298 Pilots Request for Information
Medicaid Physical-Behavioral Health Full Financial Integration
(February 12, 2018)

PILOT OBJECTIVE

Section 298 of Public Act 107 of 2017 specifies the intended objectives of these pilots as: "to test how the state may better integrate behavioral and physical health delivery in order to improve behavioral and physical health outcomes, maximize efficiencies, minimize unnecessary costs, and achieve material increases in behavioral health services without increases in overall Medicaid spending."

RESPONSE PREPARATION

1. **Applicant full name and address:**
   Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS)
   2030 Portage St.
   Kalamazoo, MI 49001

2. **The name, title, telephone number, and email address of the individual(s) who will serve as the applicant's authorized contact.**
   Jeff Patton, CEO
   269-364-6901
   jpatton@kazoocmh.org

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.

Pilots considered for this Request for Information (RFI), are to be designed to test "*fully financially integrated Medicaid behavioral health and physical benefit and financial integration demonstration models*." This request appears to represent an economic rather than a clinical model for integration that will test the feasibility and effectiveness of a "carve-in" or privatization of the Medicaid Managed Specialty Supports and Services program. The objectives of the Section 298 pilots are:

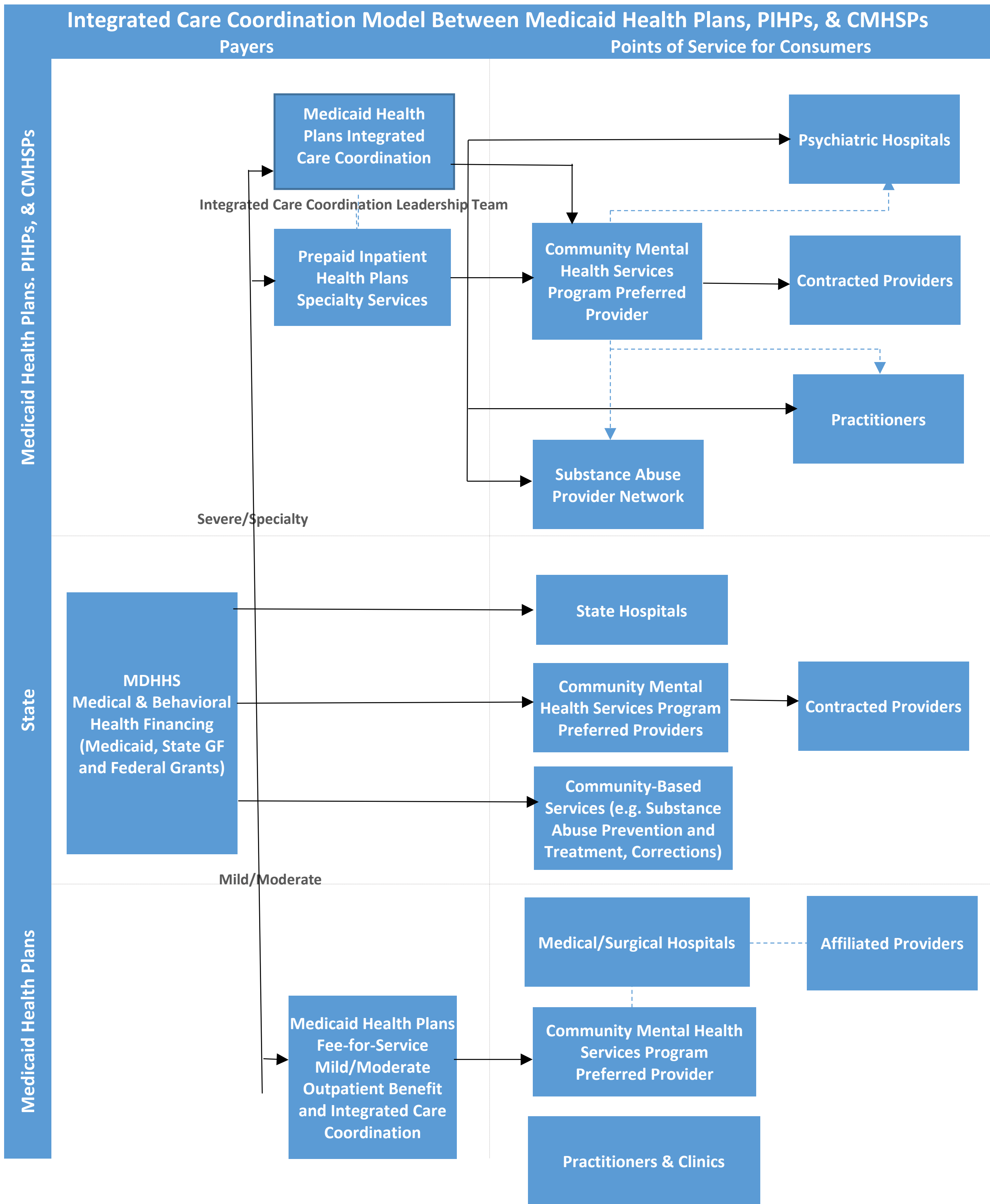
> ***… "to test how the state may better integrate behavioral and physical health delivery in order to improve behavioral and physical health outcomes, maximize efficiencies, minimize unnecessary costs, and achieve material increases in behavioral health services without increases in overall Medicaid spending."***

We believe these objectives are more aligned with the Kent County Section 298 *Full Physical and Behavioral Health Integrated Demonstration* model than proposed pilots for Full Financial Integration. What appears lacking or at least insufficient in most of the areas of this RFI that are soliciting responses

from Community Mental Health Services Programs (CMHSPs), is a firm identification of the problems to be solved, and theoretical basis for achieving the stated objectives by means of full financial integration. The main focus of this RFI seems to steer more in the direction of economic rather than population health and related clinical reasons for integrating behavioral and physical health outcomes. We believe it is a false premise to assume economic (financial) integration will automatically and uncritically lead to the improvement of behavioral and physical health outcomes. Although Medicaid behavioral health “carve-ins” are being tested in several states, (including Michigan through the MiHealth Link Medicare/Medicaid Duals Demonstration pilot), the results have not been empirically verified. This RFI is asking interested CMHSPs to demonstrate how they will maintain existing compliance with established public policies by uprooting and resettling its existing management authority for the Medicaid Managed Specialty Services system to Medicaid Health Plans (MHPs). This is an incredibly tall order given the many financial, legal and contractual complexities involved, and more importantly the unrealistic short two-year timeframe for accomplishing the transfer of managed care responsibilities. The description of our proposed pilot’s planned approach for assuring compliance with established public policies, includes an analysis of several critical issues, particularly those that align more appropriately with public welfare economics, rather than the more frequently applied classical market economics. This is a very important distinction that played a central role in our decision to propose an alternative care coordination model to that of Full Financial Integration with Medicaid Health Plans. We believe it is important to define the pressing problems of population health in Kalamazoo County and our eight-county region, which inspired us to enter into a partnership to pilot an Integrated Care Coordination model. We concluded that a Full Financial Integration pilot would require (1) specialized and incomplete contracts between Medicaid Health Plans and CMHSPs; (2) bring into full view realities and impact of limited and imperfect market competition for MHPs; (3) unpredictable transaction costs and information asymmetry; (4) uncertainty regarding the ability to generate savings for making asset-specific investments into the pilots; and (5) inherent complexities of public goods and resource distribution and how these will impact the success of the proposed pilots. We will discuss these issues in considerable detail in sections that follow, which lead to our decision to propose an Integrated Care Coordination model.

Together, Priority Health Choice, Inc. (a Medicaid Health Plan), Kalamazoo Community Mental Health and Substance Abuse Services, (a CMHSP) and Southwest Michigan Behavioral Health (a CMHSP created Regional Entity Prepaid Inpatient Health Plan and Substance Use Disorder Coordinating Agency) will enter into a collaboration to design and implement an integrated system of care pilot to improve the coordination of physical health and behavioral health services and supports for Kalamazoo County. We are fully aware that this alternative model is similar to the Kent County Demonstration, and does not meet the strict definition and requirements of the 298 Full Financial Integration model. We are also aware that the Final 298 Facilitation Workgroup Report recommends behavioral and physical health integration, but does not recommend Full Financial Integration to achieve this goal. We believe our model will satisfy all of the recommendations of the 298 Facilitation Workgroup. Moreover, given the legal and financial restrictions that prohibit CMHSPs from entering into full risk managed care arrangements with non-public entities, we believe our model is practical and will certainly be more effective, particularly given the short two-year timeframe for implementing the pilots, and providing assurances for complying with established public policies. Although, we are jointly proposing to implement this model exclusively with Priority Health Choice, Inc., and Southwest Michigan Behavioral Health, if approved by MDHHS, we will reach out to other Medicaid Health Plans in Kalamazoo County to participate in this pilot. Our proposed organizational structure (chart) to support the implementation of the pilot is provided below.

Diagram of Proposed Section 298 Integrated Care Coordination Pilot Model



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.**

The overarching goal and purpose of this model is for Priority Health Choice, Inc. to work with Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) and Southwest Michigan Behavioral Health (SWMBH) to identify shared enrollees with physical and behavioral health needs, jointly develop and implement processes to manage their care, eliminate inefficiencies and improve health outcomes. The result? An individual that receives the right care at the right time regardless of funding source, improved health outcomes, access to care and a system that provides relevant health information to care providers and shared enrollees. The current split healthcare system is difficult for individuals and providers to navigate. Our model will create more integrated care for the individual. It is designed to bridge the coordination gaps and de-fragment the health care system completely that currently exists for individuals and providers while supporting the person-centered planning process -- which is at the heart of supporting individual choice and control. This model is designed to assist individuals and families in navigating the often complicated system of healthcare and promote care coordination and integration between behavioral and physical health treatment providers. The model identifies KCMHSAS as Priority Health Choice, Inc.'s, preferred provider for mild/moderate outpatient services to support seamless and integrated care, and improve access to specialized behavioral health and intellectual or developmental disabilities supports and services for Priority Health Choice, Inc. enrollees. SWMBH will continue as the Prepaid Inpatient Health Plan (PIHP) and Substance Use Disorder Coordinating Agency for Kalamazoo County. Managed Specialty services will continue to be provided through the current contractual arrangement between KCMHSAS and SWMBH. Priority Health Choice, Inc. will work with KCMHSAS and SWMBH to identify and stratify high-risk specialty services and mild/moderate cases, including established processes, standards, shared care plans and quality metrics. Together, Priority Health Choice, Inc., KCMHSAS, and SWMBH will actively educate and engage both individuals and providers regarding system-level care coordination. The model includes a team of care management staff from Priority Health Choice, Inc., KCMHSAS, and SWMBH that assists individuals in making and keeping appointments with Peer Support Specialists who can provide outreach, support, encouragement, and basic coaching. Peer Support Specialists and Recovery Coaches have the flexibility to meet with individuals in their home as well as attend their appointments. The model is intended to support the individual and his/her current treatment providers, coordinate services (as needed) and enhance services and supports to ensure individuals are receiving the right care at the right time regardless of funding source. Priority Health Choice, Inc., KCMHSAS, and SWMBH will jointly administer, manage and monitor the model. There will be no change in the governance structure of Priority Health Choice, Inc., KCMHSAS, or SWMBH. The model is based on real time sharing of claims and clinical data which promotes transparency and accountability of publicly funded physical and behavioral health care provided through the Priority Health Choice, Inc., KCMHSAS and SWMBH. Current mechanisms for engaging individuals, family members and other community members (such as Priority Health Choice, Inc., KCMHSAS, and SWMBH board membership, Customer Advisory Councils, Substance Use Services Policy Oversight Board, etc.) will continue under this model, including foundations of person-centered and family-centered planning and education, as well as increased ability to make informed choices for individual care. In addition, an Integrated Care Coordination Leadership Team will be created to provide ongoing oversight, monitoring, and evaluation of the pilot.

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).**

Priority Health Choice, Inc., KCMHSAS and SWMBH all have expertise and experience in providing and coordinating integrated healthcare services including strong relationships with primary care providers, co-located primary care services at key sites, wellness and prevention services, and other targeted projects enhancing primary care's capacity to manage behavioral health conditions and intellectual or developmental disabilities.

Spectrum Health - Priority Health Choice, Inc. is a not-for-profit, integrated health care system with revenue of $4+ billion annually, formed through the merger of Butterworth Hospital and Blodgett Memorial Center in 1997, which includes Priority Health Choice, Inc., a 650,000 member health plan and several other subsidiaries. Priority Health Choice, Inc. is an award winning, Michigan-based nonprofit health plan nationally recognized for improving the health and lives of the people it serves. It continues to lead the industry in engaging members in their health, delivering effective health and disease management programs and working with physicians to improve health care outcomes and performance. Priority Health Choice, Inc. is one of only 20 health plans nationwide offering wellness programs accredited by the National Committee for Quality assurance, an organization which also rated it among the best health plans in the nation. The State of Michigan named Priority Health Choice, Inc. HMO the benchmark plan for all individual and group HMO plans to model. Priority Health Choice, Inc. offers a broad portfolio of health benefit options for employer groups and individuals, including Medicare and Medicaid plans. Its network includes more than 900,000 health care providers nationwide.

Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) is a county created Community Mental Health Services Program authority (CMHSP) serving Kalamazoo County that has been delivering services for over 40 years. The annual operating budget of KCMHSAS is $85 million. The vision of KCMHSAS is to provide a welcoming and diverse community partnership which collaborates and shares effective resources that support individuals and families to be successful through all life phases. KCMHSAS is guided by the following values: community, competence, diversity, effectiveness, integrity, leadership, recovery and self-determination, respect, responsibility, teamwork and trust. In addition to providing crisis and emergency mental health services 24 hours, seven days a week, KCMHSAS provides the following specialty supports and services: Supports Coordination and Case Management, Individual and Group therapies, Psychiatry, Crisis Stabilization Services for Children and Adults, Family Education and Support, Supported Employment, Skill Building Assistance, Enhanced/Supportive Healthcare Services, Respite Services for Children and Youth, Home-based and In-school Services for Children and Youth, Wraparound services for Children and Youth, Recovery Mental Health Court, and Juvenile Justice Mental Health Services.

