuals in the community including. As the care model reflects, we anticipate development of a coordination of the coordinators construct to support both the high level care management oversight and support of the MHPs and the active on the ground engagement of the consumer, family, and safety net services that support whole person health and management of key social determinants of health. The MHPs would retain their obligation to provide risk stratification and identification, and complex care management to those identified as high risk.

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).

Response:

HealthWest has been providing care coordination directly for persons with Substance Use disorders, Persons with intellectual disabilities, persons with severe and persistent mental illness and youth with serious emotional disturbances. For persons with Substance Use disorder in addition to directly

providing care coordination and other SUD interventions we also manage a network that provides care coordination. In
While currently the PIHP manages the prevention contracts for SUD, HealthWest is actively engaged in all prevention activities not only for Substance Use Disorders but prevention for mental health as well. HealthWest Staff chairs the Drug Free coalition and the Opiate Task force. The Drug Free coalition completes strategic planning and recommends prevention programs for the county. HealthWest currently is part of the review committee for prevention RFP's. Under the 298 Pilot, HealthWest would assume responsibility for the management of prevention activities and contracts in addition to the SUD network that it already manages. Since the SUD coalitions are quite successful and HealthWest is embedded in this process, management of this function is well within the current capacities of the organization. HealthWest anticipates no disruption to the current coalition activities and prevention contracts as a result of the shift in management responsibility.

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).

Response:
Consistent with CCBHC requirements, HealthWest ensures that all services are culturally and linguistically appropriate, respectful of and responsive to the health beliefs, practices, and needs of diverse consumers, and compliant with Limited English Proficiency requirements. HealthWest uses culturally and linguistically appropriate screening tools and tools/approaches that accommodate disabilities, engages treatment planning components that are sensitive to individuals' needs and histories, and ensures that all staff have received training and have demonstrated cultural competencies. This includes specific training on Michigan tribal nations as well as the unique needs of active duty military personnel and veterans. The CMHSP adopts a Person-centered and family-centered approach to all services, which recognizes the particular cultural and other needs of the individual, family and community.

HealthWest partnered with Battle Creek VAMC to establish an MOU to support access and coordination of care to local community Veterans. Discussions with Tribal Nations regarding development of an MOU are ongoing. HealthWest routinely accepts referrals, provides services, and coordinates care with the Tribal Health Center for members of the Tribal nations.

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

Response:
While CareConnect360 is expected to be an important component of care coordination, other systems will be necessary to promote community-wide care coordination in a nimble, cost-effective, and efficient manner. The CMHSP applicant envisions data interchange between a variety of information technology systems to fully-support care coordination. The CMHSP applicant is aware of ongoing efforts and pilots to develop interfaces that will allow care coordinators, with appropriate credentials, to access

key CareConnect360 data from within their native systems. This will provide behavioral health care coordinators with easy access to integrated claims data at the point of care.
The CMHSP applicant will leverage other available technologies to promote care coordination including the following:

- Admission, Discharge, and Transfer notifications from MiHIN
- Medication Reconciliation / Discharge Summaries from MiHIN
- Great Lakes Health Connect (GLHC) Virtual Integrated Patient Record (VIPR)
- Engagement and coordination with other ongoing statewide and regional care coordination and data exchange efforts such as State Innovation Model (SIM) projects, and the technology that support those projects to the extent relevant

HealthWest is also exploring ways of incorporation of CareConnect360 claims data into client records and care coordination. Such data has been used occasionally (and with great positive impact) during case consultations and care coordination for individuals with complex needs, so we intend to expand this use and to engage more staff in the accessing and utilization of CareConnect360 data. HealthWest is also in the midst of implementing Great Lakes Health Connect's (GLHC) Virtual Integrated Patient Record (VIPR), is developing processes for sending and receiving Active Care Relationship Service (ACRS) ADT files from MiHIN, is an active participant in the local State Innovation Model (SIM) project, and utilizes Zenith Technology Solutions' (ZTS) Integrated Care Delivery Platform (ICDP) for both participant- and population-level data regarding claims, episodes of care, and other measures.

A key component of using technology to coordinate care will also lie in the local care coordination information systems, which include care management, treatment planning, utilization management, referral tracking and management, integration with health information exchange tools, and other care coordination functions.

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

Response:
The electronic medical record systems of HealthWest utilizes nationwide standard formats and protocols for the sharing of information, and have been tailored to provide interoperability within a range of privacy standards. The systems are designed to align with the Michigan Mental Health Code and 42 CFR Part 2 for specially-protected information (e.g. data pertaining to the treatment of substance use disorders). This alignment includes electronic implementation of the Statewide Consent to Share Behavioral Health Information for Care Coordination Purposes (MDHHS-5515), and that consent is managed within an Electronic Consent Management System (ECMS). The ECMS is integrated with the applicant's care management system and data exchange capabilities, and provides a secure, compliant manner to exchange specially-protected health information automatically and electronically within a Health Information Exchange (HIE) infrastructure. EMR vendors are certified to ONC's certification criteria relating to the federal "Data Sharing For Privacy" (DS4P) initiative, which specifies certain data tagging and handling requirements for sharing specially-protected health information electronically.

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

Response:

HealthWest leverages electronic medical record (including practice management) and population health management information systems to improve both beneficiary care and coordination of their needs. The EMR vendor has extensive experience and is recognized as a national leader in health information exchange, with a focus on data exchange of sensitive and specially-protected information, such as information protected by 42 CFR Part 2. This experience ranges from local integrations with health systems' EHRs to community-/state-wide data exchanges (e.g. GLHC, MiHIN, etc.)

