Workgroup's Progress Status Updates and Final Report Recommendations

(FY2017 Appropriation Act - Public Act 268 of 2016)

March 15, 2017

Sec. 298. *The department shall work with a workgroup to make recommendations regarding the most effective financing model and policies for behavioral health services in order to improve the coordination of 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, Medicaid 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, full community inclusion, access to CMHSP services, 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.

(d) Ensure full access to community-based services and supports.

(e) Ensure full access to integrated behavioral and physical health services within community-based settings.

(f) Reinvesting efficiencies gained back into services.

(g) Ensure transparent public oversight, governance, and accountability.

(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, identification of ways to enhance services and supports, and identification of any gaps in services and supports. The workgroup shall consider the use of 1 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 workgroup's recommendations shall also recommend annual benchmarks to measure progress in implementation of any new financing model or policy recommendations over a 3-year period and ensure that actuarially sound per member per month payments for Medicaid behavioral health services are no less than the per member per month payments used for Medicaid behavioral health services in the fiscal year ending September 30, 2017.

(5) The department shall provide, after each workgroup meeting, a status update on the workgroup's progress and, by January 15 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, the senate and house policy offices, and the state budget office.

MDHHS

Michigan Department of Health & Human Services

RICK SNYDER, GOVERNOR
NICK LYON, DIRECTOR

Final Report of the 298 Facilitation Workgroup

Michigan Department of Health and Human Services
March 15, 2017

Executive Summary

The Section 298 Initiative is a statewide effort to improve the coordination of physical health services and behavioral health services. The Michigan Department of Health and Human Services (MDHHS) launched this initiative in response to legislative language in the Fiscal Year 2017 approved budget. The language, known as Section 298, calls upon MDHHS to form a workgroup "to make recommendations regarding the most effective financing model and policies for behavioral health services in order to improve the coordination of behavioral and physical health services for individuals with mental illnesses, intellectual and developmental disabilities, and substance use disorders."

Under Section 298, MDHHS and the workgroup must produce a report with recommendations for the Michigan Legislature. MDHHS has convened the 298 Facilitation Workgroup to assist with developing the recommendations for the report. The final report includes recommendations on policy changes, models, pilots and benchmarks for implementation.

MDHHS and the 298 Facilitation Workgroup have also hosted a series of Affinity Group meetings across Michigan to help inform the development of the recommendations. The Affinity Group process engaged more than 1,113 Michiganders during 45 separate meetings in a discussion about the best strategies for improving the coordination of physical health and behavioral health services. The Affinity Group meetings included individuals, families, providers, payers and advocates. MDHHS and the 298 Facilitation Workgroup used the input, ideas and feedback from these discussions to inform the development of the recommendations.

MDHHS and the 298 Facilitation Workgroup developed an interim report to provide an update on the status of statewide discussions and the development of recommendations. The interim report focused on recommendations for policy changes. MDHHS submitted the interim report to the Legislature on January 13, 2017.

The 298 Facilitation Workgroup approved 70 policy recommendations for inclusion in the interim report. The recommendations address the following policy issues:

1) Coordination of Physical Health and Behavioral Health Services
2) Access to Services and Continuity of Services
3) Administration of Complaints, Grievances, and Appeals
4) Protections for Mental Health and Epilepsy Drugs
5) Self-Determination and Person-Centered Planning
6) Governance, Transparency and Accountability
7) Workforce Training, Quality and Retention
8) Peer Supports
9) Health Information Sharing
10) Quality Measurement and Quality Improvement
11) Administrative Layers in Both Health Systems
12) Uniformity in Service Delivery
13) Financial Incentives and Provider Reimbursement

The 298 Facilitation Workgroup also unanimously approved the following overarching recommendation for the Michigan Legislature. The overarching recommendation should be considered in conjunction with all other policy recommendations within the report.

Overarching Recommendation: **The workgroup recognizes that the following recommendations are being made during a time of dramatic change and extraordinary innovation in health policymaking. The workgroup acknowledges that the recommendations may be affected and shaped by substantial changes in federal policy and funding over the next few years. The workgroup also strongly believes that future state policymaking on physical health and behavioral health financing and integration should be partly informed and guided by the results of demonstrations and pilots, which include (1) demonstrations and pilots that are currently operational, and (2) new models that may be established as part of the Section 298 Initiative. Finally, the workgroup recommends the State of Michigan make every effort to achieve the goals and fulfill the values that are identified as part of this report regardless of changes at the federal or state level.**

After the submission of the interim report with only the policy recommendations, MDHHS and the workgroup launched the next phase of the process, which focused on the development of recommendations for financing models. In order to generate concepts for potential models, MDHHS and the workgroup opened a statewide process for interested stakeholders to submit model proposals. MDHHS and the workgroup ultimately received 42 model proposals as part of this process. MDHHS submitted the 42 model proposals to the Michigan Legislature as a separate companion document to this final report for the purposes of public record.

MDHHS and the workgroup organized the 42 model proposals into six categories of financing models and one category of non-financing models. All seven categories are listed below, and detailed summaries are included in the following sections of the final report.

- **Model Category #1:** Statewide Behavioral Health Managed Care Organization
- **Model Category #2:** Community Mental Health Service Provider Capitation
- **Model Category #3:** Modified Managed Care Approaches
- **Model Category #4:** Current Financing Structure Enhancement
- **Model Category #5:** Local/Regional Integration Arrangements
- **Model Category #6:** Medicaid Health Plan and Prepaid Inpatient Health Plan Payer Integration
- **Model Category #7:** Non-Financing Models

After the financing models were developed, the workgroup conducted an evaluation of the financing model categories. MDHHS also completed a preliminary policy review of the model categories. MDHHS also posted the six financing models for public input.

During this time, MDHHS and the workgroup also developed two other components for the final report. The first component is a set of recommendations for benchmarks for implementation, and the second component is a high-level process map to outline the next steps for the Section 298 Initiative.

After completing the evaluation process and reviewing the comments from the public input process, the workgroup approved several recommendations on potential financing models during its March 10, 2017 meeting. The following recommendations were officially approved by a super majority (two-thirds) of the workgroup as official recommendations to the Legislature. Recommendations that appear in **bold font** were approved unanimously by all workgroup members, and recommendations that are in regular font were approved by a super majority of workgroup members.

- **Recommendation 1: The workgroup recommends that MDHHS should develop a process for evaluating model concepts that do not require policy or statutory changes for implementation.**

- **Recommendation 2: The workgroup recommends that MDHHS, informed by stakeholders, should conduct a more in-depth review of model proposals that were submitted to see if other model(s) might emerge.**

- Recommendation 3: For inclusion among models to be tested, the workgroup recommends the expansion and broadening of jointly funded, staffed and operated programs between MHPs and the local public behavioral health system for coordinating services to shared enrollees.

- Recommendation 4: The workgroup recommends the development of consistent statewide contract provisions to encourage the integration of physical health, behavioral health and intellectual/developmental disability services and supports for all populations at the point of service, which should be driven by local coordination between providers rather than statewide integration of financing.

- Recommendation 5: The workgroup recommends the use of models which improve the coordination of physical health and behavioral health services and supports through the local public behavioral health network for individuals with a mental illness, serious emotional disturbances, and substance use disorders. Within that population, the focus should be on individuals who are vulnerable and at risk for issues of increased morbidity and premature death as well as persons who are high utilizers of emergency services and hospitalization services.

  This recommendation includes the following elements:
  - The local public behavioral health network and the responsible entities for physical health, whether a health plan or private physicians, would be charged with accomplishing physical health and behavioral health coordination.
  - An Accountable Care Organization with funding from the health plan or fee for service, through the local public behavioral health network, would be responsible for the provision of coordinated physical and behavioral services for the affected populations. The Accountable Care Organization could also include other entities.
  - MDHHS should consider other strategies to address the coordination of care at the local public behavioral health network level such as using a supports coordination model rather than the case management model.

  - MDHHS should also consider using a wraparound model for youth and children with serious emotional disturbances that will address their unique needs for integration of well child and preventive health care as well as behavioral health needs.

- Recommendation 6: The workgroup recommends the establishment of an Integration Innovation Venture Capital Fund, which would provide opportunities for Local/Regional Integration Arrangements. The fund should be established and used to support, enhance or develop integration arrangements at the provider level.
  - This recommendation allows for integrated service delivery at the community level, recognizes the unique nuances of each region and is the way to best impact a person and family's experience.
  - The success of integration is significantly impacted by the relationships held between providers. This is a local issue that can only be managed and facilitated at the local level. This recommendation allows the State of Michigan to create the opportunities for willing, innovative partners without forcing structural changes based on external resources.
  - This recommendation also allows the existing MHPs and PIHPs to identify different ways to braid funding and explore various other funding methodologies while managing the risk pool.
  - As a result of the advent of the Healthy Michigan Plan and Patient Protection and Affordable Care Act, there are already several integration initiatives in place. This approach could serve as an incubator of integration that could not be achieved through a statewide, macro-level policy.

After making its final recommendations, the workgroup unanimously approved the submission of the final report with amendments to the Michigan Legislature. MDHHS submitted the final report to the Michigan Legislature on March 15, 2017.

Table of Contents

Workgroup Participants

Workgroup Members	
Arlene Kashata	Grand Traverse Band of Ottawa and Chippewa Indians
Bob Nykamp	Pine Rest Christian Mental Health Services
Bob Sheehan	Michigan Association of Community Mental Health Boards
Chris Priest	Michigan Department of Health and Human Services
Dohn Hoyle	The Arc Michigan
Dr. Stephanie Brady	Ascension, St. John Providence
Elmer Cerano	Michigan Protection and Advocacy Service
Heidi Chan	Blue Cross Complete
J. Ryan Grinnell-Ackerman	Michigan Primary Care Association
Jane Shank	Association for Children's Mental Health
Jill Gerrie	Self-Determination Advocate
Joe Sedlock	Mid-State Health Network
Kathy Swantek	Blue Water Developmental Housing
Kevin Fischer	National Association for Mental Illness
Laura Appel	Michigan Health and Hospital Association
Linda Burghardt	Area Agencies on Aging Association of Michigan
Lisa Hotovy Williams	West Michigan Community Mental Health System
Lynda Zeller	Michigan Department of Health and Human Services
Mark Reinstein	Mental Health Association in Michigan
Matt Lori	Michigan Department of Health and Human Services
Norm DeLisle	Michigan Disability Rights Coalition
Sam Price	1016 Recovery Network
Tiffany Stone	Michigan Association of Health Plans

Workgroup Alternates	
Alan Bolter	Michigan Association of Community Mental Health Boards
Dominick Pallone	Michigan Association of Health Plans
Erin Emerson	Michigan Department of Health and Human Services
Mark McWilliams	Michigan Protection and Advocacy Services
Michele Lundberg	Blue Cross Complete
Phillip Bergquist	Michigan Department of Health and Human Services
Sara Coates	Michigan Primary Care Association
Sherri Boyd	The Arc Michigan
Tom Renwick	Michigan Department of Health and Human Services

Other Workgroup Participants	
David Fosdick	State Budget Office
Eric Houghtaling	State Budget Office
Farah Hanley	Michigan Department of Health and Human Services
Geralyn Lasher	Michigan Department of Health and Human Services
Jamie Zaniewski	Governor's Office
Jared Welehodsky	Michigan Department of Health and Human Services
Jon Breems	Michigan Department of Health and Human Services
Jon Villasurda	Michigan Department of Health and Human Services
Katrina Steinsultz	Michigan Department of Health and Human Services
Kristen Jordan	Michigan Department of Health and Human Services
Sheri Falvay	Michigan Department of Health and Human Services

Workgroup Facilitator	
Phil Kurdunowicz	Michigan Department of Health and Human Services

Purpose, Limitations, Vision and Values

Statement of Purpose

The purpose of the 298 Facilitation Workgroup is to develop recommendations for the Michigan Legislature regarding "the most effective financing model and policies for behavioral health services in order to improve the coordination of behavioral and physical health services for individuals with mental illnesses, intellectual and developmental disabilities, and substance use disorders." The purpose is defined by the Section 298 legislative language that is included in the Fiscal Year 2017 appropriations act. The legislative language for Section 298 is included in Appendix 1 of this report.

Statement of Limitations for the Interim Report

The policy recommendations in the interim report are a reflection of the input and ideas from the Lieutenant Governor's workgroup and the Affinity Group process. While the policy recommendations address a wide range of challenges that are confronting the Michigan health system, the 298 Facilitation Workgroup was not able to resolve every issue that was identified during the Lieutenant Governor's workgroup, the Affinity Group process or subsequent public review process. MDHHS will continue to consider these issues and explore opportunities to address them in the future. The workgroup also believes that the insights from the public discussion that is chronicled within the interim report, in addition to the recommendations for models and benchmarks, should be used to inform future state policymaking efforts.

Vision Statement

In early 2016, Lieutenant Governor Brian Calley convened a workgroup to discuss the integration of physical health and behavioral health services in Michigan. The Lieutenant Governor's workgroup developed a report that included the following end statement. MDHHS and the newly created 298 Facilitation Workgroup will use this statement to guide the development of the Section 298 report. The report's purpose is to provide recommendations to achieve the vision as described in the 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. 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.*
>
> ** Supports are care that maintains or increases personal self-sufficiency and facilitates achievement of individual goals of independence and community inclusion, participation, and engagement.*
>
> ***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.*

Values Statement

The Lieutenant Governor's workgroup also identified a set of core values that should guide the development of the Section 298 report and serve as the basis for improving the coordination of physical health and behavioral health services. The list of values is included in Appendix 2 of this report.

Background

Description of the Current Behavioral Health System in Michigan

In Michigan, behavioral health prevention, early identification, treatment and recovery support systems are the primary responsibility of the Behavioral Health and Developmental Disabilities Administration (BHDDA). BHDDA is located within MDHHS. The Medical Services Administration (MSA) is also located within MDHHS and functions as the State Medicaid Agency. MSA's primary responsibility is oversight of Michigan's Medicaid program. MSA manages comprehensive physical health services (including outpatient mental health) for individuals with mild to moderate mental health needs.

BHDDA is responsible for the administration of state substance use disorder (SUD) appropriations, the Substance Abuse Prevention and Treatment Block Grant, the Mental Health Block Grant and Medicaid-funded specialty services and supports. BHDDA carries out responsibilities specified in the Michigan Mental Health Code and the Michigan Public Health Code. BHDDA, in partnership with MSA, also administers the Medicaid specialty services benefit for people with intellectual/developmental disabilities, adults with serious mental illness, children with serious emotional disturbances and individuals with substance use disorders.

Public behavioral health services are delivered through Community Mental Health Services Programs (CMHSP), which are public entities that are created by county governments to provide a comprehensive array of mental health services to meet local needs regardless of an individual's ability to pay. CMHSPs provide Medicaid, state, block grant, and locally funded services to children with serious emotional disturbances, adults with serious mental illness and children and adults with intellectual/developmental disabilities. Services are either provided directly by the CMHSP or through contracts with providers in the community. Some CMHSPs also contract for direct provision of outpatient treatment and other substance use disorder treatment services (residential, detoxification and inpatient rehabilitation).

Behavioral health specialty services and supports are primarily funded through Michigan's 10 Prepaid Inpatient Health Plans (PIHP). MDHHS contracts with PIHPs to operate and manage Medicaid-funded behavioral health specialty services and supports on a regional basis. PIHPs are also the responsible entities for directly managing Substance Abuse Block Grant funding and local substance abuse funding. Each PIHP contracts with CMHSPs and other providers within its region to deliver publicly-funded services and supports.

Services for individuals with mild to moderate mental illness are covered by Michigan's 11 Medicaid Health Plans (MHP), which are separate from the PIHPs. MHPs have developed a network of providers to serve the needs of individuals with mild to moderate mental health illness. Some MHPs contract with select CMHSPs to provide mental health services for individuals with mild to moderate mental health illness. Mild to moderate mental health services are a benefit that is provided as part of the contracting process for Medicaid health services, including physical health services, by MDHHS.

Please review Appendix 3 for a visual depiction of the current behavioral health system in Michigan.

History of the Section 298 Initiative

The Section 298 Initiative is a statewide effort to improve the coordination of physical health services and behavioral health services. The following section provides an overview of the history of the Section 298 Initiative. A full timeline for the Section 298 Initiative is included in Appendix 4.

