Behavioral Health Section 298 Workgroup Meeting Summary

April 11, 2016

INTRODUCTION

The Michigan Department of Health and Human Services (MDHHS) convened the Behavioral Health Section 298 workgroup for its second meeting on Monday, April 11, 2016, at the Lansing Community College West Campus. 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 the first workgroup meeting on March 30, 2016. During the meeting, the group reviewed the purpose and process of the workgroup, affirmed the core values from the first meeting, discussed what is not working in the current behavioral health system, and identified next steps. 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. Lieutenant Governor Brian Calley joined the group and discussed the importance of the workgroup's mission.

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 health* needs, and physical health* needs.[1] 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."

Ms. Zeller reported that MDHHS will define the word "supports" as it relates to the End Statement.

In order to reach this End Statement goal, the workgroup is tasked with three things:

- 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

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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.

Importance of Integrated Care

Lieutenant Governor Brian Calley thanked the workgroup participants for their effort on this important subject. He stated that it is unacceptable that people with behavioral health challenges are not treated as though they have an emergency health concern when they receive a diagnosis, unlike how they would be if diagnosed with a physical health issue. Families, feeling as though they are facing an emergency, struggle to navigate this complex system and get needed care. People with behavioral health challenges, he added, need to have health care that is just as good as those with physical health challenges. The system needs to remove barriers and limitations families currently experience, and instead help people with behavioral health challenges and disabilities live to their fullest and do what they want with their lives, including creating careers.

WORKGROUP PROCESS

Ms. Zeller provided an update on available background information and a plan for sharing information (details below). Peter Pratt, PSC president, then discussed the workgroup's ground rules.

Transparency

In MDHHS' commitment to transparency, all of the information related to the workgroup, including the background information provided by the Facts Group, can be found on the MDHHS website: www.michigan.gov/stakeholder298. Upcoming meeting agendas and presentations, past meeting notes, background information, and all other workgroup documents are available online. This public site replaces the password-protected website for the workgroup materials.

Background Information (Facts Group)

Ms. Zeller reported that the Facts Group has informed and MDHSS staff have assembled background information on health status and co-occurring disorders and mental health and corrections. This information is all available online at the website listed above. She presented several examples of the information gathered so far, including the average number of chronic conditions by population (e.g., developmental disabilities [DD], substance use disorders, serious mental illness [SMI]) and the rate of SMI in the general population compared to the corrections population.

Ground Rules

Mr. Pratt reiterated the ground rules for the workgroup meetings and explained the 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.

CORE VALUES

Mr. Pratt presented and then facilitated a discussion of the revised core values. In the revision, he explained, attempts were made to incorporate all aspects of the workgroup conversation from the first meeting, and to reduce overlap and duplication among the values. The values also have explanatory notes, when relevant.

Mr. Pratt asked the group to vote on their support for the complete set of core values. In the initial vote, the majority of participants (40 of 76) showed a green card, indicating total support; over a third showed a

yellow card (29 of 76), indicating that they have some concerns but could live with the values; and the remaining group of people (7 of 76) showed a red card, indicating they had major concerns with the values. Following the vote, participants were allowed to make "friendly amendments" to the values. Each suggested wording change went through the consensus process before being included. The list of values below shows the core values, as presented, with the additions agreed upon during the meeting in underlined text and omissions noted in strikethrough text.

- Person centered

  - Focus on highest level of functioning (maximum potential)
  - Recovery and resiliency based (including peer supports, clubhouses, drop-in centers)
  - Focus on habilitative supports and services
  - Availability of independent facilitation of a person-centered plan that ensures a truly individualized plan that will identify all necessary services and supports
  - Focus on early identification and intervention services
  - Trauma-informed

- Family-driven and youth-guided

  - Youth-guided refers to youth having a say in the decisions and goals in their treatment plans. The older youth are, the more they should be involved in their treatment plans.

- Promoting independence and embracing self-determination, freedom, and choice

  - People should be able to control who is in their lives. The behavioral health system currently determines who and what are in a person's life too often.