It is expected that this experience and the tools developed to support the various projects that are currently in place will not only be utilized for this pilot, but that they will be enhanced and refined to support a broader care coordination strategy, and to promote the broader goals and objectives of this pilot, including the following goals:

1. Provide actionable, timely, relevant, integrated, and easy-to-access information from various external sources to clinicians "on the ground" at the point of care
2. Develop and exchange shareable community care plans to all care team members, regardless of location, affiliation, or technical capability
3. Integrate data for data analytics and population health management, including utilization and risk management
4. Integrate data for outcomes measurement and management, and utilize such data for value-based service purchasing
5. Provide the best, most accurate data available to the people who need it, when they need it

Core Solutions has expressed full support of HealthWest involvement in the pilot arrangement, and will ensure that necessary files are available (and in the proper format) for submission as dictated by reporting requirements and for purposes of participating in health information exchanges (HIEs). Through the use of rigorous field-level specifications at the point of data capture in the EHR, validation processes, and application of business rules in the system, data will be available in a timely manner, without error, and in the necessary format. Technical definitions and requirements for standard data sets and reports (including BH-TEDS, Michigan Mission-Based Performance Indicator System (MMBPIS) data, QI files, ACRS files, annual needs assessment, and encounter data) have been provided to Core Solutions for incorporation into the EHR. Whether submitted to MHPs, a selected ASO, or directly to MDHHS, HealthWest will be prepared to provide these files and reports to the appropriate recipient as needed.

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).

Response:

HealthWest is proposing maintaining current capitation funding model while working towards value based payment methodologies. This will allow us to stabilize the network and give us time to work with experts on arrangements that are either adding individually or in combination, value based methods such as shared savings, process performance improvement incentives, and/or outcomes based incentives. Even keeping the financing similar to current will be a challenge as we will be working with 7 different plans and to this point we have been "plan blind". There will need to be much additional conversation and technical assistance to work through this financing model. For the plans that have a small number of enrollees this will be particularly challenging. Even keeping a sub capitation model will still require retooling some of our IT and businesses processes and it will be a challenge to not add to administrative costs. While we think ultimately the CMH should hold some downsized risk a two year timeframe does not allow for time to develop this model. This model does include the Mild to moderate population.

Risk sharing arrangements, compelled in the development of the CMHSP applicant's budget in the pilot model, are dependent upon a) MDHHS's work with its actuarial contractor to establish sound rates for pilot sites, and b) external expertise to facilitate on-going negotiations with the MHPs after selection of the pilot sites. The actuarially-sound rates upon which total Medicaid savings would be compared should encompass both the CCBHC Plus care model, the additional engagement of care coordination activities within each MHP provider network, and those managed care functions that would be shared or delegated.

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

Response:

HealthWest has limited experience in value based financing models, apart from the small incentive payments inured in existing MDHHS contracts. However, we are currently participating in several projects (non -Medicaid funded) that are value based. We are currently in discussions with Affinia to understand their experience of value based contracting to leverage their experience in developing models. We are also pin discussions with Access Health vetting possible models based on their experience. Our providers have expressed an interest in pursuing value based purchasing opportunities as well. As the Director I have had experience in both Illinois and Indiana while working for other CMH organizations in value based purchasing.

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."

Response:

As mentioned above HealthWest and its CMH counterparts expect a need for technical assistance in this area. Our experience tells us that when integrated care is implemented we do save money in physical healthcare, usually seeing savingimmediately in emergency room use and hospitalization; however we also sometimes see medical expenses go up initially as we help individuals treat medical conditions that have gone untreated. Experience also tells us that generally costs go up in behavioral health care in order to realize savings in physical health care. This is particularly true in for persons with substance use disorders, as individuals begin to proactively engage in services and supports.
In order to calculate savings we must agree upon the population of shared consumers. This could be all persons served by the CMH (any encounter) or it may be a defined sub population such as all persons served with developmental disabilities, high emergency room utilizers, 2 or more chronic health conditions, high hospitalization readmissions rates, or those identified by the plan as having difficulty engaging in primary care; for which the CMH would be identified as having primary responsibility to coordinate the coordinators**.** Once defined, historic paid claims data should help to determine the baseline cost from which cost reductions may be determined such that potential "savings" could be quantified and tracked over time. The proposed financial model also suggests a consolidation of the MHPs network for the mild/moderate behavioral health benefit into the newly constituted CMHSP pilot's network and we believe there is considerable opportunity for cost saving for this population as well, particularly those that may have other chronic health conditions or those that have been treated in an ineffective or at the wrong level of care to meet their behavioral health needs. Because the suggested 298 Pilot financial model would for the first time consolidate all of the Medicaid and Healthy Michigan Plan behavioral health funding and the other public funding sources for SUDs and CMHSPs for service delivery in a single network, we believe there are still other efficiencies we cannot yet imagine especially in areas like workforce training, network management, data collection and information technology just to name a few.

As to the considerations for the Reinvestment Plan for Savings, there will need to be processes in place to be sure all service and administrative costs are covered first particularly in transition to pilot status. A new challenge for the CMH's as a pilot, will be the recognition and sorting of revenue from 6 new MHP payers and the MBHO/ASO needing to be "federated" or pooled to support the cost of service and administration. This construct of the paid revenue to the CMHSP for each of the MHPs not being exclusively directed to their members cost of care alone, is surely a new and unique arrangement that will require much more conversation and planning. It may be possible to assign administrative cost proportional to MHP and MBO/ASO member enrollment but even this notion will be challenged by how costs are experienced for consumers enrolled in each plan and the MBHO/ASO.