The initiative started with the publication of the Fiscal Year 2017 executive budget proposal, which recommended that:

> *"..The state begin the process to better integrate mental and behavioral health services with a patient's physical health treatments. The governor expects to see improved coordination of care and a stronger focus on the needs of an individual patient by initiating a process by which all patient services are closely integrated. This budget recommendation asks the legislature and the health provider community to engage in an important conversation about integrating physical and behavioral health services into the larger consideration of patient need."*

The executive budget proposal sparked a statewide discussion on the best approach for coordinating physical health services and behavioral health services. In order to facilitate this discussion, Lieutenant Governor Brian Calley called an initial meeting of stakeholders, which resulted in the formation of a workgroup. The Lieutenant Governor's workgroup met five times from March 2016 to June 2016 and produced a final report. The final report included final legislative language for Section 298, a set of "core values" for the initiative, and a set of "design elements" for future discussions. The core values can be found in Appendix 2 of this report, and the design elements can be found in Appendix 5.

The Michigan Legislature used the recommendations from the Lieutenant Governor's workgroup to create a revised Section 298, which was approved as part of Public Act 268 of 2016. Under the new Section 298, the Michigan Legislature directed MDHHS to develop a set of recommendations "…regarding the most effective financing model and policies for behavioral health services in order to improve the coordination of behavioral and physical health services for individuals with mental illnesses, intellectual and developmental disabilities, and substance use disorders." The legislative language for Section 298 is included in Appendix 1 of this report.

In July 2016, MDHHS convened a new 298 Facilitation Workgroup to assist with the development of recommendations. The purpose of the workgroup is to facilitate a statewide discussion on the development of recommendations for policy changes, integration models and pilots and benchmarks for implementation. Workgroup membership includes representatives of individuals who use services, families, providers and payers. A list of workgroup participants is included on page 3 of this report.

The MDHHS collaborated with the 298 Facilitation Workgroup to launch a series of Affinity Group meetings to gather input and ideas for potential recommendations. The Affinity Group process featured the creation of four types of Affinity Groups: 1) eligible populations and families, 2) providers, 3) payers, and 4) Tribal health organizations. Affinity Group meetings were either hosted by MDHHS or by other organizations such as advocacy groups, service agencies, provider associations, or other community organizations. MDHHS and 298 Facilitation Workgroup created a series of questions that were used during Affinity Group questions to help facilitate group discussions.

The Affinity Groups met throughout October and November 2016 and provided a wide array of input and ideas to inform the development of potential recommendations. More than 1,113 Michiganders participated in Affinity Group discussions during 45 separate meetings.

The number of Affinity Group meetings, participants and written comments are summarized in Table 1.

Table 1: Summary of Overall Affinity Group Participation					
Type of Affinity Group	**Eligible Populations and Families**	**Providers**	**Payers**	**Tribal Health Organizations**	**Total**
Affinity Group Meetings	31	12	1	1	45
Affinity Group Participants	767	286	48	12	1113
Written Responses	82	16	9	0	107
Estimated Total Respondents*	849	302	57	12	1220

** The number of total respondents is an estimate because some stakeholders participated in an Affinity Group meeting and separately submitted written comments.*

A list of Affinity Group meetings is included in Appendix 6, and a map of Affinity Group meetings is included in Appendix 7. MDHHS and the 298 Facilitation Workgroup also summarized the comments from Affinity Group participants. Summaries of the comments from the Affinity Group process can be found in Appendix 8 (Eligible Populations and Families), Appendix 9 (Providers), Appendix 10 (Payers) and Appendix 11 (Tribal Health Organizations).

During November and December 2016, the 298 Facilitation Workgroup developed a set of policy recommendations based upon the comments from Affinity Group process. Policy recommendations that were approved by the workgroup have been included in the interim report.

MDHHS posted the interim report for public review from December 14, 2016 through January 4, 2017. MDHHS collected comments on the interim report through three types of methods:

- Web-based survey
- Written comments by mail or email
- Public forum on January 3, 2017, at the West Campus of Lansing Community College

The participation of stakeholders in the various public review methods is summarized in Table 2.

Table 2: Summary of Public Review Participation	
Number of Submitted Surveys	57
Number of Written Comments	36
Number of Forum Participants	71
Estimated Number of Total Respondents*	164

** The number of total respondents is an estimate because some stakeholders participated in the public forum and submitted comments through the survey or by email.*

The 298 Facilitation Workgroup used the comments from public review to revise the interim report. A summary of the comments from public review can be found in Appendix 12. The workgroup approved the interim report for submission to the Legislature on January 11, 2017. MDHHS submitted the interim report to the legislature on behalf of the workgroup on January 13, 2017.

After the submission of the interim report, MDHHS and the workgroup launched the next phase of the process, which focused on the development of recommendations for financing models. In order to generate concepts for potential models, MDHHS and the workgroup opened a statewide process for interested stakeholders to submit model proposals. MDHHS and the workgroup ultimately received 42 model proposals as part of this process. MDHHS submitted the 42 model proposals to the Michigan Legislature as a separate companion document to the final report for the purposes of public record.

MDHHS and the workgroup organized the 42 model proposals into six categories of financing models and one category of non-financing models. All seven categories are listed below, and detailed summaries are included in the following sections of the final report.

- **Model Category #1:** Statewide Behavioral Health Managed Care Organization
- **Model Category #2:** CMHSP (Provider) Capitation
- **Model Category #3:** Modified Managed Care Approaches
- **Model Category #4:** Current Financing Structure Enhancement
- **Model Category #5:** Local/Regional Integration Arrangements
- **Model Category #6:** MHP or PIHP Payer Integration
- **Model Category #7:** Non-Financing Models

After the financing models were developed, the workgroup conducted an evaluation of five of the six financing model categories, which included categories 1, 2, 3, 4 and 5. MDHHS included the results of the workgroup evaluation within the individual subsection for each financing model category and within Appendix 14 of the final report. MDHHS also completed a preliminary policy review of the model categories. MDHHS included the results of the policy review within the individual subsection for each financing model category and within Appendix 15 of the final report.

MDHHS also posted the six financing models for public input. The public input process for the financing models lasted from February 16, 2017 through March 3, 2017. MDHHS established two opportunities to provide input, which are described below:

- Web-based survey.
- Public forum on February 24, 2017, at the Hannah Center in East Lansing.

The participation of stakeholders in the various public input methods is summarized in Table 3.

Table 3: Summary of Public Input Process Participation	
Number of Partial or Fully Completed Surveys	705
Number of Forum Participants	62
Estimated Number of Total Respondents*	767

The results of public input are described within Appendix 16 of the final report. MDHHS and the workgroup used the comments from the public input process to refine and improve the evaluation of the individual financing models.

During this time, MDHHS and the workgroup also developed two other components for the final report. The first component was recommendations for benchmarks for implementation, which includes a list of performance metrics to measure the outcomes of the implementation of the new financing models and policy changes. The second component is a high-level process map to outline the next steps for the Section 298 Initiative. Both of these components are included in the final report.

After completing the evaluation process and reviewing the comments from the public input process, the workgroup approved several recommendations on potential financing models during its March 10, 2017 meeting. The recommendations can be found in the Recommendations for Financing Models section and Appendix 18.

After making its final recommendations, the workgroup unanimously approved the submission of the final report with amendments to the Michigan Legislature. MDHHS submitted the final report to the Michigan Legislature on March 15, 2017.

Ongoing Process

Upon the submission of the final report, MDHHS will actively seek legislative guidance on which financing model(s) and policy recommendation(s) should be prioritized for further analysis. As part of this process, MDHHS will continue to provide information to the Legislature when requested to help support legislative review and consideration of the final report.

Once the Legislature has provided additional guidance, MDHHS will conduct additional analysis on the policy implications and fiscal impacts of specific financing model(s) and policy recommendation(s). MDHHS will also develop a proposed timeline for implementing the proposed financing model(s) and policy recommendation(s). MDHHS will then report this information back to the Legislature for further consideration. MDHHS will continue to support the legislative process and seek a final decision on which financing model(s) and policy recommendation(s) should be pursued.

MDHHS will pursue pilot(s) for financing model(s) and/or service delivery reform(s) based upon legislature approval. As part of this process, MDHHS will: (1) plan for pilot(s) and identify potential pilot site(s); (2) implement pilot(s); (3) evaluate the results of the pilot(s); and (4) identify opportunities for improvement for the chosen model(s) and make decisions about whether to replicate, expand, refine and/or improve the model(s). MDHHS will consult with stakeholders throughout the development, implementation and evaluation process for the financing model and service delivery reform pilot(s).

MDHHS will also pursue specific policy recommendation(s) and policy change(s) that are related to the financing model(s) based upon legislative approval. As part of this process, MDHHS will: (1) plan for policy change(s); (2) implement policy change(s); (3) evaluate the outcomes of the policy change(s); and (4) identify opportunities for improvement and take further action as necessary. MDHHS will consult with stakeholders throughout the development, implementation and evaluation process for the policy recommendation(s) and other related policy change(s).

MDHHS will continually evaluate and seek opportunities for improvement throughout this process. MDHHS will also work with stakeholders to continue to assess alignment between the initial policy recommendation(s) and the selected financing model(s).

A graphical overview of the ongoing process for the Section 298 Initiative can be found in Appendix 13 of the final report.

Recommendations for Policy Changes

The 298 Facilitation Workgroup developed the following set of policy recommendations based upon the comments from Affinity Group process. The workgroup approved the following set of recommendations for inclusion in the interim report during its December 2, 2016, meeting. Recommendations that appear in **bold font** were approved unanimously by all workgroup members, and recommendations that are in regular font were approved by a super majority (two-thirds) of workgroup members.

The workgroup organized the recommendations into sections that reflect the different topics that were discussed during the Affinity Group process. The sections are organized as follows:

1) Coordination of Physical Health and Behavioral Health Services
2) Access to Services and Continuity of Services
3) Administration of Complaints, Grievances and Appeals
4) Protections for Mental Health and Epilepsy Drugs
5) Self-Determination and Person-Centered Planning
6) Governance, Transparency and Accountability
7) Workforce Training, Quality and Retention
8) Peer Supports
9) Health Information Sharing
10) Quality Measurement and Quality Improvement
11) Administrative Layers in Both Health Systems
12) Uniformity in Service Delivery
13) Financial Incentives and Provider Reimbursement

The 298 Facilitation Workgroup also approved an "overarching" recommendation for the Michigan Legislature. The overarching recommendation should be considered in conjunction with all other policy recommendations within the report.

Each section also includes a summary of the comments from the Affinity Group process in order to provide additional context for the recommendations.

Fiscal Note: MDHHS will provide a fiscal analysis in order to inform decisions as they pertain to the implementation of any policy recommendations that are supported and advanced as a result of this report.

Overarching Recommendation

The 298 Facilitation Workgroup approved the following overarching recommendation for the Michigan Legislature. This recommendation should be considered in conjunction with all other policy recommendations within the report.

Overarching Recommendation: **The workgroup recognizes that the following recommendations are being made during a time of dramatic change and extraordinary innovation in health policymaking. The workgroup acknowledges that the recommendations may be affected and shaped by substantial changes in federal policy and funding over the next few years. The workgroup also strongly believes that future state policymaking on physical health and behavioral health financing and integration should be partly informed and guided by the results of demonstrations and pilots, which include (1) demonstrations and pilots that are currently operational, and (2) new models that may be established as part of the Section 298 Initiative. Finally, the workgroup recommends the State of Michigan make every effort to achieve the goals and fulfill the values that are identified as part of this report regardless of changes at the federal or state level.**

Section 1: Coordination of Physical Health and Behavioral Health Services

The coordination of services is critical to the health and wellness of individuals with behavioral health needs or intellectual/developmental disabilities. For the past few decades, Michigan has been a national leader in developing and implementing policies and systems to improve the coordination of services. Despite this progress, individuals with behavioral health needs or intellectual/developmental disabilities continue to experience gaps in care or disparities in outcomes. The following recommendations seek to build upon the strengths of Michigan's current service delivery system and improve the coordination of physical health and behavioral health services.

Affinity Group Comments

Individuals and family members largely expressed a preference that the CMHSP system continue to coordinate their behavioral health services and supports. There was a general consensus among individuals and family members that they did not want all of their services directly coordinated by the health plans or any one entity. In fact, numerous participants expressed a desire to coordinate their own care. Provider and payers largely supported this direction as well, although a minority of the affinity group participants expressed a desire for funding to be managed by one entity. All affinity groups supported the idea that care coordination occur at the level of the person in the delivery system and that the person and/or the person's family members (if applicable) should have the ability to choose the organization that coordinates services.

Recommendations

Recommendation 1.1: The State of Michigan should retain system structures for Medicaid funding with (1) separate funding for and management of physical health flowing through the MHP system and (2) separate funding for and management of specialty behavioral health and intellectual/developmental disabilities flowing through the public PIHP/CMHSP system. Michigan should retain a public separately funded and managed system for non-Medicaid specialty behavioral health and intellectual/developmental disability services. CMHSPs should continue to play the central role in the delivery of Medicaid and non-Medicaid specialty behavioral health and intellectual/developmental disabilities services. The recommendation does not preclude the consideration of models of other competent, public, risk-based configurations.

Recommendation 1.2: Through the use of consistent language in state contracts with payers, MDHHS should create standards that require contracted providers to follow the wishes of the person and/or family members for the coordination of services at the point of service delivery. Each individual should have the ability to choose where services are coordinated at the point of service delivery (e.g. health home, patient-centered medical home, etc.). This choice is not a choice of payer but rather a choice of the party that will coordinate services for the individual at the point of service. These standards should also include the opportunity for the person and/or family member to coordinate services for himself or herself.

Section 2: Access to Services and Continuity of Services

The following section provides an overview of recommendations that are related to 1) the ability of individuals to access crucial physical health and behavioral health services and 2) the ability of individuals to maintain existing individual-provider relationships during changes in the service delivery system. The section includes several subsections to address specific topics regarding access to services and continuity of services. These subsections are outlined below:

- Section 2a: Substance Use Disorder Services
- Section 2b: Services for Children, Youth and Families
- Section 2c: Services for Tribal Members
- Section 2d: Continuity of Services

Section 2a: Substance Use Disorder Services

The Michigan health care system has made concerted efforts over the last few years to address the growing prevalence of substance use disorders in our state. Families and communities are on the frontlines of this epidemic and are increasingly struggling to cope with the hardship and heartbreak caused by substance use disorders. Adapting and responding to this public health challenge will require innovative thinking and a continued commitment from the Michigan health care system to improving access to substance use disorder services. The following recommendations seek to improve access and enhance the delivery of substance use disorder services.

Affinity Group Comments

Affinity Group participants emphasized several key concepts, including: (1) the need for broader access for individuals with substance use disorders; (2) increased funding for prevention and treatment services; (3) broader access to medication assisted treatment; (4) campaigns aimed at workforce education and stigma reduction; (5) the use of Screening, Brief Intervention and Referral to Treatment (SBIRT) as an evidence based practice across encounter points; (6) improved access for justice-involved individuals and veterans; and (7) the expansion of billable codes or other mechanisms for reimbursement.

Recommendations

Recommendation 2.a.1: MDHHS should ensure that citizens are universally screened for substance use disorders problems at all points of health care system encounters using a consistent battery of state-defined screening instruments.

Recommendation 2.a.2: MDHHS should ensure that citizens have on-demand access to the full array of substance use disorder services, supports, and/or treatment delineated in the American Society for Addiction Medicine (ASAM) criteria regardless of where they live in Michigan.

- **Access should not depend on the severity of illness or symptoms and should incorporate trauma competent, culture-informed, and gender-specific modalities.**
- **All health care delivery systems should ensure there are same-day access systems, including after-hours access capabilities, for individuals with substance use disorders.**

Recommendation 2.a.3: MDHHS should expand and promote the role(s) of recovery coaches and other peers across service delivery systems to improve consumer engagement and retention in services.

Recommendation 2.a.4: The Michigan Legislature and MDHHS should increase the investment in community-based prevention activities.

Recommendation 2.a.5: MDHHS should pilot value-based payment models that incentivize harm reduction and long-term recovery outcomes and adopt successful models statewide.