For the last two years, KCMHSAS has been implementing a multiyear Primary and Behavioral Health Care Integration (PBHCI) grant funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Health and Human Services. This project is referred to as the Whole Health Initiative with the primary purpose of coordinating and integrating primary/behavioral health services through the co-location of primary care services at the new KCMHSAS Bronson Healthy

Living Campus Integrated Health Services Clinic. Services have been redesigned and enhanced, following Patient-Centered Medical Home principles and standards. An Integrated Treatment Team was established, comprised of primary care physicians, mid-level practitioners, and KCMHSAS staff psychiatrists and other medical staff. Services include comprehensive care management, peer and family support, health and nutrition education, wellness programs, and mental health/substance use disorder counseling. Primary care services are provided onsite by the Family Health Center, Inc., (Kalamazoo County's only Federally Qualified Health Center). Trauma Informed Care is provided, and evidence based practices for smoking cessation, nutrition/wellness, and Million Heart campaign protocol for hypertension. We will discuss this in greater detail in the section regarding compliance with evidence-based practices.

Southwest Michigan Behavioral Health (SWMBH) is the regional Prepaid Inpatient Health Plan (PIHP) for eight Michigan counties: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren. SWMBH in partnership with the Community Mental Health Services programs (CMHSPs) provides mental health services to adults with severe and persistent mental illness, children with serious emotional disturbance, individuals with intellectual or developmental disabilities, and individuals with substance use disorders. As a Prepaid Inpatient Health Plan (PIHP), SWMBH provides oversight of the region to make sure that services are provided to consumers based on their individual needs and person-centered plans, all of which are within the guidelines established by the Michigan Department of Health and Human Services (MDHHS). The annual operating budget of SWMBH is $259 million.

SWMBH is a partner in the MiHealth Link demonstration pilot for Region 4 that began March 15, 2015. MiHealth Link coordinates supports and services for individuals who are dually eligible for both Medicare and Medicaid programs, are considered aged and/or disabled, age 21 or older, eligible for full benefits under Medicare Part A, and enrolled under Parts B and D, and receiving full Medicaid benefits. SWMBH has a capitated shared-risk corridor contract with the two MiHealth Link ICOs (Meridian Health Plan and Aetna Better Health of Michigan, Inc.), as well as special depth and breadth of care coordination including integrated care teams above and beyond those applicable to non-MHL MHPs. SWMBH is experienced in establishing sophisticated data sharing, health information exchange across the systems, and healthcare data analytics using Care Connect 360 and its special use Care Management Technologies (CMT) subscription. The MiHealth Link Integrated Care Bridge record has evolved considerably and lessons learned are applicable to our proposed Pilot.

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 Behavioral 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.

As stated earlier, we concluded that a Full Financial Integration pilot would require (1) specialized and incomplete contracts between Medicaid Health Plans and CMHSPs; (2) bring into full view realities and impact of limited and imperfect market competition for MHPs; (3) unpredictable transaction costs and information asymmetry; (4) uncertainty regarding the ability to generate savings for making asset-specific investments into the pilots; and (5) inherent complexities of public goods and resource distribution and how these will impact the success of the proposed pilots.

Increasingly, questions about the distribution and redistribution of publicly funded behavioral and physical health services and resources needed to adequately deliver them, receive private market answers and approaches. These questions are frequently, but incorrectly, addressed by attempting to make public goods appear to be private goods. When placing these same questions in the context of the legislative purpose of Section 298 demonstration and pilots, there appears to be an uncritical and certainly untested assumption that the private sector can add real and measurable value to the direct management of the Medicaid Managed Specialty Supports and Services Program, and integrate them seamlessly into the larger Medicaid physical health care system, without doing harm to what public Community Mental Health Services Programs (CMHSPs) have been achieving over the last forty to fifty years at the same cost or less. Perhaps this was the concern of drafters of this RFI when they required CMHSPs, rather than MHPs, to provide assurances for compliance with established public policies. It is unclear why this question of compliance and issuance of the RFI, for that matter, were not directed to MHPs – the ultimate accountable management systems for these pilots. This seems paramount to asking CMHSPs to provide the road map for dismantling it very existence, which in and of itself belies established public policy and law.

We are fully aware that our proposed alternative model is similar to that of the Kent County Demonstration, and does not meet the strict definition and requirements of the 298 Full Financial Integration model. However, given the legal and financial restrictions that prohibit CMHSPs from entering

into full risk managed care arrangements with non-public entities, we believe our proposed alternative model is practical, particularly given the short two-year timeframe for the pilots, and will provide assurances for compliance with established public policies.

Legislators and other public officials that promote and actively pursue the privatization of public services frequently and uncritically assume that by transferring public services to the private sector's discipline and competition, market (price) competition, administrative efficiencies and cost savings will be realized. But, how much competition, efficiencies and cost savings will really be possible when implementing the very short-term two-year Full Financial Integration pilots? What types of contractual arrangements will be appropriate between Medicaid Health Plans and CMHSPs? Is it possible to accomplish the basic goals of the 298 Full Financial Integration Pilots in a far different way? We believe this can be accomplished through an alternative care coordination model that is being proposed for consideration. Each CMHSP that responds to this RFI, should clearly understand that it will be committing its community, county and people served to a full-blown Medicaid managed care "carve-in" of the specialty services benefit under the management authority of private Medicaid Health Plans.

When asked to assure compliance with established public policies under a Full Financial Integration model, CMHSPs and MHPs should be guided and influenced, at minimum, by how they address the following issues:

- Unavoidable and Necessary Incomplete Contracting
- Transaction Costs and Information Asymmetry
- Asset-Specific Investment Requirement
- Market Failure and the Complexities of Public Goods and Resource Distribution
- Managed Care Liability Issues for Counties and CMHSPs
- Governmental Immunity Concerns
- Tort Liability
- Impact of the Current Political Environment
- Alternative Models to be Considered to Achieve Behavioral and Physical Health Integration

Unavoidable and Necessary Incomplete Contracting

Public sector contracting with the private sector in the assumed "open market" (neoclassical economics), seldom results in free and open competition among suppliers. The most interesting component of the boilerplate language of the 298 pilots for Full Financial Integration, is the requirement that all Medicaid Health Plans in selected regions will enter into single contracts with MDHHS to manage the Medicaid Managed Specialty Services Program, mild or moderate behavioral health benefit, and physical health services. We are noting here that the RFI differs and extends beyond the boilerplate and states that:

> …It is MDHHS' intent to contract with a Managed Behavioral Health Organization (MBHO), or an Administrative Service Organization (ASO). The contracted entity will serve as an extension of the state to provide payment, encounter reporting, monitoring and oversight, and as necessary other managed behavioral health functions. Pilot(s) will receive payment from and be required to report claims and encounter data to the contracted MBHO/ASO.[1]

[1] State of Michigan Michigan Department of Health and Human Services, *Request for Information (RFI) No. 180000000003, 298 Pilot(s) – Medicaid Physical-Behavioral Health Full Financial Integration,* p. 10

This suggests that Medicaid Health Plans that participate in these particular pilots may not be entering into single contracts with MDHHS, but a contract entity underneath MDHHS. We will not respond directly to this discrepancy and wait for further guidance from MDHHS as to how these contractual arrangements will involve MHPs. It remains our understanding that MHPs would be required to enter into single contracts with county-sponsored CMHSPs as the provider of behavioral health and supports.

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

Although, it is unclear whether these contracts will include CMHSP involvement in the delivery of mild/moderate outpatient behavioral health services, our alternative Integrated Care Coordination model includes the mild/moderate outpatient services. Under the Full Financial Integration pilot models, the MDHHS will be substituting its long-standing contracts with public sector monopolies (i.e., sole source contracts it currently holds with county-sponsored CMHSPs and CMHSP created PIHPs) with private sector monopolies or better still oligopolies (i.e., all Medicaid Health Plans in regions selected for pilots). Minimal, if any, competition is possible through these types of arrangements. Medicaid Health Plans (oligopolies) that pursue this type of arrangement must individually recognize some long-term benefit for entering with other Medicaid Health Plans in this type of structural collective. What will be the long-term benefit? Is this mostly ideological or political -- meaning that the desire to reduce the size of government and public services must be achieved regardless to the consequences such action places on people served and on the safety net CMHSPs? Or, is it a genuine reform effort *exclusively* geared towards the "clinical" integration of behavioral and intellectual or developmental disability specialty supports and services with physical health services for their Medicaid enrolled populations? If it is the latter, we firmly believe such an arrangement will have the potential for strengthening and not diminishing the delivery of publicly funded services.

It would also be consistent with the expressed intent of the Michigan legislature:

> **…It is the intent of the legislature that the primary purpose of the pilot projects and demonstration models use to test how the state may better integrate behavioral and physical health delivery systems in order to improve behavioral and physical health outcomes, maximize efficiencies, minimize unnecessary costs, and achieve material increases in behavioral health services without increases in overall Medicaid spending.**[3]

Although we applaud the intent of the legislature for putting forward these objectives, careful consideration should be taken into account as to whether Full Financial Integration pilots will be profitable long-term investments for Medicaid Health Plans, and if so, how they will impact each of them financially

[2] Public Act 107 of 2017

[3] Public Act 107 of 2017

during and after the two-year pilot period? Profitability for private for profit enterprises cannot and should not be demonized, criticized and certainly ignored even if the aims are directed towards addressing public interest concerns. Relatedly, it is not understood what the role and expectations of county-sponsored CMHSPs that participate in Full Financial Integration pilots in helping its Medicaid Health Plan partners to achieve profit margins? Will this be consistent with their sole statutory mission and purpose, which is to address public interest concerns? Clearly, it is not, and it should be emphasized that there is no enabling legislation that would permit CMHSPs as political subdivisions of county governments to engage directly in profit making activities? Although, this is a serious concern, it may be a moot point given the *cost neutrality* provisions legislatively put in place for these pilots. This alone may minimize or completely eliminate profit margin potential that would otherwise be expected to be generated from these pilots:

> …For the duration of any pilot project and demonstration models, any and all related benefits and cost savings of integrating the physical health systems shall be reinvested in services and supports for individuals having or are at risk of having a mental illness, and intellectual or developmental disability, or substance use disorder. Any and all realized benefits and cost savings shall be reinvested in the counties where the savings occurred.[4]

The long-term nature of the contractual relationship between the MDHHS and Medicaid Health Plans, and the Department's even longer-term relationship with CMHSPs is another concern that may impede full and open market competition. One reason for this is the relative absence of alternative managed care organizations and specialty providers to constitute a competitive market. Private for profit Managed Care Organizations often compete with one another for market share, but in reality, similar to the state, have to deal with a nationwide shortage of health care providers and suppliers. This situation is more acute for psychiatrists and other behavioral health specialty professionals. Even if there were an abundance of new types of specialty providers available, the learning curve for them would be immediate and enormous, which will likely result in massive and dangerous disruptions in services for consumers and drive up transaction costs. This may further explain why state governments (including Michigan) frequently create monopolies and oligopolies through its contractual requirements—which is antithetical to full and open market competition.

The likelihood for generating excessive transaction costs presents considerable problems for these types of complex contractual arrangements. These pilots will require incomplete contracts with CMHSPs, as opposed to usual short-term straight forward arms-length agreements between Medicaid Health Plans and its traditional providers. In situations where the principle [Medicaid Health Plans] and agent [CMHSPs] are not easily aligned and no foreseeable assurances that the agent [CMHSPs] will carry out the wishes of the principle (Medicaid Health Plan), (e.g., care coordination, system integration, and achievement of corporate margins), incomplete contracts will be acquired. This is not because the agent [CMHSPs] intends to willfully defy the wishes of the principle. It is because the principle [Medicaid Health Plans] is unlikely to know what the agent [CMHSPs] is supposed to do, because it has a limited understanding of the specialty services system (information asymmetry), government requirements (e.g., Open Meetings Act, Freedom of Information Act, statutory consumer representation on governing board, recipient rights protections and investigations, governmental immunity and tort liability concerns), and the fact that CMHSPs are subunits of county governments with limited statutory authorization to bear full financial risk for behavioral health services) and unknown transaction costs that are likely to occur when trying to

[4] Ibid.

administratively align the public behavioral and intellectual or developmental disability specialty supports and services system with the MHP physical health system. Information asymmetry also applies for CMHSPs, because of their lack of understanding of the complexities and exigencies of the medical care system. We noted that this seems to be reflected in the writing of this RFI. Surprisingly, very little is asked about how the CMHSPs will interface with MHPs to address population health and clinically related physical health concerns.

Transaction Costs and Information Asymmetry

Public officials that sponsored and supported Section 298 of Public Act 2017 seem to assume that each potential participant in these pilots has equal and adequate access to information to make informed decisions about financial and programmatic contractual requirements. This is very unlikely and warranted a closer examination before we seriously considered applying for this RFI. Medicaid Health Plans differ in size, market share, differential access to needed information, and experience in managing behavioral health services. Most, if not all, are particularly unfamiliar and inexperienced in managing what is really regarded as a long-term care specialty behavioral health and intellectual or developmental disability supports and services system. MHPs do not have ready access to information for managing and understanding the history and evolution behind the complex financing arrangements currently in place to support a diverse population of consumers in a wide variety of community living settings. Priority populations served by the public mental health system are people with serious and persistent mental illnesses, youth with serious emotional disturbance, people with substance use disorders, and people with intellectual or developmental disabilities. MHPs that participate in these pilots will have to rely heavily on their CMHSP partners to navigate a complex social supports system that covers not only their designated pilot regions, but the entire State of Michigan. The very presence of inadequate and unequal distribution of information among MHPs who are desirous of entering into Full Financial Integration pilots will certainly face the possibility of incurring excessive market-based transaction costs and unknown financial risks (adverse selection) – leaving very little opportunity to generate corporate profits or reinvest savings (asset-specific investments) back into the behavioral health specialty services system.