The CCBHC Plus model we are proposing has as a core value the desire to use "savings" at the CMHSP level which would have a "local identity" to expand services. These reinvestment strategies would be developed using local needs assessments and engaging the community and the health plans in developing gaps in services (that may or may not be a covered Medicaid service) or used to cover the under insured or non -insured individual. For example many of the people we serve drop off and on Medicaid, ensuring continuity of care during these times is critical. For example in Muskegon through the SIM project needs analysis we have identified the need for additional cross trained Community Health Workers, housing resources and substance use programs such as the "living Room model" all as strategies to decrease emergency room use and gaps in our current service continuum. In rural Lake, Mason, and Oceana counties the needs are often related to access due to transportation and/ or limited providers in areas such as Medication assisted treatment; the expansion of mobile tele psych may be indicated. Other reinvestment strategies would include training and support to our network providers in integrated care strategies and evidenced based practices.

At both HealthWest and Muskegon we are experiencing increase individuals seeking services particularly children and those with Healthy Michigan benefit. The result particularly over the last year is that expenses have exceeded revenues. The benefit is that both organizations have implemented cost saving strategies to manage this influx that are better practice models (move to more brief interventions when appropriate and mobile crisis) as well as briefer and more efficacious assessment process at the front door. The effect is getting people more quickly to the right service at the right time. However we anticipate that this influx of need may continue into the pilot period and reinvestment of saving into additional evidenced based practices such as children's crisis programs and use of technology can help stabilize the system and improve outcomes

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.

Response:

We do not anticipate that the financial arrangements of the pilot will impact the various community benefit functions of the CMHP. The financial strategy of maintaining the PEPM is meant to not only stabilize the network of Medicaid providers but to maintain the important contributions to the communities where CMHSPs are located by continuing to support the community benefit programs that are in place or in the planning stages. We have become experts at leveraging Medicaid Benefit and collaborating with other resources to maximizing programs needed by our communities. These are unique to each community as service gaps and community resources vary dramatically. One example mentioned above is the juvenile justice community based team, individuals served on this team have significant mental health and substance use teams and are assigned via specialty family court, the family court financially supports services to the families and ordered treatment that does not meet medical necessity. This is an example of flexibility that the sub capitation allows us to come up with creative means to fill gap in community and appropriately leverage Medicaid dollars. We have many other formal contracts similar to the above that leverage other resources, maximize Medicaid benefit and result in needed best practices.

Over the last two decades the largest financial support to the CMHSPs has come in some form of sub-capitation which has permitted CMHSPs to use the Medicaid and now Health Michigan funds to not only support the specialty carve out benefit to eligible consumers, but to also work with communities to develop innovative solutions to meet community need. This is only one example of multiple community initiatives.

Consistent with the CCBHC model the CMHSP is seen as a convener in the local system of care. HealthWest like other CMHSPs is recognized for this role, and staff are involved in many community associations, coalitions and community efforts. In Muskegon for example we are involved in the SIM project, Children's System of Care, The Coordinating Council, One and 21 coalition, Suicide Coalition, The Drug Free Coalition and many others. HealthWest is seen as a valuable partner in these initiatives. When there is a problem to be addressed HealthWest is called upon to provide leadership and problem solving. In addition to these formal community wide coalitions we are a trusted partner for other systems. This experience and skill comes from decades of improved understanding and navigation of other local systems whether they be law enforcement systems, judicial and forensic systems, educational systems, employment systems, housing and homeless systems, transportation systems, entitlement systems, child welfare systems, juvenile detention and probation systems, adult parole or probation systems, faith community systems, advocacy systems, self -help and recovery systems, tribal community systems, veteran's systems, health care systems and other human service systems. The motivation to understand and develop mastery over the navigation of such systems has been to improve access and resources for consumers with disabilities who could not navigate them on their own. Good collaborative partners respect each other, learn from each other and help each other, often without a single dollar for anything passing between them. The needs of our consumers are deep and wide and for many span a life time, while for others their needs will be met in these systems well after their treatment and recovery time with us is over. CMHs are working with these other systems every day to help the consumers we serve not just navigate them but to maximize what they have to offer and to create meaningful quality lives of their choosing. That means a place to live, work, learn, recreate, worship and access physical health care, while partnering with us to assist with their mental illness, substance use disorders and intellectual/developmental disability needs. We could simply not carry out our CMHSP mission without help from other systems. These relationships and understanding of how each of us is funded as well as what each can pay for helps us to maximize our resources.

As we included in our CCBHC application to the state there are several Memorandums of Understanding we can reference but due to space limitations will not do so here. Our community benefit work is described in these MOU's. Some current MOUs include Muskegon County Sheriff's department, Muskegon County Civil and District court, Battle Creek VA, Little River Band of Ottawa Indians, Coordinating Council, Affinia Health Partners, ISD, Housing coalition, Muskegon County Systems of Care to name a few..

In addition to the responsibilities we have for providing the Specialty Carve-Out benefit and our service to uninsured, commercially underinsured and Medicare consumers, the community benefits we provide defines who we are as a CMHSP and why a sub-capitated funding arrangement is being recommended to the MHPs for the 298 Pilot. Our partnership with the community is also why we have engaged our local community is developing this RFI

and solicited their support. We have held several public meetings and focus groups to educate our constituents to this pilot and the possibilities and pitfalls.