- Full community inclusion, engagement, and participation reflecting individuals' desires

- Meaningful participation and engagement defined by the person (including education and employment and choice of residence), ensuring that each individual reaches her/his fullest potential

  - People should be supported to gain and maintain meaningful integrated employment at competitive wages.
  - Integrated educational opportunities with needed supports
  - Business ownership and self-employment

- Positive outcomes for the person

  - When children are in services, the outcomes are often family-based.
  - Outcomes- and data-driven system based on evidence or best practices.

- Individuals' satisfaction with care

- Community-based

  - All services and support are local, with strong collaboration among organizations and people delivering supports and services.
  - Community is defined as including tribal nations
  - Providers should be community-based, with behavioral health and provider leadership coming from local communities.
  - People have choice of home and community-based services that are consistent with state and federal rules.

- Community is defined as inclusive of where people choose to live, work, go to school, play, and worship. It encompasses the elements of daily life that an individual chooses to participate in and should embrace race, ethnicity, faith, gender, age, LGBTQI status, and all other subcategories of our population.
- Community-based should reflect the unique ability of Michigan communities to define and build supports and services that address community- and person-defined needs and expand a community's capacity to nurture and support its members.

■ Linguistic and cultural competence and relevance (rural, urban, race, ethnicity, gender, faith, age, LGBTQI status, and all other categories of the population) to assure that all community members are well served.
- All cultures are of equal value and merit equal respect
- The system need to recognize, work with, and respect tribal nations

■ Optimal availability and access to a full array of effective care driven by people's needs and desires
- Individuals' need for the level and frequency of services must be considered (sufficiency).
- There must be a community safety net for vulnerable persons

■ Availability of a coordinated, seamless, trauma-informed system of supports and services that integrates all care for the whole person
- Coordination has to focus on the whole person, which is more than physical health and behavioral health services: social determinants of health, social supports and services—anything a person needs to be successful. For example, people may need help with finding housing, getting a driver's license, or applying for insurance, among other services.
- Persons who receive supports and services should have the support necessary to have healthy relationships
- The integration of whole person care can be best achieved when the model of care supports linkages among physical, behavioral, and social elements and promotes optimal health.
- Real- and full-time coordination of care

■ ~~Outcomes driven and based on evidence or best practices~~ (This value was moved under "Positive outcomes for the person.")
- A data-driven system supports these values.

■ Highest quality of care, supports, and services delivered by a robust, trained, and experienced workforce and volunteers
- The workforce should be well trained, well compensated, and honored for their work.

■ Invest in peer supports and peer led organizations and recognize their value
- Peer supports are a growing and important group of professional providers. People are often willing to share information with their peer supports that they would not share with their clinicians.
- This value should include the use of recovery coaches, peer support specialists, peer-led programs or organizations, and parent support partners.

■ Focus on prevention and early intervention
- Prevention and early intervention services can help avoid the need for intense behavioral health services.

- Promotion of community health and wellness <u>and stigma reduction</u>

■ Public oversight and accountability to ensure the public interest

- Transparency (access to information, open meetings)
- Array of services and supports accountable to the public and the persons and families receiving services
- People with disabilities should not be segregated in communities
- There should be community engagement through representation of persons <u>or parents and caregivers</u> in ~~the behavioral health~~ <u>publicly funded health care</u> systems on the board/governance of any managing entity
- <u>Serves as social safety net for the community</u>

■ Maximize percent of invested resources reaching direct services

- Efficient and effective delivery of services and supports from providers and administrators should produce gains that remain in the system and go to providing services and supports to people.

■ Readily available information/outreach about care, services, and supports

- People cannot find information about the behavioral health system when they need it.

■ Equity of care, services, and supports across the state

- The array of services and supports available should be consistent across counties
- Policies and procedures related to authorization of supports and services should be consistent across counties
- Where you live should not determine which Medicaid-funded or Mental Health Code required services and supports you receive

After discussing the values, another consensus vote was taken by the whole group. In the final vote, no participant proffered a red card and only a few held up yellow cards, showing that everyone was in either full agreement with the values or in enough agreement to move forward with them as is.