Recommendation 2.a.6: MDHHS should align all health care (broadly defined to include physical health, behavioral health and substance use disorders) services and supports around substance use disorders, which include:

- **Normalizing and encouraging (and reducing stigma associated with) treatment for substance use disorders.**
- **Adopting the SBIRT approach for identified substance use disorders.**
- **Educating the workforce on substance misuse, abuse and addiction as disease processes with reliable treatment regimens and outcomes.**
- **Expanding the availability of medication assisted treatment, especially in primary care settings.**
- **Demonstrably reducing risk factors and increasing protective factors.**
- **Removing barriers to on-demand access.**
- **Ensuring that benefits to which individuals and families are entitled are available within the time and distance standards established by the state.**

Recommendation 2.a.7: MDHHS should incentivize the health care system to more effectively integrate, coordinate, co-locate and/or provide substance use disorder services.

Section 2b: Services for Children, Youth and Families

The basis for the delivery of services to children is a family-driven and youth-guided approach. At the individual child and family-level, a family-driven and youth-guided approach recognizes that the child and family are the focus of service planning and that family members are integral to a successful planning process. The wants and needs of the child and his/her family are considered in the development of the Individual Plan of Service.

In addition, services for children and families are grounded in a system of care framework, where all child-serving systems collaborate together to develop "a spectrum of effective, community-based services and supports that is organized into a coordinated network." (Stroul, Blau & Friedman, 2010). The system of care philosophy supports the core values of "community-based", "family-driven", "youth-guided", and "culturally and linguistically competent". The principles of the system of care are based upon the delivery of an array of effective services and supports that include (1) promotion, prevention, and early intervention, (2) wraparound approach, (3) services in the least restrictive setting, (4) family and youth partnerships, (5) service coordination, (6) collaboration across child-serving systems, and (7) services across the age range including services for young children, youth, and young adults that are transitioning into adulthood.

The system of care approach includes both home and community-based treatment services and supports and out-of-home treatment services that are provided when necessary. The federal Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2013 issued a joint bulletin that highlighted the effectiveness of home and community-based services. This bulletin included wraparound approach, intensive in-home services, mobile crisis response, parent and youth peer support services, respite care and evidence-based treatments for trauma.[1] The following recommendations seek to accomplish the goals of providing a family-driven, youth-guided system of services and supports for children, youth and their families.

Affinity Group Comments

Individuals, families, providers and payers concurred on the importance of expanding access to screening and early intervention services. Affinity Group participants highlighted the role that schools could play in supporting this effort. Affinity Group participants also agreed that greater efforts need to be made to reduce stigma and that blame should not be placed on the child or the family. Individuals and families also emphasized the need for greater education on what services and supports are available. Affinity Group participants also supported the idea of pre-planning for youth in terms of financial planning, housing options, work opportunities and vocational training. Additionally, individuals and families noted the lack of treatment facilities for children and the difficulty in accessing services for children with serious emotional disturbances. Finally, providers and payers also agreed that training on behavioral health services and trauma-informed care should be offered to medical providers, law enforcement and school staff.

[1] Stroul B., Dodge, J., Goldman, S., Rider, F., & Friedman, R. (2015). Toolkit for Expanding the System of Care Approach. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Recommendations

Recommendation 2.b.1: MDHHS should address service gaps and geographic inconsistencies in supporting children, youth and families. These gaps include shortages of pre-crisis intervention, crisis response (including mobile response and crisis residential services), child psychiatry, respite and peer supports for children, youth and parents. MDHHS should establish clear access guidelines for each support and standards for sufficient capacity to ensure a full array of services is available.

Recommendation 2.b.2: MDHHS should fund and provide opportunities in all communities for support groups, family education and family empowerment to improve systems navigation and access to resource information.

Recommendation 2.b.3: MDHHS should require planning and coordination of services and supports for adult life (including financial planning, housing, work opportunities and vocational training) before youth age out of the children's services system.

Recommendation 2.b.4: MDHHS should allow Medicaid reimbursement for planning and transition services for youth with behavioral health or substance use disorders who are 18 to 21 years of age and who continue to meet the criteria for serious emotional disturbance regardless of whether they also meet the adult eligibility criteria for serious mental illness.

Recommendation 2.b.5: MDHHS and the Michigan Department of Education should improve collaboration and communication with schools to better provide mental health screening, early intervention, and services to children with mental health needs.

Recommendation 2.b.6: MDHHS should adopt and promote a non-judgmental, strength-based approach in providing services and supports to children, youth and families using family-driven and youth-guided principles and policies of practice.

Recommendation 2.b.7: MDHHS should develop, disseminate and require application of best practices in trauma-informed care, behavioral health needs assessment, criminal/juvenile justice diversion and discharge planning for children and youth.

Section 2c: Services for Tribal Members

In Michigan, each of the 12 federally-recognized Tribal nations is a distinct separate unit of government with designated service areas and specific service eligibility criteria. There are also non-federally-recognized Tribal nations and urban Tribal organizations within the State of Michigan that serve Tribal populations. Additionally, many Tribal citizens receive behavioral health services from a Tribal health center. These programs have been designed with Tribal self-determination as the guiding law and policy and address cultural needs of Tribal citizens. A unique, customized approach is therefore required to improve the delivery of health care services to Tribal citizens. The unique needs and status of these groups will be need to be taken into consideration by MDHHS. The following recommendations seek to address barriers that Tribal citizens encounter when attempting to access health care services.

Affinity Group Comments

Affinity Group participants described the experiences of Tribal citizens with the health care system and identified barriers that they have encountered: these barriers include access to health care services, lack of health insurance coverage, limited access to transportation, lack of coverage for traditional medicine services, inconsistent funding and a lack of culturally competent providers. Additionally, Affinity Group participants noted there is a mistaken belief that the Tribal health systems have unlimited funds and resource capacity to provide services to Tribal citizens. Affinity Group participants explained that Tribal health systems are experiencing a substantial shortage of funds and resources that are required to provide vital services.

Recommendations

Recommendation 2.c.1: The State of Michigan should acknowledge that a government to government relationship exists between the 12 federally recognized tribes and the State of Michigan. This relationship is critical to creating a Medicaid system that is responsive to the needs and concerns of Tribal citizens and Tribal governments.

Recommendation 2.c.2: MDHHS should design and operate Michigan's Medicaid system with the needs of Tribal citizens in mind and with recognition of Tribal sovereignty and Tribal self-determination.

Recommendation 2.c.3: MDHHS should consider the needs of the Native American people who are members of non-federally recognized tribes in Michigan while designing and operating Michigan's Medicaid system.

Recommendation 2.c.4: MDHHS should consider the special needs of Tribal citizens living in urban areas. The unique status and priorities of urban Indian organizations serving Tribal citizens should be addressed while designing and operating Michigan's Medicaid system.

Recommendation 2.c.5: MDHHS and Tribal nations and organizations should work together to identify separate, specific funding for federally-recognized Tribal nations, non-federally recognized tribes and urban Tribal programs for their disbursement and access to ensure equitable access to funds and quality services.

Recommendation 2.c.6: MDHHS should include the traditional healing techniques and methods that are used by Michigan's Tribal members in the set of clinical approaches that are reimbursed and covered by Medicaid.

Recommendation 2.c.7: MDHHS will work with Tribal health organizations and the federal government to identify and pursue the ability of Michigan's Tribal nations to run their own risk-based payer and provider Medicaid systems that are Tribally-owned and operated managed care organizations which are designed to serve Tribal members.

Recommendation 2.c.8: MDHHS should design and operate Michigan's Medicaid system relative to the Native American/Indian residents of the state to meet the health care needs of the Tribal members.

- **Tribal health care systems should be able to support sufficient capacity for clinical staff, (i.e., physicians, physician assistants, nurse practitioners and behavioral health staff) to meet the Tribal population needs.**

Recommendation 2.c.9: MDHHS should expand and design the data collection system used in Michigan's Medicaid program to accurately capture the Native American/Indian ethnicity of Tribal members, even when those Tribal members identify themselves as also belonging to other racial and ethnic groups. Accurate data collection is essential for the development of a precise representation of the size and needs of Michigan's Native American/Indian population.

Section 2d: Continuity of Services

Continuity in provider and support relationships is important for the delivery of physical health and behavioral health services. Consistency in supports and providers is integral to achieving the individual's long-term health and wellness goals. In addition, a well-established relationship between individual and provider can provide stability and comfort for the consumer during emergencies. Continuity in supports and services for individual also reduces errors, improves the competence of providers in those relationships, and deepens trust in both provider and payer systems. The following recommendations focus on ensuring that individuals have continued access to providers and other support personnel.

Affinity Group Comments

Individuals and families affirmed that they would like to continue to have access to their current providers. Individuals and families expressed concerns about being moved into a new system that forces them to give up their current doctors and providers. Individuals and families also emphasized the importance of minimizing disruption to service delivery and the value of individuals having stable, long-term relationships with providers.

Recommendations

Recommendation 2.d.1: Every effort should be made by MDHHS, payers and providers to maintain existing provider and support relationships as long as the supported person desires or needs. Policy should be designed with a primary goal of maintaining existing relationships.

Recommendation 2.d.2: When, for any reason, it becomes impossible to maintain those relationships, providers and supports personnel should treat the loss as potential trauma and support the person who is losing the relationship accordingly.

Section 3: Administration of Complaints, Grievances and Appeals

In Michigan, complaints, grievances, appeals and rights issues are handled by a wide range of entities. Entities that are involved in resolving complaints include local providers, service delivery agencies, payers, recipient rights offices and a formal administrative hearing system. Individuals with a complaint often struggle to navigate disparate processes with various responsible parties for different types of services, and timely resolution of complaints can be a challenge. Additionally, many of these processes are directly facilitated by a service provider or payer. This poses a potential conflict of interest because the party determining whether a complaint is valid may be the party against which a complaint has been made. The following recommendations are focused on developing and implementing a statewide approach for improving the resolution of complaints, grievances, appeals and rights issues.

Affinity Group Comments

A majority of individuals and families expressed support for having an independent entity to review service delivery issues, while maintaining the ability to promptly resolve issues at a local level before elevating it to a statewide entity. Individuals and family members also supported the use of a set timeline for resolving complaints at the local level before the issue is elevated to the statewide entity. Providers showed similar support for an independent complaint entity, with a preference for attempting to resolve issues locally first. However, some providers voiced some concern about the potential cost for operating this type of independent entity. Many payers also supported an independent centralized entity and noted the potential to minimize duplication, increase accuracy and individual satisfaction and reduce bias and decrease miscommunication. Finally, many participants encouraged the Department to align the complaint process for physical health services, mental health services and substance use disorder services and also ensure compliance with applicable federal regulations and accreditation standards.

Recommendations

Recommendation 3.1: An independent statewide infrastructure should be established by MDHHS to facilitate resolution of complaints (grievances, appeals and rights issues) that are not resolved to a complainant's satisfaction after a single attempt through a plan or local service agency (if the plan has delegated this function). Use of the new statewide process should be facilitated by a request from a complainant. The new process should use independent clinical consultation (termed "external medical review") when warranted by the nature of a complaint, and it should employ optional, non-binding mediation as an alternative dispute resolution method. The new state entity shall provide (if desired by a complainant) qualified representation at no cost to beneficiaries. These representatives will serve as impartial advocates through the process, including any State Medicaid Fair Hearings for individuals.

Recommendation 3.2: Administrative Law Judges who hear cases in the Michigan Administrative Hearing System (MAHS) should be required to seek and consider external clinical review findings (independent of MDHHS, the complainant, and the involved service provider and payer) prior to rendering a decision or order. Other than the state Fair Hearing process (conducted through MAHS), all other individual complaints not resolved to a complainant's satisfaction by a single attempt through a plan or local service agency should be directed to the new state complaint resolution entity if so requested by the individual.

Recommendation 3.3: MDHHS, in concert with stakeholders, should develop an operational plan for the implementing the previous two recommendations. Key items to be addressed in this plan should include (but are not limited to):

- **How the new statewide entity will be organized and structured (including the matter of regional and local offices);**
- **How to incorporate both Medicaid and non-Medicaid individuals served by the public mental health system;**
- **How to incorporate both Medicaid managed care and Medicaid Fee-For-Service beneficiaries;**
- **How to facilitate cases that involve both recipient rights processes and Medicaid processes; and**
- **What (if any) adaptation is needed in relation to existing recipient rights processes and offices at state, regional and local levels.**

Recommendation 3.4: MDHHS, in concert with stakeholders, should take a proactive role in ensuring PIHP and MHP compliance with new federal regulations related to adverse benefit determinations and grievances within these plans. This proactive engagement by the Department and stakeholders should include (but is not limited to):

- **Complaint and adverse benefit determination policies, procedures, notices and beneficiary materials;**
- **Standardization of processes;**
- **Responsibilities which can be delegated to another party by a plan;**
- **Qualifications and background of staff facilitating appeals and complaints;**
- **Process for how clinical consultation should be engaged; and**
- **Mitigation of the potential for inequality if the complainant lacks legal counsel while the subject of the complaint has such representation.**

Section 4: Protections for Mental Health and Epilepsy Drugs

In 2004, the Michigan Legislature added a new provision to the Social Welfare Act (MCL 400.109h) that prohibits MDHHS from requiring prior authorization for certain prescription drugs, including anticonvulsants, antidepressants, antipsychotics, non-controlled substance anti-anxiety drugs and drugs used to treat mental disorders, epilepsy and seizure disorder. In some cases, delaying access to these medications can have significant health and safety impacts, and Public Act 248 of 2004 was largely supported as legislation that would ensure timely access to these critical drug classes and prevent undue burden on physicians who prescribe these medications. The legislation, as enacted, does not extend the same prior authorization exemptions to drugs that are covered by the state's contracted managed care organizations. Since 2004, MDHHS has carved these drugs out of the MHPs; however, this approach is not required by statute. The following recommendations seek to address this issue.

Affinity Group Comments

Individuals and family members overwhelmingly responded that the current access protections for these products should be made permanent.

Recommendation

Recommendation 4.1: The Michigan Legislature should amend Public Act 248 of 2004 to prohibit both the department and its Medicaid contractors from requiring prior authorization (as defined in the act) of the following medications as they are defined and operationalized in the act: anticonvulsants, antipsychotics, antidepressants, non-controlled substance anti-anxiety drugs and drugs to treat mental disorders, epilepsy and seizure disorders.

Section 5: Self-Determination and Person-Centered Planning

Person-centered planning is a foundational element for the delivery of behavioral health and developmental/intellectual disability services in Michigan. As detailed in the Mental Health Code, "The intent of person-centered planning is to enable a person, with whatever supports and services are needed or desired, to become fully engaged in making his or her own choices and decisions to achieve the quality of life he or she desires, i.e., to achieve self-determination."

Michigan has a statutory requirement for a person-centered planning process for Mental Health Code eligible populations.[2] Person-centered planning is also required by federal regulation.[3] The proposed 1115 Waiver also includes requirements of person-centered planning and add persons with Substance Use Disorder served through the new waiver. Person-centered planning were also put forward by the Lieutenant Governor's workgroup as the primary Core Value and the basis for supports and services. Specifically, the Core Values adopted by the Lieutenant Governor's workgroup state, "The availability of independent facilitation of a person centered plan ensures a truly individualized plan that will identify all necessary services and supports."[4]

The following recommendations seek to preserve and strengthen the role of person-centered planning in the delivery of behavioral health and developmental/intellectual disability services in Michigan.

Affinity Group Comments

Individuals and families stated that person-centered planning is important because it allows individuals to be in charge of their own lives and empowers individuals to advocate for themselves. Individuals and families also expressed widespread support for being able to choose (a) when and where planning meetings are held, (b) who can attend the meeting, (c) which services and supports would be received and the people who would provide for them, and (d) who the facilitator of the person-centered planning process is. Individuals and families also highlighted the importance of individuals having the ability to change their plan to reflect changes in the individual's life, needs and goals. Finally, individuals and families expressed support for ensuring that an individual's person-centered plan is honored regardless of the individual's location in the state.

Providers and payers supported the use of independent facilitation for the person-centered planning process. Providers and payers also advocated for increasing the availability of training on person-centered planning for providers. Additionally, providers and payers encouraged MDHHS to review and update the minimum standards and requirements for person-centered planning. Finally, some payers supported having the person-centered planning process be inclusive of physical health services.

(Recommendations for this section are listed on the next page.)

