STATE OF MICHIGAN
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

Request for Information Manager: Lance Kingsbury
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This RFI seeks to obtain information on operations, management and evaluation of pilot(s) pursuant to Section 298 of Public Act 107 of 2017.

ISSUE DATE: DECEMBER 20, 2017

ANTICIPATED TIMELINE

DEADLINE FOR PROVIDERS TO SUBMIT QUESTIONS REGARDING THIS RFI: JANUARY 10, 2018

STATE ANSWERS TO PROVIDERS' QUESTIONS PROVIDED BY: JANUARY 23, 2018

DEADLINE TO SUBMIT INFORMATIONAL RESPONSES: FEBRUARY 20, 2018

ORAL PRESENTATIONS (IF NEEDED): MARCH 1 AND 2, 2018

ANTICIPATED NOTICE OF ANTICIPATED PILOT DECISION: MARCH 9, 2018

The information in this document is subject to change. Check www.michigan.gov/SIGMAVSS for the current information.

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REQUEST FOR INFORMATION INSTRUCTIONS

1. **CONTACT INFORMATION FOR THE STATE.** The sole point of contact for the State concerning this (RFI) is listed on the Cover Page. Contacting any other State personnel, agent, consultant, or representative about this RFI may result in disqualification.

2. **QUESTIONS.** Questions concerning the RFI must be emailed to the point of contact listed on the Cover Page by no later than **3:00 PM EST on January 10, 2018**. Only written questions will be accepted. Answers to questions will be posted on www.michigan.gov/SIGMAVSS under the RFI number.

3. **MODIFICATIONS.** The State may modify this RFI at any time. Modifications will be posted on www.michigan.gov/SIGMAVSS. This is the only method by which the RFI may be modified.

4. **DELIVERY OF RESPONSE.** Please provide an informational response electronically, in a searchable PDF format, no later than **11:59 AM EST on February 20, 2018,** via www.michigan.gov/SIGMAVSS. The informational response, including any attachments, must not exceed 50 pages and must be fully uploaded and submitted prior to the deadline. Any attachments that are included with the informational response should be less than 6 Gigabytes in file size. Do not wait until the last minute to submit a response, as the SIGMA VSS system requires the creation of an account and entry of certain information, in addition to uploading and submitting the materials. The SIGMA VSS system will not allow a response to be submitted after the response deadline identified above, even if a portion of the response has been uploaded. All documents must be created using tools that are compatible with the Microsoft Office Suite 97 standard desktop tools, without need for conversion. System prompts for pricing attachments and information can be disregarded.

   Questions on how to submit information or how to navigate in the SIGMA system can be answered by calling (517) 373-4111 or (888) 734-9749.

5. **MANDATORY MINIMUM REQUIREMENTS.** If the following mandatory minimums are not fulfilled the State reserves the right to disqualify an informational response:

   a. The applicant is a Community Mental Health Service Program (CMHSP).

   b. The applicant has submitted a signed memorandum of support (Attachment A) from at least fifty-percent of the Medicaid Health Plans (MHPs) within the proposed pilot region, which demonstrates their engagement in pre-planning activities.

   c. The applicant has submitted a plan demonstrating full financial integration as required under Section 298 of Public Act 107 of 2017.

Only informational responses meeting the mandatory minimum requirements will be considered for evaluation.

6. **EVALUATION PROCESS.** The State will evaluate each informational response that meets all of the mandatory minimum requirements based on the factors described below. In the event MDHHS receives more than three applications that meet the mandatory minimum requirements identified, the State reserves the right to evaluate and select the applicant(s) demonstrating preferred pilot potential.

	Evaluation Criteria	Points
1.	Miscellaneous (Sections 3, 4, 5)	15
2.	Public Policy (Section 6)	50
3.	Service Array and Delivery (Section 7)	35
4.	Financial Model and Considerations (Section 8)	35
5.	Managed Care Functions (Section 9)	50
6.	Pilot Project Evaluation (Section 10)	15
	Total	200

Proposals receiving 160 evaluation points will be considered for award.

7. **RESERVATIONS:** The State reserves the right to:
   a. Disqualify an applicant for failure to follow these instructions.
   b. Discontinue the RFI process at any time for any or no reason. The issuance of a RFI, your preparation and submission of an informational response, and the State's subsequent receipt and evaluation of your informational response does not commit the State to select you or anyone, even if all of the requirements in the RFI are met.
   c. Consider an otherwise disqualified proposal, if no other proposals are received.
   d. Disqualify an informational response based on: (1) not meeting the mandatory minimum requirements, (2) information provided by the applicant in response to this RFI; (3) the applicant's failure to complete registration on www.michigan.gov/SIGMAVSS ; or (4) if it is determined that an applicant purposely or willfully submitted false or misleading information in response to the RFI.
   e. Evaluate the response outside the scope identified in **Section 6, Evaluation Process**, if the State receives only one informational response.

8. **AWARD RECOMMENDATION.** The State will consider awarding the pilot project(s) to responsive and responsible applicant(s) who meet the minimum point threshold stated in **Section 6, Evaluation Process,** as demonstrated by the informational responses. The State will also use the results of the evaluation process stated in **Section 6, Evaluation Process** in order to select the 3 applicants. The State intends to award up to 3 pilot projects in compliance with Section 298 of Public Act 107 of 2017. Other factors may be considered in the selection of the pilots including, but not limited to, geographic region, financial impact on the current Prepaid Inpatient Health Plan, etc.

9. **ORAL PRESENTATIONS.** The State reserves the right to invite applicants for oral presentations.

10. **CLARIFICATION RESPONSE:** The State reserves the right to issue a Clarification Request to an applicant to clarify its informational response if the State determines the response is not clear. Failure to respond to a Clarification Request timely may be cause for disqualification.

11. **GENERAL RESPONSE CONDITIONS.** The State will not be liable for any costs incurred in preparation of applicant's response, delivery of the response, and any follow-up discussions with the State. This RFI process does not guarantee a pilot award and is not an offer to enter into a contract.

12. **FREEDOM OF INFORMATION ACT.** All portions of an informational response are subject to disclosure as required under the Michigan's Freedom of Information Act (FOIA), 1976 Public Act 422. However, please note the following:

    a. Under MCL 18.1261(13)(b), records containing "a trade secret as defined under section 2 of the uniform trade secrets act, 1998 PA 448, MCL 445.1902, or financial or proprietary information" are exempt from disclosure under FOIA. And under MCL 18.1470(3), "proprietary financial and accounting" information is also exempt from disclosure under FOIA.
    b. If information within an applicant's proposal falls under the aforementioned exemptions, and the applicant seeks to have it withheld from disclosure under FOIA, then by the informational response deadline, the applicant must: (1) save exempt information in a separate file (i.e., document); (2) name the file/document "FOIA-EXEMPT"; (3) label the header of each page of the file/document "Confidential–Trade Secret," "Confidential–Financial," or "Confidential–Proprietary" as applicable; (4) clearly reference within the file/document the RFI schedule, section, and page number to which the exempt information applies; and (5) verify within the FOIA-EXEMPT file/document that the information meets the FOIA exemption criteria.
    c. The State reserves the right to determine whether information designated as exempt by an applicant falls under the FOIA exemptions.
    d. Resumes, pricing, and marketing materials are not trade secrets or financial or proprietary information.
    e. **Do not** identify your entire informational response as "FOIA-EXEMPT," and **do not** label each page of your informational response "Confidential." If an applicant does so, the State may require the applicant to resubmit the informational response to comply with subsection (b) above.
    f. If the State requires an applicant to resubmit an informational response for failure to follow these instructions, the State reserves the right to disqualify the applicant if the informational response is materially changed upon resubmission. In other words, amendments to the informational response should be restricted to that which is necessary to separate confidential from non-confidential information.

13. **RIGHTS TO INFORMATION CONTAINED IN RESPONSES.** All informational responses will be considered the property of the State.

STATE OF MICHIGAN

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

1. INTRODUCTION

Section 298 of Public Act 107 of 2017 instructs the Michigan Department of Health and Human Services (MDHHS) to "…implement up to 3 pilot projects to achieve fully financially integrated Medicaid behavioral health and physical health benefit and financial integration demonstration models. These demonstration models shall use single contracts between the state and each licensed Medicaid Health Plan (MHP) that is currently contracted to provide Medicaid services in the geographic area of the pilot project."

Informed by values defined by the 298 Facilitation Workgroup and input solicited from current system respondents, this Request for Information (RFI) presents MDHHS' expectations of pilot(s). While this RFI is not intended to be prescriptive, MDHHS has outlined parameters within this RFI which shall define the structure of the pilot and serve as evaluation criteria for their selection. Once pilot regions are selected, MDHHS will continue to work with pilot partners to further operationally define and negotiate contractual parameters and conditions.

2. BACKGROUND

Michigan has employed managed care structures within its Medicaid program for nearly two decades. Throughout that time, Michigan has been a recognized leader among other states for its managed care systems. Michigan has utilized a behavioral health carve out in the managed care structure since initially implementing it. The current structure funds physical health care services through contracts with licensed managed care organizations utilizing full risk funding arrangements and competitive contracting. Specialty behavioral health services, including services for those individuals with serious mental illness, serious emotional disturbance, intellectual/developmental disabilities, and substance use disorders (SUD), are managed by sole sourced, public prepaid inpatient health plans (PIHP) utilizing shared risk funding arrangements. Under the current, carved-out, arrangement, Michigan has established a broad array of services and supports for individuals with behavioral health needs.

While the current system has developed exceptional services and capacity, the current bifurcation of funding and services management has created challenges for the successful integration and coordination of physical and behavioral health care for those with multiple comorbid conditions. There is growing national recognition of the need to integrate care at the financing, service delivery and outcome measurement levels. In response to this trend, and in recognition of the long and successful history of Michigan's implementation of managed care structures and approaches, the Michigan Legislature has instructed MDHHS to implement pilots to test the impact of financial integration for physical health and behavioral health services.

