

Behavioral Health Section 298 Workgroup Meeting Summary

April 27, 2016

INTRODUCTION

The Michigan Department of Health and Human Services (MDHHS) convened the Behavioral Health Section 298 workgroup for its third meeting on Wednesday, April 27, 2016, at the Kellogg Center in East Lansing. The stakeholders represented individuals in service and their advocates and various organizations, including community mental health service providers (CMHSPs), prepaid inpatient health plans (PIHPs), Medicaid health plans, behavioral health providers, and statewide advocacy organizations. Most participants in attendance also took part in at least one of the previous two workgroup meetings on March 30 and April 11, 2016. During the meeting, the group reviewed the purpose and process of the workgroup, continued the discussion on what is not working in the current behavioral health system, identified what is working in the current behavioral health system, and began discussing revised boilerplate language for the governor's proposed fiscal year 2017 budget. Public Sector Consultants (PSC) helped facilitate the meeting.

WORKGROUP PURPOSE

Lynda Zeller, deputy director of MDHHS' Behavioral Health and Developmental Disabilities division, welcomed workgroup members, reiterated the group's purpose, and reviewed the revised End Statement.

The overall purpose of the workgroup is to help provide MDHHS with information that helps with the design of a strengthened system that fulfills this End Statement:

“To have a coordinated system of supports and services for persons (adults, children, youth, and their families) at risk for or with intellectual/developmental disabilities, substance use disorders, mental health¹ needs, and physical health needs. Further, the end state is consistent with stated core values, is seamless, maximizes percent of invested resources reaching direct services, and provides the highest quality of care and positive outcomes for the person and the community.”

In order to reach this End Statement goal, the workgroup will:

- Develop and agree on the core values that a better system should reflect
- Develop a set of suggested concepts to offer to MDHHS and the legislature to replace the current Section 298 boilerplate language in Governor Snyder's proposed budget for fiscal year 2017
- Create the outline of a plan for how Michigan's system should be strengthened for people with behavioral health and/or developmental disability service and support needs; the plan should include high-level elements of a coordinated, seamless system for the target population that is consistent with the agreed-upon core values

¹ The World Health Organization defines “health” as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.

WORKGROUP PROCESS

Ms. Zeller shared a new timetable for completing the workgroup's tasks and provided an overview of the Section 298 webpage. Peter Pratt, PSC president, then reminded the group of the ground rules.

Workgroup Timeframe

Ms. Zeller informed the group that a fifth meeting would be added to the workgroup schedule. The intention was to complete the workgroup's tasks within four meetings by the end of May, prior to the next fiscal year's budget being completed. This, however, did not allow for enough time to fully discuss the elements needed in the new system. The added fifth meeting will be on June 22, 2016, from 10 AM to 12 PM.

Section 298 Webpage

Ms. Zeller shared that all of the information related to the workgroup, including the background information provided by the Facts Group, is available on the MDHHS website: www.michigan.gov/stakeholder298. The site is easy to navigate and available to anyone with Internet access.

The Section 298 webpage on the State of Michigan's website features an introductory message from Lieutenant Governor Brian Calley, as well as relevant information about and for the Section 298 workgroup. There are folders for each of the workgroup meetings, the core values, and resource documents compiled by the Facts Group. A list of Facts Group participants, led by Tom Landry, is provided online. The Facts Group has posted approximately 80 percent of the relevant background information online, but it plans to add more about children's services and the corrections system. Ms. Zeller clarified that the Facts Group's information is being fact-checked prior to online posting.

Ground Rules

Mr. Pratt reminded the group of its ground rules and consensus process. He stated that the group must work collaboratively and treat each other with civility and respect. He added that everything discussed will be assessed against the agreed-upon core values and that decisions will be reached by consensus, defined as approval by two-thirds of the attending members. Consensus is assessed using red, yellow, and green notecards, which were provided to each participant. A green card means total approval of the item being discussed, a yellow card means approval with reservations or questions ("I can live with it"), and a red card means the person cannot support that item at all. Two-thirds approval will be reached through a combination of green and yellow cards, not through green cards alone.