[2] The Michigan Mental Health Code establishes requirements for the person-centered planning process through MCL 330.1712.

[3] Federal regulations that establish requirements for the person-centered planning process include Section 2402(a) of the Patient Protection and Affordable Care Act, the Home and Community-Based Services Rules (42 CFR 441), and the federal Managed Care rule (81 CFR 27498).

[4] The values are outlined in Appendix 2 of this report.

Recommendations

Recommendation 5.1: Person-centered planning should be the basis for all publicly funded specialty supports and services provided to persons with a developmental disability, a mental illness and/or a substance use disorder. As part of the person-centered planning process, each individual should be able to determine the following elements of the process[5]:

- **Who, if anyone, will facilitate the process.**
  - **A person may choose to facilitate his or her own meeting.**
  - **Before making this choice, the person must be informed of the availability of facilitators who (1) are independent of the system and the providers, (2) can facilitate the meeting and assure the plan for supports and services reflects the person-centered planning, and (3) can act as the person's advocate.**
- **When the meetings will occur.**
- **Where the meetings will occur.**
- **Who will be invited and permitted to attend.**
- **How and by whom will others be invited to the meeting.**
- **What will be discussed – and not discussed – at the meeting.**
- **How will assistance be provided to support the person's participation in the process.**

Recommendation 5.2: The person-centered planning process should be faithful to the process elements as listed in the first recommendation and as detailed in MDHHS policy and guidance.

Recommendation 5.3: Decisions about the elements of person-centered planning should be made by the person at a meeting prior to the person-centered planning meeting with their facilitator.

Recommendation 5.4: The person-centered planning process involving the person's allies and supporters should be used to develop a plan for the supports and services that the person needs to achieve the life that he or she desires as a participating member of the community. This process should also determine how, where and by whom the supports and services are provided.

Recommendation 5.5: The person-centered planning process should not be subject to prior utilization management or other techniques or processes that would limit or reduce the supports and services determined as needed and/or desired through a person-centered planning process. Proposed changes regardless of origin should reactivate the person-centered planning process.

Recommendation 5.6: No assessment scale or other methodologies should be utilized to set a dollar figure or otherwise limit the person-centered planning process.

Recommendation 5.7: Arrangements that support self-determination should be available, no matter where people live in Michigan.

Recommendation 5.8: The person-centered planning process should include an opportunity for the person to use a fiscal intermediary and manage a portion of the person's budget.

[5] Most of these items were further endorsed by the Eligible Populations and Families Affinity Groups.

Recommendation 5.9: For children, youth and families, the Person-Centered Planning Policy Guideline states: "The Michigan Department of Health and Human Services (MDHHS) has advocated and supported a family-driven and youth-guided approach to service delivery for children and their families. A family-driven and youth-guided approach recognizes that services and supports impact the entire family; not just the identified youth receiving mental health services. In the case of minors, the child and family is the focus of service planning, and family members are integral to a successful planning process. The wants and needs of the child and his/her family are considered in the development of the Individual Plan of Service." As the child matures toward transition age, services and supports should become more youth-guided.

Recommendation 5.10: MDHHS should expand the person-centered planning process to (1) incorporate education for individuals on the availability of physical health services and (2) include physical health providers in the person-centered planning process as desired by the individual. This expansion should include the option to share the person-centered plan with physical health providers as desired by the individual.

Section 6: Governance, Transparency and Accountability

Currently, Michigan law establishes different governance, transparency and accountability requirements for PIHPs, CMHSPs and MHPs. For example, CMHSPs and MHPs are required to have at least one-third individual and family representation on their governing boards, but no such requirement exists for PIHPs. However, many PIHPs currently follow the practice of including one-third individual and family representation on their governing boards. In regards to transparency, CMHSPs and PIHPs are required to comply with the Michigan's Freedom of Information Act (FOIA) and Michigan's Open Meetings Act, but MHPs are not. The following recommendations seeks to improve governance, transparency, and accountability of publicly-funded services.

Affinity Group Comments

Individuals, family members, providers and payers supported the inclusion of individuals and family members on the boards. Many individuals and family members advocated that either one third or one half of the board membership for the CMHSPs, MHPs and PIHPs should be composed of individuals who use services and/or family members.

Individuals, families, providers and payers supported increased transparency. However, participants disagreed about whether FOIA and the Open Meetings Act should apply to CMHSP, MHPs and PIHPs. Individuals and families mostly supported this concept, while payers mostly opposed. In addition, individuals and their families suggested using public forums and surveys as a way to increase transparency and provide feedback to the state.

Recommendations

Recommendation 6.1: In light of the level of federal and state funding involved in the managed care arrangements that serve as the payment and risk management structures in Michigan's Medicaid system, the Michigan Legislature should require all organizations that manage Michigan's Medicaid benefit to comply with Michigan's Freedom of Information Act and the Michigan Open Meetings Act.

Recommendation 6.2: The Michigan Legislature should require at least a third of all members of boards of directors for organizations managing Medicaid benefits to be primary consumers (persons who have or currently receive services from providers managed by the organization) or secondary consumers (families of persons who have or currently do receive services from these providers). Among the primary and secondary consumers on these boards, at least half should be primary consumers.

Recommendation 6.3: MDHHS should host public forums annually to allow consumers to provide direct feedback to the state on improving coordination of behavioral and physical health services for individuals who received Medicaid services. Public forums should be widely advertised using culturally and geographically appropriate means of distribution.

Section 7: Workforce Training, Quality and Retention

Recruiting and retaining high-quality local service agency staff and providers is a challenge in Michigan. The challenge is most often centered on wages for direct support staff, which have not been competitive with other employment opportunities. This challenge is worsened by a lack of paid leave, other employment benefits, training and professional recognition. The following recommendation seeks to strengthen the behavioral health workforce to reduce turnover and improve service quality.

The Partnership for Fair Caregiver Wages, referenced in the workgroup's recommendation below, is a coalition of state-wide organizations and nonprofit providers that advocates for additional Medicaid funding to increase direct staff support wages. Section 1009 of the MDHHS Fiscal Year 2017 budget created a workgroup that is charged with identifying ways to attract and retain staff to provide Medicaid-funded supports and services.

Affinity Group Comments

All Affinity Group participants recommended raising the wages and benefits of direct care staff. Nearly all participants also emphasized the need to improve the education and training of staff. Individuals and family members emphasized the importance of longevity and stability in relationships between individuals and staff. Individuals and families also voiced concerns about the adverse impact that staff turnover has on individuals. Individuals and families also cited improving wages, benefits, hours and recognition efforts as critical to decreasing turnover.

Recommendation

Recommendation 7.1: MDHHS should implement recommendations from the Partnership for Fair Caregiver Wages, including:

- **Increasing starting wages for direct support staff to above minimum wage.**
- **Providing paid leave to direct support staff.**
- **Making available public funds for staff tuition reimbursement.**
- **Examining and improving training requirements and programs for direct support staff, including ensuring staff are paid during training.**
- **Supporting a public awareness and appreciation campaign highlighting the importance of direct support occupations.**
- **Expanding Home Help matching services registry to find and screen workers for people using self-determination.**
- **Creating a "rehabilitation review" within the criminal background check process to enlarge the applicant pool.**
- **Collecting data on workforce size, stability and compensation.**
- **Evaluating the impact of these investments and continuing to explore opportunities that support workforce recruitment and retention.**

Section 8: Peer Supports

Michigan is nationally recognized for the wide array of peer support services available to individuals served by the behavioral health system. Peers are individuals with lived experience who self-identify in utilizing behavioral health services currently or in the past. The Michigan Medicaid program instituted peer supports as a covered service in 2006, and a continuum of peer providers has evolved as a result to meet the needs of each population.

The state recognizes a variety of specialty areas in the continuum including certified peer support specialists, recovery coaches, peer mentors for persons with developmental and intellectual disabilities, youth peer support, and parent support partners. Peers have a special ability to gain the trust and respect of individuals who use services based on their shared experience. Peers work in a variety of integrated care areas and provide support to individuals in times of crisis. Peers can also facilitate the development of health and wellness goals, help connect individuals to community resources and assist individuals in navigating the service delivery system. The following recommendations seek to elevate, promote and expand the use of peer supports throughout the health care system.

Affinity Group Comments

Individuals and family members emphasized the unique ability of peers to understand the experiences of individuals. Individuals and family members explained that peers can provide incomparable support to individuals who are in recovery because peers have "lived experience." Individuals and family members also noted that peers can help individuals with navigating the service delivery system and connecting to community resources in order to address issues such as housing, employment and education. Providers highlighted the importance of strengthening reimbursement policies and practices for peer supports services and improving the training process for peers. Payers also emphasized the importance of creating billable codes for these services and improving the training process.

Recommendations

Recommendation 8.1: MDHHS should develop policy to support the use of all categories of peers across all systems of care.

Recommendation 8.2: MDHHS should increase the frequency of training certification to expand availability of trained peers and create a recertification process to ensure ongoing competency development.

Recommendation 8.3: MDHHS and its contracted entities should continue to develop and implement current evidence-based practices for best use of peers.

Recommendation 8.4: MDHHS should collaborate with contracted entities to implement wages and benefits for recovery coaches.

Recommendation 8.5: MDHHS should collaborate with contracted entities to standardize the process for determining wages across all categories of peers.

Recommendation 8.6: MDHHS should collaborate with contracted entities to develop a framework for multiple certifications and reciprocity of certification.

Recommendation 8.7: MDHHS should collaborate with contracted entities to develop provisional certification to allow billing for peer services during the six-month startup period prior to training.

Recommendation 8.8: MDHHS should collaborate with contracted entities to expand funding for peer-run organizations to reflect the general expansion in the use of peers throughout the state.

Recommendation 8.9: MDHHS should develop a confidential statewide registry to track workforce and support the connection of peers to consumers seeking peer supports.

Section 9: Health Information Sharing

Health information sharing is an essential element for improving health care service delivery and achieving better health outcomes for all Michiganders. By sharing health information, providers can enhance the coordination of services for individuals, prevent adverse health outcomes such as adverse drug events and hospitalizations and support population health efforts. Protecting the privacy of individual health information is also crucial, and the Michigan health care system must ensure that the health information is only shared when it is needed to support the delivery of health care to individuals. Over the past decade, the State of Michigan and its partners have made tremendous progress towards addressing statewide barriers that inhibit health information sharing. The State of Michigan must build upon this success to enable the sharing of behavioral health information and support the coordination of physical health and behavioral health services for individuals. The following recommendations seek to accomplish these goals.

Affinity Group Comments

Many individuals and family members agreed with the importance of sharing health information between providers to improve the coordination of health services. However, many individuals and family members believed that health information should only be shared on a "need to know" basis. Some participants wanted to provide written consent for any release of health information. Providers and payers supported increased use of electronic health records and improve health information sharing. Providers and payers emphasized the need for guidance and training to clarify legal and regulatory issues related to obtaining consent to share behavioral health information. Providers and payers also supported the use of financial incentives to help promote health information sharing.

Recommendations

Recommendation 9.1: The State of Michigan should develop and implement a statewide strategy for aligning policy, regulatory, statutory and contractual requirements to enable the sharing of behavioral health information.

- **The statewide strategy should build upon Public Act 129 of 2014 and encourage the adoption and use of the Behavioral Health Consent Form.**
- **The strategy should promote continued adoption and use of the form by CMHSPs, PIHPs and MHPs.**
- **The strategy should also encourage adoption and use of the form by primary care providers, behavioral health providers, specialists, hospitals, school-based providers and correctional facilities.**

Recommendation 9.2: MDHHS should conduct education and outreach efforts to inform individuals, families, providers and payers about the importance and value of health information sharing.

- **MDHHS and its partners should provide information to individuals and families in regards to (1) why health information sharing is crucial for improving the delivery of physical health and behavioral health services and (2) what types of protections have been instituted in state and federal law in order to ensure the privacy of individual health information.**

- **MDHHS and its partners should also should expand guidance and training opportunities on privacy and consent requirements for providers and payers. MDHHS should include guidance on obtaining consent for sharing substance use disorder information in compliance with the federal regulation known as 42 CFR Part 2.**

Recommendation 9.3: MDHHS should support local and statewide efforts to build infrastructure that will enable the secure sharing of behavioral health information across health care organizations.

- **MDHHS should continue to support the adoption and use of health information technology by providers through technical assistance programs.**
- **MDHHS should work with its partners to evaluate access and participation by providers and payers in the statewide health information sharing network. As part of this evaluation, MDHHS and its statewide partners should collaborate with stakeholders to identify and expand upon key use cases that will enable the sharing of behavioral health information. MDHHS and other payers should encourage the participation of providers in use cases that are identified through this process.**
- **MDHHS should evaluate ways to support the use of CareConnect360 by providers and payers. MDHHS should enhance access to information within the platform with a particular emphasis on information that facilitates care coordination, transitions of care and population health activities. MDHHS should also explore opportunities to expand access to new providers and community partners as appropriate.**

Recommendation 9.4: MDHHS should create a common culture of collaboration where stakeholders can identify, discuss, and overcome statewide barriers to health information sharing on an ongoing basis.

- **MDHHS should work with the Michigan Health Information Technology Commission to facilitate a discussion about the sharing of behavioral health information. Individuals with behavioral health needs, families, advocates, providers, payers and other health care organizations should be involved in the discussion. MDHHS should use the feedback from the discussion to inform the implementation of initiatives related to the sharing of behavioral health information.**
- **MDHHS should continue to collaborate with the Consent Form Workgroup to support continued implementation and improvement of the Behavioral Health Consent Form.**
- **MDHHS should coordinate with stakeholders to identify policy and regulatory barriers to health information sharing and develop strategies to increase information sharing as appropriate.**

Section 10: Quality Measurement and Quality Improvement

In Michigan, payers do not have a standardized method for measuring quality of care. Each PIHP, CMHSP or MHP develops its own set of metrics to evaluate providers in their networks. Payers and providers in Michigan are required to comply with applicable state and national practice and performance guidelines, but they are not required to use a standardized set of performance and outcome measures. The variation in metrics between payers can lead to conflicting goals for providers and the individuals that they serve if a provider is part of multiple networks. A number of national organizations have created a recommended set of standardized healthcare quality indicators and measures for states to adopt. The following recommendations seek to improve the alignment of quality measures and set the foundation for system-wide quality improvement efforts.

Affinity Group Comments

Many individuals and family members expressed a desire for healthcare outcome measures to reflect the individual's quality of life and overall health and well-being. In particular, a number of participants recommended using outcomes that measure achievement of goals in the individual's person-centered plan. Some participants suggested using specific outcome metrics such as measuring reductions in hospitalizations, incarcerations, homelessness, suicides and substance use relapse. Providers also emphasized the need to have measures that focus on individual experience and take into consideration the impact of social factors on an individual's health. Nearly all Affinity Group participants stressed the importance of implementing performance and outcome that reflect the extra resources needed for the most complex cases and do not create disincentives for payers and providers to accept these cases.

Recommendations

Recommendation 10.1: MDHHS should develop a core set of quality metrics that are standardized across systems and consistent with national standards and federal requirements, including but not limited to the State Innovation Model (SIM), and 2703 health homes.

Recommendation 10.2: MDHHS should convene a workgroup to evaluate existing performance metrics and eliminate metrics that do not align with state and national practice and performance guidelines. Increased emphasis should move to measurement of outcomes from measurement of compliance.

Recommendation 10.3: MDHHS should adopt and publish universally applicable standards of performance (commonly known as "site review standards") to which all providers are held accountable by a designated entity (a PIHP, CMHSP or a MHP, but not more than one).

Section 11: Administrative Layers in Both Health Systems

In Michigan's healthcare system, resources go through multiple administrative layers. Funding for specialty behavioral health and physical healthcare services often pass through several administrative layers. Stakeholders have called for greater uniformity, consistency and cost effectiveness in the system without loss of capacities and expertise. The following recommendations encourage uniformity of administrative requirements, which should result in greater efficiency in administrative structures and greater availability of resources for services.

Affinity Group Comments

All Affinity Group participants supported reducing the layers of bureaucracy in the publicly funded behavioral health system. Participants believed that reducing layers of bureaucracy would result in greater funding for services and improved service delivery. However, there was no clear consensus on how this goal should be accomplished.