Asset-Specific Investment Requirement

Contracting efficacy requires three basic elements:

1) Frequency or volume of transactions generated by the relationship;
2) Degree of uncertainty in the contract situation, including the quality of outputs (behavioral health and I-DD services); and
3) Need to make asset-specific investments to execute the contract[5]

One of the requirements of Section 298 of Public Act 107 of 2017 is that MHPs interested in participating in the Full Financial Integration pilots will be required to reinvest all savings back into the behavioral health system – not back into the physical health side of their operations. Although not specifically stated, this could be easily interpreted to mean that savings will have to be reinvested into the public community mental health system. If this is the case, such an arrangement would be attractive for CMHSPs that are struggling to secure and maintain adequate levels of state and federal funding to meet increasing demands for services. However, it could also mean that savings could be reinvested in the mild or moderate behavioral health benefit operations of the MHPs that are more closely aligned with physician practices and other related physical health services. This warrants further clarification from MDHHS.

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[5]Williamson, Oliver E. 1985. *The Economic Institution of Capitalism.* New York: New York Free Press.

On a positive note, the more frequently MHPs and CMHSPs that participate in these or alternative pilots transact business with one another, the more cost effective it will be for them to meaningfully integrate behavioral and physical health services and supports, and make asset-specific investments. However, the greater degree of uncertainty about service quality, information asymmetry, and unexpected financial resources needed to support the pilots (e.g., to address adverse selection), transaction costs will become unpredictably excessive and both organizations will be exposed to unwanted and unsustainable financial risks. MHPs should be keenly aware that Full Financial Integration pilots will force them to operate outside of the open market, contrary to what they have been accustomed to in carrying out their commercial, Medicaid and Medicare physical health services operations. Before deciding to participate in these pilots, MHPs and CMHSPs should carefully understand the dynamics of market failure that is created by complexities inherent in public goods (i.e., behavioral health and intellectual or developmental disability specialty services) and resource distribution of those specialty services (public value).

Market Failure and the Complexities of Public Goods and Resource Distribution

The public mental health system in Michigan and throughout the country is often faced with two related questions: (1) Under what arrangements is the public best served through the delivery of mental health services; and (2) What is the public value for these services and resources needed to deliver them? These questions assume that the private competitive market (classical economics) has failed (market failure) to adequately deliver services to certain specific populations that society has identified as a public interest and, therefore, in need of support. Market failure occurs when (1) transaction costs are excessive, (2) information is not readily available for businesses to fairly compete in the open market (information asymmetry), and as discussed earlier monopolies and oligopolies are formed through state contracting requirements that ultimately impede or circumvent fair and open competition. Michael Marlow best explains the importance of recognizing the presence of market failure when placing value and prices on public goods:

> Under ideal conditions related to competition, information and the absence of externalities, private competitive markets allocate resources efficiently. For government to play a legitimate role, then, either ideal conditions must not be present or *efficiency must not be the most important criterion for directing resource allocation.*[6]

Publicly funded behavioral health specialty supports and services are by definition *public goods*, which mean that they either will not be supplied by the private market or, if supplied, will be supplied in insufficient quantity and/or quality. Because public goods are not sold, as are private goods, they never enter the true market system. This appears to be antithetical to the contemporary managed care approach in the nation's medical care industry; including specialty behavioral health care. Robert L. Heilbroner and Lester C. Thurow, in *Economics Explained*, present three defining features of public goods, which are as follows:

1. Consumption of a public good by one individual does not interfere with its consumption by another;
2. No one can be excluded from the use of a public good; and
3. All public goods can be provided only by collective decisions.[7]

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[6] Marlow, Michael L. 1998. *Public Finance.* New York, NY: Dryden Press

[7] Robert L. Heilbroner and Lester C. Thurow, *Economics Explained,* (New York: Simon & Schuster, 1982) pp. 167-170.

The availability of specialty behavioral health (including substance use disorder services) and intellectual or developmental disability supports and services (public goods) creates its own demand. For example, if a Medicaid beneficiary in the State of Michigan is entitled to a "medically necessary" service that is approved in the Medicaid State Plan and federal waivers to the State Plan, she or he cannot be denied or excluded from receiving these services (entitlements) regardless to whether these services are in short supply or unavailable in certain regions of the state. Public goods are considered legal rights. In ideal conditions, the competition among suppliers (providers) to deliver these services reduces transaction costs (e.g., costs of gathering information, making decisions, carrying out trades, writing contracts, making payments, and other tasks involved in coordinating economic activity) -- and by doing so, increases the supply of specialty services. In order to reduce transaction costs, however, the business environment has to offer certain benefits to suppliers such as a large enough consumer base (i.e., economies of scale) to manage financial risk and generate income, easy access to banking and other lending institutions, easy access to public services such as heat, water, electricity, transportation, communications, supplies, office facilities, equipment, etc.

As mentioned earlier, Section 298 of Public Act 107 of 2017 is intended to test pilots in order to better integrate behavioral and physical healthcare, but also "maximize efficiencies, minimize unnecessary costs, and achieve material increases in behavioral health services without increases in overall Medicaid spending." It should be noted here that efficiency in the public sector *may not* be the most important criterion for directing resource allocation of behavioral health and intellectual or developmental disability specialty supports and services. The reason for this is that the concept itself is frequently misunderstood and misapplied to public interest concerns. We normally think of efficiency as the act of reducing transaction costs, streamlining operations, and rationing services to distribute scarce resources to the most number of individuals. This is the utilitarian neoclassical economic approach to resource allocation, and is in direct conflict with the contemporary social justice approach (Rawlsian Theory of Justice), which argues that "just" societies must first attend to the needs of those least well-off. It should be emphasized here that the Michigan Mental Health Code is built on the latter economic philosophy by establishing priority populations and mandating dedicated resources for public assistance for this specialty services consumers.

Many economists, on the other hand, define efficiency far differently from the most common working understanding of the concept—the "market driven" understanding that appears to underscore the legislative intent of the 298 Full Financial Integration pilots. Joseph Stiglitz, a 2001 Nobel Memorial Prize winner in economics presents two theorems of neoclassical economics that specify conditions necessary for competitive markets to attain efficiency. The first theorem is:

> Under certain conditions, competitive markets lead to an allocation of resources with a very special property: there is no rearrangement of resources (no possible change in production and consumption) such that someone can be made better off without, at the same time, making someone else worse off. Resource allocations that have the property that no one can be made better off without someone being made worse off are called **Pareto-efficient** allocations. Pareto-efficiency is what economists mean when they talk about efficiency.[8]

The second theorem states that:

> Every point on the utility possibilities curve can be attained by a competitive economy provided we begin with the correct distribution of resources.[9]

[8] Joseph E. Stiglitz, *Economics of the Public Sector,* (New York: Second Edition, W.W. Norton & Company, 1998), p. 63.
[9] Ibid., p. 64

Notice here that the second theorem assumes that, "the correct distribution of resources," must exist in order for market competition to thrive. But, what exactly is the correct distribution of resources and to what extent is this afforded to most Americans in general and for people in particular who are served by the public mental health system? In other words, how does one apply the logic of efficiency to people who receive public goods—goods for which they do not bear full costs, and in many instances only a fraction of the costs? This relates directly to the demand side of economics, in that most consumers of the public mental health system lack the special knowledge to shop for a specialty services and providers the way she or he would buy a car or groceries, and lack perfectly free choice of CMHSPs, PIHPs, and other types of managed care organizations and insurers. Also, because society (e.g., supported by provisions in Michigan's Constitution and Mental Health Code) has decided that no individual with mental illness, serious emotional disturbance, intellectual or developmental disability should lack needed specialty supports and services, demand is not constrained by private purchasing power.

Aside from these economic issues and philosophies, several important legal issues should be considered before any CMHSP and MHP participates in pilots requiring Full Financial Integration. The first legal issue is that *CMHSPs are Not Non-Profit Corporations and Cannot Create Non-Profit Corporations.* Only county governments in the State of Michigan can create a Community Mental Health Services Program (CMHSP).[10] Geographically contiguous CMHSPs may form a CMHSP regional entity, which is not a private nonprofit corporation.[11] A county cannot directly form a private nonprofit corporation "in the absence of constitutional or statutory provision."[12] Michigan precedent, however, suggests that a county possibly can participate as a member of a private nonprofit corporation, furnish initial funding to a nonprofit corporation and pay ongoing membership dues to a corporation, provided it can be demonstrated that the county advancing a *public purpose* and is not giving away anything of value in exchange for adequate consideration. In determining whether a county's contributions to a nonprofit corporation are in exchange for adequate consideration, Michigan courts and the Attorney General's Office ("AGO") have given deference to any decision by the legislature specifically to allow entities to participate in a particular type of non-profit corporation.[13]

In the context of the Michigan Economic Development Corporations Act, which facilitates economic development projects by public agencies (including without limitation "commercial" projects), for example, the AGO determined that the statute properly conferred upon a county the discretion to transfer public funds to such a private nonprofit corporation in order to engage in economic development activities on the county's behalf.[14]

Even in the absence of explicit legislative authority for a public agency to participate and fund a specific type of non-profit corporation, the Michigan Supreme Court has held that a municipality can participate in and pay membership dues to a nonprofit corporation if such membership serves the welfare of the municipality.[15] The court expressed a broad view of what constitutes a public purpose (and therefore a municipal purpose), by focusing on purposes that benefit all residents. Interestingly, the court noted that public health is such a public purpose.[16] More interesting, the AGO subsequently has indicated that,

[10] Public Act 258 of 1974, Michigan Mental Health Code, 330.1204., Section 204 (1), (2), (3), (4), Chapter 2, County Community Mental Health Programs
[11] Public Act 258 of 1974, Michigan Mental Health Code, 330.1204b., Chapter 2, Regional Entity.
[12] 27 Op. Att'y Gen. 6563 (Jan. 26, 1989).
[13] *Id.; Alan v. Wayne County,* 200 N. W. 2d 628 (Mich. 1972); *Mays v. City of Kalamazoo,* 25 N.W. 2d 787 (Mich. 1947).
[14] 27 Op. Att'y Gen. 6563 (Jan. 26, 1989).
[15] *Mays v. City of Kalamazoo,* 25 N.W., 2d 787 (Mich. 1947).
[16] *Ibid.*

absent explicit legislative authority, one or more municipalities cannot form a nonprofit corporation, or contribute or appropriate funds to a nonprofit corporation.[17] This restriction against formation of a nonprofit corporation has been applied by the AGO to disallow such activity even if the legislature has generally, by statute, encouraged inter-governmental cooperation.[18]

Managed Care Liability Issues for Counties and CMHSPs

The assumption by a CMHSP of managed care responsibilities from a non-governmental entity (e.g., Medicaid Health Plan) creates the potential for significant tort and contractual/financial exposure. Potential tort exposure arises by virtue of certain responsibilities assumed by the CMHSP that may impact upon the availability or quality of statutorily mandated behavioral health and intellectual or developmental disability specialty supports and services (i.e., quality assurance, provider credentialing, access to services, and utilization review and management). Potential contractual/financial exposure is created by virtue of service contracts entered into by the CMHSP [and possibly the MHP), and by any other financial obligations incurred in order to establish and operate the proposed fully financially integrated managed care pilot program. The fact that MHP "managed care" contracts intends to reimburse CMHSPs under a risk-based payment methodology causes inherent financial risk assumption.

Governmental Immunity Concerns

In the context of the proposed 298 pilot to effect Full Financial Integration between "willing" Medicaid Health Plans (MHPs) and "willing" county-sponsored Community Mental Health Services Programs (CMHSPs), liability considerations are complicated by the fact that managed care functions will be assumed not only by MHPs, but also CMHSPs that are public governmental created entities. Public entities are afforded significant immunity from tort liability. An entity contracting with a CMHSP Entity, may not be afforded such immunity, nor may such immunity extend to a non-public entity (e.g. Medicaid Health Plan) that is affiliated with a CMHSP entity. Moreover, county governments that create CMHSPs should have and may in the future express concerns regarding potential exposure for legal and financial liabilities assumed by CMHSP entities that "willingly" enter into the 298 Pilots as put forward in Section 298 of Public Act 107 of 2017.

Tort Liability

The laws of the State of Michigan provide, with some exceptions, that all *governmental agencies* shall be *immune* from tort liability in all cases wherein the government agency is engaged in the exercise or discharge of a *government function.*[19] The immunity extends to negligence, but does not appear to extend to gross negligence and does not apply to intentional conduct. In addition, the immunity explicitly does not extend to "the ownership or operation of a hospital or county medical care facility.[20] The latter exception, on its face, does not appear to exclude from immunity for the CMHSP, the ownership or operation of a "full risk" managed care program. A plaintiff conceivably could assert that the intent underlying this exception should cause a CMHSP (and, possibly, its sponsoring county or counties) to be liable for negligence in the ownership or operation of such a "full financial risk" managed care program.

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[17] 199 op. Att"y Gen. 5212 (Aug. 17, 1977).
[18] 27 Op. Att'y Gen. 6563 (Jan. 26, 1989); 444 Op. Att'y Gen. 6411 (dec. 19, 1986); 897 Op. Att'y Gen. 5750 (July 29,1980); 46 Op. Att'y Gen. 5448 (Feb. 13, 1979); 199 Op. Att'y Gen. 5212 (Aug. 17, 1977).
[19] Mich. COMP. LAWS ANN. § 691.1407(2), (3) (West 1986, Supp. 1995-96).
[20] MICH. COMP. LAWS ANN. §691.1407(4) (West 1986, Supp. 1995-96). A "county medical facility" is defined as a nursing care facility which is owned by a county or counties. MICH. COMP. LAWS §333.20104 (1986).

It should also be mentioned that judicial interpretation of the governmental immunity provisions of the Michigan Code indicates that a private (non-public) entity is not entitled to avail itself of the governmental immunity.[21] As a result, neither non-public health care providers furnishing services under the auspices of a CMHSP Entity, nor commercial MHPs that render management services to the CMHSP Entity, should rely upon the immunity. Moreover, a non-public entity (such as a private not-for-profit corporation) affiliated with one or more CMHSP Entities might not benefit from such immunity.