WHAT IS NOT WORKING

Mr. Pratt continued the discussion, which began during the April 11 workgroup meeting, on what is not working in the current system, and how those deficits could be improved. Only comments made during the April 27 workgroup meeting are provided below as a continuation of the conversation captured in the April 11 workgroup meeting summary. The majority of the concerns raised during the conversation related to service delivery, but others related to administration and oversight or payment. If a comment was sent in after the workgroup meeting, it is given in italics.

Delivery

- Community members and volunteers should be integrated more often into activities for those with behavioral health needs. Funding restrictions make it difficult to bring people from the community to interact with those in behavioral health services. The University of Chicago showed that contact between those in behavioral health services and those not in services is the best way to reduce stigma.

- Person-centered planning (PCP), including the makeup of the team invited to help determine plans, does not consistently reflect the true needs and wants of the individual. An authentic PCP process is provided to those who have limited needs and, therefore, lower expenses. This does not comply with state and federal law. The PCP process needs to be independently facilitated, rather than through the service delivery system or funder for the services. This could be improved through increased and improved PCP trainings, which should include those in leadership positions, so they will better understand what should be implemented and expected in the PCP process.
- There are not enough beds available for those who need psychiatric hospitalization. A person may not be eligible for an open bed because of their HMO plan (e.g., an individual's sick days were maxed out), making it more difficult and time consuming to locate a bed for that person in a crisis.
- Physical management is never properly implemented. Some agencies have, as a result, gotten rid of all physical management and restraint options, and have implemented alternatives instead, such as creating a culture of gentleness.
- There is insufficient funding for the behavioral health system to support services and housing options needed for those with intellectual or developmental disabilities (IDD), serious mental illness (SMI), and those who exited state institutions.
- There is also insufficient funding for the services and supports needed for those with substance use disorders (SUD). Only 7 percent of the total behavioral health budget is spent on SUD services, which is a large disparity when compared to the actual needs for the SUD population.
- Reimbursements are not available to support care integration activities for patients shared by physical and behavioral health providers. This limits and delays coordinated care.
- *Mental health, social services, education, and corrections must better coordinate to provide real social and emotional support. This should be done within the schools as well as at the state level, as is done in Massachusetts. By coordinating these programs at the state level, school budgets are in place at the district and school building level to allow for the necessary supports at the individual school site. Some sites require more extensive involvement than others. For example, the McKinley Schools in Boston, which educate adjudicated, emotionally impaired youth, have court workers in addition to social workers, public and private (coordinated) mental health professionals in addition to educators in the school building. At other schools, there may be less need for regular court involvement and the social work staff in the building handle cases including court appearances. Coordinated budgeting at the state level makes for a cost-effective delivery system while still achieving good outcomes.*
- People with the Healthy Michigan Plan through Blue Cross Blue Shield have cost-sharing requirements that keep them from accessing the services and providers needed for their care. This should be addressed to reach more families.
- Retaining good peer and recovery coaches is difficult when they are reimbursed only \$12 or \$15 per session. If this position is truly valued, it needs to be reimbursed at a higher rate or quality providers will not offer this service.
- As the safety net system, CMHSPs need the flexibility to address and support the broad health needs of their service population, including needs related to school, housing, and employment.
- There is a lack of communication with and understanding by emergency room (ER) departments about the preemptive efforts that community providers have implemented before an individual reaches the ER.
- Graduate education programs are not being filled with Michigan residents.
- *Access to behavioral health services for people with mild or moderate conditions via the Medicaid health plans is insufficient.*
- *Those with mild or moderate behavioral health needs also do not have enough choice of providers via Medicaid health plans.*

- *People with severe and persistent mental illness and/or IDD have insufficient access to physical health care. This population is often challenged by traditional office-based physical health care systems.*