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.

Response:

**T**he unenrolled population statewide is made up of approximately 500,000 people. These individuals account for approximately $800 million in capitation payments and $1 billion in spending (approximately 40% of total Medicaid spending). How this population is supported in Michigan's transition to a financially integrated system is critical to the success of the pilot both in terms of outcomes attainable from integration efforts and opportunities for healthcare savings and reinvestment. At HealthWest, this population accounts for approximately 26% of the people the organization serves. These individuals consistently are some of the highest utilizers and most complex cases where coordination and true integration has the greatest opportunity for impact. Upon analysis of this population we found they are more likely to have multiple payers (Medicare and Private Insurance along with Medicaid) and also a higher likelihood of multiple health providers and social service agencies involved in their individual plan of service, maximizing the need for coordination. Our proposed model of coordinating the coordinators is critical to improved outcomes for these individuals. It is HealthWest's experience that these individuals often struggle to find adequate primary care and to adhere to medical regimens that support their whole person health wellness and recovery.

HealthWest sees three potential options for how the unenrolled population could be successfully managed in the 298 Pilot: 1) ASO as written into original RFI, 2) Capitation for behavioral health dollars directly to selected pilot CMHSP, and 3) Capitation for behavioral and physical health dollars to selected pilot CMHSPs for shared risk managing, the last being our preferred solution. Any solution should include financial integration of both physical and behavioral health care dollars.

- ASO: First, Since the 298 Pilot is intended to be a full financial integration pilot, an ASO could be developed as proposed in the original RFI. We would suggest the ASO would manage both the behavioral health and the physical health dollars for unenrolled population. Otherwise the addition of the ASO structure truly is duplicative of the PIHP structure and merely creates another management entity for the Pilot CMHSPs to manage and work with outside of the scope of financial integration.

- Behavioral Health Capitation to CMHSP: An alternative, if MDHHS does not want to integrate the physical health funds into the ASO with the behavioral health dollars, is to capitate and pass the behavioral health dollars to the CMHSPs to manage as part of their overall capitation. This is only marginally different than how MDHHS contracts with the FQHCs for the unenrolled populations. The Pilot CMHSPs can then manage the care for the specialty population with little impact to the services of the consumer and without the added layer of administration created by the ASO. In this scenario we would need to work with the MDHHS and the FQHC's to

create models that integrate the funding and create a mechanism to reinvest the shared savings in behavioral health.

- Full Capitation for Behavioral Health and Physical Health: MDHHS would pass the entire capitation for the unenrolled population to the chosen three 298 Pilot CMHSPs. Those pilot entities could collectively manage those dollars for the unenrolled population. Within that arrangement, one of the pilot CMHSPs would act as the primary managing entity. An Advisory Board with representation from across the pilot sites could be appointed specifically for the oversight of the dollars for the unenrolled population. Within this construct, it would also be possible for the chosen pilot sites to pool the capitated dollars for the unenrolled population and create an ACO with a trusted partner that would manage both the primary care and behavioral health dollars and risk. This also keeps management of the Unenrolled Medicaid dollars within the responsibility of the Public system while also assisting in managing the level of risk created by the unenrolled population within a comprehensive network that understands the complex needs of this group.

HealthWest is discourages use of two specific options for successful management of the unenrolled population: 1) Maintaining dollars for unenrolled populations with the PIHPs and 2) Fee-for-service payment for behavioral health to the pilot CMSHPs. We do not feel that these options would meet the intent of the 298 legislation to integrate the funding and reinvest the savings for this population.

- Unenrolled Capitation flows through PIHP: It seems inadvisable in a financial integration pilot aimed at producing efficiency to sustain two different types of managed care entities with very different stated interests. This would require pilot CMHSPs to maintain their delegated responsibilities and governance interests within the PIHP while also managing a set of different delegated functions with the MHPs. There would be no ability in this arrangement for the CMHSPs to fully divest of functions that might be better served by an MHP than by a PIHP. Additionally, in conversations with the MHPs, they have repeatedly expressed no interest in pilot models that include arrangements with current PIHPs.

- Fee-for-Service Payment for Behavioral Health to CMHSPs: HealthWest also discourages a fee-for-service arrangement with MDHHS for behavioral health services for the unenrolled population. As discussed previously in this RFI, the magnitude of risk associated with the unenrolled population cannot be adequately managed with fee-for-service payments. Although the FQHCs maintain these fee-for-service relationships with MDHHS they also have federal grants and wraparound payments to offset the unpaid costs of these arrangements. Additionally, the FQHCs have access to a broader array of service codes and options that can assist in covering costs associated with delivery for persons with complex needs.

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.

Response:

HealthWest proposes to continue to provide access to all specialty behavioral health services as a delegated function, consistent with the MDHHS Policy Attachment p 4.1.1 Access System Standards. In addition, the CMHSP will provide access and referral to Substance Use Disorder services in their role as Coordinating Agency for SUD services and supports in this pilot, this is a function that HealthWest currently provide as it is delegated from our PIHP. The CMHSP will be responsible for Screening, Level of Care Determination, Data Collection, Identification of priority populations, Eligibility Determination, Referral and Disposition, and Outreach and Engagement as needed to underserved populations. Eligibility determination for all individuals seeking access to specialty behavioral health services and supports will be the responsibility of the CMHSP. It is expected that the MHPs will provide oversight and monitoring of these functions as described in MDHHS policy.