It is important to emphasize that the immunity only extends for governmental functions, and that governmental functions include only those activities expressly or implied mandated by law. Those activities undertaken by a governmental agency (i.e., CMHSP) for pecuniary gain are not immune. A CMHSP Board is *required* under the Michigan Mental Health Code to undertake a number of activities on behalf of the CMHSP, including without limitation: (1) approval of the operating budget (also subject to the approval by MDHHS); (2) those activities necessary and appropriate to secure private federal and other public funds to help support the CMHSP; and (3) approval and authorization of all contracts for the provision of services.[22] These explicitly mandated activities should be afforded immunity from tort liability.

Not only did we carefully analyze legal issues presented above, we do not believe politics should be a motivating factor for participating in the Full Financial Integration pilots. We also paid considerable attention to the current political landscape during our planning, which contributed heavily in our decision to propose an alternative pilot model.

Impact of Current Political Environment

Before any CMHSP and MHP participates in any model of the 298 pilots (i.e., Kent County model or Full Financial Integration), each should carefully consider the risks associated with the rapidly changing state and federal political environments, that are threatening to destabilize the health care industry in the United States. For example, by ending the tax penalty for people who do not have health insurance coverage, beginning in 2019, it is predicted that more people will have to purchase the full cost of insurance. We do not know what that means for Healthy Michigan or the Medicaid program. Relatedly, during Fiscal Year 2017, Governor Rick Snyder announced that if the Healthy Michigan Medicaid Expansion Plan is eliminated as a result of actions to repeal and replace the ACA, the cost for Michigan to sustain the program would be $800 million. Without the federal enhanced matching funds, the Governor said that the state would not be able to support this program. Nick Lyon, Director, MDHHS restated the Governor's claim during his interview at the October 2017 Community Mental Health Association Fall Conference in Traverse City. He further advised the audience that it is uncertain whether the $200 million that was removed from the CMHSP general fund appropriation to support Healthy Michigan would be restored if the Healthy Michigan Plan is eliminated. Interestingly enough, Mr. Lyon in that same interview encouraged the implementation of innovative integration pilots in addition to the ones proposed under Section 298. We are following his advice, and in order to assure compliance with established public policies, propose an alternative to the Full Financial Integration pilot model.

Alternative Model to be Considered to Achieve Behavioral and Physical Health Integration

We are proposing an alternative model that will achieve the objectives of the 298 Full Financial Integration Pilots. After carefully weighing the strengths and weaknesses of the full integration models submitted to

[21] *Roberts v. City of Pontiac,* 440 N.W. 2d 55 (Mich. Ct. App. 1989): *Jackson v. New Center Community Mental Health Services,* 404 N.W. 2d 688 (Mich. Ct. App. 1987); and *Hayes v. Emerich,* 416 N.W. 2d 350 (Mich. Ct. App. 1987).
[22] MICH. COMP. LAWS § 330.1226 (1996).

the 298 Facilitation Workgroup, none would be legally suitable or practical, particularly given the RFI requirement for assuring compliance with established public policies. The major reason is that CMHSPs are not full risk bearing entities. A full-risk capitation arrangement or fee-for-service payment structure would place CMHSPs at considerable and unsustainable financial risk for the delivery of specialty services and potentially the mild-moderate outpatient benefit. Also, as mentioned earlier, the assumption by a CMHSP of managed care responsibilities from a non-governmental entity (e.g., MHP) creates the potential for significant tort and contractual/financial exposure. Even if it were possible for the Medicaid Health Plans to "flow-through" capitation payments to the CMHSP for specialty services, each would have to create a shared risk arrangement similar to what MDHHS has in place with PIHPs. Why? CMHSPs, (including authorities) are political subdivisions of county governments that created them. This means that county governments will also be exposed to these same financial risks. There is no enabling legislation that would permit CMHSPs to bear full financial risk for the delivery of public behavioral health and intellectual or developmental disability specialty supports and services. Section 3330.1116 of the Michigan Mental Health Code puts forward powers and duties of the Michigan Department of Health and Human Services for purposes of preserving the public "safety net" mission and purpose of CMHSPs:

> (1) Consistent with section 51 of article IV of the state constitution of 1963, which declares that the health of the people of the state is a matter of primary public concern, and as required by section 8 of article VIII of the state constitution of 1963, which declares that services for the care, treatment, education, or rehabilitation of those who are seriously mentally disabled shall always be fostered and supported, the department shall continually and diligently endeavor to ensure that adequate and appropriate mental health services are available to all citizens throughout the state…To this end, the department shall have the general powers and duties to do all of the following:
>
> > (a) Direct services to individuals who have a serious mental illness, developmental disability, or serious emotional disturbance. The department shall give priority to the following services:
> >
> > > (i) Services for individuals with the most severe forms of serious mental illness, serious emotional disturbance, or developmental disability.
> > >
> > > (ii) Services for individuals with serious mental illness, serious emotional disturbance, or developmental disability who are in urgent or emergency situations.
> >
> > (b) Administer the provisions of chapter 2 so as to promote and maintain an adequate and appropriate system of community mental health services programs throughout the state. In the administration of chapter 2, it shall be the objective of the department to shift primary responsibility for the direct delivery of public mental health services from the state to a community mental health services program whenever the community mental health services program has demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of that service area.[23]

We do not believe the Medicaid program should be used to dilute and undermine the state's statutory obligation to support CMHSPs. Finally, the current political climate is not conducive for MHPs and CMHSPs to enter into an unreasonably short two-year timeframe to achieve successful implementation of Full Financial Integration pilots. The infrastructure necessary for financially incorporating the current CMHSP system into the predominantly managed care physical health administrative structure of Medicaid Health Plans would take more than two years to accomplish. As learned during the 2013-14 consolidation of

[23] Michigan Mental Health Code, Act 258 of 1974, Section 330.1116, *Powers and Duties of Department.*

PIHPs from 18 to 10, material transition costs – direct, indirect and opportunity – occurred. We have no reason to believe it will be any different in Full Financial Integration pilots. More importantly we believe Full Financial Integration is not necessary to achieve the goal of integrating behavioral and physical health delivery systems.

In this regard, we believe that our proposed alternative model should be considered to achieve the goals put forward in Section 298 of Public Act 107 of 2017, which is for the state to test how it may better integrate behavioral and physical health delivery systems for improving behavioral health outcomes. More than a year ago, Michigan submitted a §1115 waiver proposal to the Centers for Medicare and Medicaid Services (CMS). When approved, this demonstration waiver would permit the State of Michigan to implement the Section 298 Full Physical and Behavioral Health Integration between willing CMHSPs and all willing Medicaid Health Plans. What is encouraging about this particular federal waiver authority is that the state had already expressed its desire to integrate behavioral and physical health services in the Medicaid program in a variety of ways that are not limited to the restrictions of any of the 298 pilots:

> A vital component of this Demonstration is the alignment of quality and financial incentives between traditional Medicaid Health Plans and Michigan's Specialty Service System. Michigan in concert with the development of the ASC (Accountable System of Care) and its pursuit to be one of the pilot demonstration states for the Certified Community Behavioral Health Clinic Services, intends to advance integrated care services for the entire Specialty Services population. These changes will require PIHPs and their CMHSP providers to meet quality reporting requirements, develop enhanced SUD provider systems, and provide or partner with traditional health plans to ensure access for persons with mild and moderate behavioral health disorders. These linkages are directly intended to identify and provide education prevention and treatment (SBIRT) for persons with SUD, provide housing first initiatives and provide incentives for increased access to primary care and the coordinated tracking of High utilizers of emergency department usage and hospital admissions/readmissions.[24]

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.

KCMHSAS will utilize the existing Customer Advisory Council (CAC) and Family Support Advisory Council structure to provide a voice/avenue for active consumers of KCMHSAS authorized services to learn more about the operations and policies of integrated behavioral, intellectual or developmental disabilities and physical health services, available and upcoming community resources, and provide feedback as an advisory group to the KCMHSAS Board of Directors. The Advisory Councils will be involved in a targeted manner to address issues identified through the planning, implementation and evaluation of the pilot. SWMBH will maintain a Substance Use Disorder Oversight Policy Board for Kalamazoo County and the balance of Region 4 in Southwest Michigan in accordance with Section 287(5) of the Michigan Mental Health Code.[25] As part of the annual monitoring system, individuals are provided the opportunity to provide feedback regarding the services they are receiving, including principles of person-centered

[24]Michigan Department of Health and Human Services, *Pathway to Integration,* Michigan's §1115 Waiver Proposal for persons with Severe Mental Illness, Substance Use Disorders, Intellectual and Developmental Disabilities and Children with Serious Emotional Disturbances to the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, June 21, 2016.

[25]Michigan Mental Health Code, Act 258 of 1974 as amended, Section 287(5).

planning, self-determination, trauma informed care, and coordination between and among services providers.

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.

In our model, SWMBH will retain its statutory management responsibilities as the MDHHS-designated community mental health entity for the provision of substance use disorder services for Kalamazoo County and Region 4. This arrangement will assure compliance with Section 330.1287 of the Michigan Mental Health Code.

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.

The proposed model continues to support access to the full array of specialty behavioral health services and supports, as well as individual choice in services and providers currently offered through Priority Health Choice, Inc., KCMHSAS and SWMBH. The system level care management elements of this model will be implemented based on a three-way Business Associate Agreement between Priority Health Choice, Inc., KCMHSAS, and SWMBH, allowing communication to coordinate benefits and services for shared consumers. This model offers an opportunity for enhanced care coordination, physical and behavioral health integration and collaboration among behavioral health (including SUD services), intellectual or development disability specialty supports and services, and physical health treatment providers. This model is not intended to replace existing providers and/or services, but to support the individual and their current treatment providers to ensure integrated care that treats the whole person.

The Integrated Care Coordination Model demonstrates a collaborative system of care between Priority Health Choice, Inc., KCMHSAS and SWMBH, designed to improve the coordination of physical health and behavioral health services and supports. The overarching goal and purpose of this model is for partners in this pilot model to work together to identify shared Medicaid enrollees with behavioral, intellectual or developmental disability and physical health service needs, jointly develop and implement processes to manage their care, eliminate inefficiencies and improve health outcomes. The result? An individual that receives the right care at the right time, improved health outcomes, access to care and a system that provides relevant health information to care providers and shared enrollees. As stated earlier, this RFI does not sufficiently define the problem that the objectives of 298 are created to achieve. The problems we have identified extend beyond ensuring access to the full array of specialty behavioral health services and supports. Our Integrated Care Coordination model provides these assurances through KCMHSAS's

existing contracts with Priority Health Choice, Inc. and SWMBH. But, how are we proposing to identify, build and expand upon initial efforts in population health and integrated care? SWMBH issued a draft Tactical Plan for *Population Health and Integrated Care* for the period beginning July 1, 2016 to December 31, 2017, which provides key analysis from SWMBH's Care Management Technologies (CMT) software. Data revealed that of the 172,500 Medicaid unique eligibles in Southwest Michigan, (which includes all physical and behavioral conditions), nearly one-third have a mental health primary diagnosis. Please refer to other key population health trends in the chart below:

SWMBH Care Management Technologies (CMT) Trends and Analysis
Within the SWMBH population, eligible with severe Mental Illness (SMI) have two times as many medical hospitalizations and ER visits as their counterparts who do not have a Severe Mental Illness (SMI) diagnosis.
SWMBH eligible with severe Mental Illness (SMI) are twice as likely to have a chronic health condition (61.3% vs. 29.4%) compared to those without Severe Mental Illness (SMI).
The Intellectual/Developmental Disabled (IDD) population is at particularly high risk of complications of chronic health conditions. About a quarter (34.3%) of eligibles without an IDD diagnosis had a chronic health condition while nearly three quarters (70%) of the IDD population had at least one chronic condition.
There are significantly higher rates of hospitalizations (232 per 1,000 eligibles) for individuals with IDD compared to non-IDD population (147 per 1,000 eligibles). Three thousand three hundred fifty (3.350) hospital days per year per thousand persons for the IDD population compared to 1,756 per thousand for the non-IDD population.
The rates of ambulatory care sensitive conditions (those conditions best treated in outpatient settings) were prevalent and similar for the SMI and IDD populations.
Those with high-risk multi-morbidity patterns were more than nine times at risk for hospitalizations and the relative risk of ER visits was at least three times of the rate for individuals with no multi-morbidity.
Hypertension and Coronary Artery Disease represent the highest percentages for both those with severe Mental Illness (SMI) and without Severe Mental Illness (SMI)
The Duals (both Medicare and Medicaid) population compared to the total for all others has significantly higher physical co-morbidities across all diseases.
For SWMBH as a whole, fewer psychotropic prescriptions were provided by a psychiatrist (47.2%) while non-psychiatrists provided more psychotropics (52.8%)

Given the magnitude of these trends, it is particularly concerning that the current split in the healthcare system is difficult for individuals and providers to navigate. The partners in this pilot will collaborate to create a system of care that allows coordination that creates more integrated care for the individual. It is designed to bridge the coordination gaps and de-fragment the healthcare system complexity that exists for individuals and providers while supporting the person-centered planning process which is at the heart of supporting individual choice and control. Our pilot will serve as a testing group for additional types of complementary and ancillary services; self-determination and person-centered-planning in physical healthcare; enhanced healthcare information exchange and shared healthcare data analytics; consumer assistive technologies, etc.

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

KCMHSAS monitors and ensures appropriate network adequacy in order to provide the full array of services to meet the needs of individuals. In collaboration with SWMBH, an annual review of network adequacy throughout Region 4 is completed. The Network Adequacy report evaluates Access to Services; Cultural, Ethnic, Racial and Linguistic needs of consumers; Availability of Practitioners and Providers; Transportation availability within the region; and Provider specialties. KCMHSAS formally reviews its own network adequacy through a Service Review Process for the full-service array based on an established service review schedule and established procurement policies and procedures, at a minimum of every two years. KCMHSAS utilizes its established Provider Network Workgroup to review and approve the expansion of or changes to its provider network when needs arise outside of the formal scheduled review process.