Administration and Oversight

- Individuals receiving Supplemental Security Income (SSI) have very small or no discretionary incomes. Regulations should restrict housing agencies (e.g., group homes and apartments) from raising their rates when SSI increases.
- Providers often work across multiple CMHSPs and PIHPs, each of which have their own information systems. Providers also develop their own systems because of the limitations of CMHSP and PIHP systems. It is a challenge to providers, CMHSPs, and PIHPs to access all of the needed information from the multiple systems and with limited functions of those systems. Integrated care would be easier if the same data system was used across the state, at least at the PIHP level, which the CMHSPs could then also use.
- Providers need to deliver integrated care in more innovative ways. The behavioral health system can be paternalistic, causing providers to be “dinged” on audits for not recommending integrated care items, such as colonoscopies. This could be improved by refining the privacy laws to allow for better data sharing between providers.
- PCP lacks sufficient oversight and training. As a result, staff and agencies are not fulfilling PCP obligations.
- The behavioral health system needs to engage individuals in services further by including them on more boards and committees.
- *Those with mild or moderate behavioral health needs seeking care via the Medicaid health plans do not have an adequate due process system when they are unable to access care or dissatisfied.*

Payment

- Legislators do not know enough about the needs or the problems experienced in the behavioral health system to make informed regulation or funding decisions. They need to be better informed so they will know who will be affected and how needed services become unavailable due to changes in laws or funding. A lot of effort is made to educate the legislators, but because of term limits, this takes a great deal of effort. The MDHHS staff could assist with providing fair and consistent knowledge and understanding of the system and its population to the legislators.
- Too much money is spent on legal fees regarding recipient rights and appeals. This money should be going into direct services.
- There is no measure of which services and supports are needed, but not provided, to support those in the behavioral health system (i.e., unmet need). Only what is being provided is being measured. Although the behavioral budget looks like a lot of funding, if there is significant unmet need, then the budget is insufficient. Legislators need to know this information in order to make funding decisions about the behavioral health system.
- Some restrictions on how risk reserves can be used by CMHSPs should be removed. The current restrictions encourage CMHSPs to hoard funds. New ways to fund clinical risk should be developed.
- *The Medicaid spend down is not working for individuals and families; it acts like an unaffordable copay. Employed individuals with disabilities should have to contribute to their services, but the amount required is more than most people can afford, and this affects the ability to continue working or to receive services.*

WHAT IS WORKING

Participants shared examples of what is working well in the behavioral health system across multiple aspects of system, including service delivery, administration and oversight, and payment for the system. Similar to what is not working, most of the comments shared relate to service delivery. Participants were asked to offer recommendations on how these aspects could work even better or how they could work well for more people. If a comment was submitted after the workgroup meeting, it is given in italics.

Service Delivery

Participants shared positive comments about service delivery related to providers, integrated care, housing and clinical approaches, as well as several other areas.

Providers

- The paraprofessional supports—parent support partners (PSPs) and community living supports (CLS)—that families receive can be integral to success. These supports can help sustain children remaining in the community and their homes. PSPs help families receive the services and supports outlined in a child’s individualized education plan (IEP) when schools would otherwise not honor the IEP. CLS providers can act as a mentor to children in services, spending time with them and taking them into the community to do engaging and fun activities.
- Michigan has been ahead of many other states in the development and use of a full continuum of peer supports (e.g., PSPs, recovery coaches). These supports can positively affect a family or youth’s direction toward recover and positive outcomes. This could be improved further by allowing the home and community-based waiver (HCBW) to cover more of these services.
- Service providers need to be more fully engaged in the community. Peer support specialists help individuals in services navigate the system, get to primary care appointments, and secure necessary housing supports. These things would not be possible if the provider were sitting behind a desk; they are engaged and active with those they work with and are regularly in the community.
- Peer support and peer-delivered services hold tremendous value. The voices of people who are receiving or have received services carry a different, but essential kind of education than those of other providers. A hierarchy or caste system is starting to form among peer providers between those who can and those who cannot be certified as peer supports. There should be statewide education opportunities on peer-delivered services that can be easily duplicated.
- SUD services are building momentum with the use of recovery coaches and peer supports through the PIHPs. They are building good relationships in the community and are helping those in SUD services with housing, school enrollment, and other assistance like getting legal identification. SUD services are often forgotten as a part of behavioral health. Progress could be lost if SUD is no longer managed by the PIHPs with state oversight.
- The shift to a chronic disease model has helped our SUD system. The use of recovery coaches has been helpful to those receiving SUD services, but leadership needs to further support SUD services and populations.
- Peer supports in Jackson County help support employment opportunities for those in services by helping to develop resumes for assisting with employment applications and build resumes through funding from the PIHP. We need to keep these innovative programs.
- Michigan has great providers, but because of the state’s retiring population and provider burnout, the number of high-quality providers needed is dwindling. The Triple Aim (i.e., the goal of improving health, improving quality, and reducing costs) needs to become the Four Aims, with the addition of supporting providers. Providers need to be considered and supported more in their work, and they should be asked how they can be better supported.