Under the current system, two very significant and distinct benefit management philosophies coexist. These include a structure that centers around a Medicaid beneficiary, ensuring that appropriate healthcare services are accessible, coordinated and effective. This structure seeks to

provide integrated physical and behavioral healthcare, as needed, to all beneficiaries. Simultaneously, this has also included a structure that is focused on managing the behavioral health needs of the community while providing needed, integrated services to those individuals in need. It is the department's intent to preserve and integrate the values of each of these structures as it pilots financial integration.

To this end, all pilots will be expected to comply with current public policy requirements of Michigan's public behavioral health system. MDHHS also expects that all pilots will maintain the full, current array of services that are supported by the specialty services carve-out and related waivers, and required by current contracts. These expectations should drive the funding model employed by pilot participants, which must comply Section 298 of Public Act 107 of 2017. Additionally, both PIHPs and MHPs are required to comply with federal Medicaid managed care regulations, which include but are not limited to: requirements for access, provider network management and capacity, medical loss ratio, enrollee information, and grievance and appeals. These regulations will also apply to the implementation of required managed care functions within the pilot sites.

A description of the current system is included under Attachment B.

3. 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 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."

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RESPONSE PREPARATION

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

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

Response:

West Michigan Community Mental Health (WMCMH)
920 Diana Street
Ludington, MI 49431

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

Response:

Lisa A. Williams, Ph.D.
Executive Director
231-843-5489 or 231-233-3023
lisaw@wmcmhs.org

Please note that WMCMH is submitting this RFI application as a single CMH but because of similarities in proposed care and financing model, would consider being grouped with HealthWest or HealthWest and Saginaw for the purposes of the 298 Pilot. They are the partner CMHs referenced throughout this RFI response.

3. Provide the proposed organizational structure (chart) to support the implementation of the pilot. The organizational structure should delineate (1) the role of the CMHSP; (2) the relationship of the CMHSP to all MHPs in the pilot region; and (3) the relationship of the CMHSP to MDHHS.

Response:

Please see the graphic provided in **Attachment B** (2 pages). Question 4 response describes the relationships between the entities described in the graphic.

You'll note that WMCMH's graphic contains specific reference to the ASO that was proposed in the initial 298 RFI. WMCMH was prepared to submit its RFI on the evening of February 12th, when it received notice on Friday (February 9) afternoon that the date and the content of the RFI had changed significantly. As such, WMCMH's RFI response is specific to the original RFI specified Model elements (including the ASO). WMCMH did complete an additional response for the newly added 8e that is included in the RFI which does include reference to the ASO as a distinct and viable option.

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

Response:

State to MHPs: The state will pay two Medicaid capitation payments to each of the six MHPs, one for physical health and one for behavioral health for all their enrolled members.

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

As the structure was originally proposed in the RFI, the state will pay a capitation payment to the ASO for behavioral health services for the unenrolled populations. The unenrolled population makes up as little as 30% and as much as 50% of the Medicaid population (depending upon the CMHSP). Therefore, how this population is supported and managed in the context of a financial integration pilot is critical to the ultimate outcomes of the 298 Pilot process. WMCMH and its partner CMHSPs would expect, in order to maximize efficiency, that the delegation principles and care model proposed would be consistent across the MHPs and the ASO.

MHPs to CMHSP: MHPs will be payers for the Enrolled Medicaid and Healthy Michigan substance use disorder (SUD), mental illness (MI), severe emotional disturbance (SED), and intellectual and developmental disability (I/DD) populations, inclusive of the mild-to-moderate (M2M) population currently managed by the MHPs. The specialty services for these populations will be contracted to the CMHSP and its provider network. This payment structure will include a mixture of a PEPM and value-based arrangement (more description on potential payment methodologies in question 8). PEPM will be paid for the traditional behavioral health services (including M2M) and expanded CCBHC type services. The MHP and CMHSP may agree to additional value-based payment arrangements for either additional services the MHP selects to contract for with the CMHSP or for new service areas collectively identified and prioritized by the MHP/CMHSP partners. As delegation arrangements are established, the MHPs may add dollars to the capitation or set up additional value based payment mechanisms for functions delegated to the CMHSP. Additionally, for functions that the CMHSP performs locally on behalf of the MHP, additional funding mechanisms may be discussed either via fee-for-service, value-based payment or, additional dollars in capitation.

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

County Government to CMHSP: The counties associated with the CMHSP (Mason, Lake and Oceana Counties for WMCMH) will make payments directly to the CMHSP for PA2 dollars for SUD and prevention services and for local match. The CMHSP will be accountable to the standards of CMHEs for the functions associated with the PA2 dollars.

CMHSP to Local Care Networks: As is currently the case, the CMHSP will retain necessary managed care functions to support the locally established systems of care and the specialty service delivery network for the MI, SED, IDD, and SUD populations. Additionally, WMCMH will assume necessary managed care functions for the locally established M2M network. Specific managed care functions to be performed by WMCMH for the local specialty services network will likely include access and eligibility, quality management, and provider network management.

Additionally, WMCMH and the MHPs will work to identify and collectively support a collaborative model across the existing healthcare networks in the 298 Pilot areas. They will especially explore mechanisms to support the CCBHC Plus collaborative care model for all populations served in the Pilot region, but most especially relationships between the CMHSP specialty and community network and the local FQHCs, Physician Organizations (POs) and ACOs, primary care and specialty care providers, and hospital systems.

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

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

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

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

Response:

Direct Care Integration Experience: WMCMH has been an active participant in local efforts to integrate care at the individual/clinical and population levels. Examples include primary care integration (via local FQHCs and Hospital systems) as well as diverse, cross-system integration with other community entities (schools, local United Way organizations, courts, DHHS offices, health departments, University of Michigan, SUD providers, NREX, regional VA (BCVAMC).

WMCMH has participated in two separate co-location efforts with local FQHCs and has been part of larger hospital system coordination and collaboration efforts around access to psychiatric care (grand rounds, team staffing, local community committees around behavioral health access) and coordination of care (huddles and team staffing). WMCMH teams assisted local hospital psychiatric teams in transitioning patients into primary care when the hospital system closed its local inpatient unit and its specialty psychiatric practice. Additionally, WMCMH supports and transitions its consumers from specialty services to primary care services as their need for more intensive, specialty behavioral health interventions decreases. WMCMH has experience co-locating primary care on site in its CMHSP clinics several years ago and plans to add this primary care capacity back into its service array through a local physician partnership. The primary goal is to assist consumers with no primary care access in getting physical health needs met.

WMCMH established an MOU with the Battle Creek VAMC for coordination of care for veterans. WMCMH currently provides services to veterans in its three counties and has all eligible clinicians paneled through Tricare. WMCMH is also in the process of becoming a telehealth site for the Battle Creek VA to improve access to culturally competent, veteran specific, and evidence based psychiatric and physical health care for local veterans.

Finally, WMCMH also co-locates staff in three local school districts (including 2 teen health clinics).

WMCMH has peers on staff who are trained in wellness coaching and is expanding peer coaching access through Mental Health Block Grant dollars. WMCMH has staffed the MC3 program to increase pediatrician access to psychiatric services. WMCMH provides psychiatric consultation to primary care upon request for local primary care offices and FQHCs.

Specific to Substance use disorders, in addition to performing all SUD delegated functions (except prevention), WMCMH has fostered partnerships towards care integration with:

-- Local physicians' offices around the Specialty Pregnancy Assistance (SPA) program, supporting healthier moms and babies impacted by substance abuse;

-- Leeward initiative and the Mason County Substance Abuse Prevention Coalition to support community-wide access for families to medication lock-boxes;
-- Red Project to improve community-wide access and training to Narcan. WMCMH provided training for all law enforcement officials across its three counties and Narcan kits for every law enforcement vehicle;
-- Local FQHCs to support enhanced rural community access to Medication Assisted Treatment (MAT; via specialty MAT grant).

Financial Integration Practice: WMCMH's involvement in fiscal integration has been primarily in its relationships with local schools and system of care/care network partners. Through a community funder, dollars and services are pooled to support an enhanced whole person care model to kids in schools. WMCMH's contribution to the integration is primarily through hiring of Masters level clinical staff and supervision to those staff as they provide services in the school setting. Other community partners who provide financial and resource support to make the project successful include local DHHS offices, United Way, Pennies from Heaven Foundation, the ESD, Northwest Michigan Health Services, and all Mason County Schools. The purpose of the program is to support kids and families who have unmet healthcare needs. Many of these children and families do not meet criteria for traditional CMHSP services or have substandard insurance plans to support their families' temporary mental health need. Additional examples of financial integration (often community benefit) activities are described throughout the RFI.

MHP Preplanning and Engagement Efforts: WMCMH and HW began meeting with the MHPs in July, 2017. The first official meetings to explore a financial integration partnership occurred with Priority Health and then Meridian on July 21, 2017. WMCMH and HW have continued this partnership to explore relationships with the plans. Additionally, Saginaw County CMH (SCCMH) joined the partnership in November and has continued since that time and throughout the RFI process. Dates of subsequent meetings by plan are provided below:

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

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

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

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

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

During these meetings, the MHPs and CMHSPs discussed the need for Clinical, Business Operations, and Financial Integration for a model to be successful. The CMHPs proposed a care delivery and care coordination model which builds on traditional CMHSP specialty services, via the constructs of the Certified Community Behavioral Health Clinics (CCBHC). The CCBHC-Plus model would comprise all behavioral health populations including MI, SED, SUD, and I/DD. The CMHSPs would also, as part of the 298 Pilot, assume responsibility for the M2M population, currently managed by the MHPs. The CMHSP and/or its provider network would continue to provide the comprehensive array of services that are necessary to create access, stabilize people in crisis, convene social supports in the community, and provide early intervention and the necessary treatment for those with the most serious, complex mental illnesses and addictions. The CMHSP would also integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration.

