Behavioral Health Section 298 Workgroup Meeting Summary

June 22, 2016

INTRODUCTION

The Michigan Department of Health and Human Services (MDHHS) convened the Behavioral Health Section 298 workgroup for its fifth and final meeting on Wednesday, June 22, 2016, at Lansing Community College West Campus in Lansing, Michigan. The workgroup stakeholders represented individuals in service and their advocates, as well as various organizations, including community mental health service providers (CMHSPs), prepaid inpatient health plans (PIHPs), Medicaid health plans (MHPs), behavioral health providers, and statewide advocacy organizations.

During this meeting, the group reviewed the work it had completed so far, voted on the system design elements proposed by the small groups during the previous workgroup meeting, learned about and discussed MDHHS's intended next steps for redesigning the behavioral health system, and discussed concerns from participants regarding the workgroup process. Public Sector Consultants (PSC) helped facilitate the meeting.

WORKGROUP ACCOMPLISHMENTS

After welcoming workgroup members, Lynda Zeller, deputy director for MDHHS's Behavioral Health and Developmental Disabilities Administration, reviewed the products the workgroup has created that will help reach the following 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 health[1] 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.

Through a consensus voting process, the workgroup has developed:

- A set of core values that a better system should reflect
- Replacement concepts and language for MDHHS and the legislature to consider in its Section 298 boilerplate language for the fiscal year 2017 budget, many of which were subsequently adopted by the legislative conference committee.
- Design elements for a reimagined behavioral health system, including elements related to service delivery, administration and oversight, and payment and structure.

DESIGN ELEMENT VOTING

The workgroup, through small groups, developed and then presented their preferred design elements at the May 19, 2016 meeting. Between June 2 and June 15, workgroup members then voted online for (a) the five design elements that they thought would best reach the desired end statement and (b) two elements that

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[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.

would least move the system towards its desired end statement. Seventy-two workgroup members participated in this online voting. The entire list of elements was sent to the workgroup, along with the number of votes for and against each item, with the elements that received votes from more than 10 percent of those voting (i.e., 8 or more votes) in bold. In the new listing, design elements were organized by theme (e.g., person-centered care, service integration) rather than by small group category (delivery, administration and oversight, payment and structure), as several elements crossed categories.

During the June 22 workgroup meeting, members voted first by theme on each of the bolded elements, and then members were able to request a vote on any non-bolded element under that theme. Members were able to provide clarification about the design elements. Using green, yellow, and red voting cards, members voted for as many design elements as they wanted to. Design elements achieved consensus if they received at least two-thirds of the green and yellow cards from the workgroup members present. This created three sets of design elements:

- First, those that received more than ten percent of the vote in the online vote *and* received a consensus vote during the workgroup meeting. These design elements are bolded below under Consensus Supported Design Elements.

- Second, those that did not receive more than ten percent of the online vote, but *did* receive a two-thirds consensus vote during the workgroup meeting. These design elements are listed under Consensus Supported Design Elements.

- Third, those that were developed and presented as preferred design elements by the small groups during the May 19 workgroup meeting, but that did not receive two-thirds of the vote from the larger workgroup during the June 22 meeting, regardless of whether or not they received more than ten percent of the vote during online voting. This group of elements also includes those that were not requested by a member for a vote during the June 22 meeting. These design elements are provided under Other Design Elements.

Consensus Supported Design Elements

The following design elements received consensus votes from the workgroup members during the June 22 workgroup meeting. Sixty-four people participated in the voting, requiring 42 yellow and green cards to pass. The bolded items are those that also received more than ten percent of the online vote, when members could only vote for five items. The design elements are divided into the three categories of service delivery, administration and oversight, and payment and structure. Where clarifying information was offered by a workgroup member, it is provided in italics. The theme of each element is provided in parentheses.