- 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).

Response:

The CMHSP will utilize standardized screening, level of care and functional assessment tools where available and appropriate for all individuals seeking specialty behavioral supports and services. While we use all tools currently required by the state (CAFAS, PECFAS, LOCUS, ASAM, SIS etc.) we have begun to use the CANS and ANSA to recommend levels of care and as this tool is valid and reliable for this purpose across populations and will be embedded in the person centered planning process. We have already begun work to embed LOCUS and ASAM into the ANSA. For the pilot period, these tools (ANSA, CANS + required tools referenced above) will be used to assist in level of care determination and to ensure that services are provided consistent with individuals' assessed needs. Due to the multitude of standardized assessments required across all populations, and lack of evidence that these tools are all contributing to an improved understanding of individuals need for services and supports, we are asking for consideration of some relief in state requirements in this area.

HealthWest currently is utilizing Mobile Response and Stabilization as access point for youth. Youth may walk in for same day assessment or the team will respond in the community at school, home, pediatrician's office, family court etc for immediate screening and assessment. For adults we utilize same day access and brief intervention when appropriate. Persons seeking substance use treatment can

be screened and assessed at HealthWest or any SUD provider in our network. For all populations we have 24 hour mobile crisis. In addition we have an MOU with Little River Band of Ottawa county to improve access with their tribal members (working collaboratively with Muskegon office).

b. Customer Service

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

Response:

The CMHSPs have been advised by certain MHPs that customer services functions must be retained by the MHPs due to their accreditation standards, and that all members' services correspondence must be handled by the MHP. This includes Member/Customer Services Handbooks, Grievance and Appeal notification, and other member correspondences. The CMHSP will need to work closely with the multiple MHPs in each locality to ensure that the administrative burden here is minimized. Consideration should be made for these functions to be delegated if possible to ensure that members are provided with accurate and consistent information about their rights and services. The CMHSP will retain the specific function of Recipient Rights as defined in the Mental Health Code (as distinguished from Enrollee Rights or Member Services) during this pilot. While we understand that the plans must retain this function we also recognize that the local CMH (per our accreditation and best practice) must maintain some customer service functions to respond to consumer complaints at the local level and must also have a local handbook; this will need to be coordinated with the plans.

- 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.

Response:

In dialog with the MHPs, it has been acknowledged that the MHPs do not currently have the content knowledge and competencies required to administer the customer services functions for specialty behavioral health services under the current federal waivers and PIHP contracts. Additional technical assistance will be required to ensure compliance in this area. The CMHSPs have indicated their willingness to continue to perform these functions in a delegated arrangement, however this appears to be incongruent with accreditation standards in some key areas which will need additional dialog and problem solving.

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.

Response:

Core Solutions has expressed full support of applicant's involvement in the pilot arrangement, and will ensure that necessary files are available (and in the proper format) for submission as dictated by reporting requirements and for purposes of participating in health information exchanges (HIEs). Through the use of rigorous field-level specifications at the point of data capture in the EHR, validation processes, and application of business rules in the system, data will be available in a timely manner,

without error, and in the necessary format. Technical definitions and requirements for standard data sets and reports (including BH-TEDS, Michigan Mission-Based Performance Indicator System (MMBPIS) data, QI files, ACRS files, annual needs assessment, and encounter data) have been provided to Core Solutions for incorporation into the EHR. Whether submitted to MHPs, a selected ASO, or directly to MDHHS, applicant will be prepared to provide these files and reports to the appropriate recipient as needed.

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

Response:
One of the essential business requirements for our implementation of Cx360 is the capacity to distinguish among and manage multiple funding streams within one system, particularly SUD funds, which must flow concurrently yet separately from mental health funds. Additionally, Cx360 gives us the ability to manage the data, claims, encounters, and reporting requirements of the array of SUD service providers in the community. Performing these SUD Coordinating Agency functions is something that HealthWest has the ability to do (and has been doing in Muskegon County since 2014), with demonstrated capacity and competency to fulfill this role.
An individual's MHP enrollment/assignment is one required element entered in the insurance/funding portion of the client profile, along with other details regarding policies, benefits, and eligibility. This information can be used to route claims and encounters appropriately, as well as direct reporting to the appropriate MHP.

- 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.

Response:
Both West Michigan and HealthWest are currently delegated this responsibility and have capacity to report SUD information. We are not currently tracking prevention reporting but our systems will be updated to include these reporting requirements.

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

Response:
HealthWest has the ability to report BH TEDs and other reporting requirements directly to MDHHS and meet all contractual obligations. Our Electronic Health Record vendor does have experience in Michigan in meeting state requirements as well as across the nation including data exchange, data reporting, and analysis capabilities. Further they are willing to work with us to make any necessary adjustments to meet any additional needs as a result of the 298 pilot. Additional costs for extensive systems changes due to 298 pilot reporting may need be included factor in the development of actuarially sound rates.

d. <u>Claims Management</u>

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

Response:
HealthWest has a long history of claims payment, including complex edits for the specialty services

provider network. It is anticipated that the CMHSPs would retain this function for the pilot. Claims payment is connected to the authorization, person-centered planning process. Specific, intricate rules around claims payment exist within the behavioral health systems, particularly the EDIT rules which allow for multiple units to be allowed and where interdependencies exist with other specific services. Core Solutions (C360) can produce and process valid claims and encounters in HIPAA compliant formats.

- 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."