Direct care coordination in the pilot for individuals with (or at risk for) behavioral health conditions, inclusive of all current populations served with the addition of the M2M population, would be the responsibility of the CMHSP, where individuals could be offered a range of supports from brief interventions to very intensive daily contact. CMHSPs use a multidisciplinary team approach; those teams addressing the highest level of need include psychiatrist, nurse, master's level clinician, case manager, peer/recovery support coach, and employment specialist. Far beyond integrating funding, the CMHSPs believe that care coordination, particularly for those with behavioral health needs and co-morbid chronic health conditions, is critical to success in this model. The proposed models of care coordination are "boots on the ground," often seeking out

and engaging individuals in the home, emergency room, in jails, homeless shelters and/or other community locations.

Additional dialog with MHPs is needed to ensure that the care management functions required of the MHPs as a managed care entity provide support and oversight (but not redundancy) to the care coordinators providing direct support to individuals in the community. In the proposed 298 Pilot model, the MHPs would retain their obligation to provide risk stratification and identification and complex care management to those identified as high risk.

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

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

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

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

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

Response:

During meetings with the MHPs beginning in July 2017, WMCMH and partner CMHSPs have repeatedly called attention to these key public policies, as well as specific operational requirements inured in current PIHP contracts and federal waivers. WMCMH is currently in compliance with these policies and has offered technical assistance to the MHPs to support understanding and compliance in their oversight/monitoring responsibilities. The MHPs have additionally sought technical assistance and education from MDHHS related to their responsibilities under these policies. In some instances (i.e. reciprocity), certain conflicts with current

accreditation requirements have been identified. MHPs/CMHSPs will need to continue to work collaboratively to resolve discrepancies and/or conflicting requirements.

b. Describe how consumer engagement will occur, including how feedback will be used to inform policy development and implementation, program performance review, recovery plan development, network adequacy, etc.

Response:

WMCMH has multiple mechanisms in place to engage consumer input and guidance in policy development, program and service development, quality improvement, and network adequacy. WMCMH exceeds the Mental Health Code requirements and meets the CCBHC requirements for consumer and family member representation on the WMCMH Board. The WMCMH Consumer Advisory Panel (or CAP) meets at least monthly, more if necessary, to provide input on key areas of operation within the organization. CAP members sit on various organizational and PIHP committees (e.g., Quality, Accessibility, Public Policy Advocacy, Recipient Rights) and workgroups (e.g., EMR implementation, facilities) and provide critical input and direction on organizational activities and policy. They also provide a feedback loop between those committees and the full CAP to ensure consumer engagement above and beyond committee representation.

WMCMH employs peers on all of its teams including youth peers, Parent Support Partners, Certified Youth Support Specialists, and SUD Peer Recovery Coaches. WMCMH peers are embedded members of organizational teams who support consumers, the organizational team, and decision-making. WMCMH also regularly engages consumer feedback from all populations via recovery surveys, consumer satisfaction surveys, and focus groups.

WMCMH Leadership has shared educational information and sought input from the CAP over time on the CCBHC model, efforts toward integration of care, and on its intention to respond to the RFI. Should WMCMH be awarded a Pilot opportunity, significant consumer participation in the integration of care design and on the enhanced coordination of care model between the MHPs and the CMHSP is essential.

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

c. Explain your plan to assure compliance with Section 330.1287 of the Michigan Mental Health Code (Public Act 258 of 1974 as amended) regarding MDHHS designated Community Mental Health Entities responsibilities for the implementation of SUD treatment and services.

Response:

WMCMH has been an outpatient SUD provider for more than seven years and is currently delegated to perform managed care functions for substance use services from the Lakeshore Regional Entity (LRE; the PIHP for WMCMH). The LRE currently maintains the SUD Advisory Board and retains prevention functions. Under the 298 Pilot, WMCMH would continue performance of the SUD managed care functions and would take on responsibility for substance use prevention services in its three counties. WMCMH is actively engaged in all prevention activities occurring within the three counties (including participating on the review committee for the prevention RFPs submitted by prevention contractors to the LRE). In addition to ongoing integrated SUD activities at WMCMH, the organization has established a full SUD delivery team. The team includes two Masters level therapists, one Peer Recovery Coach, and one SUD Care Manager. WMCMH is in the process of hiring a supervisor to assist in managing the team and coordinating the SUD provider network. WMCMH has several grants associated with SUD, including a grant to provide SUD services in all three county jails, a grant for Narcan training and distribution, and a grant to enhance Medication Assisted Treatment (MAT)

access across our counties. WMCMH will continue to seek out these grants and plans to add peers and care management capacity to its SUD team.

WMCMH anticipates establishing a subcommittee of the WMCMH Board to perform the functions of the SUD Advisory Board consistent with the MDHHS contract. That SUD Advisory Board would consist of appointees from each of the three county departments, SUD provider community, consumer representation, and potentially MHP representation as well. Depending on the location and philosophical alignment of other 298 Pilot sites, WMCMH would consider co-developing this SUD Advisory Board function with another pilot site.

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

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

Response:

WMCMH is proposing a CCBHC Plus model for this pilot, designed to provide a comprehensive range of mental health and substance use disorder services, particularly to vulnerable individuals with the most complex needs. WMCMH will offer the following services either directly or through a formal contract with a designated collaborating organization (DCO). In addition to the full array of Medicaid-funded behavioral health specialty services provided through the CMHSP and/or its provider network as defined by the Michigan Medicaid Provider Manual, WMCMH will provide the following services for ALL behavioral health populations:

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

WMCMH has been a provider of outpatient SUD services for seven plus years. WMCMH will provide a comprehensive array of services necessary to create access, stabilize people in crisis, and provide the necessary treatment for those with the most serious, complex mental illnesses and addictions. WMCMH will also integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration. The CCBHC Plus model proposed for this pilot includes all behavioral health populations including children and adults with MI, SUD, SED, I/DD, and M2M. Under the 298 Pilot, WMCMH would also receive capitation and have management responsibility for the M2M population and its network that is currently served under the MHPs. The expansion of the specialty services network to include early intervention is critical to the integration pilot and to efforts to improve long-term outcomes for individuals with behavioral health conditions.

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

Response:

WMCMH is a direct provider of most specialty behavioral health and SUD services (approximately 80% of WMCMH services are directly provided), while also managing a large provider network. It is the intent of WMCMH to maintain responsibility of its current network management responsibilities as well as workforce development and continuing education for the specialty behavioral health network. To ensure consistency in care delivery during the pilot period, WMCMH will provide fidelity oversight and credentialing in evidence based practices. The MHPs would have a critical role in developing network capacity for key services including MAT and psychiatry, improving and expanding provider relations with primary care and hospitals, and leveraging their network adequacy and contract management expertise to develop and expand the CMHSP provider network.

WMCMH will continue to ensure access to the full range of specialty behavioral health services and supports in the local community whenever possible, either via direct service provision or contract with its local network of providers. It is hoped that the communities in the pilot program will benefit from MHP expertise in recruiting key medical professionals such as psychiatrists, nurse practitioners, and addictions specialists to enhance its current service array.

c. The public mental health system has encouraged (and in some cases contractually required) the use of evidence-based practices. Describe your plan to maintain use and validation of specialty behavioral health evidence-based practices.

Response:

Below is a list of the Evidence Based Practices (EBPs) currently being implemented at WMCMH as well as the process for ensuring consistency of implementation of practice and certification where required:

Evidence Based Practice	**Certification and/or Review**
PMTO - Parent Management Treatment – Oregon Model	recertification every year; reviewed at Credentialing and Privileging (C&P)
CBT - Cognitive Behavioral Therapy	individual supervision; reviewed at C&P
FPE - Family Psycho Education	training hours maintained; reviewed at C&P
SFBT - Solution Focused Brief Therapy	Reviewed at C&P
DBT - Dialectical Behavioral Treatment	Supervision; Reviewed at C&P
ACT - Assertive Community Treatment	Program recertified every three years by MDHHS; required trainings; including the doctors; Reviewed at C&P
IMH – Infant Mental Health	Certification; Reviewed at C&P
Supported Employment	Training required; Certification; Reviewed at C&P
Motivational Interviewing	Training required (certified trainers on staff; Reviewed at C&P
TREM – trauma recovery and empowerment (for women)	Training required; Adherence to program protocols; Reviewed at C&P
TREM-M – trauma recovery and empowerment (for males)	Training required; Adherence to program protocols; Reviewed at C&P
IDDT – Integrated Dual Disorder Treatment	Training required; Adherence to program protocols and model for care; Reviewed at C&P
WHAM – Wellness, Health and Medical	Training required; Reviewed at C&P
SMART Recovery	Training and Certification required; Reviewed at C&P
TF-CBT –Trauma Focused Cognitive Behavioral Treatment	Certification; Reviewed at C&P

WMCMH consistently evaluates new EBPs and requires training and certification, where appropriate, of staff and teams to meet the needs of its consumers and communities. In addition to the list of EBPs implemented, WMCMH is also developing critical competencies in the areas of children's 24-hour mobile crisis (anticipate expanding to adults), on site primary care access, and MAT. WMCMH further shares its training opportunities and invites community providers to participate to expand access locally and more broadly to its communities.