Integrated Care

- The Kent School Services Network (KSSN) in Kent County is working well in 30 local schools. This service network combines physical health, mental health, and social workers together to help families and children. This is similar to the Pathways to Potential program, but *KSSN is a much more robust support system. Pathways social workers return to their offices in the summer months even though summer school is in session, and those in summer school are often the students most in need of support. Pathways needs to be permanent and year round.* KSSN has identified the problems kids and families are experiencing and helps them year round in a natural school and community setting.
- Innovative collaborations to integrate mental health services into the community are occurring in Michigan. Kalamazoo Valley Community College has partnered with Bronson Health Group and Kalamazoo Community Mental Health (CMH) on a new Healthy Living campus that incorporates a mental health clinic into a community college campus.
- An engagement center in Ypsilanti has partnered with St. Joseph Hospital and the University of Michigan Health System to help get individuals avoid physical restraints when in compliant and helps connect individuals to services and a support person. This program sees 1,400 people a year.
- There has been successful integration between SUD services and the hospitals, where staff positions are shared by both entities in two hospitals through a grant from the federal Office of Recovery and Assistance. If there were more funding available, more of these shared positions could exist in more hospitals.

Decision Making and Housing Arrangements

- In some places in the state, people in services have real control over their lives. They can decide who is in their lives, who they do or do not want to live with, have some control over their personal budgets, and have control over their services and service providers. Everyone in services should be able to have a self-determined life, not just those in limited “pockets” across the state.
- When a culture of gentleness is developed, the person’s environment is arranged so they can live a better, more dignified life where they can make changes in their own life; this leads to fewer behaviors that require physical intervention.
- There are more supportive living arrangements options available for individuals in the behavioral health system than in the past. There are more people with disabilities who are living in their own homes. This trend should continue, but SSI benefits need to be reviewed, as this impacts available resources and housing options. When discussing housing options with clients, providers need to be sensitive about the individual’s financial situation and to be clear about what Medicaid funds can be used to support a person’s living arrangement.
- Oakland and Macomb County are using a community housing network model where housing is separated from needed support services; this has been good for families.
- In Detroit, there is an effort to build providers’ capacity to understand the HCBW and its restrictions. Providers are prepared for the rules, implementation time frames, and the ramifications. Providers need help transitioning from the current business model (group homes) to a new model that supports a staffing agency approach instead. There needs to be more housing stock available to support this change.

Care Approaches

- *PCP can help families and consumers implement goals of health, independence, and socialization; it serves as a tool of accountability to the team and individual served. It is a way to measure progress and an individual’s or family’s success. PCP can work better if the purpose of the process is better understood as more than a plan to authorize services.*

- Evidence-based practices (EBPs), such as dialectic behavioral therapy (DBT), help both children and adults, in their recovery. CMHSPs have implemented dozens of EBPs to support individuals in service, and many individuals are making large improvements in their lives because of these practices.
- Kevin’s Law, which requires assisted outpatient treatment (AOT) for those who are otherwise unwilling to accept services, helps people get necessary treatment. AOT could help more people if there were more funding to support it and more people were aware of it.
- CMHSPs are working hard to use gentleness and respect when working with individuals, including those who have a caregiver. For example, providers are speaking to the individual in services about their care, instead of talking around them to their caregiver instead. More providers, both those in physical health and behavioral health, should be trained to treat people respectfully by speaking to them instead of about them.
- The use of alternatives to guardianship to protect people rather than remove their rights is working well in some places. People’s right to autonomy and to make decisions about their lives should be happening more often. The use of guardianship for those in services has removed their autonomy and has been terrible.
- There has been an increase and improvement in crisis intervention training and law enforcement agencies’ use of jail diversion. Police officers are often the first contact with people on the street and in crisis.
- High-performing agencies could collaborate to create an agreed-upon set of standardized core services as the foundation of a statewide service delivery model.