WHAT IS NOT WORKING

Mr. Pratt then facilitated a discussion on what is not working in current system and how those deficits could be improved. The majority of the concerns raised related to service delivery, but others related to administration and oversight or payment. Participants were invited to send additional comments about challenges in the current system by Tuesday, April 12 at 5 PM. These comments are included in the summary below in italicized text. Some participants sent documents or reports, which are not included in the summary but will be stored on the website.

Delivery

Participants raised several concerns about the delivery of care. Many of these challenges involve access to care, but also include availability and use of community education programs and community organizations, challenges with workforce development, direct caregivers' compensation, and others.

Access

■ Primary care practices identify people who need behavioral health services, but the availability of care differs across the state, and for many there is no place for physical health providers to send patients to access needed behavioral health care.

- Jails and prisons lack sufficient access to mental health services, and too many people are incarcerated who have serious mental health conditions. The corrections population could also be reduced, in part, by using mental health and specialty courts whenever applicable.

- Those needing substance use treatment face insufficient access to services. People are reluctant to use involuntary treatment options. The involuntary treatment laws are underutilized.

- There are not enough physicians or psychiatrists for those with public or private insurance coverage. Behavioral and physical health should be addressed together more often. Psychiatrists and physicians should treat uncomplicated conditions without having to refer the patient to another provider. For example, physicians should be able to treat mild depression and anxiety, and psychiatrists should be able to treat uncomplicated diabetes and hypertension. Providers need to be trained to be able to offer this integrated care.

- There are not enough psychiatric hospital beds and alternative settings. Psychiatric hospitals are not staffing to their total bed availability, so even if a hospital has open beds, they are unavailable because of low staffing levels. Hospitals should be held accountable for this when there is such difficulty getting inpatient beds for some populations. Additionally, temporary protective care should be available through alternative and step-down settings, such as crisis residential facilities, to lessen the need for psychiatric hospitalization.

- People in temporary protective care are discharged within seven days, which is often before they are stabilized or have a complete discharge plan. When temporary protective care is required, it should be available for up to 30 days, to ensure that stabilization and a complete discharge and transition plan are in place.

- It is difficult for individuals and their families to navigate the behavioral health system, including when entering into services, transitioning from children's services to adult services, or being released from jail or prison. There should be a roadmap or flow chart, with navigators to assist people in knowing where to go, whom to call, and what to do for various services and situations. Peer- and family-led organizations, which employ people with prior knowledge gained from personal experience with the system, could be better utilized to help individuals and their families navigate the complex system. Helping families would alleviate fear, stress, and worry about accessing services.

- There has been an influx of people accessing substance use disorder (SUD) services, but they are not being connected to peer supports or recovery coaches. The use of these supports is critical, especially for those discharged from jail or prison. Established recovery community organizations can be better utilized and connected to primary care and federally qualified health centers (FQHCs).

- Primary care practices are not providing comprehensive behavioral health care, even though this is where most people access care. Physical health should include behavioral health screening and assessment as a part of standard care. This will reduce stigma and ensure everyone is assessed for behavioral health challenges. This could help identify people who need services before severe or persistent issues arise.

- SUDs are common, but frequently go unrecognized and unaddressed. Primary care practices should conduct a screening all of their patients for substance use. They should use a symptom-based performance measure, such as the amount of time between when symptoms were recognized and when SUD was diagnosed.

- *Access to supports and housing options, especially for teens and adults with highly aggressive or violent behaviors, is inadequate and leave parents of these individuals with few or no options. Alternative housing options, such as foster care settings with no more than three individuals, should be made available. Additional funding is needed to support the increased staffing necessary and for certification and training to ensure high-quality staff.*

- Individuals who need specific services to help their recovery, independence, and quality of life are unable to access these services because they are not deemed medically necessary. The definition of

"medically necessary" is too narrow and should be broadened or better understood to account of quality of life care; this could allow for a shift in how dollars for services are allocated.

Community Education, Information, and Outreach

■ The faith community is not adequately integrated into behavioral health services. As a result, some people are unwilling to attend places of worship that have members with behavioral health challenges. More effort should be made to educate the faith community about behavioral health challenges and to integrate the faith community into service delivery.

■ Peer-led, community-based education is underutilized. To show people that their experiences are truly valued, people previously or currently in behavioral health services should be encouraged and paid to share their stories.