Recommendations

Recommendation 11.1: MDHHS should complete an assessment of the existing administrative layers in the public behavioral health and physical health system to identify redundancies and duplication of oversight in the administration of Medicaid services. The assessment will serve as the basis for developing an administrative model that provides a service system that is person-centered, effective and efficient; reduces redundancy; and supports coordination across all layers of the behavioral and physical health system including regulatory requirements from the consumers to the providers, payers and up to the state level.

Recommendation 11.2: MDHHS should develop uniform and consistent standards for the provision of behavioral health and physical healthcare services, including substance use disorder services, to support the efficient administration and effective service delivery for all individuals who receive Medicaid services. The standards will include, but are not limited to, common contract language, consistency and reciprocity of training requirements and expectations, quality measurement and performance metrics, financial and program audits, simplification and consistency of billing procedures, credentialing of providers and standard member benefits.

Recommendation 11.3: MDHHS should convene a workgroup of stakeholders to evaluate the efficacy of administrative structures, regulatory requirements, and associated costs necessary to support efficient, effective, integrated, person-centered service delivery across payers and providers.

Section 12: Uniformity in Service Delivery

In Michigan, there are currently 10 PIHPs, 46 CMHSPs and 11 MHPs that each have their own provider network, structure and administrative processes. As a result, a wide variety of service delivery methods exists among payers and providers in the state. For example, each PIHP and MHP has its own definitions, structures and expectations for processes such as contracting, audits and reports, screening tools, documentation, site reviews, consent management and quality metrics. Furthermore, for CMHSPs, the range of supports and services available in their provider networks is not uniform across the state, and access to services for citizens can differ between CMHSPs. The following recommendations seek to improve the uniformity of service delivery throughout the system.

Affinity Group Comments

Individuals and families emphasized the need for consistent standards of care, consistency in staff and service providers, more uniform pay and benefits, and standard measures and metrics. Provider concerns focused primarily on administrative matters. Concerns included the need for consistency and uniformity across the state in contracting, auditing, and performance monitoring (including reciprocity or deemed status based on another party's review); consistent and streamlined documentation standards; reduction or elimination of redundancies across systems and consistent reporting requirements; and the development of common language between physical and behavioral health providers whenever possible. Many providers noted that while standardization and consistency are goals that should be pursued, variation in local assets and needs should be taken into account. Payers also identified several issues, which included clearly defining roles and responsibilities of various parties in the system, providing incentives to achieve consistent processes among payers, reviewing legacy and current requirements with a focus on modernizing or eliminating redundancies and enhancing Health Information Exchange capabilities across the payer and provider systems.

Recommendations

Recommendation 12.1: MDHHS should ensure that individuals have on-demand access to urgent and emergent medical, behavioral and substance use disorder services, supports and/or treatment no matter where they live in the state.

Recommendation 12.2: MDHHS should ensure that individuals have reasonable, timely, and geographically uniform access to medical, behavioral and substance use disorder services, supports and/or treatment no matter where they live in the state.

- Access should not depend on the severity of disability, illness or symptoms.
- All healthcare delivery systems should operate same-day access systems (either directly or through referral), including after-hours access capabilities.

Recommendation 12.3: MDHHS should align all healthcare services and supports (broadly defined to include medical, behavioral, and substance use disorders) to:

- Remove barriers to on-demand access.
- Ensure benefits to which individuals and families are entitled are available within the time and distance standards established by MDHHS.

Recommendation 12.4: MDHHS should decrease sub-state variation, duplication, and redundancy by:

- Establishing rigorous provider network adequacy standards to ensure that the full array of services is accessible to every Michigander.
- Incentivizing the development of convenient care clinics as public/private partnerships between payers for the delivery of primary care, behavioral health and substance use disorder services.
- Clearly defining the roles and responsibilities of MHPs, PIHPs, CMHSPs, federally qualified health centers and/or other providers and delineating responsibilities that should be performed exclusively by each party.
- Adopting and publishing universally applicable standards of performance (commonly known as "site review standards") to which all providers are held accountable by a designated entity (either a PIHP, CMHSP or an MHP, but not more than one).
- Adopting and publishing universally applicable standards of performance in important public policy areas, including but not limited to: self-determination and person-centered, family-driven and youth-guided planning with integrity; criteria for priority service admission; standardization of the pre-admission screening processes across the state, uniformity in the availability of peer supports and services; standards for respite care and qualifications; and designation of a minimum service array that must be available in all areas of the state.
- Providing real incentives to achieve state-defined consistency expectations and require reporting on defined consistency-related metrics.

Section 13: Financial Incentives and Provider Reimbursement

In Michigan, payers currently use a range of payment methodologies to compensate providers for physical and behavioral health service delivery (generally separately). Many of the payment methodologies in use today do not adequately direct provider payment toward meaningful processes of care or individual outcomes: payment methodologies instead are designed to be volume-oriented or capitated structures. Financial incentives designed to reward high-value, effective service delivery may present an opportunity to not only improve individual outcomes, but also ensure strong return on investment. Furthermore, financial incentives, if structured in a manner that addresses individual concerns, may be a key element in encouraging and reinforcing the importance of strongly coordinated care at the point of service delivery. The following recommendations seek to define an approach for using financial incentives to improve the quality of care.

Affinity Group Comments

Individuals and family members indicated that they were generally not supportive of the use of financial incentives to drive the behavior of payers and/or providers in the Medicaid system. Their concerns revolved around the potential impact on access and utilization that may occur as payers and providers worked to capture these financial incentive payments. However, payers and providers viewed the use of incentives as an important strategy in managing and paying for Medicaid benefits in order to achieve statutory and contractual performance requirements. Payers and providers suggested opportunities to design financial incentives in a manner which addressed the concerns of individuals and families.

Recommendation

Recommendation 13.1: As MDHHS and its contracted Medicaid payers implement financial incentives, the incentives should be designed to accomplish the following objectives, while addressing concerns expressed by consumers to ensure that incentives will not result in reduced care, access or appropriate utilization:

- **Foster high quality and customer-oriented performance of the Medicaid benefit.**
- **Advance the provision of person-centered and coordinated healthcare, services and supports.**
- **Assure that the needs of enrollees with complex multi-dimensional needs are addressed in a timely manner.**
- **Enable the use of financial incentives across all payer systems including specialty behavioral health.**

Furthermore, Medicaid payer contract performance measures should report on the effectiveness of these incentives.

Recommendations for Financing Models

After the submission of the interim report, MDHHS and the 298 Facilitation Workgroup launched the next phase of the process, which focused on the development of recommendations for financing models. To generate concepts for potential models, MDHHS and the workgroup opened a statewide process for interested stakeholders to submit model proposals. MDHHS and the workgroup received 42 model proposals as part of this process. MDHHS submitted the 42 model proposals to the Michigan Legislature as a separate companion document to the final report for the purposes of public record.

MDHHS and the workgroup organized the 42 model proposals into six categories of financing models and one category of non-financing models. All seven categories are listed below, and detailed summaries are included in the following subsections of the final report.

- **Model Category #1:** Statewide Behavioral Health Managed Care Organization
- **Model Category #2:** CMHSP ((Provider) Capitation
- **Model Category #3:** Modified Managed Care Approaches
- **Model Category #4:** Current Financing Structure Enhancement
- **Model Category #5:** Local/Regional Integration Arrangements
- **Model Category #6:** MHP or PIHP Payer Integration
- **Model Category #7:** Non-Financing Models

After the financing models were developed, the workgroup conducted an evaluation of the financing model categories. Wherever possible, the workgroup used a consensus process for the review of the financing model categories. When consensus could not be achieved, a vote of the workgroup was taken. Any votes that were taken are documented in the final report.

The workgroup evaluated five of the six financing model categories, which included categories 1, 2, 3, 4 and 5. The workgroup did not evaluate categories 6 and 7 for the following reasons:

- **Model Category #6:** A majority of the workgroup voted not to evaluate model categories that did not align with the policy recommendations. The workgroup determined the MHP or PIHP Payer Integration Model category cannot adhere to Policy Recommendation 1.1 from the interim report. As a result, the workgroup did not evaluate this model category. However, MDHHS did complete a policy review for the model category, and the model category was posted for public input.
- **Model Category #7:** The Section 298 boilerplate language specifically focuses on the development of recommendations for financing models. All of the models within this category do not explicitly impact service financing. As a result, the model category will be included for reference only in the final report.

The workgroup evaluated the five remaining financing model categories based upon the goals that were outlined in sub-section 2 of the Section 298 boilerplate language. The legislative language for Section 298 is included in Appendix 1 of the final report. As part of this process, the workgroup assessed whether each individual model category had strengths or challenges that would influence the ability of the health system to achieve each boilerplate goal. The workgroup also identified additional considerations for each model category that would need to be resolved before the state government considers implementing the model. MDHHS included the results of the workgroup evaluation within the individual subsection for each financing model category and within Appendix 14 of the final report.

MDHHS also completed a preliminary policy review of the model categories. The policy review included two components, which are described below. MDHHS included the results of the policy review within the individual sub-section for each financing model category and within Appendix 15 of the final report.

- MDHHS identified whether changes to state law, policy, contracts, waivers or the state plan would be required as part of implementing each of the financing model categories.

- MDHHS also identified for each category whether any other states are currently pursuing or have implemented similar models. Please note that models that have been implemented in other states may differ from Michigan's model in several ways, which may include (1) what services and supports are available under the model, (2) which populations are served under the models, (3) whether the payers within the system are public or private and (4) whether the providers within the system are public or private.

MDHHS also posted the six financing model categories for public input. The public input process for the financing model categories lasted from February 16, 2017, through March 3, 2017. MDHHS established two opportunities to provide input, which are described below:

- Stakeholders could complete an online survey to provide input on the draft financing models. As part of the survey, MDHHS asked stakeholders to identify strengths and challenges for each model category. The survey also included an opportunity for stakeholders to indicate whether they believed that each model category had the potential to improve the coordination of physical health and behavioral health services. Stakeholders could use a sliding scale from 1 (strongly disagree) to 100 (strongly agree) to express their views on this issue.

- MDHHS also hosted a public forum at the Hannah Center in East Lansing to gather comments on February 24, 2017, from 9 a.m. to 12 p.m.

The results of public input are described within Appendix 16 of the final report. MDHHS and the workgroup used the comments from the public input process to refine and improve the evaluation of the individual financing models.

After completing the evaluation process and reviewing the comments from the public input process, the workgroup voted on several recommendations during its March 10, 2017, meeting. The following recommendations were approved by a super majority (two-thirds) of the workgroup as official recommendations to the legislature. Recommendations that appear in **bold font** were approved unanimously by all workgroup members, and recommendations that are in regular font were approved

by a super majority of workgroup members. For more information on the voting process on recommendations, please see Appendix 18 of the final report.

- **Recommendation 1: The workgroup recommends that MDHHS should develop a process for evaluating model concepts that do not require policy or statutory changes for implementation.**

- **Recommendation 2: The workgroup recommends that MDHHS, informed by stakeholders, should conduct a more in-depth review of model proposals that were submitted to see if other model(s) might emerge.**

- Recommendation 3: For inclusion among models to be tested, the workgroup recommends the expansion and broadening of jointly funded, staffed and operated programs between MHPs and the local public behavioral health system for coordinating services to shared enrollees.

- Recommendation 4: The workgroup recommends the development of consistent statewide contract provisions to encourage the integration of physical health, behavioral health and intellectual/developmental disability services and supports for all populations at the point of service, which should be driven by local coordination between providers rather than statewide integration of financing.

- Recommendation 5: The workgroup recommends the use of models which improve the coordination of physical health and behavioral health services and supports through the local public behavioral health network for individuals with a mental illness, serious emotional disturbances, and substance use disorders. Within that population, the focus should be on individuals who are vulnerable and at risk for issues of increased morbidity and premature death as well as persons who are high utilizers of emergency services and hospitalization services.

  This recommendation includes the following elements:
  - The local public behavioral health network and the responsible entities for physical health, whether a health plan or private physicians, would be charged with accomplishing physical health and behavioral health coordination.
  - An Accountable Care Organization with funding from the health plan or fee for service, through the local public behavioral health network, would be responsible for the provision of coordinated physical and behavioral services for the affected populations. The Accountable Care Organization could also include other entities.
  - MDHHS should consider other strategies to address the coordination of care at the local public behavioral health network level such as using a supports coordination model rather than the case management model.
  - MDHHS should also consider using a wraparound model for youth and children with serious emotional disturbances that will address their unique needs for integration of well child and preventive health care as well as behavioral health needs.

- Recommendation 6: The workgroup recommends the establishment of an Integration Innovation Venture Capital Fund, which would provide opportunities for Local/Regional Integration Arrangements. The fund should be established and used to support, enhance or develop integration arrangements at the provider level.

- This recommendation allows for integrated service delivery at the community level, recognizes the unique nuances of each region and is the way to best impact a person and family's experience.
- The success of integration is significantly impacted by the relationships held between providers. This is a local issue that can only be managed and facilitated at the local level. This recommendation allows the State of Michigan to create the opportunities for willing, innovative partners without forcing structural changes based on external resources.
- This recommendation also allows the existing MHPs and PIHPs to identify different ways to braid funding and explore various other funding methodologies while managing the risk pool.
- As a result of the advent of the Healthy Michigan Plan and Patient Protection and Affordable Care Act, there are already several integration initiatives in place. This approach could serve as an incubator of integration that could not be achieved through a statewide, macro-level policy.

Model Category #1: Statewide Behavioral Health Managed Care Organization

The Statewide Behavioral Health Managed Care Organization model category consolidates Michigan's 10 regional PIHPs into one statewide PIHP, which is referred to in several models as an Administrative Services Organization (ASO).

Today, 10 PIHPs operate and manage Medicaid-funded behavioral health specialty services and supports on a regional basis. PIHPs are also the responsible entities for directly managing Substance Abuse Block Grant funding and local substance abuse funding. Each PIHP contracts with CMHSPs and other providers within its region to deliver publicly-funded services and supports.

If this model category were implemented, MDHHS would contract with a single, statewide organization to serve as the ASO for the entire state. The ASO would be responsible for administering serious mental illness, emotional disorder, developmental disability, intellectual disability and substance use disorder services for all individuals are enrolled in the Medicaid program. The ASO would be responsible for contracts with and payments to providers of the services above, including CMHSPs. Model proposals in this category believed a single ASO, rather than regional PIHPs, would streamline the specialty behavioral health system, provide greater consistency in collaboration with MHPs and better support regional/local service provider coordination.

MDHHS and the 298 Facilitation Workgroup used the following model proposals to develop the statewide behavioral health managed care organization model category: 1, 17, 18 and 24.

Policy Review

Based upon the policy review, the State of Michigan would need to enact the following changes to implement the Statewide Behavioral Health Managed Care Organization model category.

Model Category	Change to State Law	Change to Policy	Change to Contract(s)	Change to Waiver(s) or State Plan
#1: Statewide Behavioral Health Managed Care Organization	No	Yes	Yes	Yes

Examples in Other States: Maryland currently operates a specialized financing model for behavioral health services and supports with a single private ASO that provides oversight of service delivery. Prior to 2016, Iowa had contracted with one entity to act as a statewide behavioral health organization, but Iowa is now pursuing a consolidated managed care organization model that integrates primary care and behavioral health benefits.

Workgroup Evaluation

Strengths:

- The workgroup believed that transitioning from 10 PIHPs to a single statewide behavioral health managed care organization may help improve the consistency of policies, procedures and processes for the delivery of specialty behavioral health services on a statewide level.

- The workgroup also believed that this model category could promote greater uniformity in service delivery but that uniformity across the state may be limited based upon the local availability of providers.
- The workgroup also noted that the model would preserve the public governance of the specialty services system.
- The workgroup believed that a single statewide organization could achieve greater efficiencies and economies of scale for the administration of specialty behavioral health services as opposed to having 10 separately administered PIHPs.

Challenges:

- The workgroup noted that transitioning towards a single behavioral health managed care organization would not automatically lead to improvements in the coordination of physical health and behavioral health services: the workgroup explained that the statewide organization would still need to coordinate with different MHPs to promote integrated service delivery.
- The workgroup also noted that the ability of the state to achieve efficiencies in transitioning to a single statewide organization may be limited because the statewide organization would still have to possess adequate capacity and infrastructure in order to assume the former responsibilities of all 10 PIHPs.
- The workgroup emphasized the potential risk of having to rely upon one organization to administer all specialty behavioral health services when a suitable back-up organization may not exist in case of an emergency.