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

Response:

WMCMH has been part of collocation of behavioral health services in both FQHCs that serve the three-county area. WMCMH partners, coordinates care, and provides behavioral health services to consumers served in both of the adolescent health clinics located in its three counties. WMCMH also provides SUD individual and group treatment across all three county jails and coordinates services and care with primary care services in those jails. As mentioned previously, WMCMH was an early partner in the MC3 initiative, aimed at improving pediatrician access to psychiatric services and consultation. WMCMH staff members (care managers and/or aids) typically attend all primary care appointments with IDD consumers and often with consumers involved in Assertive Community Treatment (ACT). WMCMH Wellness Coordinators on the MI-adult team routinely consult with primary care when developing person-centered plans and health and wellness goals. They often solicit input and obtain support from primary care physicians in incorporating physical health and wellness goals into person-centered planning. These Wellness Coordinators also inform primary care physicians of any changes in medications, changes in mental health status, and psychiatric hospitalizations.

Additionally, WMCMH conducted a brief pilot in 2012 to bring primary care access directly into clinic sites. Although initial efforts were successful in meeting the needs of consumers without adequate access to primary care, WMCMH has struggled to find primary care partners to support this practice in an ongoing way across three counties. WMCMH continues to explore these options and seeks other avenues to improve primary care access to consumers. WMCMH anticipates the MHPs to be a critical partner in improving primary care access for consumers who currently have inadequate or no access to primary care.

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

Response:

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

Additional dialog with MHPs is needed to ensure that the care management functions required of the MHPs as managed care entities provide support and oversight (but not redundancy) to the care coordinators providing direct support to individuals in the community. As the care model reflects, WMCMH anticipates development of a "coordination of the coordinators" construct between the MHP Care Coordinators and the CMHSP Care Managers. This construct would aim to support both the high level care management oversight of the MHPs and the active on the ground engagement of the consumer, family, and safety net services required to maintain recovery for persons with complex behavioral health needs. The MHPs would retain their obligation to provide risk stratification and identification, and complex care management to those identified as high risk.

WMCMH will work with its EMR Vendor, PCE Systems, to ensure this clinical workflow and process is supported from a technical standpoint at the CMHSP side in a manner that is simple, clear, and cost effective for all other potential community partners and stakeholders. This may include a combination of direct interfaces among various information systems, as well as, potentially, the utilization of community-based information sharing portals to allow data sharing with organizations that may not have the technical capability or resources to build the necessary interfaces into the information systems. The goal is to deploy tools that remove barriers and allow all healthcare providers to participate in data exchange, integrated health, and care coordination regardless of their size, capability, and technical platform.

f. Explain how the applicant will meet all capacity and competency requirements for care coordination and service delivery that are new to the pilot members (i.e. Substance Use Disorder Services, Services for Individuals with Intellectual or Developmental Disabilities, Services for Individuals with Severe and Persistent Mental Illness, Services for Children and Youth with Serious Emotional Disturbances).

Response:

WMCMH has established a full SUD delivery team to support the needs of consumers with SUD. The team includes two Masters level therapists, one Peer Recovery Coach, and one SUD Care Manager. WMCMH is in the process of hiring a supervisor to assist in managing the team and coordinating the SUD provider network. This is in addition to implementation of IDDT to support individuals with co-occurring disorders across WMCMH teams.

WMCMH is actively engaged in all prevention activities occurring within its three counties (including participating on the review committee for the prevention RFPs submitted by prevention contractors to the LRE). Under the 298 Pilot, WMCMH would assume responsibility for the management of prevention activities and contracts in addition to the SUD network that it already manages. Since the SUD coalitions are quite successful and WMCMH is actively engaged in these activities across the three counties, management of this function is well within the current capacities of the organization. WMCMH anticipates no disruption to the current coalition activities and prevention contracts as a result of the shift in management responsibility.

WMCMH has been awarded several grants to expand SUD services, including grants to:

- Provide SUD services in all three county jails,
- Train in Narcan administration as well as coordination distribution of Narcan kits (to law enforcement and family members of individuals using opiates, and
- Enhance MAT access across the three counties.

WMCMH anticipates continuing, with MHP support, to seek out grant opportunities to enhance the SUD delivery options available to people in the three county area.

g. Explain how principles of cultural competence will be used to support and inform integrated care (include current or proposed coordination with Michigan Tribal Nations).

Response:

Consistent with CCBHC requirements, WMCMH ensures that all services are culturally and linguistically appropriate, respectful of and responsive to the health beliefs, practices, and needs of diverse consumers, and compliant with Limited English Proficiency requirements. WMCMH uses culturally and linguistically appropriate screening tools and tools/approaches that accommodate disabilities, engages treatment planning components that are sensitive to individuals' needs and histories, and ensures that all staff have received training and have demonstrated cultural competencies. This includes specific training on Michigan Tribal Nations, as well as the unique needs of active duty military personnel and veterans. WMCMH's person and family centered planning approach embraces and supports any specific cultural, spiritual or other unique needs of the individual and family to be successful in their community.

WMCMH partnered with the Battle Creek VAMC to establish an MOU to support access and coordination of care to local community veterans. WMCMH has also partnered with the VAMC to become a referral and telemedicine site for the VA. The launch of this effort is in process and will be fully operational by May 2018.

Discussions with Tribal Nations regarding development of an MOU are ongoing. WMCMH routinely accepts referrals, provides services, and coordinates care with the Tribal Health Center for members of the Tribal Nations.

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

Response:

While CareConnect360 is expected to be an important component of care coordination, other systems will be necessary to promote community-wide care coordination in a nimble, cost-effective, and efficient manner. WMCMH envisions data interchange between a variety of information technology systems to fully support care coordination. WMCMH is aware of ongoing efforts and pilots to develop interfaces that will allow care coordinators, with appropriate credentials, to access key CareConnect360 data from within their native systems. This will provide behavioral health care coordinators with easy access to integrated claims data at the point of care.

WMCMH will leverage other available technologies to promote care coordination including the following:

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

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

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

Response:

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

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

Response:

WMCMH leverages its electronic medical record (R3), including practice management and population health management information systems, to improve both beneficiary care and coordination of its needs. PCE Systems has extensive experience and is recognized as a national leader in health information exchange, with a focus on data exchange of sensitive and specially-protected information, such as information protected by 42 CFR Part 2. This experience ranges from local integrations with health systems' EHRs to community-/state-wide data exchanges (e.g. GLHC, MiHIN, etc.).

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

1. Provide actionable, timely, relevant, integrated, and easy-to-access information from various external sources to clinicians "on the ground" at the point of care
2. Develop and exchange shareable community care plans to all care team members, regardless of location, affiliation, or technical capability

3. Integrate data for data analytics and population health management, including utilization and risk management
4. Integrate data for outcomes measurement and management, and utilize such data for value-based service purchasing
5. Provide the best, most accurate data available to the people who need it, when they need it

PCE Systems has implemented the data exchange protocols necessary to support the MiHealthLink Dual Eligible Demonstration Project for both MHPs and PIHPs. Through MiHealthLink, PCE has demonstrated the capability to exchange complex and comprehensive data sets in highly customized national standard formats and protocols with the MHPs. WMCMH expects to take advantage of this expertise and technology to provide enhanced data integration with the health plans.

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

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

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

Response:

WMCMH's primary interest in financing as it relates to support of the 298 Pilot is in advancing current capitation funding models towards the direction of value-based payment methodologies. WMCMH envisions the arrangement beginning in a capitation/subcapitation arrangement and adding, either individually or in combination, value based methodologies such as shared savings, process or performance improvement incentives, and/or outcome-based incentives. Capitation combined with value-based payment options or incentives maintains the stability of the specialty services network through the pilot period. This allows for distribution of risk across populations such that necessary services can be delivered across a community spectrum, inclusive of community supports that address the social determinants of health that are not neatly bundled into fee-for-service payment arrangements. Maintaining financing similar to the current methodology will not be without its challenges, as 298 Pilot CMHSPs will be required to work with six different MHPs plus an ASO. This will require some retooling of IT and business practices in a time when pilot requires minimizing administrative cost. To this point, CMHSP delivery and funding models have been predominantly "plan blind." Additional conversation and technical assistance will be needed to work through this financing model. For the MHPs that have a small number of enrollees, this may be particularly challenging.

Purely fee-for-service methodologies do not support the coordination of care model described earlier in the RFI and would require even more substantial revisions to business and IT systems to support than described above. Ultimately, WMCMH supports and would like to work progressively toward a model of downside risk. Unfortunately, such a shift in risk model is not feasible in the period of a two-year pilot.

The ability to move to more advanced payment mechanisms during the period of the 298 Pilot is dependent upon several factors. First, MDHHS must work with its actuaries to establish sound rates for pilot sites. Second, the CMHSPs and MHPs agree that external expertise and consultation in how to achieve such transformation in a meaningful way without jeopardizing the stability of the network is essential to the success of the pilot. Finally, the actuarially-sound rates upon which savings would be compared and determined should

include the costs associated with CCBHC Plus care model, the addition of care coordination activities within each MHP Provider network, and those managed care functions that would be shared or delegated.

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

Response:

WMCMH is currently exploring value based purchasing in its work to establish partnerships and develop a network of MAT providers within its three-county area. Specifically, MAT providers will be identified and supported via grant dollars in receiving all necessary training to support certification and adherence to the evidence-based care model. WMCMH provides outpatient therapy, case management, and recovery coaching for all consumers receiving MAT through the grant. Based upon the number of consumers the primary care provider agrees to serve via MAT, WMCMH pays an incentive payment monthly for shared planning for those cases with the WMCMH SUD care team.

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

"For the duration of any pilot projects and demonstration models, any and all realized benefits and cost savings of integrating the physical health and behavioral health systems shall be reinvested in services and supports for individuals having or at risk of having a mental illness, an intellectual or developmental disability, or a substance use disorder. Any and all realized benefits and cost savings shall be specifically reinvested in the counties where the savings occurred."