Response:

As mentioned above we are currently managing the SUD benefit. We will need to build infrastructure to also manage prevention benefit. We are currently implementing a new EHR, CORE solutions, while we are currently testing the functions we are confident that the SUD functions include all MDHHS and Mental Health Code requirements, including encounter processing, state reporting, SUD BH-TEDS, access and referral management, claims processing, and utilization management.

e. <u>Quality Management</u>

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

Response:

During this pilot, certain Quality Management functions would be retained by the MHPs/ASO, including the development of an annual Quality Assessment and Performance Improvement Program (QAPIP) plan and report, managing compliance with MDHHS contractual requirements, managing outside entity review processes (e.g., external quality review, accreditation), and conducting research. It is recommended that other Quality Management functions, including conducting on-site monitoring of providers in the provider network, provider education and oversight, and analyzing critical incidents and sentinel events be delegated to the CMHSPs with shared oversight by the MHPs/ASO according to common standards and guidelines for the purpose of administrative efficiencies and reducing

redundancy. HealthWest has an internal Quality Department that is dedicated to performance improvement activities and currently performs these functions.

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

Response:

During this pilot, HealthWest will be responsible for implementing the QAPIP and any associated Performance Improvement Projects as written by the MHPs/ASO, and will submit any and all data as required for quality reporting. To avoid administrative and operational burden, it is strongly recommended that the MHPs/ASO share a common Performance Improvement Project (PIP) for the duration of the pilot.

f. Utilization Management

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

Response:

Based on initial meetings with the MHPs, additional dialog will need to occur to determine retained and delegated Utilization Management functions. CMHSPs believe they are best suited to perform access and service eligibility determination within established consistent protocols. Standardized processes for service authorization and utilization review by the MHPs will need to be developed during the pilot. Both HealthWest and West Michigan are in early stages of implementing the CANS and ANSA across populations to inform the PCP and utilization Management process. The CANS and ANSA are reliable and valid tools for predicting levels of care for specialty behavior health services, and used across the nation by managed care, MBHO's and states for this purpose. Consistent implementation of such tools will provide for consistency of benefit across the pilot and provide meaningful data to the MHPs and CMHSPs to monitor utilization management and perhaps support outcomes monitoring and even value-based purchasing. Both HealthWest and West Michigan are embedding this into their PCP process and their Electronic health records.

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

Response:

The CMHSPs, in dialog with the MHPs, have drawn attention to the need for consistent utilization management criteria and processes across all plans in each geographic region to avoid unnecessary administrative burden. One of the issues in Michigan is there are not good common definitions of service array across geographic areas (with the exception of some evidenced based practices like ACT and Clubhouse). We are working at aligning our service arrays across West Michigan and HealthWest so that we can have agreed upon service array/program descriptions across geographic areas. We propose working with all three pilots to cross walk service arrays to develop common descriptions. This will allow for the Health Plans to understand specialty behavior health care services and provide oversite of utilization management.

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

Response:

CMHSPs are currently providing services consistent with the Medicaid Provider Manual and MDHHS contract; current service authorizations meet Medical Necessity Criteria and are consistent with person-centered planning guidelines. Therefore, no changes to individuals' service plans or authorized services are anticipated as a result of initiating this pilot project, and services will continue uninterrupted

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

Response:

This is an area where additional technical assistance may be needed to ensure compliance with parity rules. CMHSPs are committed to complying with regulations as defined and operationalized by MDHHS. Using the parity survey that MDCH utilized for the PIHP to review compliance with parity would be a process we can use to ensure that we are in compliance and also develop consistent policies across health plans. (reference attachment if room)

- 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).

Response:

While not new, HealthWest currently performs the majority of SUD managed care functions, including utilization management, on behalf of the PIHP. HealthWest has experience conducting utilization management and managing capacity of the SUD network. HealthWest EMR system supports both the management and provider functions associated with the SUD network.

g. <u>Network Management</u>

- 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.

Response:

Provider Network Management typically includes the functions of 1) network development and procurement (and re-procurement), 2) provider contract management (including oversight), 3) network policy development, 4) credentialing, privileging and primary source verification of professional staff, and 5) background checks and qualifications of non-credentialed staff. The intent of the CMHSPs in this pilot is to continue to subcontract with its provider network in addition to directly providing some specialty services in order to meet network adequacy standards for capacity, access to care, and time and distance standards per MDHHS contract requirements.

- 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.

Response:

The CMHSP anticipates no disruptions to its current provider network. The functions of contracting, credentialing and provider readiness review would remain the responsibility of the CMHSP, with oversight and monitoring by the MHPs to ensure compliance with managed care requirements and

accreditation standards. It is anticipated that the MHPs will leverage their provider network expertise to enhance the current provider network in areas such as psychiatry and medication-assisted treatment.

- 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.).

Response:

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

h. Managed Care Oversight and Performance Monitoring

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

Response:

To the extent that the CMHSPs are already performing many managed care functions for the specialty services and supports that they currently manage, the recommendation is that the MHPs accept the pre-delegation review that was previously conducted by the PIHPs. In any instance where a new delegation is being considered, it is recommended that one entity perform the pre-delegation review and that the results of that review are accepted by the other parties, to the extent that this is possible under current accreditation standards.

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.

Response:

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

a) improvement of the coordination between behavioral health and physical health

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

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

Response:

HealthWest has been awarded several state and federal grants requiring evaluation. In addition we have participated in several research projects requiring evaluation and have been a test site for the development of an evidenced based practice requiring comprehensive date reporting. While historically we have had to develop add on data sets and other mechanisms to report data if it was not embedded in our EHR, we have successfully met the evaluation requirements of our projects. However we are scheduled to go live with Core Solutions this summer and will have an expanded capacity to manage through our EHR.