Additional Considerations:

- The workgroup questioned whether creating a single ASO is a change that could be piloted.
- The workgroup also noted that the state would also be required to delineate the differences in roles and responsibilities between (1) the CMHSPs and the statewide organization and (2) the statewide organization and MDHHS.
- Finally, the workgroup noted that the state would have to navigate challenges with transitioning away from regional governance boards under the PIHPs and establishing a new statewide governance structure.

Other Notable Comments from the Public Input Process:

- Some respondents highlighted the potential for a statewide ASO to promote alignment amongst the CMHSPs on issues such as recipient rights, contracting, auditing and credentialing.
- Respondents voiced concerns that transitioning towards one statewide entity would prevent the state from recognizing geographic differences in service delivery between rural and urban areas.
- Respondents emphasized the importance of addressing local concerns within the governance model for the new statewide organization.
- Several respondents indicated that the State of Michigan would need to make decisions about how funding for Substance Use Disorder Treatment and Prevention Services would be handled if the number of PIHPs is consolidated.
- Respondents also indicated the importance of ensuring that local offices for recipient rights, customer services and grievances and appeals are still available.[6]

[6] The 298 Facilitation Workgroup notes that the workgroup created recommendations in regards to the administration of complaints, grievances and appeals that can be implemented regardless of which financing models are pursued.

Model Category #2: CMHSP (Provider) Capitation

The CMHSP (Provider) Capitation category allows a CMHSP to receive direct capitation payments from MDHHS to manage and provide behavioral health services and supports. This category in effect removes the PIHP component of Michigan's current managed care structure and places the service provider (a CMHSP) in a position to manage behavioral health services and supports for their population while also accepting some financial risk for that population.

If this category were implemented, MDHHS would pay CMHSPs to either directly offer or sub-contract with other service providers to provide serious mental illness, emotional disorder, developmental disability, intellectual disability and substance use disorder services through state-administered capitated arrangements.

MDHHS and the 298 Facilitation Workgroup used the following model proposals to develop the CMHSP capitation category: 8 and 9.

Policy Review

Based upon the policy review, the State of Michigan would need to enact the following changes to implement the CMHSP (Provider) Capitation model category.

Model Category	Change to State Law	Change to Policy	Change to Contract(s)	Change to Waiver(s) or State Plan
#1: CMHSP (Provider) Capitation	Yes	Yes	Yes	Yes

Examples in Other States: Washington has a financing system that is based upon "carved-out" Behavioral Health Organizations, which are local entities (some public and some private) that assume responsibility and financial risk for providing substance use disorder treatment as well as mental health services that were previously overseen by the counties and Regional Support Networks. Pennsylvania, New York and California are examples of other states that have implemented similar models.

Workgroup Evaluation

Strengths:

- The workgroup noted that this model preserves local control and public governance for the delivery of specialty behavioral health services.
- The workgroup emphasized that direct contracting between the CMHSPs and MDHHS could increase the amount of funds that are available at the local level, which could support greater access and flexibility in service delivery in local communities.

Challenges:

- The workgroup noted that switching from 10 PIHPs to 46 CMHSPs would undermine consistency and uniformity of service delivery on a statewide level.

- The workgroup also noted that contracting with the CMHSPs directly would also not automatically improve the coordination of physical health and behavioral health services: workgroup members explained that service delivery reforms would have to be pursued in conjunction with direct contracting in order to achieve greater service coordination.
- The workgroup noted that the elimination of PIHPs would not remove administrative requirements within the system: the workgroup explained that the administrative functions that were historically performed by the PIHPs would need to be assumed by either the CMHSPs or the State of Michigan.
- The workgroup noted that many CMHSPs may not have the staffing resources to adequately manage contractual and regulatory requirements that are currently required of the PIHPs.
- The workgroup also indicated that some CMHSPs may not have a sufficiently large population in order to assume full risk for managing the population.
- The workgroup explained that the transferring of responsibilities from the 10 PIHPs to the 46 CMHSPs would lead to increased costs due to all CMHSPs having to develop the same administrative capacity.
- The workgroup stated that implementing this model category would require the state to significantly expand its capacity and staffing to provide oversight of the 46 CMHSPs.

Additional Considerations:

- The workgroup noted that the State of Michigan would need to establish a new regulatory framework for MDHHS to provide oversight of the CMHSPs in their new role.
- The workgroup also indicated that MDHHS would need to substantially amend and alter its contracts with CMHSPs in order to incorporate responsibilities for both parties.

Other Notable Comments from the Public Input Process:

- Several respondents stated that CMHSPs have the capacity to manage funding for local populations and prioritize services that are more effective for addressing the needs of individuals and communities.
- Some respondents noted that pursuing this model category would give CMHSPs more flexibility to participate in other local/regional provider collaborations and pursue partnerships that strengthen the local safety net.
- Several respondents indicated that the state could also ensure accountability and uniformity across the CMHSPs through the development and enforcement of contracts and standards.
- A few other respondents expressed concern whether CMHSPs should be responsible for financial risk management and care coordination/direct service provision at the same time.
- Respondents noted that the behavioral health system had made significant progress towards enhancing consistency of policies, procedures, and programming and that implementing this model category may undo that work.

Model Category #3: Modified Managed Care Approaches

The Modified Managed Care approaches category is characterized by either altering one or both of Michigan's current managed care structures or introducing a managed care approach that changes the responsibilities of one or both managed care entities.

Today, there are two types of managed care organizations that are currently responsible for funding the delivery of physical and behavioral health services. Behavioral health specialty services and supports are primarily funded through Michigan's 10 PIHPs. Services for individuals with mild to moderate mental illness are covered by Michigan's MHPs separate from the PIHPs. MHPs are also primarily responsible for funding the delivery of Medicaid-funded physical health services.

If this category were implemented, one potential option within this category would require MDHHS to assume the functions associated with paying for behavioral health services that are currently supported by PIHPs. A group of regional organizations, which would functionally be a merger of CMHSPs and PIHPs, would assume responsibility for managing and providing services.

A second option within this category would create a different type of managed care structure that is neither a PIHP or MHP as currently implemented in Michigan. Examples of a potential structure would be an Integrated Care Organization (ICO) similar to those used in the MI Health Link program, or "care integrator." Individuals would be able to choose between receiving services through this new type of managed care organization or receiving services through the current system of MHPs and PIHPs.

MDHHS and the 298 Facilitation Workgroup used the following model proposals to develop the modified managed care approaches category: 2, 15 and 31.

Policy Review

Based upon the policy review, the State of Michigan would need to enact the following changes to implement the Modified Managed Care Approaches model category.

Model Category	Change to State Law	Change to Policy	Change to Contract(s)	Change to Waiver(s) or State Plan
#3: Modified Managed Care Approaches	Yes	Yes	Yes	Yes

Examples in Other States: Arizona, Connecticut, Florida, Kentucky and Oregon have implemented some form of modified managed care approach. Examples of these approaches are outlined below:

- Arizona implemented an integrated physical and behavioral health program for Medicaid beneficiaries with serious mental illness for the whole state in 2015.

- Florida has launched a fully integrated specialty plan to manage Medicaid benefits for individuals with serious mental illness in 8 of 11 regions. This plan provides all medical and behavioral health services.

- Oregon funds behavioral and physical health services through local health entities called Coordinated Care Organizations (CCOs). CCOs have a single budget with fixed growth rate and are accountable for a defined set of population-level outcomes.

Workgroup Evaluation

The workgroup decided to evaluate the individual model proposals within this category as opposed to the category itself due to significant variation within the model proposals. The individual evaluations for the model proposals are outlined below. The workgroup also noted that all of the model proposals within this category advocated for the creation of new entities to coordinate services and that there would be a significant learning curve for the newly created entities regardless of model proposal.

Model #2: This model proposal called for the blending of CMHSPs and PIHPs into new regional health organizations that would assume some responsibility for managing and coordinating services. MDHHS would also assume significant responsibility for paying for services and providing system oversight.

- **Strengths:**
  - The workgroup noted that the proposal could significantly reduce barriers to accessing services for eligible individuals and that this model would also strengthen local control.

- **Challenges:**
  - The workgroup noted the model proposal lacked mechanisms for ensuring coordination and accountability in service delivery in the absence of a managed care structure.
  - The workgroup also expressed concerns about transitioning back to Fee-For-Service arrangements under this proposal, which may inhibit efforts to pursue payment reform and shift the focus of reimbursement from volume to value.
  - The workgroup mentioned that this proposal would require a significant build-up in capacity and staff within the state government in order to provide monitoring and oversight of the newly created regional health service organizations.

Model #15: This model proposal called for the creation of ICOs that could have responsibility for managing and paying for behavioral health services. The proposal also called for the creation of a behavioral health accountable care organization to coordinate care at the service delivery level.

- **Strengths**
  - The workgroup noted that this proposal builds upon the MI Health Link demonstration in terms of promoting integration between physical health and behavioral health services.
  - The workgroup also indicated that this proposal combines improved integration and alignment at the payer level with service delivery level reforms through the creation of a behavioral health Accountable Care Organization.
  - The workgroup specifically highlighted the emphasis on using health information exchange and health information technology as a strength of this model.

- **Challenges**
  - The workgroup noted that the creation of an ICO may not align with recommendation 1.1 of the interim report if the governance structure for the ICO is not public.

- The workgroup questioned how the ICO would navigate differences in the administrative structure of both systems such as differences in the process for grievances, complaints and appeals.
- The workgroup noted that the State of Michigan would need to fully explore the results and lessons learned from the MI Health Link demonstration before pursuing this model.

Model #31: The proposal called for the creation of a care integrator who would provide care management for a specific population (i.e. individuals with intellectual/developmental disabilities).

- **Strengths**
  - The workgroup noted that the care integrator within this model proposal may be able to strengthen the coordination of physical health and behavioral health services at the service delivery level.
  - The workgroup stated that this proposal builds upon the experience of the organization with delivering specialty supports and services for individuals with intellectual and developmental disabilities.

- **Challenges**
  - The workgroup questioned whether this model proposal was scalable beyond the initial community and identified sub-population: if this model is not scalable, the workgroup expressed concerns about whether it would undermine uniformity in service delivery.

Other Notable Comments from the Public Input Process:

- The vast majority of comments focused on the option of creating an ICO. Respondents noted that this option builds upon the progress under the MI Health Link Demonstration.
- Several respondents emphasized the benefits of integrating physical health and behavioral health funding in order to coordinate service and supports for individuals with complex needs.
- Several respondents specifically highlighted opportunities for creating a continuum of care for individuals with mild, moderate, and severe mental illness.
- Other respondents voiced support for the model proposal's emphasis for allowing the individual to select their own coordinator.
- Several respondents also highlighted the option for individuals to choose whether they wanted to receive services from an ICO or whether they preferred to receive services through the CMHSP/PIHP system.
- A large number of respondents expressed concerns about whether this model category would create another administrative layer and not improve integration at the point of service.
- Respondents also voiced concerns about whether having multiple competing ICOs would drive up costs and increase fragmentation of the system.
- A few respondents also stated that giving consumers multiple choices in terms of payers may be confusing. The respondents specifically noted that consumers may not understand that choosing a certain payer may affect their ability to access certain providers.
- Several respondents questioned whether the governance for the ICO is public or private and whether the ICO would be able to align with recommendation 1.1 of the interim report.
- Many respondents wanted to know more about the results of the MI Health Link demonstration in order to determine whether the model should be replicated in other parts of the states; some respondents also wondered whether this model could only be replicated in urban areas and may not be appropriate for rural areas.

Model Category #4: Current Financing Structure Enhancement

The Current Financing Structure Enhancement category largely maintains Michigan's currently separated PIHP and MHP managed care organizations. This category uses administrative options such as contracts between MDHHS, MHPs and PIHPs to improve the effectiveness of integration across the separate payers.

If this category were implemented, MDHHS would use contracts with both types of managed care organizations to apply service quality and outcome performance measures that are shared by both payers. These measures would emphasize joint accountability between PIHPs and MHPs for individuals in the Medicaid program. The measures would also encourage integration between managed care organizations through the use of financial incentives. This category strengthens current managed care structures and ensures PIHPs and MHPs are supported in pursuing integration activities and payment approaches with contracted service providers.

MDHHS and the 298 Facilitation Workgroup used the following model proposals to develop the current financing structure enhancement category: 20, 27 and 34.

Policy Review

Based upon the policy review, the State of Michigan would need to enact the following changes to implement the Current Financing Structure Enhancement model category.

Model Category	Change to State Law	Change to Policy	Change to Contract(s)	Change to Waiver(s) or State Plan
#4: Current Financing Structure Enhancement	No	Yes	Yes	No

Examples in Other States: Alabama, Arkansas, Maine, Montana, North Carolina, North Dakota, Oklahoma, South Dakota and Vermont have implemented models that fall into this category. All of the preceding states operate a form of Primary Care Case Management or health homes, which fund behavioral health services primarily via contracts with primary care providers. This approach also pays a case management fee to providers in addition to regular Fee-For-Service payments; these payments are not risk-based and include performance-based risk/reward.

Workgroup Evaluation

Strengths:

- The workgroup noted that this model category promotes shared accountability and collaboration between the MHPs and PIHPs on improving outcomes for their enrollees.
- The workgroup also noted that this model builds upon the experience and strengths of the existing system and aligns with current initiatives such as the Shared Metrics initiative.
- The workgroup indicated partnerships between MHPs and PIHPs under this model category could use payment reform and other mechanisms (including incentives) to support reforms at the service delivery level.

Challenges:

- The workgroup noted this model category maintains the current bifurcation between the physical health and behavioral health financing.
- The workgroup also noted that this model category focuses on increasing alignment across payers at the statewide level and does not address integration at the service delivery level: the workgroup explained that the state may also need to pursue service delivery level reforms in conjunction with this model category.
- The workgroup noted that this model could strengthen the measurement of uniformity of service delivery across the system but does not directly institute any mechanisms to remediate identified gaps in uniformity on a statewide level.

Additional Considerations:

- The workgroup noted that the State of Michigan will need to determine which populations are included as part of this model (e.g. shared enrollees, specific specialty service populations, Fee-For-Service, etc.).
- The workgroup also indicated that the State of Michigan will need to design a governance structure that supports collaboration and accountability for partnerships between the MHPs and PIHPs.
- The workgroup also mentioned that the State of Michigan will need to strengthen contracts and quality measurement systems in order to hold MHPs and PIHPs accountable for collaborating across the system.

Other Notable Comments from the Public Input Process:

- Many respondents indicated that this model category mostly preserves the current system and would be the least disruptive for consumers and providers: several respondents noted that this model category could be implemented primarily through amendments to contracts.
- Respondents also stated that this model category allows for necessary regional variation.
- A few respondents noted that this category could also leverage statewide health information sharing efforts in order to support service coordination.
- Several respondents also expressed doubts about whether the MHPs and PIHPs could work productively together.
- A few respondents also questioned whether implementing this category could add complexity to the system through new administrative layers or duplication of administrative services.
- Several respondents also highlighted the importance of addressing information technology compatibility issues and health information privacy issues in order to improve health information sharing.
- Finally, several respondents articulated concerns about the use of incentives: respondents specifically focused on the need to ensure that incentives are centered on improving the experience of the individual as opposed to financial management.

Model Category #5: Local/Regional Integration Arrangements

The Local/Regional Integration Arrangements category focuses on encouraging integration of service delivery within a local or regional entity. The local or regional entity could either be a single provider entity such as a CMHSP or a collective group of providers. Model proposals in this category referenced Certified Community Behavioral Health Centers or Accountable Systems of Care as examples of organizations that could serve as local or regional entities.

If this category were implemented, it would initially make minimal changes to overarching managed care structure that is composed of the MHPs and PIHPs. The local or regional entity would blend payments from multiple sources (such as the MHPs and PIHPs) in order to promote integration of physical and behavioral health services at the service delivery level. The providers within the local/regional collaboration would have a shared responsibility to deliver all services to covered populations.

MDHHS could expand implementation of the model category by directing managed care organizations to engage in certain types of payment or contracting arrangements or establishing financing mechanisms which generally redistribute some capitated payments that are currently received by PIHPs and MHPs to risk-bearing provider entities.