Response:

Much like the financing model considerations above, extensive technical assistance and support from finance experts in shared savings and value-based payment methodologies will be necessary to support a successful pilot. Shared experience across both the CMHSPs and MHPs indicates that when models of integrated care are implemented substantial, savings are realized in physical healthcare. Most immediate savings are usually seen in emergency room use and hospitalization. However, it is not unusual to also see an increase in medical expenses initially as individuals with untreated medical conditions who suddenly develop access to medical treatment. Experience also suggests that costs in behavioral health care often go up in order to realize savings in physical health care. This is particularly true for persons with SUD, as individuals engage proactively in treatment and supports.

In order to calculate savings, the CMHSP pilot sites and MHPs must agree upon the population of shared consumers. This could be all persons served by the CMH (any encounter). More complex, but also more likely to demonstrate more immediate outcomes, is to work through an identified or pre-defined subpopulation for whom the CMHSP would have the defined, primary responsibility to "coordinate the coordinators." Those subpopulations could be defined by any number of variables. Examples of subpopulations could be: all persons served with IDD, high emergency room utilizers, persons with two or more chronic health conditions, hospitalization readmissions, or those identified by the plan as having difficulty engaging in primary care.

Once defined, historic paid claims data would assist in determining the baseline cost from which cost reductions may be compared. As such, potential "savings" could be quantified and tracked over time.

The proposed clinical and financial model also suggests a consolidation of the MHPs network for the M2M behavioral health benefit into the newly constituted CMHSP Pilot's specialty services network. WMCMH and its CMHSP partners see considerable opportunity for cost savings for this population as well, particularly those that may have other chronic health conditions or those who have been treated at an inadequate or ineffective level of care to meet their behavioral health needs.

For the first time, the financing model and proposed funding flow permit consolidation of all funding streams into one concentrated, specialty services network. Specifically, Healthy Michigan and Medicaid for SUD, MI,

IDD, SED, and M2M, combined with PA2, block grant, and local match, would have the ability to be pooled at the level of care delivery, thus fostering total integration of delivery. WMCMH and its partner CMHSPs anticipate still other efficiencies not yet identified in the areas of workforce training, network management, data collection, information technology, etc., just to name a few.

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

The CCBHC Plus care model has the core value of using "savings" at the CMHSP level (which would have lost its "Medicaid identity" to become "local dollars") to expand services. These reinvestment strategies would be developed using local needs assessments and engaging the community and the MHPs in understanding gaps that may or may not be a covered Medicaid service or necessary services to cover under-insured or non-insured individuals. For example, many individuals served in the CMHSP system move off and on Medicaid. Ensuring continuity of care during these times is critical. In rural Lake, Mason, and Oceana counties the needs are often related to access due to transportation and/or limited providers in the area for services such as MAT. In this situation, the expansion of mobile services or telepsychiatry may be indicated. By contrast, in the Muskegon SIM project, needs analysis has identified the need for additional cross trained Community Health Workers, housing resources and substance use programs such as the "Living Room Model" all as strategies to decrease emergency room use and gaps in current service continuum. Other reinvestment strategies would include training and support to network providers or system of care partners in integrated care strategies and evidenced based practices.

At both WMCMH and HW there has been an increase in individuals seeking services, particularly children and those with Healthy Michigan benefit. The result, particularly over the last year, is that expenses have exceeded revenues. Both organizations have implemented cost saving strategies to manage this influx. Changes have resulted in better practice models (move to more brief interventions when appropriate and mobile crisis) as well as briefer and more focused assessment process at the front door. Consumers are now more quickly directed to the right service at the right time. However, this influx of need may continue into the pilot period and reinvestment of savings into additional evidenced based practices such as children's crisis programs and use of technology can help stabilize the system and improve outcomes.

d. Specify how the financial arrangements of a pilot will address the various "community benefit" functions of the CMHSP such as various pooled funding arrangements, social services collaborative agreements, and other relevant community activities.

Response:

There is no reason to believe that the financial arrangements recommended for the pilot will impact the various community benefit functions of the pilot CMHSPs. Maintaining the PEPM is intended not only to stabilize the network of Medicaid providers, but also to uphold (and ideally expand) the important contributions to the CMHSPs' communities by continuing support to existing community benefit programs or to programs in early development. CMHSPs have become experts at leveraging Medicaid benefit and myriad funding sources to collaborate with other organizations and safety net providers. These collaborations and the needs they address are unique to each community as service gaps and community resources vary dramatically, even across a single CMHSP. An example provided above references a care integration model in Mason County where various community partners contribute critical staffing resources and occasionally dollars to address a gap in access for kids with inadequate insurance or modest level need. This has been incredibly successful in Mason County, but has not launched in Oceana or Lake Counties. Instead, these communities have leveraged health department grant dollars and other community partnerships to support school based health clinics. These joint efforts maximize the value of the Medicaid benefit and result in much needed best practice that extends beyond the Medicaid benefit and deep into local communities.

Consistent with the CCBHC model, the CMHSP is seen as a convener in the local system of care. WMCMH is recognized for this role in its local communities. Staff are involved in many community associations, coalitions and community efforts. Across the three counties, WMCMH staff participate in three substance abuse coalitions, community coordinating councils, wraparound teams, hospital community mental health coalitions, court supported drug treatment initiatives, community criminal justice collaboratives, county and community partnerships for jail diversion and DOJ grants, housing initiatives, community schools initiatives, and great start collaborative, to name just a few. In all these groups WMCMH is considered both a necessary partner and a leader in identifying community solutions.

In addition to these formal community wide coalitions, WMCMH is a trusted partner for other systems. This experience and skill comes from decades of understanding and navigating across local systems in ways other organizations are not compelled (ranging from law enforcement systems, judicial and forensic systems, educational systems, employment systems, housing and homeless systems, transportation systems, entitlement systems, child welfare systems, juvenile detention and probation systems, adult parole or probation systems, faith community systems, advocacy systems, self-help and recovery systems, tribal community systems, veteran's systems, health care systems and other human service systems). The mastery and knowledge in navigating these systems improves access and resources for consumers with disabilities who could not navigate them on their own. Good collaborative partners respect each other, learn from each other, and help each other, often without a single dollar passing between them. The fact is that the needs of many CMHSP consumers are deep and wide and often span a life time and even generations. For many consumers, their needs will be met in these systems well after their treatment at their local CMHSP is complete.

The WMCMH vision contains a statement specific to advocating "for innovative systems of care that support people with complex needs in leading meaningful lives in their communities." For CMHSP consumers, working with these systems and leading these community initiatives helps create foundations not just for meeting consumer needs, but for engaging consumers in defining meaningful community participation for themselves and creating meaningful lives of their choosing. The mission of WMCMH is to partner with consumers to make life choices consistent with their values that help them create an environment to live, work, learn, recreate, worship and receive physical health care. This is done as part of supporting consumer recovery and promoting resiliency associated with behavioral health challenges. Carrying out the mission and vision of the CMHSP system is simply not possible without these complex local community networks. The critical nature of these relationships and partnerships is also why WMCMH and its CMHSP partners have engaged their local communities, consumer advisory panels, and provider networks in supporting the development of the RFI response.

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

Response:

The unenrolled population statewide is made up of approximately 500,000 people. These individuals account for approximately $800 million in capitation payments and $1 billion in spending (approximately 40% of total Medicaid spending). How this population is supported in Michigan's transition to a financially integrated system is critical to the success of the pilot both in terms of outcomes attainable from integration efforts and opportunities for healthcare savings and reinvestment. At WMCMH, this population accounts for approximately 30 – 35% of the people the organization serves. These individuals consistently are some of the highest utilizers and most complex cases where coordination and true integration has the greatest opportunity for impact. It is WMCMH's experience that these individuals often struggle to find adequate primary care and to adhere to medical regimens that support their whole person health wellness and recovery. The population typically has involvement of multiple insurance providers, medical specialists, and social service providers. Elements of care from all of these perspectives must be coordinated and included in the individual plan of service. As such, maximizing "coordination of the coordinators" is critical to improved outcomes for these individuals.

WMCMH sees three potential options to successfully manage the unenrolled population in the 298 Pilot: 1) ASO as written into original RFI, 2) Capitation for behavioral health dollars directly to selected pilot CMHSP, or 3) Capitation for behavioral and physical health dollars to selected pilot CMHSPs for shared risk managing. To be clear, the third option is the preferred option. Any solution should include financial integration of both physical and behavioral healthcare.

- Option 1—ASO: Since the 298 Pilot is intended to be a full financial integration pilot, an ASO could be developed as proposed in the original RFI but expanded beyond behavioral health. Such an ASO would manage both the behavioral health and the physical health dollars for unenrolled population. If the ASO does not include physical healthcare in the capitation, it truly is duplicative of the PIHP structure and merely creates another management entity for the 298 Pilot CMHSPs to manage and work with outside of the scope of financial integration.

- Option 2—Capitation for Behavioral Health to CMHSP: An alternative, if MDHHS does not choose to integrate the physical health funds into the ASO with the behavioral health dollars, is to capitate and pass the behavioral health dollars directly to the CMHSPs to manage as part of their overall capitation. This is only marginally different than how MDHHS contracts with the FQHCs for the unenrolled populations. The Pilot CMHSPs can then manage the care for the specialty population with little impact to the services of the consumer and without the added layer of administration created by the ASO. This would necessarily require the 298 Pilot CMHSPs to work with MDHHS and its FQHCs to create local models that integrate funding and create a mechanism for shared savings to be redirected to behavioral health.

- Option 3—Full Capitation for Behavioral Health and Physical Health to CMHSP: The preferred option from WMCMH's perspective would be for MDHHS to pass the entire capitation for the unenrolled population to the chosen 298 Pilot CMHSPs. Those pilot entities could collectively manage those dollars for the unenrolled population. Within that arrangement, one of the pilot CMHSPs could act as the primary managing entity. An Advisory Board with representation from across the pilot sites could be appointed specifically for the oversight of the dollars for the unenrolled population. Within this construct, it would also be possible for the chosen pilot sites to pool the capitated dollars for the unenrolled population and create an ACO with a trusted partner that would manage both the primary care and behavioral health dollars and risk. This also keeps management of the Unenrolled Medicaid dollars within the responsibility of the Public system while also assisting in managing the level of risk created by the unenrolled population within a comprehensive network that understands the complex needs of this group.