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.

Response:

Reinvestment of savings is interpreted by HealthWest and its partner CMHSPs to specifically mean savings generated in the engagement of 298 Pilot activities for implementation of the care model (CCBHC Plus) and the unification of physical health and behavioral health funding streams under the fiduciary management of the MHP (or the ASO/MBHO for the unenrolled population). Care networks that were previously funded by the MHP prior to 298-Pilot engagement would not be eligible to receive savings reinvestment (e.g. physical health, care coordination, MHP-funded psychiatry or other mild/moderate service providers, etc.) outside of the CMHSP and its local care network.

Fiscally-sound formularies to calculate shared savings (or loss) through 298 Pilot care integration activities are predicated upon measurement before and after integration activities occur, to determine quality, costs of service, utilization of evidence-based practices, beneficiary outcomes and/or consumer satisfaction.

National CCBHC-required measures would be the foundation for quality measurement. Additionally, quality standards and model metrics would be based upon Meaningful Use and MACRA/PQRS/MIPS metrics. The CCBHC Plus model will further incorporate metrics and measures for carefully defined populations that will measure total cost of healthcare at baseline and at each successive year of pilot. Stated succinctly, it will identify whether the CCBHC Plus model improves outcomes and decreases total cost of care.

On an on-going basis (e.g. quarterly), measurement criteria would be engaged to financially quantify the efficacy of the pilot integration activities along these lines, with savings identified in the application of fiscally-sound formularies. Additional expertise to facilitate the development of a savings identification model would occur in negotiations between MDHHS, MHPs and HealthWest and its CMHSP partners after award of the pilot sites.
Reinvestment into CMHSPs on a quarterly basis would be made on shared savings (not loss) within the following, equal priorities:

- Implementation of evidence-based practices
- Improvement of care coordination activities
- Recovery opportunities for persons with mental illness and/or substance use disorders
- Engagement of support services for children and families to reduce adverse childhood events in the mitigation of severe emotional disturbances
- Improved community engagement for persons with intellectual and/or developmental disabilities to foster meaningful social interactions, employment and independence

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.

Response:
HealthWest and its partner CMHSPs, and MHP's have agreed they will need an agreed-upon behavioral and physical healthcare financing expert(s) that will work with 298 Pilot Participants to provide technical assistance in identifying:

- Start-up and development costs for implementation of the CCBHC-Plus Clinical Model
- Costs to support changes in process and IT systems to meet the intentions of the 298 Pilot in achieving integration of fiduciary and care responsibilities for CMHSPs, ASO and MHPs
- Rate-setting for care coordination and care management functions that are new to CMHSPs, including identification of corresponding billing/reporting (HCPCS) codes
- Assessment of resources needed to initiate service to populations compelled in the implementation of the CCBHC-Plus Clinical Model that are otherwise underserved or not currently served by CMHSPs and their provider networks
- Fiscally-sound formularies to calculate shared savings (or loss) through 298 Pilot care integration activities, clearly articulating that return of ***all*** resulting savings (not loss) are made to the corresponding CMHSPs.

        - CMHSPs may also pass on savings directly to their provider networks based on treatment-level shared savings models
    - Development of sub-capitated model of Medicaid financing for traditional Medicaid specialty behavioral health services during the 298 Pilot period, similar to current funding arrangements with their PIHPs, that protects both CMHSPs and MHPs from unnecessary risk
        - During the pilot, CMHSPs would like to partner with MHPs to consider value-based purchasing opportunities that are data driven and informed by evidence-based practices. The VBP development cycle would provide CMHSPs and providers with pay for planning, pay for participation, and ultimately, pay for outcomes/performance. The goal would be to develop replicable, state-wide behavioral and physical healthcare models for care and financing integration.
- MDHHS should compel joint, collaborative 298 Pilot committees across all MHPs and CMHSPs to engage in shared learning and identify opportunities for administrative efficiencies and minimizing redundancies :
    - Finance: To engage cost and revenue formula dialogs, standardize efficiencies to reduce administrative burden, and monitor revenues, expenses and risk for each organization in the pilot. (It is understood that specific information about MHP financials are proprietary to each organization).
    - Provider Network: To understand the MHPs processes for oversight/monitoring of the CMHSP applicant's local care network, and the level of shared responsibility and/or delegation to the CMHSP applicant to provide local care network adequacy assessment, contract management and oversight, the application and modification of MHP policies to accommodate BH policies, credentialing, privileging and primary source verification of professional staff, and background checks/qualifications of non-credentialed staff.
    - Quality: To ensure measurement activities meet accreditation and 298-pilot measurement guidelines, as well as the need to develop a shared Performance Improvement Project, determine process for performing on-site monitoring of local care network providers, manage regulatory and corporate compliance for BH. (It is understood that disclosure of specific quality initiatives, approaches and incentives are competitive advantages between each MHP and may not be shared).
    - Customer Service: To fully understand distinctions between customer service, appeals & grievances, and behavioral health Recipient Rights, including consumer involvement and participation in planning activities and development of the community benefit.
    - Utilization Management: To understand the limits of where the CMHSP applicant performs access and eligibility, and engages utilization management protocols within MHP accreditation and BH guidelines
    - Information Systems Management: To ensure consistent definition of expectations that are aligned for all MHPs in providing data interchange, use, and reporting.
- To fully manage the finances and care coordination of the population, MDHHS or the PIHPs must provide the full encounter data extract on all Medicaid beneficiaries in the coverage area
- MDHHS provision of guidance and technical expertise to the CMHSP applicant and MHPs in the implementation of public policies throughout the public behavioral health system, including:
    - 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
- 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