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.

Our Integrated Care Coordination model does not alter, reduce or eliminate any required or voluntarily implemented EBPs. KCMHSAS is a certified CMHSP and uses a variety of specialty behavioral health evidence-based and promising practices. These practices are listed in Attachment 1. We also want to mention here that in addition to these EBPs, we have added other EBPs that address socioeconomic and racial disparities related to access of prevention physical health treatment/community services directly related to wellness/nutrition and exercise. KCMHSAS uses the CDC recommended protocol: *"Effective Approach to High Blood Pressure Control"* (American Heart, American College of Cardiology, CDC). We are currently implementing *Peer-to-Peer Tobacco Dependence Recovery Program* (TDRP) and *Weight Watchers* (WW). We justify our choice of TDRP via a review of research literature. The integration of tobacco treatment into the mainstream of substance use and other behavioral health treatment is rapidly becoming a nationwide best practice (Schroeder, 2007), with peers as integral. In a recent meta-analysis of peer-support programs for smoking cessation among disadvantaged groups, Ford et al (2013) reviewed eight studies, concluding that *interventions that improve social support for smoking cessation may be of greater importance to groups such as those with serious mental illnesses,* who often experience fewer opportunities to access these kinds of supports informally. They also concluded that peer-support programs (of which Peer-to-Peer TDRP is one) are emerging as highly effective and empowering ways for people to manage health issues such as tobacco use in a socially supportive context. Along the same lines, a recent study that surveyed Iraq and Afghanistan era Veterans found that the veterans expressed strong interest in a peer support component to their treatment (Gierisch et al, 2012). We also justify our choice of WW via review of the research on effectiveness, beginning with Ball et al's (2001) study that established clinically significant weight loss for people with schizophrenia going through the intervention. More recently, in a seminal study out of John Hopkins (March 2013 New England Journal of Medicine), researchers found that the support of programs that teach simple nutrition messages and involve counseling/coaching and regular exercise classes, people with serious mental illnesses (SMI) can make healthy behavioral changes and achieve significant weight loss (Daumit et al. 2013). Weight Watchers (WW) is one such program that has been widely adopted with people with SMI (e.g., State of New

Hampshire Health Choices Healthy Changes Initiative). These findings make the program an obvious choice to incorporate in our Whole Health Initiative and Integrated Care Coordination pilot. Both EBPs are also congruent with our current specialty service delivery model that supports community inclusion and integration of peers with lived behavioral health experience.

Peer-to-Peer TDRP will be initiated by Certified Peer Support Specialists (several of whom are veterans) within the Recovery Institute of Southwest Michigan, Inc.; a local private non-profit peer operated organization with about 20 staff. TDRP incorporates individual and group treatments, motivational engagement strategies, coaching, and educational activities. Weight Watchers is well aligned with our value of having individuals with behavioral health conditions be welcomed for participation and inclusion into "mainstream" programs and supports in community settings. Our Whole Health Initiative promotes increased knowledge and awareness with nutrition and exercise, assisting individuals to work toward a healthier lifestyle. Our collaboration with Weight Watchers provides individuals with coaching and real-life insights, meal planning, increased activities; and Weight watchers online resources. Roles and responsibilities of KCMHSAS Peers, Priority Health Choice, Inc. community health workers and SWMBH outreach personnel will be clearly delineated so as to avoid consumer confusion or inefficient resource use.

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

The overall purpose and goal of the Integrated Care Coordination model is to develop and expand an innovative and cost-effective model that coordinates care, services, and community resources in ways that promote the health of adults, youth and families with behavioral health and intellectual or developmental disabilities (target populations) in Kalamazoo County. This plan will allow Priority Health Choice, Inc., KCMHSAS, and SWMBH to collaborate in order to systematically integrate health care providers to meet all of a person's health needs and engage in joint care coordination for shared Medicaid enrollees where care is experienced as a single system treating the whole person. There are four key activities involved in achieving our purpose:

1. Healthcare Hot-spotting and Predictive Modeling
2. Embedded care Management
3. Enhanced supports for children and youth with mild or moderate behavioral health conditions and needs.
4. Close collaboration with, and provision of on-going education and consultation to, Kalamazoo County primary care providers, behavioral health providers and community services providers regarding integration and system-level care coordination.

The above mentioned four key activities will improve the health and wellness of adults and particularly children and youth by achieving the following objectives:

1. Improve access to physical and behavioral healthcare
2. Assure physical and behavioral health services are coordinated and integrated
3. Improve the physical and behavioral health of adults, children and youth served.

Please refer to Attachment 2 for a summary of our planned activities and timeframes for completion.

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.

The model is designed to improve collaboration and information sharing between Priority Health Choice, Inc. KCMHSAS, and SWMBH to identify shared enrollees, jointly develop and implement processes to manage their care, eliminate inefficiencies, improve health outcomes and implement a care model that extends beyond the traditional organizational silos requiring coordination. It was developed to align with, and strongly support, the core values and recommendations included in the 298 report. The goals of the model are to (a) Increase access to behavioral health services and physical health services (primary care), (b) decrease health care costs, (c) provide the right care at the right time regardless of funding source (d) increase engagement and self-management skills (e) increase coordination with treatment providers and provide information to the individual to make informed decisions regarding overall healthcare and (f) develop a coordinated care plan that focuses on communication, collaboration and coordination between the provider team on behalf of the individual. The coordinated care plan will include, but is not limited to, the following care management activities: (1) assistance with ways to navigate the health care system and receive health care services, (2) coordination of benefits with the Medicaid Health Plan Care Manager, (3) communication and coordination between KCMHSAS providers, Priority Health Choice, Inc. providers and primary care providers on behalf of the individual, (4) patient education and self-management skills for individuals, (5) recommendations for community resources to enhance health and wellness, (6) and other needs or barriers the individual faces that may impact her or his ability to access or engage in healthcare. The coordinated care plan is not a replacement for the person-centered plan. The model is based on real time sharing of claims and clinical data which promotes transparency and accountability of publicly funded physical and behavioral health care provided through Priority Health Choice, Inc., KCMHSAS and SWMBH. Priority Health Choice, Inc. will work with KCMHSAS to identify and stratify high-risk cases including established processes, standards, shared care plans and quality metrics. Priority Health Choice, Inc. and KCMHSAS will actively educate and engage both individuals and providers regarding system-level care coordination.

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).

KCMHSAS is experienced in providing coordinated, high quality specialty behavioral health services for the population included in this RFI. KCMHSAS is enhancing its capacity and competence in three key areas presented below:

Substance Use Disorders:

KCMHSAS has experience managing SUD services as a former PIHP that coordinated SUD care for a 4-county region, as well as more recently, directly providing SUD outpatient services. Related services include psychiatric and *Medication Assisted Recovery* for co-occurring substance use disorders by

KCMHSAS staff psychiatrists, physician assistants and nurse practitioners, *Certified Peer Health Coaches* on site 20 hours per week to work with individuals to improve their own health status and recovery work

Integrated Primary/Behavioral Health Care Services:

For the last two years, KCMHSAS has been implementing a multiyear Primary and Behavioral Health Care Integration (PBHCI) grant funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Health and Human Services. We refer to this project as the Whole Health Initiative with the primary purpose of coordinating and integrating primary/behavioral health services through the co-location of primary care services at our new KCMHSAS Bronson Healthy Living Campus Integrated Health Services Clinic. Services have been redesigned and enhanced, following Patient-Centered Medical Home principles and standards. An Integrated Treatment Team was established, comprised of primary care physicians, mid-level practitioners, and KCMHSAS staff psychiatrists and other medical staff. Services include comprehensive care management, peer and family support, health and nutrition education, wellness programs, and mental health/substance use disorder counseling. Primary care services are provided onsite by the Family Health Center, Inc., (Kalamazoo County's only Federally Qualified Health Center). Trauma Informed Care is provided, and evidence based practices for smoking cessation, nutrition/wellness, and Million Heart campaign protocol for hypertension.

More specifically, health home and primary care related services include psychiatric and *Medication Assisted Recovery* for co-occurring substance use disorders by KCMHSAS staff psychiatrists, physician assistants and nurse practitioners, *Certified Peer Health Coaches* on site 20 hours per week to work with individuals to improve their own health status or assist the primary care physician connections, comprehensive *Transitional Care Services* for those in psychiatric inpatient hospitals, and *Emergency Mental Health and Crisis Stabilization* responses to any primary care physician in Kalamazoo County.

Care Coordination with Medicaid Health Plans:

This pilot establishes a shared care coordination function between Priority Health Choice, Inc. (including primary care services), KCMHSAS and SWMBH. This care coordination activity will inform the utilization management plan as it relates to needed quality improvement regarding utilization management practices (including addressing access to primary and behavioral health care needs). Priority Health Choice, Inc. is providing technical assistance in care coordination activities that is increasing KCMHSAS staff experience and competency in this area. The care coordination team consists of a Care Coordinator and Peer Support Specialist at KCMHSAS, and a Care Manager and Community Health Worker at Priority Health Choice, Inc. The KCMHSAS Care Coordinator is the individual whose primary role is to assist the treatment providers and individual to navigate all systems of care for care to be experienced as a single system treating the whole person. Within Priority Health Choice, Inc., care managers provide telephonic support and education to individuals diagnosed with complex and often unmanaged chronic physical and/or behavioral health conditions.

The Peer Support Specialist/Parent Support Partner and Community Health Worker assist the Care Coordinator and Care Manager in engaging individuals and carrying out the goal of integrated and coordinated care between the Priority Health Choice, Inc.'s primary care/physical health providers and

the KCMHSAS behavioral health and intellectual or developmental disabilities specialty provider network. A Coordinated Care Plan is developed in Care Connect 360 (CC360) to focus on communication, coordination, and collaboration between the provider team on behalf of the individual. The Coordinated Care Plan is a planning tool that addresses the healthcare needs of the individual and the barriers an individual may face when attempting to access care and how the healthcare team will communicate to address these needs and/or barriers. Plan to plan care coordination of a specific small group of shared members between Priority Health Choice, Inc. and SWMBH has been in place for some time. Priority Health Choice, Inc. and SWMBH have shared metrics attached to a Performance Bonus Incentive Pool. For this pilot, Priority Health Choice, Inc., KCMHSAS and SWMBH will refine functions and tasks in care coordination to adhere to pilot goals.

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).

Cultural competence is the ability to interact effectively with people of different cultures. In practice, both individuals and organizations can be culturally competent. Culture must be considered at every step of the Strategic Prevention Framework (SPF). "Culture" is a term that goes beyond just race or ethnicity. It can also refer to such characteristics as age, gender, sexual orientation, disability, religion, income level, education, geographical location, or profession. Cultural competence means to be respectful and responsive to the health beliefs and practices—and cultural and linguistic needs—of diverse population groups. Developing cultural competence is also an evolving, dynamic process that takes time and occurs along a continuum.[26]

The population of focus in this pilot is older, poorer, and more racially diverse, than the overall Kalamazoo County population. Sub-population disparities include access (i.e., socioeconomic status impacting primary care access), services (i.e., higher rate of emergency department and inpatient services, and less access to preventative care) and outcome disparities (i.e., higher BMI, smoking and hypertension rates, risk of early morbidity). Kalamazoo County is an urban county located in southwest Michigan. The percentage of persons below the poverty level is higher for Kalamazoo County in comparison to the state (19.1% vs. 16.8%), and the socioeconomic status lower still, with 96% of those in poverty eligible to receive Medicaid benefits. Kalamazoo County ranks 42nd out of 82 counties in Michigan when compared to other counties in the state in healthy behavioral (*County Health Rankings & Roadmaps, 2014)* despite having more primary care physicians per 1000 residents, a higher college attendance rate and fewer children in poverty than in Michigan on average. Adults with (61.3% vs. 29.4%), have two times as many medical hospitalizations/Ed visits, less access to preventive care and/or follow disease management protocol (Southwest Michigan claims data), and Kalamazoo County is no anomaly to these statistics. Data show that the target population, *especially those without a primary care physician,* is comprised of more populations of color, making the work of securing the Access barriers are particularly high for veterans (*55% without a primary care physician).* Smoking (per self-report) is 47.3% for those without a primary care physician, compared to 36% for the general population of adults with serious mental illnesses, 80% for those with schizophrenia, and 70% for those receiving services from four (4) CMHSPs in Southwest Michigan.

[26] Substance Abuse and Mental Health Services Administration (SAMHSA).

The primary purpose for our Whole Health Initiative, which will carry-forward into our proposed Integrated Care Coordination pilot, is to improve quality of life for adults with serious mental illnesses, children with serious emotional disturbance, persons with substance use disorders, and intellectual or developmental disabilities, and reduce socioeconomic and racial disparities in access, use, and outcomes. Although these specialty services populations are more likely to have chronic health conditions, they are less likely to receive necessary preventative care, less likely to have an identified primary care physician, and more likely to use hospital emergency departments to receive primary care services. Low literacy and lack of connection to their primary care physician is common for these populations, as interviews with consumers reveal the top three reasons for lacking a primary care physician being: No perception of ongoing or future physical health needs; history of being "fired" from a primary care practice due to multiple missed appointments or situations such as violation of pain medication agreement; and Urgent care needs (real and perceived) are met through the Emergency Department services.

Staff we hired to implement EBPs presented earlier, match our commitment for hiring diversified staff, including members of minority groups, diverse cultural backgrounds, individuals that are able to interpret and speak Spanish, etc. EBP material are written at a 4th grade level to meet literacy requirements, produced in Spanish and translators are available when needed. KCMHSAS has a large provider panel that allows it to offer demographic matching of providers with those individuals served. We demonstrate commitment to honor people's choice of service providers to the maximum extent possible. We have an ongoing cultural competency curriculum with staff that includes respective differences, and addressing prejudices. Our policies address non-discrimination, equal opportunity in hiring, Trauma Informed Care services, and person-centered planning. We recruit and hire diverse staff (ethnicity, religion, gender, and age) that have knowledge of and training in EBPs. We remain committed to incorporating peers, of diverse backgrounds, within each of our service areas as those with lived experience have better success at engaging others with serious mental illnesses, serious emotional disturbances, substance use disorders, and intellectual or developmental disabilities. Veterans are encouraged to access these services as well, and our existing Whole Health Initiative and future Integrated Care Coordination pilot will remove regional barriers of transportation (especially relevant to veterans) to those desiring to participate.