WMCMH discourages two alternative options for management of the unenrolled population in the 298 Pilot: 4) Unenrolled capitation flows through PIHP, and 5) Fee-for-service payment for behavioral health to the pilot CMSHPs.

- Option 4—Unenrolled Capitation flows through PIHP: If the goal of a financial integration pilot is to produce efficiency, WMCMH advises against sustaining two different types of managed care entities with very different stated interests. Flowing unenrolled dollars through the PIHPs would require pilot CMHSPs to maintain their delegated responsibilities and governance interests within the PIHP while also managing a set of different delegated functions with the MHPs. There would be no ability in this arrangement for the CMHSPs to fully divest of functions that might be better served by an MHP than by a PIHP. Additionally, in conversations with the MHPs, they have repeatedly expressed no interest in pilot models that include arrangements with current PIHPs.

- Option 5—Fee-for-Service Payment for Behavioral Health to CMHSPs: WMCMH also discourages a fee-for-service arrangement with MDHHS for behavioral health services for the unenrolled population. As discussed previously in this RFI, the magnitude of risk associated with the unenrolled population cannot be adequately managed with fee-for-service payments. Although the FQHCs maintain these fee-for-service relationships with MDHHS they also have federal grants and wraparound payments to offset the unpaid costs of these arrangements. Additionally, the FQHCs have access to a broader array of service codes and options that can assist in covering costs associated with delivery for persons with complex needs.

9. **Managed Care Functions**: Federal regulations set specific requirements for the performance of most managed care functions. In the PIHP system, performance of many of the managed care functions are delegated to the CMHSPs within the region. This delegation is intended to support the community behavioral health management role of the public behavioral health system. In the physical health delivery system, the MHPs have well developed systems and structures for

performing the required managed care functions in a way that is consistent with both regulatory and accreditation requirements. It will be important, as part of administering managed care functions, that pilots balance community presence, compliance, and administrative efficiency in the performance of required managed functions.

a. Access

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

Response:

WMCMH proposes to continue to provide access to all specialty behavioral health services as a delegated function, consistent with the MDHHS Policy Attachment p 4.1.1 Access System Standards. In addition, WMCMH will provide access and referral to SUD services in its role as Coordinating Agency for SUD services and supports in the 298 Pilot. Specifically, WMCMH has experience in providing this function for SUD, as it is currently performing it on behalf of its PIHP. WMCMH will be responsible for Screening, Level of Care Determination, Data Collection, Identification of Priority Populations, Eligibility Determination, Referral and Disposition, and Outreach and Engagement as needed to underserved populations. Eligibility determination for all individuals seeking access to specialty behavioral health services and supports will be the responsibility of WMCMH. It is expected that the MHPs will provide oversight and monitoring of these functions as described in MDHHS policy.

- Explain the processes for assessing and ensuring adequate access to appropriate specialty behavioral health screening, assessment, and ongoing service (including but not limited Native Americans, children and adolescents, and persons with substance use disorders).

Response:

WMCMH will utilize standardized screening, level of care and functional assessment tools where available and appropriate for all individuals seeking specialty behavioral supports and services. While WMCMH and its CMHSP partners currently use all tools required by the state (CAFAS, PECAFAS, LOCUS, ASAM, SIS), these organizations have additionally begun utilization of ANSA and CANS to recommend levels of care. These tools are reliable and valid for this purpose across populations and will soon be embedded in the assessment and person-centered planning process. For the pilot period, these tools (ANSA, CANS + required tools referenced above) will be used to assist in level of care determination and to ensure that services are provided consistent with individuals' assessed needs.

b. Customer Service

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

Response:

WMCMH has been advised by certain MHPs that Customer Services functions must be retained by the MHPs due to their accreditation standards, and that all member services correspondence must be handled by the MHP. This includes Member/Customer Services Handbooks, Grievance and Appeal notification, and other member correspondences. WMCMH will work closely with the multiple MHPs in its region to ensure that the administrative burden here is minimized. Consideration should be made for these functions to be delegated wherever possible to ensure that members are provided with accurate and consistent information about their rights and services, particularly as the breadth of the behavioral health benefit is new to the MHPs. WMCMH will retain the specific function of Recipient Rights as defined in the Mental Health Code (as distinguished from Enrollee Rights or Member Services) during this pilot.

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

Response:

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

c. Reporting

- Describe the applicant's IT capacity to interface with various MHP systems including the ability to submit Behavioral Health Treatment Episode Data Set (BH TEDS) and encounter data to the appropriate MHP for submission to MDHHS.

Response:

Complex business rules and associated functionality in electronic data systems are necessary to comply with the reporting requirements of the MDHHS Specialty Supports and Services contract for public behavioral health and SUD reporting requirements. WMCMH maintains systems that can provide these required data sets (e.g. BH-TEDS, Encounter Data, QI / DD-Proxy, Critical Events, etc.) making available datasets to the MHPs in the formats as specified by MDHHS. These formats will allow MHPs to accept these in MDHHS formats if the MHPs develop (or contract to receive) the technical capability to receive, process, and submit these files. These data sets can also be generated and submitted directly to MDHHS in the event that development of these data systems is impractical or infeasible given the short duration of the pilot. Alternatively, WMCMH and the MHPs may separately contract with an Administrative Services Organization, partnered with established vendors that have demonstrated capabilities in this type of reporting, to produce a clearinghouse to provide a reporting method to MDHHS and the health plans. This will require further dialog between WMCMH, its pilot partners, and the MHPs after selection of the pilot sites.

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

Response:

WMCMH's electronic medical record system (R3) also includes practice management functionality built to track the funding source of beneficiaries and produce encounter files. The MHP enrollment is tracked within the system via a funding policy, which can be used to route required reporting to the appropriate MHP.

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

Response:

Because WMCMH maintains delegated responsibility for the SUD provider network, WMCMH's current electronic medical record system (R3) is capable of reporting all critical SUD data elements to the PIHP (as it does currently) and/or to MDHHS. The only SUD function that WMCMH is not capable of reporting around right now is the prevention-related services. WMCMH is assured by its EMR vendor that these capacities can readily be built into the current system to support such reporting.

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

Response:

WMCMH utilizes an electronic medical record system (R3) from a responsive vendor, PCE Systems, with a proven record of meeting state reporting requirements both in Michigan and elsewhere, including data exchange, data reporting, and analysis capabilities. While the capabilities are proven to meet any 298 Pilot analysis need, the costs for extensive systems changes to WMCMH's EMR to meet unique pilot reporting requirements may need be an included factor in the development of actuarially sound rates.

d. Claims Management

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

Response:

WMCMH has a long history of claims payment, including complex edits for the specialty services provider network. It is anticipated that the CMHSPs would retain this function for the pilot. Claims payment is connected to the authorization, which is inured in the person-centered planning process. Specific, intricate rules around claims payment exist within the behavioral health systems, particularly the EDIT rules which allow for multiple units to be allowed and where interdependencies exist with other specific services. The person-centered plan, authorizations for services, and claims are managed through the EMRs at the CMHSPs. WMCMH has the capacity to reconcile claims payment with MHPs and provide all necessary data.

- Explain the partner CMHSP's capacity and competency (including electronic infrastructure) to manage substance use disorder (SUD) services claims consistent with the following SUD financing arrangement.

  "The Michigan Mental Health Code requires that publicly funded substance use disorder services be managed by a "department designated community mental health entity" (department designated CMHE). The Mental Health Code also defines certain requirements that a department designated CMHE must meet. MHPs do not meet the definition of an entity that qualifies to be a department designated CMHE. Consequently, MHPs in the pilot region must sub-contract with their CMHSP for the management of Medicaid funding for SUD services.

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

Response:

PCE is currently the information technology vendor for seven agencies (six PIHPs, and one delegated CMHSP) that operate SUD "Coordinating Agency" functions, with two additional PIHPs going live in the near future. These SUD functions include all MDHHS and Mental Health Code requirements, including encounter processing, state reporting, SUD BH-TEDS, access and referral management, claims processing, and utilization management. WMCMH currently manages the SUD benefit and utilizes the PCE platform for this function. Infrastructure is readily available in PCE systems to support development of management of the prevention side of the SUD benefit.

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.

Response:

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

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

Response:

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

f. Utilization Management

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

Response:

Based on initial meetings with the MHPs, additional dialog will need to occur to determine retained and delegated Utilization Management functions. WMCMH and its CMHSP partners believe they are best suited to perform access and service eligibility determination within established consistent protocols. Standardized processes for service authorization and utilization review by the MHPs will need to be developed during the pilot. Both WMCMH and HW are in the early stages of implementing the CANS and ANSA across population to inform the PCP and Utilization Management process. The ANSA and CANS are reliable and valid instruments that are used across the nation for predicting levels of care. These instruments are used by some MBHOs nationally for this purpose as well. Consistent implementation of such tools will provide for consistency of benefit across the pilot and provide meaningful data to the MHPs and CMHSPs to monitor utilization management and perhaps support outcomes monitoring and even value-based purchasing. Both WMCMH and HW have embedded ANSA and CANS into their PCP processes and their EMRs.

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

Response:

WMCMH and its partner CMHSPs, in dialog with the MHPs, have drawn attention to the need for consistent utilization management criteria and processes across all plans in each geographic region to avoid unnecessary administrative burden. The pilot CMHSPs, as described above, are working to align their assessment and level of care process to support consistency of benefit across the 298 Pilot sites.