■ *People in service and their families are unaware of the community organizations that work with families and people with mental illnesses and developmental disabilities, because these organizations do not have marketing or outreach funding available. These organizations can play an important role in helping individuals and their families know where to go for information, know what questions to ask to make sure they are getting adequate support, and help avoid emergency crises. There should be money allocated for outreach and to make sure all target populations (e.g., the economically disadvantaged, veterans, those with SMI) know where and how to get help and who to get it from.*

■ More efforts to destigmatize behavioral health are needed, including for those who work inside the behavioral health system. There can be more stigma about behavioral health care among service providers than from the public. When providers talk down to people in SUD, DD, and mental health services, it sends a message to others about how to treat people with behavioral health challenges.

■ People with behavioral health challenges are not fairly represented by the media. The media focuses on people in services when they break the law or are involved in shootings, but does not show examples of people's behavioral health successes and recovery. If media showed individuals with behavioral health challenges leading a good, productive life, mental health would be further destigmatized.

■ Prevention, education, and outreach programs are the first to lose funding when budgets decrease, but these programs help people avoid more intensive and expensive services, e*specially when some people (e.g., children) do not meet current Mental Health Code criteria for CMH services. There should be more emphasis and funding for behavioral health education, outreach, and prevention programs.*

Workforce

■ Individuals receiving services are not recognized enough for their talents, skills, and abilities. Peer support and drop-in programs should be better funded to empower people to advocate for themselves and use their talents within the system, including as paid staff when possible. The system would be a better and more responsive system if it fully used the talents of those in the services.

■ Peer support staff are not adequately paid for their contributions to individuals' care. Peer supports are a critical service to an individual's support team, especially during the person-centered planning (PCP) process, where they help individuals in service find their voice and be a strong advocate for their needs. Staff need to be better paid and their services need to be covered by health insurance.

■ There is a high rate of turnover in direct care staff. Direct care staff need to be adequately compensated in order to attract quality staff and improve the quality of care provided. *All group home and direct care staff should be certified and trained prior to working with individuals in the system. If someone is willing to go through and pay for a certification, he/she is serious and passionate about this work, but he/she should be paid a higher wage ($15 per hour) as a result.*

Other Delivery Concerns

- *The 20-visit HMO benefit through the Medicaid Health Plans creates fragmented care rather than integrated care. This benefit should be covered by (carved back out to) the PIHPs, and provided through the CMHSPs instead.*

- Providers that market themselves as a one-stop-shop are disingenuous when they do not accept all insurers. Providers need to be honest about whom they can serve and about what services they can provide.

- FQHCs are not equipped to provide comprehensive care to those with serious or persistent chronic conditions, although they succeed at providing integrated care for those with mild conditions. There is no clear or consistent care transition between the FQHCs and CMHs. Peer support networks and community health workers (CHWs) could be utilized more often to help with these transitions. The state should support the education and standardization of CHWs and peer supports.

- Services and supports are not delivered in the same way across the state. For example, PCP and self-determination (SD) are not used consistently for SMI or SUD populations. The PCP process does not consistently include an independent facilitator and SD is encouraged in some places, but not in others. *Additionally, disability-specific situations need to be supported instead of implementing home- and community-based rules.*

- *The behavioral health system does not work for those with private insurance who show signs of anxiety, depression, or suicide. Access to care for these individuals is limited by high copays, a limit on the number of allowed visits by the insurer, and availability of proven effective service options (e.g., dialectical behavior therapies and mindfulness classes). Instead of providing holistic, effective care, people are given powerful mood-stabilizing drugs, which can have adverse side effects, and no comprehensive follow-up. This lack of comprehensive care can create emergency crises, which can eventually place people in the public mental health system, where more services and supports are available to them. More should be done to provide comprehensive behavioral health care, including effective program options, to this population. Behavioral health care visits should not have a copay, and, like other preventive care and treatment decisions, care should be decided by the individual, physicians, and their behavioral health providers, not by insurance companies.*

- Many SUD providers began providing services in 2014 under the Healthy Michigan Plan. The SUD system, made up of many of these new providers, needs more time to define and create mechanisms to deliver, administer, and pay for these services.