KCMHSAS has established a Provider Agreement with the Pokagon Band of Potawatomi Indians, a federally recognized Indian Tribe located in Dowagiac, Michigan, to provide behavioral health services, mainly psychiatric services, to Pokagon Band Citizens. In addition, Jeff Patton, CEO, of KCMHSAS is a member of the Pokagon Band of Potawatomi Indian Health Services Advisory Council.

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

We have closely reviewed the plan contained in the §1115 Demonstration waiver application submitted to CMS by the MDHHS, that pertains to the use of CareConnect360 and other health information technology. Pending approval of the §1115 Demonstration waiver, we intend to adopt this plan and follow future direction given by MDHHS. It is very likely that this plan will be implemented during the second year of our proposed Integrated Care Coordination pilot and the federal Demonstration waiver period. The portion of the application that pertains to CareConnect360 is provided below:

Since this proposal is not solely focused on cost savings but rather maintaining Michigan's robust coverage and service array (including the expanded use of peer supports and self-determined arrangements) for Specialty Service Populations, the goal of this demonstration is to actually create a robust evaluation that tests both quality and cost outcomes between traditional Medicaid Health Plans (MHPs) and Michigan's Specialty Services System.[27] These incentives would be specifically targeted for persons with SMI, SUD, IDD and SED. Key indicators would include the joint identification and tracking of high risk/utilizing populations, the prevention of modifiable risk factors[28], access to care incentives, pilot demonstrations through Accountable Systems of Care and the enhancement of co-occurring (SMI/SUD) services and the use of "Specialized Complex Care Managers" for individuals considered "High Utilizers." Since many of the cost drivers related to "High Utilizers" occur from increased emergency department usage or inpatient hospital utilization, testing what quality and clinical measures actually impact decreased utilization and tracking where savings actually accrues (hospitals, health plans, PIHP's) for this population will be one of the demonstration's major evaluation components.[29]

To meet these objectives, Michigan has recently implemented an integrated care analytics program (known as Care Connect 360 or CC 360) that enables the state and providers to access retrospective Medicaid claims and encounter data for both behavioral health and physical healthcare services including prescription drug information. Through an existing contract, Michigan will conduct an evaluation to measure and monitor the outcomes for the Pathway to Integration Waiver. The following is a partial list of quality indicators to be refined and measured during the demonstration with additional CMS technical assistance (specifically for the enhanced SUD services). Michigan will submit the completed design of the evaluation within 90 days of the application approval.

- Enhance/incentivize the ability of Specialty Services System payers and providers to work with traditional MHPs and to jointly develop measures to identify high risk populations within this Specialty Service System. This includes strategies to identify individuals with substance use issues or disorders.
- Develop linkages that directly impact social determinants of health, including the use and dissemination of models to prevent homelessness, early intervention models that promote clinical practices for serving youth and adults with SUD.
- Increase rate of outpatient services including assignment of a primary care physician, physician office, or clinic visits (including home health and urgent care) per 1,000 member months.
- Decrease rate of emergency department (ED) visits per 1,000 member months.
- A decrease in hospital admissions for these specific populations (both medical and psychiatric).
- Rate of follow up appointments kept with Specialty Service System providers.

[27] Integrated Care Resource Center, Technical Assistance Brief: State Options for Integrating Physical and Behavioral Health Care, MCO/PCCM, and BHO Partnership Facilitated by Financial Alignment.
[28] Obesity, smoking cessation, homelessness, substance use, diabetes and cardiovascular disease management.
[29] Michigan Department of Health and Human Services, *Pathway to Integration,* Michigan's §1115 Waiver Proposal for persons with Severe Mental Illness, Substance Use Disorders, Intellectual and Developmental Disabilities and Children with Serious Emotional Disturbances to the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, June 21, 2016.

Hot-spotting, a data driven process for the timely identification of patterns and trends to guide targeted intervention and follow up to better address individual needs, improve care quality and reduce costs, will also be utilized. Use of claims data will reveal individuals that may benefit from or need healthcare solutions. Care coordination team members will work together using Care Connect 360 to develop risk stratification criteria, identifying individuals/members with high needs who could benefit from care coordination. Interactive Care Plans will be created in CC360 that can be reviewed and updated by both KCMHSAS and Priority Health Choice, Inc. Admission, Discharge, and Transfer (ADT) from the HIE is automatically flagged in the KCMHSAS EHR and provides additional information on at-risk individuals who could benefit from care coordination. Predictive modeling will be used to identify and proactively reach out to individuals at risk of developing complex conditions.

Priority Health Choice, Inc., KCMHSAS, and SWMBH have made material investments in HIE and HDA. Specifically, SWMBH is a multi-year subscriber to MIHIN, with multiple use cases active and more in panned development. KCMHSAS benefits from this relationship and has further similar relationships supporting HIE in their specific healthcare ecosystem. Further, SWMBH was an active proponent, supporter and co-developer of the early stages of Care Connect 360. SWMBH actively support the participating CMHSPs in Region 4 in using the application to further the goals of improved integration, collaboration and health status outcomes. KCMHSAS is among SWMBH's top users of CC 360, and will support expansion of access to it for Priority Health Choice, Inc. for pilot members. Since 2015 SWMBH has been a Care Management Technologies (CMT) https://www.relias.com/solutions/population-health-management licensee, providing access to PIHP staff and Region 4 participating CMHSPs. CMT is a well-developed healthcare data analytics platform with built in algorithms, alerts, clinical direction, physician communications and the like. It has served SWMBH well and will pursue expanding access to Priority Health Choice, Inc. and their PCPs with enrollees involved in the Pilot.

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

KCMHSAS's electronic health record contains information from CC360 as well as from Great Lakes Health Connect (HIE), which provides a more comprehensive picture of the individual's needs and services. Interactive Care Plans are created in CC360 so that they can be reviewed and updated by both KCMHSAS, Priority Health Choice, Inc. and the SWMBH.

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

Admission, Discharge, and Transfer (ADT) from the HIE is automatically flagged in the KCMHSAS EHR and provides additional information on at-risk individuals who can benefit from care coordination.

8. **Financing Model and Consideration:** 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).

Given the cost-neutrality requirements of this RFI, it is not clear whether or to what extent the MDHHS's intent to contract with an ASO/MBHO will impact the overall costs of the pilot. As stated earlier, Section 205 of the Michigan Mental Health Code CMHSPs does not permit a CMHSP to enter into full risk managed care arrangements with non-governmental entities, and financially obligate any unit of government other than itself. We will not respond any further on this subject until we get more clarity from MDHHS regarding this provision of the pilot.

Our model will not disrupt current funding streams and Medicaid financing arrangements. This means that Medicaid capitation payments would continue to be made to KCMHSAS from SWMBH for the Specialty Services Program. Priority Health Choice, Inc. will provide fee-for-service payments for the mild or moderate behavioral health populations. In addition, as part of this collaborative funding model Priority Health Choice, Inc. will fund Peer Support Specialists to perform outreach and engagement for pilot participants.

This model does not eliminate the Regional Entity PIHP (Southwest Michigan Behavioral Health). It assures the continuation of capitation payments to KCMHSAS, paid through SWMBH. It is important to emphasize that this model does not financially destabilize the eight (8) county PIHP region, and offers a meaningful role for the SWMBH. More importantly, this model preserves the statutory "safety net" mission and purpose of the KCMHSAS, and does not expose it and its creating county to harmful financial risk exposure associated with managed care. Data sharing and analytics are also very important components of this model for evaluating success and future sustainability. Priority Health Choice, Inc., KCMHSAS are partners in the overarching goal for integrating behavioral and physical health services. The success of this alternative Integrated Care Coordination model can be shared and expanded quickly to other parts of the Southwest Michigan region and throughout the state after the pilot ends. Please refer to the diagram in Attachment 3 that illustrates the Alternative Integrated Care Coordination model. Beginning in Fiscal Year 2016, SWMBH's contract with MDHHS contains a shared risk and earned savings contractual arrangement through the Performance Based Incentive Pool. This arrangement in large part is aligned with all MHPs, geared towards mutually addressing access and care coordination. This experience has strengthened SWMBH's effort and activities with MHPs, and has created a deeper, broader and timelier beneficiary-focused communication between and among MHPs, CMHSPs, and other medical and behavioral providers. We are prepared in Year 2 of this Pilot to assess the feasibility of implementing a wide range of alternative payment mechanisms between partners including, but not limited to case rates, performance bonus pool, shared risk, and others that may be created by MDHHS.

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

The existing 1915(b)(3) and 1915(c) waiver authorities do not expressly permit value-based financing between MHPs and PIHPs for the Managed Specialty Services Program. KCMHSAS does not have experience or the legal mechanism to enter into such arrangements with MHPs. However, SWMBH is a partner in the MiHealth Link Medicare/Medicaid Dual Eligibles Demonstration pilot. The MiHealth Link demonstration pilot is implemented under a §1915(c) Home and Community Based Medicaid waiver authority. Through the MI Health Link Demonstration pilot, SWMBH has considerable experience with shared risk and shared savings with its two Integrated Care Organizations (ICO), which are Medicaid Health Plans. Specifically, the SWMBH arrangement with ICOs is a risk-based, capitated approach with a risk-reward structure similar to that of the SWMBH contractual arrangement with MDHHS. This arrangement has incentivized fiscal prudence, timely access to enrollees, and shared quality metrics.

The pending MDHHS §1115 Demonstration waiver application proposes to implement future value based purchasing models during the second year of the waiver period. Assuming approval of the waiver, we will follow the state's lead and direction in the second year of our pilot to put in place a value-based purchasing model with Priority Health Choice, Inc. and SWMBH. Because KCMHSAS has an existing fee-for-service payment contract with Priority Health Choice, Inc. for the mild/moderate outpatient benefit, we will build on this service architecture to establish a Category 2A Alternative Payment Model (APM). Payments incorporated in this classification involve payments for infrastructure investments that improve quality of care for enrollees, even though payment rates are not adjusted in accordance with performance metrics. This may include payments designated for staffing of care coordinators or upgrading our electronic medical records. For purposes of this pilot, this would be an initial step in making investments in these and similar delivery enhancements that will likely improve enrollee experience and quality of care. These payments could be traditional FFS or per member per month (PMPM) capitation payments. What is important is that they will represent an initial step forward toward payment reform during and after the pilot period. It is important to mention here that this may set the stage to progress to a more sophisticated mechanism for an effective management set of service encounters, an episode of care, and all integrated health services delivered to shared enrollees. This would lead to the possible implementation of Category 3 APM payments built on a higher-level fee-for-service architecture that will be based on cost performance (savings) against agreed upon performance targets. As the Category 3 APM preferred provider of Priority Health Choice, Inc., other MHPs, and SWMBH after this pilot ends, KCMHSAS would be positioned to meet future agreed upon cost reduction and quality targets to be eligible for shared savings payments. Payments in Category 3 would be structured to encourage KCMHSAS and its provider network to deliver effective and efficient care. Payments may be episode based to encourage care coordination because they would cover a complete set of related services for the service encounter that may be delivered not only directly by KCMHSAS, but multiple providers in the KCMHSAS provider network. If the Category 3 APM is successful, Category 4 may be pursued. Category 4 represents the furthest departure from traditional fee-for-service payments, while simultaneously ensuring that KCMHSAS and its provider network possess the strongest possible incentives to deliver high quality and efficient care.[30]

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[30]Health Care Payment Learning and Action Network, *Alternative Payment Model Framework and Progress Tracking (APM FPT) Workgroup,* Final White Paper, Version Date: January 12, 2016

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."

We are currently using Care Connect 360 to access retrospective Medicaid claims and encounter data for both behavioral health and physical healthcare, including prescription drug information, to make care coordination decisions and assure access to needed behavioral health, IDD and physical health services. For purposes of this RFI, we will use, at minimum, the following quality indicators that MDHHS has submitted to CMS for the §1115 waiver approval:

- Enhance/incentivize the ability of Specialty Services System payers and providers to work with traditional MHPs and to jointly develop measures to identify high risk populations within this Specialty Service System. This includes strategies to identify individuals with substance use issues or disorders.
- Develop linkages that directly impact social determinants of health, including the use and dissemination of models to prevent homelessness, early intervention models that promote clinical practices for serving youth and adults with SUD.
- Increase rate of outpatient services including assignment of a primary care physician, physician office, or clinic visits (including home health and urgent care) per 1000 member months.
- Decrease rate of emergency department (ED) visits per 1,000 member moths.
- A decrease in hospital admissions for these specific populations (both medical and psychiatric).
- Rate of follow up appointments kept with Specialty Service System providers.

In addition, we will provide twelve-month savings estimates by cost type using propensity score weighted regression to evaluate the differences in total cost of care, inpatient facility, outpatient facility, professional, prescription and other types of costs. Due to the short term of this pilot, these savings estimates will be identified and could result in a reinvestment plan for services which continue beyond the two-year pilot period.

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.

Since there are no changes to the financial arrangements in this pilot, the community benefit functions of the CMHSP will remain in place. More importantly, this model preserves the statutory "safety net" mission and purpose of KCMHSAS and does not expose it and its creating county to harmful financial risk exposure associated with managed care.