Service Delivery

- **Integrate at the level of the person needing treatment or services (i.e., deliver services when and where they are needed and provide care coordination.)** (Service Integration)

- **Require all providers to coordinate care with other providers, regardless of the health system or who is paying for the services. Coordinated care should use a statewide standard release form between physical health and behavioral health (including substance use disorders [SUD]) to allow the individual receiving services to agree and consent to information sharing. Coordinated care needs to treat the whole person, no matter their needs, which may change over the course of treatment.** *This should not supersede an individual's privacy rights, if he/she opts to not share his/her information with others.* (Service Integration)

- **Ensure that person-centered plans (PCPs) are developed with integrity.** *The plan should be developed based on the needs, hopes, and dreams of the consumer, not on the resources available, staff or financial, to implement it.* (Person-Centered Care)

- **Provide person-centered care coordination supports to ensure connection to as well as provision and utilization of needed and desired services to promote a good quality of life as defined by the person.** (Person-Centered Care)
- **Workforce: Recruitment and retention of a high-quality workforce through investment in professional development, adequate compensation, appropriate credentialing, scope of practice, and career ladders.** (Workforce)
- **Elevate peer supports and peer voice as a core service and include this in all service delivery options, including planning, prevention, and early intervention. Peer supports should be offered at intake in the initial authorization of services.** (Access to Services)
- Person-Centered Planning: Shared development of an integrated care plan from the beginning, in an evidence-supported, trauma-informed system of care. *A trauma-informed system of care includes those who receive services and providers who may be traumatized by the work they do.* (Person-Centered Care)
- Offer individualized, person-centered care plans for everyone, regardless of ability or illness. (Person-Centered Care)
- Educate behavioral health and physical care professionals to enhance their knowledge of people-first language, person-centered care principles, and trauma-informed care. (Person-Centered Care)
- Certify and adequately compensate direct care staff. *Direct care staff refers to anyone who does direct care work. Certifications could provide protections to direct care staff who work in a non-licensed settings and would provide greater assurance to individuals that direct caregivers will be able to perform the work needed in their homes.* (Workforce)
- Consider a certification process for direct care staff for specialized services with training and wages that are commensurate. (Workforce)
- Capacity: Local and rapid access to all levels of care, including emergency, intermediate, long-term, and step-down care, in keeping with full mental health parity with appropriate efficiencies from integrated electronic health records (EHRs) and telehealth. (Access to Services)
- Increase scope and availability of SUD services to all persons at all sites. (Access to Services)
- Increase early intervention services (i.e., physical health, SUD, trauma, mental health) for adolescents prior to crises occurring. (Access to Services)
- Implement and incentivize outcome-based service delivery models rather than encounter-driven service delivery models. (Other Service Delivery)
- Standardize behavioral health screening, assessment, and treatment in primary care. (Other Service Delivery)

Administration and Oversight

- **Carve in physical health services to the community mental health service providers (CMHSPs) for people with behavioral health and physical health care needs.** (Administrative Structure)
- **Have an independent, state-level entity for all grievances, appeals, and rights complaints of CMHSPs and MHPs service applicants and recipients.** (Administrative Structure)
- **Retain state administration of all Medicaid mental health and epilepsy drugs.** *The state categorizes mental health drugs in this way; it is not meant to indicate a preference for one type of mental health drug over others.* (Administrative Structure)
- **Create savings in administrative costs by streamlining administrative requirements, reducing paperwork, and providing uniform training. Redirect those funds into the services to individuals.** (Savings Reinvestment)
- **Implement electronic sharing of information between agencies in order to ensure smooth transitions for individuals receiving services across counties and statewide.** (Other Administration)

- Evaluate the value of multiple tiers of administration and oversight (i.e., the state, prepaid inpatient health plans [PIHPs], regional intermediary administrators [e.g., Wayne and Oakland Counties], and local administrators) to guarantee access and address unmet need. (Administrative Structure)

- Develop uniform policies, procedures, and operational definitions for the entire public behavioral health system. (Administrative Structure)

- Find a way to standardize administrative functions without diminishing services (e.g. credentialing crisis line, training, rates). (Administrative Structure)

- Ensure efficiencies and savings are reinvested in the system. *The "system" means service delivery.* (Savings Reinvestment)

- Streamline paperwork and administrative requirements to reduce administrative burdens. (Paperwork and Reporting)

- Include geographic, consumer, and provider representation to ensure public oversight is tied to local communities. (Governance Structure)

Payment and Structure

- Maximize the use of community resources to ensure efficiencies with community mental health (CMH) funding. For example, learning to cook can be achieved through outreach to a community college, rather than hiring a nutritionist. (Funding Flexibility)

Other Design Elements

The remaining design elements below are those presented by the small groups during the May 19 workgroup meeting, but did not receive a consensus vote during the June 22 meeting, regardless of whether or not they received more than ten percent of the online vote. These are organized into the three categories of service delivery, administration and oversight, and payment and structure. Clarifying information about a design element is provided in italics, when available. The theme of each element is provided in parenthesis.