- The values developed by the workgroup need to be used in the entire behavioral health system, including for SUDs. SUDs are not fully integrated or included in the behavioral health system, including releases from hospital, availability of housing support, and other services.

Administration and Oversight

Although only a handful of participants raised administration and oversight concerns during the workgroup meeting, several more were sent in afterwards (provided in italics). Administration concerns varied significantly and included issues with inefficiency, monitoring, inconsistent policies, recipient rights, and more.

Inefficiencies

- The amount of paperwork required of parents and providers is excessive and becomes a deterrent to accessing and providing care for children. Reducing paperwork for families and providers will make the system more efficient.

- *MDHHS should require one electronic health record system with streamlined forms that meet all the requirements used by CMHs/PIHPs. A statewide workgroup could be established to select software and then develop and finalize all necessary forms.*

- Medicaid requires too many audits—many of them redundant—for behavioral health services, which are not required under the Medicaid Health Plans. There should be more uniformity in the audits and a reduction in the number of audits required.

- *There is administrative overlap. PIHPs add an unnecessary administrative layer, and each of the CMHSPs also has its own administrative structure. PIHPs should be eliminated, and there should be a reduction in the number of CMHSPs. The remaining CMHSPs should have enough people they are responsible for providing care to (covered lives) so that the federal government will allow the state to allow CMHSPs to contract for both Medicaid and non-Medicaid services.*

Monitoring

- *Staff working with individuals in supported living arrangements (SLAs) are difficult to monitor and do not have the same regulations as staff in licensed settings (e.g., the administration and tracking medications). This can result in poorly delivered care in SLAs. Team coordinators for all SLA settings should be required to have the same level of training as group home supervisors, and they should be paid for the added responsibilities. SLAs should be required to track medication administration in the same manner as licensed settings and to have communication books, since most staff shifts do not overlap.*

- *There are abuses in the adult and children's foster care systems. There should be increased monitoring of these systems to reduce this.*

- *There is a conflict of interest with utilization management and service authorizations.*

Inconsistent Policies

- There is a lack of uniformity across CMHs in the criteria needed to access services and this impacts the PCP and SD process. People can get one service in one part of the state, but with the same circumstances they cannot get it in another part of the state. There should be a law, revised contract, or a policy change to correct this so there is a uniform system and criteria across the state.

- *Effective January 2014, all states were supposed to be operating under mental health insurance parity, according to federal law. An analysis by the Mental Health Association of Michigan (MHAM) of over 80 Michigan health plans in late 2014, however, showed this was not fully happening. There should be stronger regulatory monitoring and enforcement of insurance markets in Michigan, specifically on mental health parity.*

- *Physical management techniques are not consistent across the state. MDHHS should issue approved techniques, rather than relying on each CMHSP to issue its own. MDHHS should create a manual to train and certify the trainers (or contract with an entity to do this) so that there is statewide consistency.*

Recipient Rights

- *The MDHHS-Office of Recipient Rights (ORR) should audit licensed psychiatric hospital units in the same manner in which they audit CMHSPs. Currently, each CMHSP ORR is responsible for reviewing each licensed psychiatric hospital unit with which it contracts. Many times, multiple CMHSP ORRs complete reviews of the same hospitals, which is a waste of resources. A single MDHHS ORR audit would provide better and more consistent oversight and complaint investigation of licensed psychiatric hospital units.*

- The grievance and appeals process is too onerous on the complainant. There needs to be an independent entity, such as the mental health commission, that investigates grievances and that CMHs report to regarding grievances and appeals.

- *Complaints of staff who violate recipients' rights are poorly tracked. A statewide database for the complaint investigation system should be created. This database should include all the complaints for all the counties in Michigan. Each ORR would login to complete its investigative functions. All recipient rights staff should have access to determine if an applicant (in any county) had a substantiated*

allegation to prevent him/her from "county-hopping" to gain employment after having been terminated due to a substantiated complaint.