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.**

Although the Medicaid Managed Specialty Supports and Services Program does not include funding and service provisions for individuals who are not enrolled in a Medicaid Health Plan, CMHSPs are mandated by law to serve these individuals. Section 330.1206 of the Michigan Mental Health Code (Code) states that "The purpose of a community mental health services program shall be to provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic service area, regardless of an individual's ability to pay." The Section 330.1208 of the Code further states that "(1) Services provided by a community mental health services program shall be directed to individuals who have a serious mental illness, serious emotional disturbance, or developmental disability; (2) Services may be directed to individuals who have other mental disorders that meet criteria specified in the most recent diagnostic and statistical manual of mental health disorders published by the American psychiatric association and may also be directed to the prevention of mental disability and the promotion of mental health. Resources that have been specifically designated to community mental health services programs for services to individuals with dementia, alcoholism, or substance abuse or for the prevention of mental disability and the promotion of mental health shall be utilized for those specific purposes; (3) Priority shall be given to the provision of services to individuals with the most severe forms of serious mental illness, serious emotional disturbance, and developmental disability. Priority shall also be given to the provision of services to individuals with a serious mental illness, serious emotional disturbance, or developmental disability in urgent or emergency situations; (4) An individual shall not be denied a service because an individual who is financially liable is unable to pay for the service. This population is currently managed by KCMHSAS and will continue under this proposed alternative pilot. Similar to all 46 CMHSPs in the state, KCMHSAS funds the delivery of behavioral health specialty supports and service for priority populations that are not enrolled in Medicaid Health Plans (e.g., fee-for-service Medicaid beneficiaries or uninsured individuals) with state general fund appropriations and local county match allocations, and state Medicaid fee-for-service reimbursements. In addition to these funding sources, we welcome other options MDHHS is considering for the management of specialty behavioral health benefits for this population during the pilot(s).

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 system, the MHPs have well developed systems and structures for performing the required managed care systems and structures for performing the required managed care functions in a way that is consistent with both regulatory and accreditation requirements. It is important, as part of administering managed care functions, that pilots balance community presence, compliance, and administrative efficiency in the performance of required managed care functions.

The respective managed care contractual responsibilities between MDHHS and Priority Health Choice, Inc. and MDHHS and SWMBH will remain in place. It is important to mention here that under this pilot, SWMBH assess each managed care function with KCMHSAS and Priority Health Choice, Inc. to identify and

revise managed care function roles and responsibilities where indicated and beneficial to the goals of the 298 Boilerplate and our alternative Coordinated Integrated Pilot model.

a) <u>Access</u>

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

KCMHSAS maintains an Access management system necessary for publicly funded mental health services through an integrated comprehensive access system, regardless of point of entry or contact. KCMHSAS anticipates no changes to maintaining the responsibility for Access for specialty behavioral and intellectual or developmental disabilities specialty supports and services because of this pilot. KCMHSAS will remain responsible for the delegated functions for operating an Access Center, including meeting compliance with the established contractual Access Standards and making decisions based on medical necessity and level of care guidelines to approve, pend, or deny requests for authorization to requested services, consistent with SWMBH policy and practices.

- **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).**

The KCMHSAS system ensures sufficient access system capacity to determine a consumer's eligibility for supports from the public mental health system in a timely manner; managing resources (including service and provider capacity, availability and accessibility of resources to meet service needs and demands); ensuring compliance with various funding eligibility and service requirements; and assuring associated quality of care and appropriate referral and placement in the specialty services system, or linkage to other community resources. A face-to-face comprehensive bio-psychosocial and/or clinical evaluation, including a level of care assessment (LOCUS, CAFAS, SIS, etc.), is completed by an appropriately licensed and credentialed professional that obtains appropriate and necessary information about consumers seeking entry into the public specialty services system. The information is used to match an individual's need with the appropriate care setting, care level and service intervention. Once a consumer is determined eligible for specialty behavioral health and intellectual or developmental disability specialty services, referrals are made (i) to a public mental health and/or substance use disorder network provider; (ii) an appropriate external community resource, including Priority Health Choice, Inc. and other MHPs; and within the KCMHSAS direct-operated service system: (iii) from one practitioner to another, including a referral to a primary care physician; and (iv) from one setting to another. KCMHSAS will serve as the Preferred Provider in this pilot, and as such, will be regarded as the single point of entry for consumers seeking services and assistance with formal authorization for SUD services through SWMBH. As the Preferred Provider of Priority Health Choice, Inc. KCMHSAS will serve as the access point for individuals seeking mild or moderate outpatient behavioral health from KCMHSAS. These services will be made available to other MHPs in Kalamazoo County, as needed to coordinate care and authorization services. KCMHSAS has a contract with all MHPs in Kalamazoo County for mild or moderate outpatient services.

b) Customer Service

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

Customer Services will continue to be provided by KCMHSAS, including the function of managing grievances and concerns for this alternative Integrated Care Coordination pilot as a central point of contact. KCMHSAS intends to work with Priority Health Choice, Inc. and SWMBH to develop a streamlined system for Customer Services for those individuals within the pilot project.

- **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.**

KCMHSAS will maintain its current responsibilities for managing Customer Services for specialty behavioral health and intellectual or developmental disabilities supports and services while Priority Health Choice, Inc. will maintain the function of Customer Services for the mild to moderate and primary physical health services.

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.**

KCMHSAS has the capacity and ability to submit BH TEDS in the format set by MDHHS. KCMHSAS also has the capacity and ability to submit encounter data to Priority Health Choice, Inc. Presently KCMHSAS submits all encounter data and BH TEDS to SWMBH, and will continue to do so in this pilot. In turn, SWMBH will continue to submit KCMHSAS's BH TEDS to MDHHS, as well as for other participating CMHSPs in Region 4.

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

KCMHSAS's Practice Management System / EMR interfaces with MPHI to identify the funding sources known to CHAMPS/Bridges. There is automation to ascribe funding sources based on that eligibility. The appropriate funding sources are utilized when adjudicating claims and services.

- **Describe your current capacity and readiness to report required substance use disorder data and information to meet SUD reporting requirements as specified in the PIHP contract.**

SWMBH reports the BH Teds for SUD and will continue to do so for this pilot. KCMHSAS has the same EHR as SWMBH's, and has the capacity to report and submit these data.

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

KCMHSAS began submitting BH Teds to SWMBH in 2015.

d) <u>Claims Management</u>

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

Under this pilot, KCMHSAS will continue authorizing services, processing and adjudicating claims for the Medicaid Specialty Services program. Priority Health Choice, Inc. will approve and process mental health claims for the mild to moderate population, and SWMBH will approve and process claims for the SUD population.

- **Explain the partner CMHSPs 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."

In this pilot, SWMBH will continue to manage the SUD services and claims. SWMBH meets the definition of a Community Mental Health Entity. We are also proposing that there would be no change to the community block grant and liquor tax funding process with SWMBH.

e) Quality Management

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

This pilot is a partnership between Priority Health Choice, Inc. KCMHSAS, and SWMBH. A three-way MOU will be established between the Priority Health Choice, Inc., KCMHSAS and SWMBH clarifying the role of each party with respect to quality management and improvement functions. This pilot retains the contractual relationship between MDHHS and SWMBH, specifying quality management requirements, and the contract between SWMBH further specifies the quality management functions that are delegated to KCMHSAS. The three-way MOU between Priority Health Choice, Inc. KCMHSAS and SWMBH will outline how integrated health quality improvement functions will be carried out for consumers participating in this pilot. MOUs will address the following areas:

- Currently Quality Management functions are largely delegated by SWMBH to KCMHSAS, and we would anticipate this arrangement continuing under this pilot. SWMBH is responsible for submitting required Quality Management reports to MDHHS.
- As a CARF accredited organization, KCMHSAS has a Quality Improvement Policy and Plan that meets federal, state and accreditation standards, and ensures Best Practice Guidelines are adhered to and compliance issues are adequately addressed and reported.
- KCMHSAS also carries out these functions for its contracted provider network as outlined in contracts between KCMHSAS and each contract provider organization.
- The KCMHSAS Quality Improvement Plan supports the SWMBH Quality Assurance Performance Improvement Program (QAPIP) by reporting detailed quality indicator data (including incident reporting, MMBPIS and PIP information) to SWMBH. Because this pilot includes the specialty services Kalamazoo County Medicaid population, current incident reporting, MMBPIS and Performance Improvement Project information will continue to be reported through SWMBH.
- KCMHSAS would work with Priority Health Choice, Inc. and other MHPs during this pilot period to assure that Medicaid Health Plans understand the Quality Management expectations under the Medicaid Specialty Services program requirements, and will provide quality improvement data to Priority Health Choice, Inc., particularly regarding the MDHHS and accrediting body mild/moderate outpatient services program reporting requirements during the pilot period.

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

KCMHSAS currently contracts with Priority Health Choice, Inc. as well as all Kalamazoo County Medicaid Health Plans for mild/moderate behavioral health outpatient services, and Priority Health Choice, Inc. and one other Medicaid Health Plan for CHAP (Children's Healthcare Access Program) services. These

contracts include an expectation that KCMHSAS comply with the Medicaid Health Plan Quality Improvement programs, which KCMHSAS is in full compliance. We expect this arrangement to continue and to expand to include Medicaid Specialty Services that are integrated with Primary Care services. This integration of Quality Improvement plans (integrating the behavioral and primary care quality improvement activity) will be developed over the course of the pilot, as outlined in the KCMHSAS and Medicaid Health Plan MOUs.

f) Utilization Management

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

Utilization Management assures medically necessary services are delivered at the scope, intensity and duration appropriate to clinical need and person-centered planning. Activities include prospective, concurrent and retrospective reviews for service authorization and monitoring and addressing under and overutilization of services. The SWMBH Utilization Management plan establishes clinical criteria and protocol for system eligibility and authorization decisions and establishes the plan for quality improvement, including review of clinical records to assure standards are met and services are provided in accordance with the person-centered plan. SWMBH is responsible for establishing the UM plan for Region 4, in consultation with participating CMHSPs. The implementation of the UM plan, including service authorization decisions are largely delegated to KCMHSAS as a local care management function, with annual audits to review performance in this area. MOUs between partners in this pilot will address specifics in this area, but generally:

- Current delegated functions will remain as outlined above, with SWMBH establishing the UM Plan and care guidelines, and KCMHSAS completing delegated functions.
- This pilot establishes a shared care coordination function between Priority Health Choice, Inc. (including primary care services) and KCMHSAS. This care coordination activity will inform the UM plan as it relates to needed quality improvement regarding utilization management practices (including addressing access to primary and behavioral health care needs).
- Utilization Management for Substance Use Disorder services should be completed in the context of medically necessary physical and other behavioral health services for individuals served. This pilot will provide the opportunity for increased coordination of care and required utilization management activities. In the first year of the pilot, Priority Health Choice, Inc., KCMHSAS and SWMBH will research and pilot methods for shared utilization management and care coordination responsibilities for individuals served. This will allow KCMHSAS to work closely with other SUD providers in Kalamazoo County serving pilot consumers, and to assure consents to release information are in place to facilitate care coordination with Priority Health Choice, Inc. and other Medicaid Health Plans for shared enrollees. These methods will be formalized in the second year of the pilot through appropriate contractual relationships.

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

In this Pilot, KCMHSAS will continue to partner with SWMBH for management of the Medicaid Specialty Services program for consumers receiving services, including consumers participating in this pilot. This approach includes using current SWMBH UM criteria and processes for all consumers, regardless of whether they are enrolled with Priority Health Choice, Inc. or other MHPs (avoiding the concern of each MHP having different UM criteria for their enrolled members).

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

This pilot will not require a transition of UM, person-centered planning, or authorization responsibilities for pilot consumers.

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

An Integrated Care Coordination Leadership Team will be created to support the partnership among and between Priority Health Choice, Inc., KCMHSAS and SWMBH. This team will regularly review parity compliance issues and make necessary process and benefit adjustments to assure parity compliance is met.

- **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).**

KCMHSAS has organizational and staff experience with utilization management activities related to substance use disorder services, having previous experience as the former regional Substance Abuse Coordinating Agency and PIHP prior to 2014. KCMHSAS will partner with SWMBH to assure delegated UM responsibilities for SUD services are managed consistent with SWMBH policy and protocols currently in place.

- Integrated Care Coordination (for PH and BH needs) is also a developing area of capacity and competency for KCMHSAS. KCMHSAS has been partnering with Priority Health Choice, Inc. over the last several months to develop protocols and processes for this function. KCMHSAS also has experience with integrated behavioral health and primary care services through the Whole Health Initiative. This experience will support any Utilization Management functions related to primary health care that emerge in the course of this Pilot. We encourage physical health plans and primary care physicians to adapt self-determination and person-centered-planning principles and practices.

g) Network Management

- **Explain your planned approach to network management including delegated activities. Describe how the network management approach will address access and availability standards defined in current contracts.**

Currently KCMHSAS completes network management responsibilities, holding contracts with behavioral health network contract providers for all specialty services for Kalamazoo County residents, except for SUD treatment and prevention services. This management responsibility allows KCMHSAS to assure access and availability standards are met, as provider contracts include these standards in boilerplate language. This approach also allows KCMHSAS to assure consumers are authorized for assessment and initial treatment services within the access standard timelines. SWBMH is directly responsibility for the network management for SUD treatment and prevention services for Kalamazoo County, and is responsible for oversight and monitoring of KCMHSAS delegated provider network management functions.

Under this pilot, the network management approach will remain consistent with current practice which includes state-wide agreements between PIHPs in provider review reciprocity and direct care worker training reciprocity. KCMHSAS will directly provide Medicaid specialty services and will continue to hold contracts with contract providers for behavioral health and intellectual or developmental disability specialty supports and services, assuring access and availability (assuring adequate providers are available to meet capacity needs). SWMBH will continue to manage the provider network for SUD treatment and prevention services, willingness to assess entry into three-party contracts with all providers to allow for the delegation of UM and care coordination activities from SWMBH to KCMHSAS to assure coordination of care.

- **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.**

KCMHSAS anticipates no changes to its contract provider network because of this pilot. KCMHSAS will remain responsible for the contracting, credentialing and provider reviews for behavioral health and intellectual or developmental disability specialty supports and services under this pilot.