Service Delivery

- Increase colocation and other models of integration at the service provision level (i.e., SUD, physical health, mental health, and social services). Require this integration of all payers. (Service Integration)

- Provide, system-wide, 1) independent facilitation of PCPs—independent of the provider network and independent of the budget; 2) independent case management that will find the most efficient ways to deliver independent facilitation of the PCP; 3) PCP that follows the person. (Person-Centered Care)

- Allow the financial process to follow the PCP. (Person-Centered Care)

Administration and Oversight

- Restructure the PIHP system to include three to five PIHPs. Create regional Offices of the Inspector General with investigative and subpoena powers. (Administrative Structure)

- Create a rewards-based system allowing departments that are creating savings to redirect those savings into improving services. (Savings Reinvestment)

- Ensure compliance with state and federal regulations through the use of standardized reporting, rules, and regulations. This will help eliminate duplication in those items, as well as eliminate non-value-added services. (Paperwork and Reporting)

- Streamline the quality reporting process and ensure timely access to performance monitoring data across the system. (Paperwork and Reporting)

- Restructure the governance board appointment process to reduce conflict and increase competence. *This is intended for PIHP and CMH boards to look at conflicts and the level of competence needed to be an effective member of the board.* (Governance Structures)

- Provide oversight to ensure that supports around the individual are based on self-determination with benchmarks for living skills and skill development. (Governance Structures)
- Align behavioral health and physical health care requirements. This requires creating mechanisms for shared costs and shared savings and expanding integrated health information systems. (Other Administration)
- Ensure that safety net protections are in place, in part, by maintaining mechanisms for horizontal or cross-system planning. (Other Administration)

Payment and Structure

- Utilize one integrated system per enrollee for payment, benefits, and administration for physical and behavioral health, managed by one entity that holds the contract with the state. This system should include:
    - A standard integrated Medicaid fee schedule that covers both behavioral health and physical health payments to providers, regardless of who provides the service;
    - Direct contracts with local, county partners and public entities, including CMHs, local health departments, and provider groups;
    - A baseline fee for service with reimbursement and value-added services, such as quality bonuses, delegated credentialing, utilization efficiency, risk sharing, care coordination, and network management. (System Integration)
- Develop an integrated system per enrollee that is made up of a number of parties that have specialized managed-care expertise that is tightly coordinated. This would be similar to the current system but with better coordination. This system would include:
    - A standard integrated Medicaid fee schedule that covers both behavioral health and physical health payments to providers, regardless of who provides the service;
    - Direct contracts with local, county partners and public entities, including CMHs, local health departments, and provider groups;
    - A baseline fee for service with reimbursement and value-added services, such as quality bonuses, delegated credentialing, utilization efficiency, risk sharing, care coordination, and network management. (System Integration)
- Create a financing model that recognizes the needs of each population (any mental illness, serious emotional disorders, intellectual and developmental disability, and SUD), the severity of the individual's diagnosis, and the individual's outcomes. Refer to the financing model that was used, before managed care began (1990–2003), which used a case rate instead of fee-for-service payment. (Funding Flexibility)
- Employ a flexible financial system that can adjust to a person's changing needs. (Funding Flexibility)
- Ensure that funding mechanisms support desired local or culturally-based practices, even if not an evidence-based practice or covered by Medicaid. (Funding Flexibility)
- Ensure that payment mechanisms reflect ability to identify any unmet needs for specific populations. (Funding Flexibility)
- Establish incentive and penalty contracts to ensure integrated care through value-based design contracts. (Other Funding)
- Incentivize a payment system that places primary care elements in behavioral health treatment settings. (Other Funding)
- Promote coordination of services and appropriations of health, human services education, and corrections, as is done in Massachusetts' model. (Other Funding)

- Utilize a condition-based alternative payment methodology that is reflective of services and costs, and which covers both behavioral and physical health care needs. (Other Funding)
- Hold the payment methodology accountable to local communities and the individual and families being served. (Other Funding)

BEHAVIORAL HEALTH SYSTEM REDESIGN NEXT STEPS

Elizabeth Hertel, MDHHS Director of Policy and Legislative, explained the department's plans to move this work forward in the months ahead. She noted that the final FY 17 budget boilerplate language, which passed the House and Senate in early June, requires MDHHS to work with a workgroup to submit a report by January 15, 2017 that will include a recommendation on how to implement service integration. Using a previous department implementation project structure, four MDHHS staff—Farah Hanley, Elizabeth Hertel, Chris Priest, and Lynda Zeller—would form an executive policy group that will report directly to Nick Lyon, MDHHS Director. This executive policy group will be responsible for drafting the final report required in the boilerplate language.