Other Service Delivery

- Michigan’s is consumer-focused, evidence-based, and outcomes-driven behavioral health system has found ways to make efficiencies that have been reinvested back into services and supporting CMH principles. For example, Kalamazoo CMH increased training and the Detroit-Wayne Mental Health Authority increased hourly wages by \$1, all without new funding. More of this investment could happen if the behavioral health system is able to keep funding gained through efficiencies.
- Behavioral health recovery happens, in a holistic way, for people in Michigan. Service providers truly care about people, about their quality of life, about being a member of the community, and about living the life they want to live. In other places in the world, this is not happening. Although people may receive insurance or get needed medications elsewhere, there is not a lot of focus on the person’s quality of life.
- Community-based activities, like Gleaners’ Cooking Matters™ classes in St. Clair County and the In-SHAPE program in CMHs, are helping people.
- There are opportunities for individuals in services to have fun experiences in the community. For example, they can be background actors on local sets. It can feel like being an Oscar winner when the audience claps for an individual who asks questions as an audience member.
- Anti-stigma efforts are making progress, but there needs to be more effort and further stigma reduction, especially around IDD services. There should be more collaboration with Michigan Rehabilitation Services (MRS) to ensure that this is truly peer led.
- Facility improvements can make spaces more inviting and even save the facility money over time. St. Clair County CMH has made its facility more spacious and put in artificial lighting that mimics real sunshine. More facilities could make similar improvements.

Administration and Oversight

- A good value to those being served and for taxpayers is a combination of both efficiency and effectiveness. The state and providers are striving for a behavioral health system with a low administrative rate, good outcomes, and approval from regulators and consumers.
- People in services and their advocates are involved more often than before in service design and on boards and committees, including in the Section 298 process. The ideas and experiences shared by those in services are very important and need to be fully considered in system design. There should be even more involvement at this level from those in services, this involvement should happen consistently across the state, and individuals should be paid to share their thoughts and ideas whenever possible.
- Having the state responsible for all Medicaid mental health and epilepsy medications has decreased the odds that patients experience medication delays, denials, or therapeutic substitutions (which is not akin to using a generic medications). The mechanisms the state uses to fund this are not hurting the CMHSPs or the HMOs. This could be improved by examining if there are other drugs used by several individuals in behavioral health services that the state could also manage.
- The administrative oversight for SUD, in at least some counties, has helped practices assist consumers by ensuring the best possible quality of service.
- Michigan's public mental health system has over 40 years of history and experience to use as it continues to improve itself. It is a value-based system that reinvests its resources into its services. It was at the forefront of the removing people from state institutions and developing community alternatives.
- *The availability and access to due process mechanisms for persons with complaints or concerns in the PIHP/CMHSP system (i.e., dispute resolution up to and including an administrative law judge) is working well.*
- *The separation of responsibilities and accountability between CMHSPs as provider organizations and PIHPs as managed care organizations is working well. This could be improved by establishing clearer expectations regarding delegated and nondelegated managed care functions and by requiring accreditation of PIHPs.*

Payment

- Carving out behavioral health funding has worked well in Michigan. It has led to innovative practices and positive outcomes for consumers; other states look to Michigan to help them develop their systems. Behavioral health needs to work collaboratively with the health plans, and not see each other as competitors. The system needs to focus on continuity and consistency across the state, further integrated care, uniform rates, and publicly presented positive outcomes. Where a person lives should not determine the quality of care they can get.
- Michigan's use of Medicaid funding to financially support the state's safety net system has subsidized costs and turned Medicaid into the safety net system.

BOILERPLATE DISCUSSION

Ms. Zeller explained that Michigan's House and Senate appropriations subcommittees have each replaced the governor's original budget proposal boilerplate with new language. The House and Senate versions of the boilerplate focus on the process for designing a better integrated system. These committees plan to finalize the boilerplate language in May in a joint House-Senate conference committee. The House and Senate are interested in hearing the Section 298 workgroup explain what it thinks should be considered in the boilerplate language.