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

Response:

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

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

Response:

Additional technical assistance may be needed to ensure compliance with parity rules. WMCMH and its CMH partners are committed to complying with regulations as defined and operationalized by MDHHS.

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

Response:

WMCMH currently performs the majority of SUD managed care functions, including utilization management, on behalf of the PIHP. WMCMH has experience conducting utilization management and managing capacity of the SUD network. WMCMH has an EMR system that supports both the management and provider functions associated with the SUD network.

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.

Response:

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

- Retention of the provider network is a priority for consumers and advocates. Describe how the applicant will preserve the current network and how contracting, credentialing, and provider readiness review will be managed during the pilot transition.

Response:

WMCMH anticipates no disruptions to its current provider network. The functions of contracting, credentialing and provider readiness review would remain the responsibility of the CMHSP, with oversight and monitoring by the MHPs to ensure compliance with managed care requirements and accreditation standards. It is anticipated that the MHPs will leverage their provider network expertise to enhance the current provider network in areas such as psychiatry and medication-assisted treatment.

- To achieve administrative efficiency, describe the degree to which consistent network management practices will be developed and adopted for the pilot region (including reciprocity for credentialing, training, site reviews, etc.).

Response:

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

h. Managed Care Oversight and Performance Monitoring

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

Response:

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

10. **PILOT PROJECT EVALUATION:** (The applicant must work cooperatively with the MDHHS designated evaluator and are required to participate in all activities related to the pilot project evaluation summarized in Attachment C)
    a. Broadly describe your approach for measuring the performance of the pilot.

Response:

WMCMH is prepared to work with its CMHSP partners, the MHPs, MDHHS and the University of Michigan to establish meaningful metrics that assess critical outcomes of the 298 Pilot. WMCMH will support and collaborate with the evaluators to establish the identified performance metrics outlined in the 298 Pilot boilerplate language to measure the impact on the following metrics and outcomes:

a) Improvement of the coordination between behavioral health and physical health
b) Improvement of services available to individuals with mental illness, intellectual or developmental disabilities or substance use disorders
c) Benefits associated with full access to community-based services and supports
d) Consumer health status
e) Consumer satisfaction
f) Provider network stability
g) Treatment and service efficacies before and after the pilot project
h) Use of best practices
i) Financial efficiencies

WMCMH is fully prepared to engage in the development of additional metrics that reflect integration of care outcomes, metrics related to improved coordination, and shared savings. WMCMH has recently adopted a new electronic medical record (R3) through PCE Systems and is confident in its ability to collect and report any data necessary to inform the pilot and pilot outcome monitoring process. Furthermore, PCE Systems stands ready to assist in the evolution of the product to support participation in the pilot.

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

Response:

As described above, WMCMH has recently implemented a new electronic medical record system (R3). WMCMH is confident in the abilities of its staff and in its partnership with PCE to create any necessary changes and modifications to the system to support full participation in the pilot. PCE has been actively engaged in the RFI response and is eager to participate in supporting the critical elements of data collection, data sharing, data transfer, and system integration to support WMCMH success in the 298 Pilot.

c. Specifically explain the method you will use to (1) measure savings as defined in the 298 boilerplate, and (2) assuring any savings are reinvested in services and supports for individuals having or at risk of having a mental illness, intellectual or developmental disabilities, or a substance use disorder. Please also address services and supports for children with serious emotional disturbances as part of your response.

Response:

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

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

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

On an on-going basis (e.g. quarterly), measurement criteria would be engaged to financially quantify the efficacy of the pilot integration activities along these lines, with savings identified in the application of fiscally-sound formularies. Additional expertise to facilitate the development of a savings identification model would occur in negotiations between the MHPs, WMCMH, its CMHSP partners, and MDHHS after award of the pilot sites.

Reinvestment into WMCMH and its CMHSP partners would occur on a quarterly basis would be made on shared savings (not loss) within the following, equal priorities:

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

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

Response:

WMCMH, its partner CMHSPs, and MHPs have agreed that they will require a mutually selected behavioral and physical healthcare financing expert(s) that will work with 298 Pilot Participants to provide technical assistance in identifying:

- Start-up and development costs for implementation of the CCBHC-Plus Clinical Model;
- Costs to support changes in process and IT systems to meet the intentions of the 298 Pilot in achieving integration of fiduciary and care responsibilities for CMHSPs, ASO and MHPs;
- Rate-setting for care coordination and care management functions that are new to CMHSPs, including identification of corresponding billing/reporting (HCPCS) codes;

- Assessment of resources needed to initiate service to populations compelled in the implementation of the CCBHC-Plus Clinical Model that are otherwise underserved or not currently served by CMHSPs and their provider networks;
- Fiscally-sound formularies to calculate shared savings (or loss) through 298 Pilot care integration activities, clearly articulating that return of all resulting savings (not loss) are made to the corresponding CMHSPs
    - CMHSPs may also pass on savings directly to their provider networks based on treatment-level shared savings models;
- Development of sub-capitated model of Medicaid financing for traditional Medicaid specialty behavioral health services during the 298 Pilot period, similar to current funding arrangements with their PIHPs, that protects both CMHSPs and MHPs from unnecessary risk
    - During the pilot, CMHSPs would like to partner with MHPs to consider value-based purchasing opportunities that are data driven and informed by evidence-based practices. The VBP development cycle would provide CMHSPs and providers with pay for planning, pay for participation, and ultimately, pay for outcomes/performance. The goal would be to develop replicable, state-wide behavioral and physical healthcare models for care and financing integration.

MDHHS should convene the following joint, collaborative 298 Pilot committees across all MHPs and CMHSPs to engage in shared learning and identify opportunities for administrative efficiencies and minimizing redundancies:

- Finance: To engage cost and revenue formula dialogs, standardize efficiencies to reduce administrative burden, and monitor revenues, expenses and risk for each organization in the pilot. (It is understood that specific information about MHP financials are proprietary to each organization).
- Provider Network: To understand the MHPs processes for oversight/monitoring of the CMHSP applicant's local care network, and the level of shared responsibility and/or delegation to the CMHSP applicant to provide local care network adequacy assessment, contract management and oversight, the application and modification of MHP policies to accommodate BH policies, credentialing, privileging and primary source verification of professional staff, and background checks/qualifications of non-credentialed staff.
- Quality: To ensure measurement activities meet accreditation and 298-pilot measurement guidelines, as well as the need to develop a shared Performance Improvement Project, determine process for performing on-site monitoring of local care network providers, manage regulatory and corporate compliance for BH. (It is understood that disclosure of specific quality initiatives, approaches and incentives are competitive advantages between each MHP and may not be shared).
- Customer Service: To fully understand distinctions between customer service, appeals & grievances, and behavioral health Recipient Rights, including consumer involvement and participation in planning activities and development of the community benefit.
- Utilization Management: To understand the limits of where the CMHSP applicant performs access and eligibility, and engages utilization management protocols within MHP accreditation and BH guidelines.
- Information Systems Management: To ensure consistent definition of expectations that are aligned for all MHPs in providing data interchange, use, and reporting.

To fully manage the finances and care coordination of the population, MDHHS or the PIHPs must provide the full encounter data extract on all Medicaid beneficiaries in the coverage area.

MDHHS should provide guidance and technical expertise to support the MHPs in the implementation of public policies throughout the public behavioral health system, including:

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

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

STATE OF MICHIGAN

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

ATTACHMENT A

298 Pilot Request for
Information Memorandum of
Support

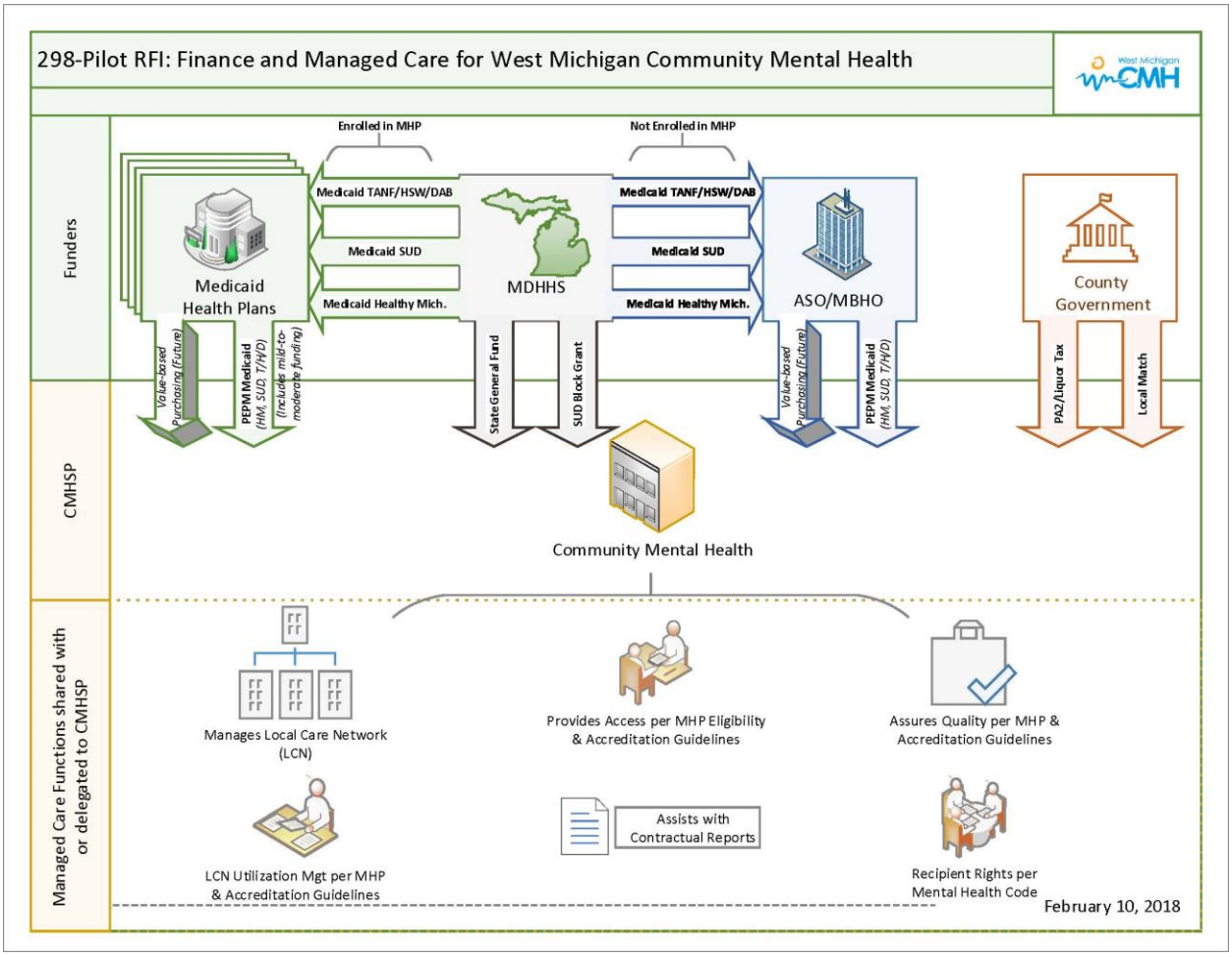
The following Medicaid Health Plans: Blue Cross Complete of Michigan, Meridian Health Plan, McLaren Health Plan, Molina Healthcare, Priority Health, and UnitedHealthcare have participated in substantive discussions with West Michigan CMH regarding a proposed Section 298 Pilot. Discussions have included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