**The State of Michigan sincerely appreciates the time and effort put forth in your response to this Request for Information.**

**STATE OF MICHIGAN**

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

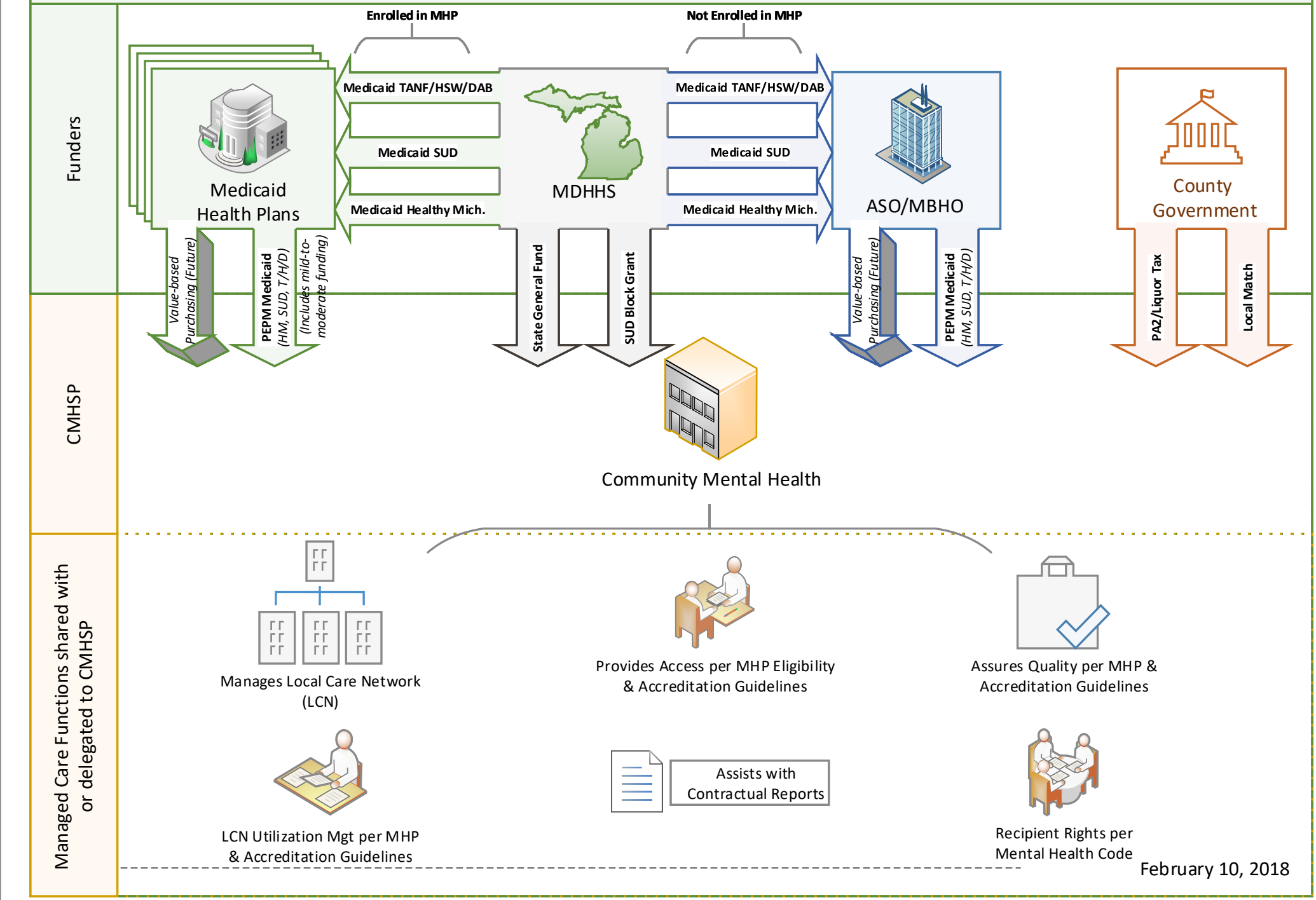
**ATTACHMENT A**

298 Pilot Request for Information
Memorandum of Support

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

| | | |
|---|---|---|
| J.d. Chan | Mark Ipresident | 2/1/18 |
| Signature Blue Cross Complete of Michigan Authorized Official | Name and Title | Date |
| Sean Kendall | Sean Kendall, President | 2-2-18 |
| Signature Meridian Health Plan Authorized Official | Name and Title | Date |
| | President + CEO | 2/1/18 |
| Signature McLaren Health Plan Authorized Official | Name and Title | Date |
| Christine Surdock | Christine Surdock, President | 2/2/18 |
| Signature Molina Healthcare Authorized Official | Name and Title | Date |
| | | |
| Signature Priority Health Authorized Official | Name and Title | Date |
| Dennis J. Mouras | Dennis J. Mouras, CEO | 02/02/2018 |
| Signature UnitedHealthcare Authorized Official | Name and Title | Date |

# 298-Pilot RFI: Finance and Managed Care for HealthWest




February 10, 2018

# 298-Pilot RFI: Care Integration Model (CCBHC Plus) for HealthWest