Mr. Pratt asked the workgroup to review the House and Senate versions of the Section 298 boilerplate language and then to vote with red or green cards only on which version they prefer. Following a vote, the workgroup was given time to suggest “friendly amendments” to the version that most workgroup members preferred. He explained that the boilerplate language need not fully describe the behavioral health system. It is meant to describe a process for the work on designing the system to continue. The group voted, by a large margin, to start with the House subcommittee (HB 5274) version. The workgroup then began discussing how the boilerplate should be altered and which sections of the Senate subcommittee (SB 789) version should be added.

The group agreed to add bullets (a) and (b) from SB 789, but to strike “high-value” from SB 789 (a). Bullets pulled from the Senate version were originally moved under HB 5274 (5) during the workgroup meeting, but were then moved to HB 5274 Sec. 298 (2) for clarity. Additionally, there was a request to define “medical” in SB 789 (b). Members discussed the merits of adding recommendations for the use of pilot programs and the use of evidence-based, best, and promising practices, without stifling innovative ideas to meet the needs of the service population. No decisions about the types of practices to encourage were agreed upon during the workgroup meeting. A workgroup member emailed an additional comment after the meeting *that individuals in services want to have the opportunity to be a part of identifying what works and what does not work.*

The House Subcommittee (HB 5274) Section 298 language, with agreed-upon amendments in underline and strikeout, reads:

(1) The department shall work with a workgroup to make recommendations regarding the most effective financing model and policies for behavioral and physical health services for individuals with mental illnesses, intellectual and developmental disabilities, and substance use disorders. The workgroup shall include, but not be limited to, the Michigan Association of Community Mental Health Boards, the Michigan Association of Health Plans, and advocates for consumers of behavioral health services.

(2) The workgroup shall consider the following goals in making its recommendations:

- (a) Core principles of person-centered planning, self-determination, and recovery orientation.
- (b) Avoiding the return to a medical and institutional model of supports and services for individuals with behavioral health and developmental disability needs.
- (c) Coordination of physical health and behavioral health care and services at the point at which the consumer receives that care and those services.

(SB 789 Sec. 296 (a)) Increase access to ~~high-value~~ community-based services consistent with the core values of the workgroup and resident choice of provider.

(SB 789 Sec. 296 (b)) Increase access to integrated behavioral and physical health services within community-based settings.

(3) The workgroup’s recommendations shall include a detailed plan for the transition to any new financing model or policies recommended by the workgroup, including a plan to ensure continuity of care for consumers of behavioral health services in order to prevent current customers of behavioral health services from experiencing a disruption of services and supports. The workgroup shall consider the use of one or more pilot programs in areas with an appropriate number of consumers of behavioral health services and a range of behavioral health needs as part of that transition plan.

(4) The department shall provide, after each workgroup meeting, a status update on the workgroup's progress and, by December 1 of the current fiscal year, a final report on the workgroup's recommendations to the Senate and House appropriations subcommittees on the department budget, the Senate and House fiscal agencies, and the state budget office.

(5) No funding that has been paid to the prepaid inpatient health plans in prior fiscal years from the Medicaid mental health services, Medicaid substance use disorder services, Healthy Michigan plan – behavioral health, or autism services appropriation line items shall be transferred or paid to any other entity without specific legislative authorization through enactment of a budget act containing appropriation line item changes or authorizing boilerplate language.

Given time constraints, there was not a final consensus on the boilerplate language and what should be added. Therefore, members were asked to send in additional comments and recommendations for the boilerplate language. Recommendations that were submitted after the meeting are available in a separate document. These recommendations will each be voted upon at the May 19 meeting.

NEXT STEPS

Ms. Zeller closed the meeting by reiterating the purpose of the workgroup, reminding members what is to come in future meetings, and thanking everyone for their commitment and effort on this project.

The next meeting will be held at the Lansing Community College West Campus on Thursday, May 19, 2016, from 1:30 to 3:30 PM. The fourth workgroup meeting will reprise the conversation on boilerplate concepts and begin the discussion on the elements needed in a better system.