Hertel also stated that, in addition to the executive policy group, MDHHS will set up three external response groups made up of separate stakeholders. One response group will be comprised of consumers and their families, a second of providers, and a third of state association representatives. The specific individuals on the response groups, she added, have not yet been determined. To keep the groups focused and able to provide feedback quickly to the executive policy group, the response groups will be kept small. Phil Kurdunowicz, from MDHHS Office of Policy, will act as a liaison between the internal executive policy group and the external response groups. In order to ensure transparency, the Section 298 website (www.michigan.gov\Section298) will be maintained, with new information uploaded as it becomes available, and the current listserv will still be used to send out information and to get valuable feedback from the larger group.

A workgroup member requested that MDHHS include consumers, family members, advocates, and providers on a workgroup that would work directly with the internal executive policy committee to develop a plan on how to move behavioral and physical health care toward system integration. He added that the boilerplate requires a workgroup, which is different from response groups, and that the workgroup should be separate from the response groups.

Ms. Zeller assured the group that MDHHS's intent for the next steps is collaboration. MDHHS has received feedback that the large group process has inhibited some voices, especially consumers, from being heard. MDHHS is not trying to keep anyone out of the workgroup, but MDHHS needs to be able to quickly create a draft plan that a diverse set of stakeholders can review.

A member called for a motion to include an unspecified number of people on the workgroup, as called for in the boilerplate language. The workgroup, which would include the four people named to the internal executive committee, would develop the details for system integration. The motion was seconded, and passed by the workgroup.

OTHER COMMENTS

A workgroup member reiterated and expanded on her concern from the previous meeting that the workgroup has not adequately addressed the needs of tribal nations. She expressed that other workgroup members were focused only on protecting their interests, that the tribal nations have not had an adequate voice in the process, and that they have not been asked to continue to work in this process. To that point, she noted the workgroup's vote at the last meeting to not recommend specifying in budget boilerplate language that federally-recognized tribes be included in a workgroup that would be convened to continue

work on integration of physical and behavioral health services. The member's tribal council intends to write to the governor about their concerns and to consider legal action.

Several members responded to her concern. One member shared that, at the time of voting on the boilerplate amendments, she did not see a reason to include tribal nations in the boilerplate language when other groups were not specifically mentioned. She was unaware that tribal nations are sovereign, meaning separate from the United States, which could warrant their inclusion. Another workgroup member explained that she did not support the proposed boilerplate language regarding tribal nations because it only included federally recognized tribes, which left out state recognized tribes and tribal councils. A member asked if there were any votes on design elements during the current meeting that suggested opposition to tribal nations, as he was unaware of any votes against tribal nations in the design elements. Another member added that many members did not get everything they wanted in the boilerplate amendments, nor in the design elements, but that it is important to respect the group process. Ms. Zeller added that she appreciates the workgroup member's willingness to bring the concerns of the tribal nations forward to the group and thanked her for her contributions to the process. Because of the tribal nations' presence on the workgroup, she added, tribal nations are included directly in the core values of the strengthened behavioral health system.

As a result of the discussion, a workgroup member proposed a motion that this group would like to go on record that the future process should include federally and state recognized tribes and be broadly representative of Michigan's racial and ethnic diversity, in addition to those named in the boilerplate. The motion was seconded and carried.

WORKGROUP CONCLUSION

Chris Priest, MDHHS Deputy Director for Medical Services, thanked the group for their willingness to have these important conversations and for their contributions to the discussion on improving the system. Michigan, he added, is further along in service integration than many other states. Recent federal regulatory activity will impact both physical and behavioral health services, and because of all the good work done in Michigan, the State is well positioned to address these upcoming challenges and changes.

Ms. Zeller also added her appreciation for the group's hard work and professionalism over the five meetings and for their respect of the workgroup process. She ended by thanking the volunteers who have continued to attend and contribute to the meetings, but who are not paid to be there.