- **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.).**

Similar to the above statement, KCMHSAS anticipates no changes to its contract provider network because of this pilot. KCMHSAS will remain responsible for the contracting, credentialing and provider reviews for behavioral health and intellectual or developmental disability specialty supports and services under this pilot.

h) <u>Managed Care Oversight and Performance Monitoring</u>

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

KCMHSAS has established policies, procedures, and monitoring mechanisms to ensure the performance, quality, regulatory and contract compliance of each provider that holds a contract with KCMHSAS. The monitoring of contract providers and KCMHSAS direct operated services, includes oversight and review of Organizational Practices, Clinical Records, Claims Verification, Financial compliance as applicable, and site reviews from the Office of Recipient Rights. The Organizational Practices Review monitors contractually required functions of an organization or entity to ensure compliance. As stated in other sections of this RFI, KCMHSAS has systems in place to provide oversight and monitor performance in the areas of Quality Management, Utilization Management, Customer Service, Financial, Credentialing, and Reporting functions. KCMHSAS receives an annual delegation audit from SWMBH as a means of providing oversight and ensuring compliance with expectations of functions that are contractually delegated to KCMHSAS. KCMHSAS cannot sub-delegate managed care functions absent written approval from SWMBH.

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.

The approach for measuring the performance of the pilot is the impact it has on access to care, coordination of care, and outcomes of care. Measuring performance will require information from all three parties (Priority Health, Inc. KCMHSAS and SWMBH) as all will have data pertaining to these measurements. Some of the data important for performance measurement includes improved access to primary care, number of individuals with complex conditions identified through hot spotting and engagement via proactive outreach, decrease in intensive service utilization including emergency department and intensive psychiatric services. Where applicable, we will mirror the evaluation protocols developed and implemented by the 298 Pilot University of Michigan Evaluation team.

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

KCMHSAS and our pilot partners have the administrative and technical capacity and experience to participate in and support the evaluation-related activities including utilization, expenditure and outcome-related data both before and after implementation. KCMHSAS is well connected to consumers in our community and have partnered with them for evaluation activities similar to those outlined in the evaluation plan. This includes surveys conducted through the Home and Community Based Services (HCBS) process, consumer involvement in the CCBHC process, and evaluation activities through multiple SAMHSA grants.

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.

Priority Health Choice, Inc., KCMHSAS and SWMBH have significant resources in quality, business and financial analysis capabilities and competencies. Our county and region is fortunate to have multiple university assets. Statistical analysis of behavioral health and physical health utilization and costs before and after pilot initiation will occur. Where possible, we will conduct control client matching and other more sophisticated methods. Savings will be quantified and used as first dollars spent in accordance with expectations of the 298 pilots in subsequent years.

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.

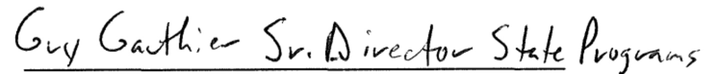
Technical assistance around permissible Medicaid payment alternatives, including performance incentives and shared savings is a need.

298 Pilot Request for Information
Memorandum of Support

Priority Health Choice, Inc. is pleased to offer partnership and support to Kalamazoo Community Mental Health & Substance Abuse Services (KCMHSAS) for a proposed Section 298 Pilot. The proposed Integrated Care Coordination Model, launched in January 2018, is a collaborative model between Priority Health Choice, Inc. and KCMHSAS designed to assist our shared enrollees with behavioral and physical health co-morbidities navigate the healthcare system and promote care coordination between the behavioral and physical health treatment providers. Under this model, individuals will have access to the right care at the right time, reduced health care costs and utilization of intensive services, and improved health outcomes. This Population Health Management approach will provide real-time access of relevant health information to enrollees, care providers and partnering organizations to support integrated care management. The initial financing model includes applicable fee-for-service billing and investment from both entities. Ongoing financing and alternative funding models will be based on anticipated shared savings and success with the initial stage of implementation.

Priority Health Choice, Inc. has participated in substantive discussions KCMHSAS regarding a proposed Section 298 Pilot and is committed to continuing discussions with the KCMHSAS to reach a final agreement regarding a proposed 298 pilot in KCMHSAS region. This Memorandum of Support is not a legally binding agreement between us and does not obligate either of us to enter into an agreement regarding a 298 pilot.

Signature MHP Authorized Official



Name and Title of MHP Authorized Official

Priority Health Choice, Inc.
Name of MHP

Date

ATTACHMENT 1

- Whole Health Action Management (WHAM)
- Dimensions Smoking Cessation
- In Shape
- Dialectical Behavioral Treatment (DBT)
- Trauma-Focused Cognitive Behavioral Therapy
- Motivational Interviewing
- Seeking Safety
- Cognitive Behavioral Therapy (CBT) (promising practice)
- Parent Management Training of Oregon (PMTO) *
- Integrated Co-Occurring Treatment (ICT Homebased services for youth-promising practice)
- Individual Placement and Supported (IPS)
- Certified recovery coach – Certified peers, Recovery Coaches, and Families Support Partners, and youth peer support specialist
- First Episode early intervention for psychosis - RAISE
- Assertive Community Treatment (ACT) *
- Medication Assisted Recovery Program
- Prescription long acting injectable medication for Substance Use Disorder and Mental Health
- Wrap Around for Youth
- Wellness Recovery Action Plan
- Integrated Dual Disorder Treatment (IDDT) *
- Screening, Brief Interventions, and Referral to Treatment (SBIRT)
- Supported Employment *

Note: EBPs and promising practices with asterisks* identifies those that are required by MDHHS

ATTACHMENT 2

Section 298 Proposed Integrated Care Coordination Model

Current and Planned Activities to Physically Co-Locate or Otherwise Integrate Physical Health and Behavioral Health Services

The overall purpose and goal of the Integrated Care Coordination model is to develop and expand an innovative and cost-effective model that coordinates care, services, and community resources in ways that promote the health of adults, youth and families with behavioral health and intellectual or developmental disabilities (target populations) in Kalamazoo County. This plan will allow Priority Health Choice, Inc., KCMHSAS, and SWMBH to collaborate in order to systematically integrate health care providers to meet all of a person's health needs and engage in joint care coordination for shared Medicaid enrollees where care is experienced as a single system treating the whole person.

There are four key activities involved in achieving our purpose:

1. **Healthcare Hot-spotting and Predictive Modeling**

   a. Hot-spotting is a data driven process for the timely identification of patterns and trends to guide targeted intervention and follow-up to better address individual needs, improve care quality and reduce costs. Use of claims data will reveal that target populations may benefit from or are in need of integrated healthcare solutions.
   b. Predictive modeling will be used to identify and proactively reach out to individuals within our target populations who are at risk of developing complex behavioral health and co-morbid physical health conditions.

2. **Embedded care Management**

   a. The Embedded Care management team consists of a care Manager embedded at KCMHSAS, a Care manager at Priority Health Choice, Inc., and a Care Management Support Specialist. The Care Managers will utilize the healthcare hotspotting process to assist the treatment providers and the individual, parent and/or family to navigate all systems of care in order for care to be experienced as a single system treating the whole person. The role is distinct and separate from traditional targeted case management services and does not provide Medicaid billable services.
   b. Care Management is an evidence-based integrated care practice in which coordination of care is emphasized in order to reduce fragmentation and unnecessary use of services, prevent avoidable conditions and to promote increased self-management of both behavioral and physical health conditions. A Care Manager is a trained professional (LMSW or RN) who works with and/or manages complex and/or chronic care individuals. The Care Manager utilizes information from the hotspotting process to coordinate with treatment professionals from both the behavioral health system of care and the medical/physical health community. The KCMHSAS Care Manager is the individual whose primary role is to assist the treatment providers and the individual to navigate all systems of care in order for care to be experienced as a single system treating the whole persons. Within Priority Health Choice, Inc., Care Managers provide telephonic support and education to individuals diagnosed with complex

and often unmanaged chronic physical and/or behavioral health conditions. It is important to note that the Care Manager is not synonymous with a case Manager, a person within the KCMHSAS and SWMBH specialty services system that provides Targeted Case Management (TCM) services to individuals with severe mental illness diagnoses as outlined in the Michigan Medicaid Manual.

c. The Care Management Support Specialist is a Certified Peer Support Specialist and/or Parent Support Partner and/or person with lived experience who assists the Care manager in carrying out the goal of integrated and coordinated care between the behavioral health care provider and primary care/physical healthcare providers as well as Priority Health Choice, Inc. and the KCMHSAS and SWMBH behavioral health and intellectual-developmental specialty services system of care.

d. A Coordinated Care Plan is developed, when applicable, to focus on communication, coordination, and collaboration between the provider team on behalf of the individual. The Coordinated Care Plan is a planning tool that addresses the healthcare needs of the individual and the barriers an individual and family may face when attempting to access care and how the healthcare team will communicate to address these needs and/or barriers. The coordinated care gaps and de-fragment the healthcare system complexity that exists for consumers and the provider team while supporting the person-centered planning process which is at the heart of supporting individual choice and control.

e. The Embedded Care Management team will:

    i. Offer and provide primary care provider education and consultation to manage behavioral health concerns.

    ii. Build strong working relationships with Kalamazoo County primary care providers for the purposes of system-level care coordination education provision, care conferences, consultation and collaboration.

        - Care conferences scheduled as needed to assist with resolution of issues that are preventing successful progress, when goals have been met or transition of care is needed.

    iii. Assist with coordination of benefits between Priority Health Choice, Inc., KCMHSAS preferred provider network, and SWMBH PIHP regional managed specialty services system on behalf of the individual/parent/family, behavioral health and primary care/physical health providers.

    iv. Assist with communication and coordination among KCMHSAS providers, Priority Health Choice, Inc. providers and primary care providers on behalf of the individual/parent/family, behavioral health and primary care/physical health providers.

    v. Provide patient education and self-management skills for individuals, parents and families.

    vi. Provide referrals for resources to enhance health and wellness.

    vii. Implement disease management, a system of coordinated healthcare interventions and education for individuals who have chronic or long-term healthcare needs. Individuals will receive self-education materials from healthcare providers for the purposes of better understanding their diagnoses conditions and how to best manage their healthcare needs. It requires a whole system support which may include

embedded Care Management staff, families, friends, clinical professionals, and primary care to assist the individual in improving his or her health, wellness and quality of life while minimizing the effects of the disease.

3. **Enhanced supports for children and youth with mild or moderate behavioral health conditions and needs.**

   a. KCMHSAS will serve as Priority Health Choice, Inc.'s preferred provider for mild/moderate outpatient services to support seamless and integrated care and improve access to specialized behavioral health services.

      i. Currently Priority Health Choice, Inc. and all Medicaid Health Plans manage the medical and physical healthcare for Medicaid enrollees and the behavioral health mild/moderate outpatient benefit service needs. SWMBH and all PIHPs coordinate behavioral and social service care for people with serious mental illnesses, children and youth with serious emotional disturbances, people with substance use disorders, and people with intellectual and developmental disabilities. When individual's behavioral health needs extend beyond mild or moderate behavioral health outpatient services, she or he must seek continued services from KCMHSAS. Designating KCMHSAS as the preferred provider of Priority Health Choice, Inc. for the mild/moderate behavioral health outpatient benefit services, and adding these services to KCMHSAS's overall continuum of care will remove the split-system barrier and coordination of care challenges for individuals thus supporting a single system of care model that treats the whole person.

   b. In addition to providing outpatient mental health services for children and youth with mild/moderate behavioral health needs, this model will provide access to enhanced supports not included (billable or reimbursable) in the mild/moderate outpatient Medicaid benefit including:

      1. Parent Support Partner Services/Peer Support Specialist Services
      2. Short term urgent patient outreach activities
      3. Assistance with navigating the health care system
      4. Access to Children's Health Access Program (CHAP) services to assist with connection to primary care or addressing needs and barriers relevant to social determinants of health.

4. **Close collaboration with, and provision of on-going education and consultation to, Kalamazoo County primary care providers, behavioral health providers and community services providers regarding integration and system-level care coordination.**

   a. The embedded care management team will build strong working relationships with Kalamazoo County primary care providers for the purposes of system-level care coordination, education provision, care conferences, consultation and collaboration.

b. Marketing and training materials including a co-branded brochure will be developed for use by Priority Health Choice, Inc. and KCMHSAS to introduce identified shared children, youth and families to the model.
c. Face-to-face meetings with large primary care offices will be arranged to introduce the model and request support in improving members' access to primary care services.
d. Priority Health Choice, Inc., KCMHSAS and SWMBH will partner to present seminars on "Coordinating Care with a Medicaid Health Plan." These CEU-eligible seminars will be attended by behavioral health case managers and providers in Kalamazoo County.

The above mentioned four key activities will improve the health and wellness of youth by achieving the following objectives:

4. Improve access to physical and behavioral healthcare
5. Assure physical and behavioral health services are coordinated and integrated
6. Improve the physical and behavioral health of adults, children and youth served.

The pilot plan below outlines deliverables and timeframes:

Year 1
Quarter 1: Implementation Activities
1. Acquire and develop Integrated Care Coordination Model staff. 2. Develop hotspotting and predictive modeling strategies. 3. Jointly develop and implement processes to manage and improve physical and behavioral health care. 4. Initiate process to establish KCMHSAS as Priority Health Choice, Inc's preferred provider for mild/moderate outpatient services to support seamless and integrated care and improve access to specialized behavioral health services. 5. Develop program evaluation analytics and methodology.
Quarter 2: Services and Program Evaluation
1. Program launched and adults, children and youth served. a. Implement processes to manage and improve physical and behavioral healthcare. b. Ensure access to outpatient services and enhanced supports. 2. Priority Health Choice, Inc., KCMHSAS and SWMBH actively educate KCMHSAS providers, primary acre, and community service providers and primary care (education) in key concepts of system level care coordination. 3. On-going program monitoring and evaluation.
Quarter 3-4: Services and Program Evaluation
1. Continue activities outlined in Quarter 2
Year 2
Quarter 1-2: Services and Program Evaluation
1. Continue activities in Quarter 2, Year 1. 2. Program evaluation for Year 1 completed in Quarter 1
Quarters 2-4: Services, Program Evaluation and Sustainability Planning
1. Continue activities outlined in Quarter 2, Year 1 2. Establish sustainability plan to continue model.

ATTACHMENT 3

298 Integrated Care Coordination Pilot Model