Other Administrative Concerns

■ *Behavioral health has not had a statewide focus since the now-named MDHHS was reorganized in the mid-1990s, when it became a state "super-department" comprising multiple health-focused divisions underneath Community Health, including Medicaid. This approach has not enhanced integration and coordination, but has instead hidden behavioral health under Medicaid. There should be a department of mental (or behavioral) health to offer a state-level focus.*

■ *The state expects CMHSPs to implement programs and policies without adequate information or communication (i.e., Applied Behavioral Analysis and the Healthy Michigan Plan). It is difficult to change and properly implement these new programs with little disruption to the individuals being served. There should be more proactive planning, decision making, and communication of requirements to providers so these changes can be better implemented.*

■ There is a conflict of interest when the PCP facilitator is employed by the same agency that funds the services and supports that an individual will receive. The facilitator should be independent of the agency funding the individual's services and supports.

■ Although data sharing has progressed over time and data is now more accessible, it is not improving the system for those in services.

■ *Many services that CMHSPs provide are not based on set fee schedules. There should be a fee schedule to incorporate rates for all behavioral health services provided.*

■ *The system divide between physical and mental health creates an enormous barrier in identifying current health plan enrollees with behavioral health conditions (and vice versa); this makes intervention, access to care, delivery of services, and care coordination incredibly difficult. Instead, the Medicaid health plans should contract with the CMHSPs (and other contracted behavioral health providers). CMHSPs can continue to administer behavioral health services as a contracted provider. This would remove the PIHPs from the delivery system, as their sole responsibilities would be handled through the Medicaid health plans and CMHSPs.*

Payment

Participants had concerns about how the system is funded, the level of funding available, and which services can be funded.

■ There are insufficient general fund (GF) dollars available for those with Medicaid spend downs, who must pay out-of-pocket for all medical costs until their remaining income is within the guidelines for qualifying for Medicaid. *If someone works part time, he/she may lose his/her Medicaid coverage, requiring a spend down before being able to receive health benefits or prescription coverage. The monthly spend-down amount is more than most people can afford, so these individuals go without treatment. Additional GF dollars should be available and MDHHS' income requirements for coverage should match the requirements for Social Security.*

■ *Funding for the system is inadequate to hire and maintain a quality direct care workforce, provide necessary ancillary services, adequately serve the SUD population's needs, or make up for serving additional people not accounted for in Medicaid expansion and requirements for actuarial soundness.*

■ *Medicaid funding cannot fully fund the PCPs of people served by the system. The use of past spending as the major driver of actuarial soundness places a cap on Medicaid funding that prohibits the full funding of these PCPs. The expected costs needed to fully fund the PCPs across the state should be used as the basis for the funding of the state's publicly funded behavioral health system.*

- *There is a lack of GF dollars available to serve the needs of people without Medicaid, in settings where Medicaid cannot be used (e.g., jails, juvenile detention centers), and for those without insurance or with commercial insurance benefits that do not cover behavioral health or developmental disability services and supports. General funding should be increased for the state's CMH system to close these gaps.*

- Paying for Medicaid/Medicare dual-eligibles will need to be addressed going forward.

- Funding allocation is inadequate. CMHSPs are subsidizing programs funded by for-profit companies, such as outpatient therapy, nursing, and wraparound services.

- The current dual-eligible integrated care demonstration programs are not working well, and the majority of people are opting out. If the state uses a pilot program with the Medicaid health plans, the state should not require dual-eligibles to enroll in a Medicaid plan that covers both Medicare and Medicaid, because people end up losing their original and preferred Medicare coverage.

- There is a disincentive for the behavioral health system to participate in an integrated system if behavioral health providers are not compensated for their role in creating medical cost savings. Currently, when behavioral health providers create and maintain healthy individuals who do not experience emergency health situations, medical savings are given to the Medicaid Health Plans, and not kept within the behavioral health system. These savings should be negotiated as an incentive for the behavioral health system to work collaboratively with the medical system to help individuals have healthy outcomes and behaviors.

NEXT STEPS

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

The next meeting, which will be held at the Kellogg Center on Wednesday, April 27, 2016, from 10 AM to noon. The meeting will include a conversation on what is working well in the current system and begin to discuss the elements needed in a better system. Additionally, workgroup participants may offer suggestions for background information by sending requests to ShippyD@michigan.gov.