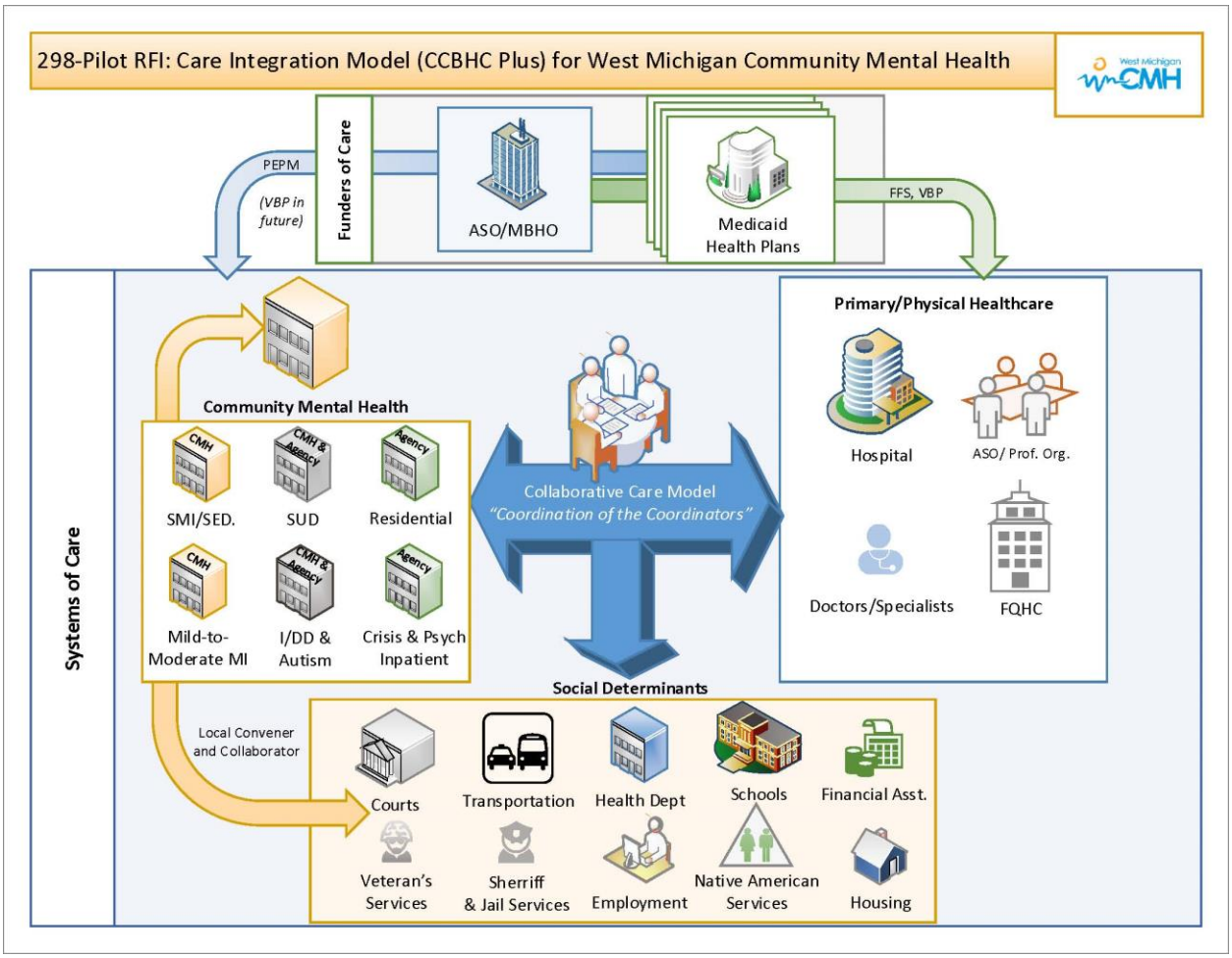
J. Chan	MVP Vice President	2/1/18
Signature Blue Cross Complete of Michigan Authorized Official	Name and Title	Date
S. Kell	Sean Kendall, President	2-2-18
Signature Meridian Health Plan Authorized Official	Name and Title	Date
	President + CEO	2/1/18
Signature McLaren Health Plan Authorized Official	Name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

STATE OF MICHIGAN

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

ATTACHMENT B




298-Pilot RFI: Care Integration Model (CCBHC Plus) for West Michigan Community Mental Health
PEPM
(VBP in future)
Funders of Care
ASO/MBHO
Medicaid Health Plans
FFS, VBP
Systems of Care
Community Mental Health
CMH
SMI/SED.
CMH & Agency
SUD
Agency
Residential
CMH
Mild-to-Moderate MI
CMH & Agency
I/DD & Autism
Agency
Crisis & Psych Inpatient
Collaborative Care Model
"Coordination of the Coordinators"
Primary/Physical Healthcare
Hospital
ASO/ Prof. Org.
Doctors/Specialists
FQHC
Social Determinants
Local Convener and Collaborator
Courts
Transportation
Health Dept
Schools
Financial Asst.
Veteran's Services
Sherriff & Jail Services
Employment
Native American Services
Housing

STATE OF MICHIGAN

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

ATTACHMENT C

Michigan's Section 298 Pilot Evaluation Plan

Conducted by the University of Michigan

Under Section 298 in Public Act 107 of 2017, the Michigan legislature directed the Michigan Department of Health and Human Services (MDHHS) to develop and implement up to three pilots and one demonstration model to test the integration of physical and behavioral health services. The Michigan legislature also directed MDHHS to contract with one of the state's research universities to evaluate the pilot(s) and the demonstration model. MDHHS contracted with the Institute for Healthcare Policy and Innovation (IHPI) at the University of Michigan in November 2017 to serve as the project evaluator.

The evaluation will inform future efforts to improve the integration of services on a statewide level by determining the most effective financial and clinical integrated care models. The evaluation aims to compare changes in healthcare utilization, expenditures, and outcomes for Medicaid consumers before and after implementation of the Section 298 pilots and demonstration models. This evaluation will yield information about whether the pilot programs and demonstration project are successful in affecting the structure, processes and outcomes of care. The evaluation will also provide insights regarding whether the pilots and demonstration project can be replicated elsewhere in Michigan.

- Once the pilot sites have been selected,[1] the evaluation team, in partnership with MDHHS, will select **comparison sites**[2] for the pilot and demonstration sites.

- The evaluation team will conduct **on-line pre-evaluation surveys** with key stakeholders and informants to solicit feedback on which structure, process, and outcome measures are likely to have the greatest impact and relevance and can also be collected through reasonable means during the pilot period.

- The evaluation team will develop **survey questionnaires and a data analysis plan** incorporating this feedback where appropriate. The team will develop different surveys for each of the following populations: individuals with mental illness (MI) and/or substance use disorders (SUD), individuals with intellectual and development disabilities (IDD), and children with serious emotional disturbance (SED).

[1] MDHHS has selected Kent County as the demonstration site.

[2] Participating as a comparison site is voluntary. The participation of comparison sites will be invaluable to the outcomes, analysis, and recommendations contained in the final report. The evaluation team aims to minimize administrative burden by focusing on data that is obtained from short provider and beneficiary surveys, data contained in the data warehouse, and data already collected by the sites.

- The evaluation team will analyze **baseline administrative and claims data** for the pilot, demonstration, and comparison sites and compile the selected measures from these data sources. This data is available in the MDHHS Data Warehouse.

- The evaluation team will conduct **on-line baseline surveys with administrators and providers** at the pilot, demonstration, and comparison sites.

- The evaluation team will conduct **telephone baseline surveys** with consumers at the pilot, demonstration, and comparison sites. These surveys will gather data regarding a wide range of health conditions and services, in addition to satisfaction with services and quality of life.

- The evaluation team will conduct **post-implementation surveys with administrators, providers, and consumers** at the pilot, demonstration, and comparison sites and analyze the survey data.

- The evaluation team will analyze **post-implementation administrative and claims data** for the pilot, demonstration, and comparison sites.

- The evaluation team will provide **preliminary data analysis and findings** in written form and at key stakeholder meetings for feedback.

- The evaluation team will assemble and **disseminate a final report**.