MDHHS and the 298 Facilitation Workgroup used the following model proposals to develop the local/regional integration arrangements category: 3, 4, 7, 11, 26 and 32.

Policy Review

Based upon the policy review, the State of Michigan would need to enact the following changes to implement the Local/Regional Integration Arrangements category.

Model Category	Change to State Law	Change to Policy	Change to Contract(s)	Change to Waiver(s) or State Plan
#5: Local/Regional Integration Arrangements	No	Yes	Yes	No

Examples in Other States: Many states (including Michigan) have implemented local or regional integration arrangements. Examples of this model in other states includes Coordinated Care Organizations in Oregon. Examples of this model in Michigan include the MI Care Team initiative and the State Innovation Model.

Workgroup Evaluation

Strengths:

- The workgroup noted that this model category focuses on improving integration at the service delivery level, which most directly impacts the experience of individuals and families.
- The workgroup also emphasized the value of being able to pool resources at the local level: workgroup members explained that the pooling of resources enables the provider collaboration to be more flexible and innovative in meeting the unique needs of individuals and communities.

- The workgroup also indicated that this model category could be pursued without making changes to the overarching managed care structure for publicly funded services.
- The workgroup also mentioned the potential for provider collaborations to build on and align with other innovation initiatives in Michigan, which may include initiatives like the State Innovation Model and MI Care Team.

Challenges:

- The workgroup noted that physical health providers and behavioral health providers have historically had different philosophies about how services and supports should be delivered and that provider collaborations would have to learn to address differences in culture.
- The workgroup mentioned that the provider collaborations under this category would be dependent upon the availability of providers within individual local communities who can meet specific service needs.
- The workgroup also noted that only individuals who are receiving services from providers within the collaborative would experience the benefits of greater coordination of services.
- The workgroup further explained that this model category by itself does not address uniformity or consistency issues at the statewide level.
- The workgroup indicated noted that many provider collaborations may require some start-up funding in order to develop key capacities and that delivering services through provider collaborations may initially cost more in the short run.

Additional Considerations:

- The workgroup noted that the State of Michigan would need to sort out how payers would participate in this model.
- On a related note, the workgroup also stated that the State of Michigan would need to articulate what the respective roles and responsibilities of providers and payers would be within this model: workgroup members explained that the delegation of risk to provider collaboratives under this model may also involve the delegation of specific functions from payers to providers.
- The workgroup also indicated that the State of Michigan may also need to address how financing for the delivery of mild to moderate mental health services is impacted under this model.
- The workgroup noted that the State of Michigan would need to develop a strategy for replicating this model category outside of the initial pilot communities because the local availability of providers in different parts of the state may inhibit certain types of provider collaboratives.
- The workgroup noted that the State of Michigan would need to navigate specific issues with this model category in terms of governance of publicly funded services: workgroup members noted that this model category potentially involves partnerships between non-profit, public entities and for-profit or private entities, which creates unique challenges in terms of governance and stewardship of public resources.

Other Notable Comments from the Public Input Process:

- A few respondents specifically highlighted the possibility of improving the coordination of the mild-to-moderate mental health services with services for severe mental illness.
- Several respondents stated that the flexibility in funding that would be enabled through these provider collaborations may allow providers to expand access to critical services.

- Other respondents highlighted the potential to implement shared savings arrangements that would permit providers to retain funding and reinvest in services if the providers met certain performance targets.
- Several respondents indicated that model category could easily be piloted and would be less disruptive to consumers and providers during implementation.
- Several respondents expressed concerns about transferring risk for managing care to the provider level and questioned what the impact on the service delivery would be: respondents noted that performance metrics and outcome indicators would be needed to avoid inconsistencies in care.
- A few respondents also indicated that providers may experience difficulties with managing risk across a smaller population.
- Some respondents felt that this category did not make significant changes to the current system and that the time and costs that would be required to implement these changes would not be worth the investment.
- Some respondents also expressed concerns about how the State of Michigan would ensure adequate oversight and accountability for provider collaborations at the local level: a few respondents specifically wondered how the State of Michigan would ensure uniformity of access when a broad array of different provider collaborations could be created across various communities.
- Finally, a few respondents highlighted the challenges of the State of Michigan in coordinating multiple integration initiatives at the same time: the respondents noted that the State of Michigan would need to develop a strategy for tracking the results of all of the various pilots.

Model Category #6: MHP or PIHP Payer Integration

The MHP or PIHP Payer Integration model category incorporates a comprehensive range of physical and behavioral health services within either a MHP or PIHP. Model proposals in the MHP or PIHP payer integration category discontinue Michigan's current separated Medicaid payer system and instead propose that either MHPs or PIHPs assume responsibility for administering Medicaid-funded physical and behavioral health services.

If integration were implemented within a MHP, MDHHS would redirect current behavioral health funding received by PIHPs to MHPs through the use of a capitated payment arrangement. MHPs would expand their provider networks to contract with and credential with behavioral health service providers in addition to their existing providers.

If integration were implemented within a PIHP, PIHPs would receive Medicaid funding to administer physical health services for individuals in the Medicaid program that are currently receiving specialty behavioral health services from a PIHP. PIHPs would expand their provider networks and capacity to offer a range of physical health services in addition to their existing services and providers.

The model proposals in this category were not consistent on the inclusion of long-term services and supports (LTSS) or mild/moderate behavioral health services within MHP or PIHP payer structures.

MDHHS and the 298 Facilitation Workgroup used the following model proposals to develop the MHP or PIHP payer integration category: 6, 14, 19, 22, 23, 25, 37, 38, 39, 40 and 42.

Policy Review

Based upon the policy review, the State of Michigan would need to enact the following changes to implement the statewide behavioral health managed care organization model category.

Model Category	Change to State Law	Change to Policy	Change to Contract(s)	Change to Waiver(s) or State Plan
#6: MHP or PIHP Payer Integration	Yes	Yes	Yes	Yes

Examples in Other States: 15 states currently have some form of integrated contract for physical health and behavioral health services. The 15 states are Iowa, Kansas, Louisiana, Massachusetts, Minnesota, Nebraska, New Mexico, New York, Nevada, South Carolina, Tennessee, Texas, Vermont and West Virginia. Colorado is also planning to integrate their behavioral health organizations and physical health organizations into one administrative agency.

Workgroup Evaluation

The 298 Facilitation Workgroup determined the MHP or PIHP payer integration model category cannot adhere to Policy Recommendation 1.1 from the interim report. As a result, the workgroup did not evaluate this category, and the model category is included in the final report for reference only. Any

feedback that was received on the model category as part of this public input survey is summarized below and included in Appendix 15.

Summary of Public Input

Strengths:

- Several respondents believed that integrating the financing for physical health and behavioral health services would reduce administrative complexity and encourage payers to focus on the needs of the "whole person."
- Other respondents noted that implementing this model category would simplify credentialing, paneling, billing and payment for providers.
- Some respondents emphasized the potential of the model category to improve uniformity in the use of quality and outcome measures and support the effective use of incentives.
- Some respondents emphasized the opportunity to reduce unnecessary service utilization through the implementation of this model category.

Challenges:

- A large number of respondents voiced concerns about whether MHPs would focus on maximizing profits instead of improving the quality of services: respondents questioned whether MHPs would employ strategies to reduce costs such as rate reductions and service denials.
- Several respondents expressed concerns that consumer access and person-centered planning could be limited as a result.
- Several respondents also identified issues with ensuring public governance, local accountability and transparency if the state government transitioned towards using MHPs.
- A few stakeholders expressed concerns about whether competition between multiple competing health plans in one area could have a negative impact on the delivery of services.
- Other stakeholders inquired about whether MHPs have the experience and expertise to manage specialty behavioral health services.
- Several respondents also indicated that the State of Michigan would need to make decisions about how local funding and funding for Substance Use Disorder Treatment and Prevention Services would the state transitions towards contracting with MHPs for all services.

Model Category #7: Non-Financing Models

As part of reviewing the model proposals, MDHHS and the 298 Facilitation Workgroup identified a large number of proposals which do not seem to directly impact service financing. MDHHS and the workgroup therefore created a separate category of non-financing models. Nearly all of these models involve some level of enhancement to current provider reimbursement or the addition of a new type of reimbursement for services.

MDHHS and the 298 Facilitation Workgroup used the following model proposals to develop the non-financing models category: 5, 10, 12, 13, 16, 21, 28, 29, 30, 33, 35, 36 and 41.

The Section 298 boilerplate language specifically focuses on the development of recommendations for financing models. All of the models within this category do not explicitly impact service financing. As a result, this model category will be included for reference only in the final report.

Policy Review

The Section 298 boilerplate language specifically focuses on the development of recommendations for financing models. All of the models within this category do not explicitly impact service financing. As a result, MDHHS and the 298 Facilitation Workgroup did not conduct a policy review of the non-financing model category.

Workgroup Evaluation

The Section 298 boilerplate language specifically focuses on the development of recommendations for financing models. All of the models within this category do not explicitly impact service financing. As a result, the 298 Facilitation Workgroup did not evaluate the non-financing model category.

Summary of Public Input

The Section 298 boilerplate language specifically focuses on the development of recommendations for financing models. All of the models within this category do not explicitly impact service financing. As a result, MDHHS did not post the non-financing model category for public input.

Recommendations for Benchmarks for Implementation

As part of the Section 298 boilerplate language, the Michigan Legislature directed MDHHS to develop "annual benchmarks to measure progress in implementation of any new financing model or policy recommendations." MDHHS consulted with the 298 Facilitation Workgroup on this issue, and the workgroup provided the following guidance to MDHHS on the development of benchmarks. Please note that the word "performance metrics" is used interchangeably with "benchmarks" for the purposes of the recommendations.

- MDHHS should focus on identifying the following types of performance metrics:
    - Metrics that are currently being used in Michigan.
    - Metrics that span across all relevant populations that would be affected by potential financing models and policy changes under the Section 298 Initiative. Affected populations will include, but are not limited to (1) individuals with physical health needs, (2) individuals with mild-to-moderate behavioral health needs, (3) individuals with serious mental illness, (4) children with serious emotional disturbances, (5) individuals with intellectual/developmental disabilities, (6) individuals who are recovering from a substance use disorder, and (6) tribal members.
    - Metrics that represent outcomes for both health status and quality of life.

- MDHHS should give deference to metrics that are (1) derived from research, (2) feasible in terms of being able to be calculated annually, and (3) overarching to the extent that the metrics would synchronize with any potential financing models or policy changes that are implemented.

- The workgroup noted that the chosen benchmarks are minimum metrics that will apply across all financing models and policy changes, but each financing model and policy change will have more in-depth evaluative criteria that are inclusive of specific process and outcome metrics. The metrics may also need to be adjusted based upon which financing model(s) and policy change(s) are pursued by the Legislature.

- The workgroup concluded that all performance metrics should support the attainment of the vision as outlined in the Section 298 Interim Report and the final End Statement from July 2016, which is as follows:

    "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. 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."

Based upon this guidance, MDHHS and the 298 Facilitation Workgroup identified a series of potential performance metrics to measure the progress of implementing new financing models and policy changes. Please review Appendix 17 for a list of recommended performance metrics.

Appendixes

The interim report contains the following appendixes to provide additional context and background information on the Section 298 Initiative:

Appendix 1: Section 298 Boilerplate Language

Sec. 298. (1) The department shall work with a workgroup to make recommendations regarding the most effective financing model and policies for behavioral health services to improve the coordination of 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, Medicaid 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, full community inclusion, access to CMHSP services 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.

(d) Ensure full access to community-based services and supports.

(e) Ensure full access to integrated behavioral and physical health services within community-based settings.

(f) Reinvesting efficiencies gained back into services.

(g) Ensure transparent public oversight, governance and accountability.

(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 to prevent current customers of behavioral health services from experiencing a disruption of services and supports, identification of ways to enhance services and supports and identification of any gaps in 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 workgroup's recommendations shall also recommend annual benchmarks to measure progress in implementation of any new financing model or policy recommendations over a three-year period and ensure that actuarially sound monthly payments for Medicaid behavioral health services are no less than the monthly payments used for Medicaid behavioral health services in the fiscal year ending Sept. 30, 2017.

(5) The department shall provide, after each workgroup meeting, a status update on the workgroup's progress and, by Jan. 15 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, the Senate and House policy offices, and the state budget office.

(6) Except for pilot programs described in subsection (3), 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.

Appendix 2: Final End Statement and Core Values

FINAL END STATEMENT AND CORE VALUES
Sec. 298 Behavioral Health Work Group
April 11, 2016

The project end statement and core values have been revised to reflect the discussion at the March 30, 2016, and April 11, 2016, meetings of the work group and a small number of comments emailed after the first meeting. Similar ideas have been combined when possible in the interest of conciseness, consistency and clarity.

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. 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.

** Supports are care that maintains or increases personal self-sufficiency and facilitates achievement of individual goals of independence and community inclusion, participation and engagement.*

***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.*

Values

- 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. As youth age, 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 the people in a person's life.

- 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.

- 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 and investment in peer supports and peer-led organizations and their value recognized.
  - 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 and 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.
  - Stigma reduction and promotion of community health and wellness.

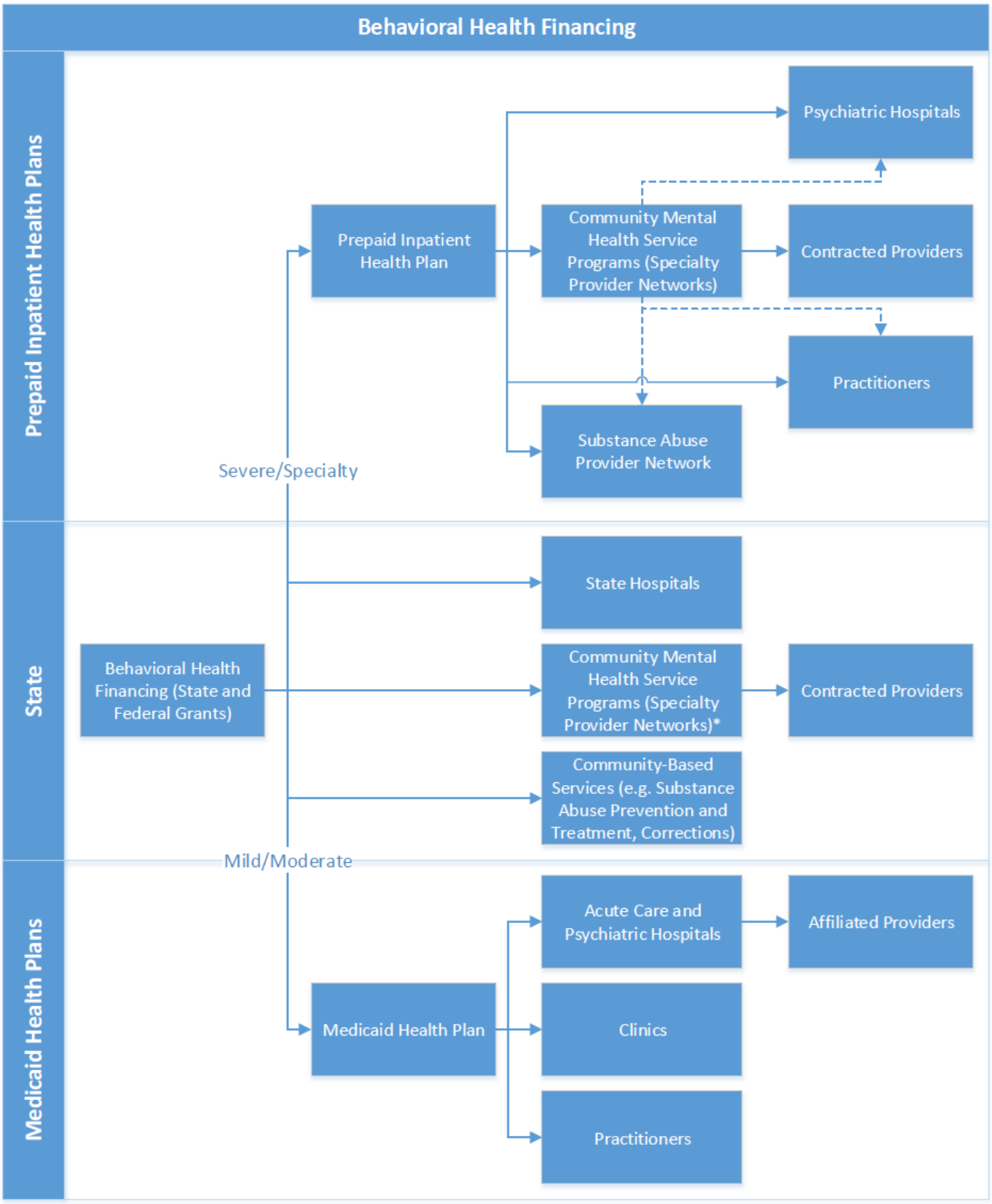
- Public oversight and accountability to ensure the public interest.
  - Transparency (access to information, open meetings).
  - Array of services and supports accountable to the public and the persons and families receiving services.
  - People with disabilities should not be segregated in communities.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

- 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.

Appendix 3: Diagram of the Current Behavioral Health System in Michigan



Appendix 4: Overall Timeline for the Section 298 Initiative

The following timeline provides a high-level overview of the Section 298 Initiative. Please note that this timeline is tentative and subject to change.

Time Period	Activity
February 2016	The Fiscal Year 2017 executive budget proposal was proposed and includes a set of recommendations on integrating physical health and behavioral health services. The executive budget proposal sparks a statewide discussion on the best approach for coordinating physical health services and behavioral health services.
March 2016 – June 2016	Lieutenant Governor Brian Calley convened a workgroup to discuss physical health and behavioral health integration. The original workgroup met five times and produced a report. The report included revised language for the appropriations bill, a set of "core values" and key "design elements" for future discussions.
June 2016	The Michigan Legislature incorporated the recommendations from the Lieutenant Governor's workgroup into the 2017 appropriations bill. The new Section 298 Initiative requires MDHHS to develop a report with recommendations for the Michigan Legislature by January 2017.
July 2016 – September 2016	MDHHS launched the 298 Facilitation Workgroup to assist with the development of the report and related recommendations. MDHHS and the workgroup collaborated on developing the Affinity Group process.
October 2016 – November 2016	MDHHS conducted the Affinity Group process. During this process, MDHHS met with various stakeholders and collected input from stakeholders to help inform the development of policy recommendations.
November 2016 – December 2016	MDHHS and the 298 Facilitation Workgroup developed draft policy recommendations for the interim report.
December 2016 – January 2017	MDHHS posted the interim report for public review in December. Public review for the interim report will continue through early January. MDHHS and the 298 Facilitation Workgroup will use the comments from public review to revise and finalize the interim report. The interim report will be submitted to the Michigan Legislature by Jan. 15, 2017
January 2017 – March 2017	MDHHS and the 298 Facilitation Workgroup collected and evaluated model proposals. MDHHS and the workgroup also conducted a public input process to gather comments on the models. MDHHS and the workgroup also developed a high-level process map and recommendations for benchmarks for implementation. The draft financing model categories, benchmarks for implementation and high-level process map were incorporated into the final report, which was submitted to the Legislature by March 15, 2017.

Appendix 5: Design Elements from the Lieutenant Governor's Workgroup

The Lieutenant Governor's workgroup proposed the following design elements for a new system as part of the workgroup's report. The newly created 298 Facilitation Workgroup used the design elements from the report to help guide the Affinity Group process. **Please note that the following design elements do not represent recommendations from the 298 Facilitation Workgroup for the purposes of the interim report.** The following design elements received consensus votes from the members of the Lieutenant Governor's Workgroup during the June 22, 2016 meeting.

- 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 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, and 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)

The remaining design elements were presented by the small groups during the May 19 meeting of the Lieutenant Governor's workgroup but did not receive a consensus vote during the June 22 meeting.

- Service Delivery
    - Increase colocation and other model 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)

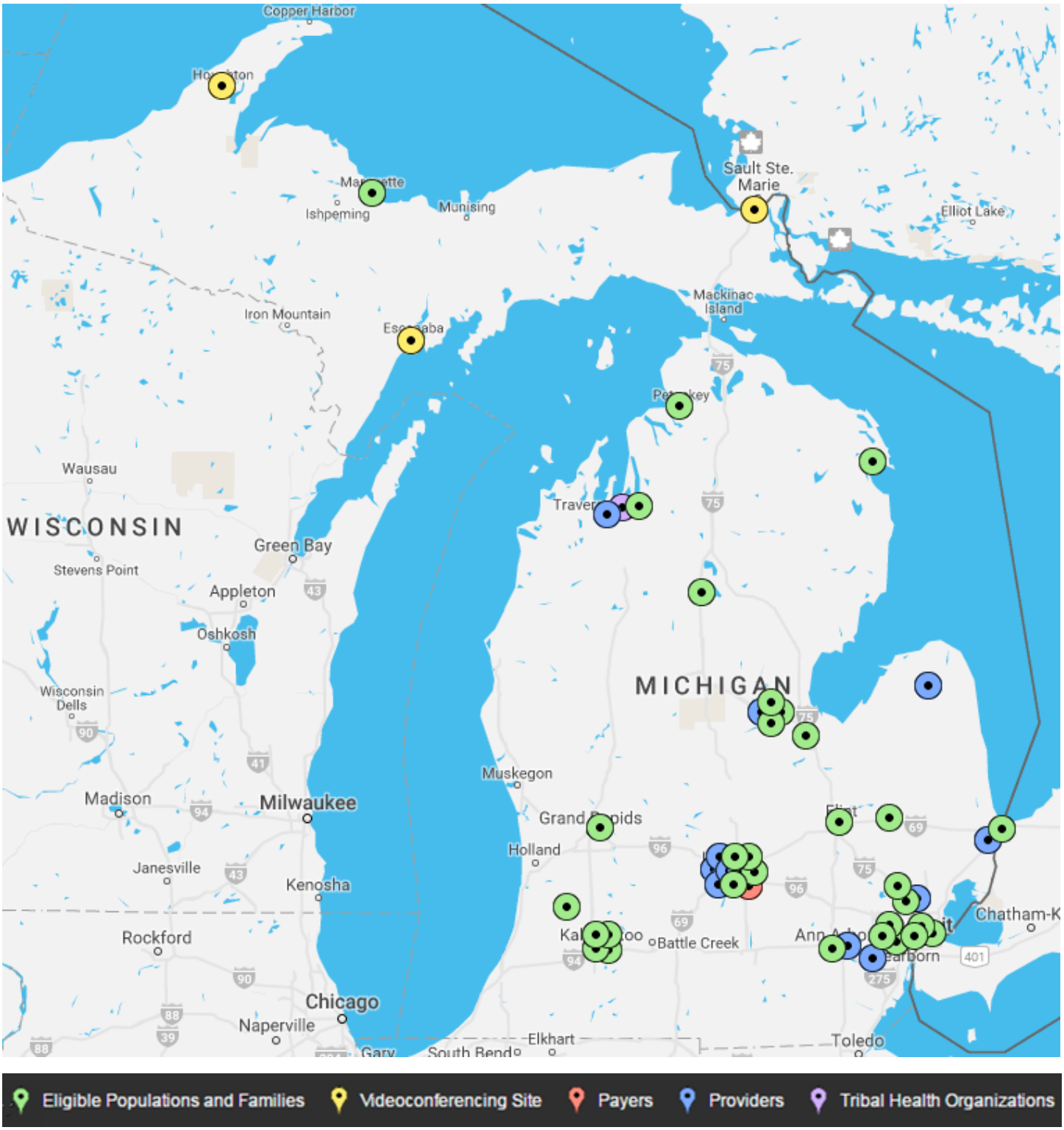
- Develop an integrated system per enrollee that is made up of a number of parties that have specialized managed-care expertise that is tightly coordinated. This would be similar to the current system but with better coordination. This system would include:
  - A standard integrated Medicaid fee schedule 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)

Appendix 6: List of Affinity Group Meetings

Date	Type of Meeting	City
October 4, 2016	Eligible Populations and Families	East Lansing
October 4, 2016	Eligible Populations and Families	Midland
October 4, 2016	Eligible Populations and Families	Flint
October 5, 2016	Eligible Populations and Families	East Lansing
October 7, 2016	Eligible Populations and Families	Houghton Lake
October 13, 2016	Eligible Populations and Families	Allegan
October 17, 2016	Eligible Populations and Families	Midland
October 17, 2016	Eligible Populations and Families	Midland
October 17, 2016	Eligible Populations and Families	Troy
October 18, 2016	Eligible Populations and Families	University Center
October 18, 2016	Eligible Populations and Families	Kalamazoo
October 19, 2016	Eligible Populations and Families	Kalamazoo
October 20, 2016	Eligible Populations and Families	Auburn Hills
October 21, 2016	Eligible Populations and Families	Detroit
October 21, 2016	Providers	Ann Arbor
October 24, 2016	Eligible Populations and Families	Redford
October 24, 2016	Providers	Acme
October 25, 2016	Eligible Populations and Families	Livonia
October 25, 2016	Eligible Populations and Families	Lansing
October 25, 2016	Eligible Populations and Families	Detroit
October 25, 2016	Eligible Populations and Families	Grand Rapids
October 25, 2016	Eligible Populations and Families	Kalamazoo
October 25, 2016	Tribal Health Organizations	Acme
October 26, 2016	Eligible Populations and Families	Lansing
October 26, 2016	Eligible Populations and Families	Detroit
October 27, 2016	Eligible Populations and Families	Alpena
October 27, 2016	Providers	Belleville
November 1, 2016	Eligible Populations and Families	Lapeer
November 1, 2016	Eligible Populations and Families	Redford
November 2, 2016	Eligible Populations and Families	Kalamazoo
November 2, 2016	Payers	Okemos
November 2, 2016	Providers	Bad Axe
November 3, 2016	Eligible Populations and Families	Ann Arbor
November 7, 2016	Providers	Lansing
November 7, 2016	Providers	Marysville
November 8, 2016	Providers	Troy
November 8, 2016	Providers	Midland
November 8, 2016	Providers	Lansing

Date	Type of Meeting	City
November 8, 2016	Providers	Lansing
November 9, 2016	Eligible Populations and Families	Port Huron
November 9, 2016	Providers	Lansing
November 10, 2016	Eligible Populations and Families	Marquette
November 10, 2016	Videoconferencing Site	Escanaba
November 10, 2016	Videoconferencing Site	Houghton
November 10, 2016	Videoconferencing Site	Sault Ste. Marie
November 10, 2016	Providers	Lansing
November 16, 2016	Eligible Populations and Families	Rapid City
November 18, 2016	Eligible Populations and Families	Petoskey

Appendix 7: Map of Affinity Group Meetings



*The Affinity Group meeting for Eligible Populations and Families in Marquette included a videoconferencing option. Individuals and families from three other community mental health service providers teleconferenced into the meeting. These three remote sites are marked on the map as "Videoconferencing Sites".

Appendix 8: Summary of Affinity Group Feedback (Eligible Populations and Families)

MDHHS has been exploring strategies for improving the coordination of physical health and behavioral health services. This initiative, which is known as Section 298, is based upon a legislative requirement in this year's budget. Under Section 298, the Michigan Legislature has directed MDHHS to develop a report with recommendations on this issue.

In late 2016, MDHHS facilitated a series of Affinity Group meetings for eligible populations and families. The purpose of the meetings was to collect input, feedback and ideas on ways to inform the development of the policy recommendations for the legislative report. During the meetings, participants were given a set of questions to answer regarding the delivery of physical health and behavioral health services in Michigan. MDHHS also provided individuals with the option to submit comments in writing outside of the Affinity Group meetings. This document summarizes the comments that were provided during the meeting and in writing.

Summary data on the number of Affinity Group meetings, number of participants and number of respondents are included below.

Summary of Affinity Group Participation (Eligible Populations and Families)	
Number of Affinity Groups	31
Number of Affinity Group Participants	767
Number of Written Comments	82
Estimated Number of Total Respondents*	849

** The number of total respondents is an estimate because some stakeholders participated in an Affinity Group meeting and separately submitted written comments.*

<u>Coordination of Physical Health and Behavioral Health Services</u>

During the Affinity Group process, MDHHS used two different questions to determine the preferences of individuals and families for the management of physical health and behavioral health services. Both questions and the related responses are included below:

> **Version 1:** If you receive supports and services from a Community Mental Health (CMH) program that are paid for by Medicaid, would you like your CMH program to help coordinate all your health care? If so, what and how?
>
> **Response:** The majority of participants valued the supports coordination that CMHSPs are currently providing for behavioral health services. Participants noted CMHSPs are able to "get to know" individuals and build relationships with individuals and their families. However, the majority of participants voiced concerns about CMHSPs also coordinating their physical health services. Some participants did not believe that CMHSPs have the capacity or staffing to manage the delivery of physical health services on a large scale. Many participants also noted that family members are already helping individuals with coordinating services. Some participants also noted that any care management activities by the CMHSPs should be optional for individuals who are receiving services.

Version 2: If the state decides that all your health care services and supports (behavioral and other) will be managed by one entity, would you prefer this entity to be a CMH program or a Medicaid health maintenance organization (HMO)?

Response: The majority of participants preferred that CMHSPs manage the delivery of services. A small group of participants did express a preference that the HMO manage the delivery of services. Several participants wanted to stay with the current system and voiced opposition to having one entity manage all services. Some participants argued that it should be optional to have one entity manage all services. Many participants supported stronger communication between physical health and behavioral health providers in terms of coordinating services and managing multiple medications.

MDHHS also posed a question to participants on whether they would prefer to keep access to their current service providers. The vast majority of participants affirmed that they would like to continue to have access to their current providers. Some participants expressed concerns about being restricted to a certain provider network. Some participants also emphasized the importance of minimizing disruption to service delivery and the value of individuals having stable, long-term relationships with providers.

Finally, MDHHS asked participants to identify which services or conditions are the biggest problems in regards to the coordination of all services. Participants identified a wide variety of issues, but some of the most common issues were dental services, medication management and transportation.

Administration of Complaints, Grievances and Appeals

MDHHS asked participants a set of questions in regards to the administration and resolution of complaints, grievances, and appeals. The questions explored a variety of issues, which are described in further detail below.

MDHHS asked participants about which entity should be responsible for administering complaints, grievances, and appeals. During the Affinity Group process, MDHHS used two different versions of this question. One version of the question asked about whether complaints, appeals and grievances should be administered by a new independent statewide organization or an existing state agency. The other version of the question asked whether an individual would want to take a complaint, grievance or recipient rights issue to a provider, payer, or another entity that does not have financial involvement in their care.

A majority of participants expressed support for having an independent entity to review service delivery issues. Some participants noted that this entity should be separate from CMHSPs due to complaints being “buried” at the local level. However, some participants expressed concerns about centralizing the resolution of service delivery issues. These participants voiced concerns that the new entity would become overwhelmed with resolving issues across the state. Many participants also wanted to have a local, “face-to-face” option for quickly resolving issues. Several participants also questioned whether complaints about physical health and behavioral health services can be handled the same way. Several participants noted the importance of educating individuals and families about the process and procedures for filing complaints and appeals in addition to suggesting the possibility of having an independent ombudsman to review service issues and advocate for individuals.

MDHHS also asked participants about the possibility of offering individuals the option to use mediation services to address service delivery issues. Many participants voiced support for having this option but did not want the option to limit the ability of an individual to file a formal complaint or grievance. Some participants also noted the importance of the mediator being able to resolve issues quickly. Some participants highlighted the opportunity for county mediators to play this role.

MDHHS asked participants whether they would prefer to have an option to promptly resolve issues at a local level before elevating it to a statewide entity. A majority of participants supported this option if it included a set timeline for resolving issues at the local level. Participants also noted that this opportunity should be optional for individuals.

MDHHS asked a final question about whether changes to the complaints process should also apply to physical health and behavioral health services outside of a CMHSP. MDHHS did not receive definitive feedback on this issue. However, some participants voiced support for having a consistent approach to resolving issues with service delivery.

Protections for Mental Health and Epilepsy Drugs

Under state law, MDHHS directly manages Medicaid prescriptions for mental health and epilepsy drugs. MDHHS asked Affinity Group participants about whether they would like to make these protections permanent. The vast majority of participants confirmed that the protections should be permanent. Some participants expressed opposition to "fail first" policies and noted that different mental health drugs may not be comparable with each other. One participant noted that issues with prescriptions should be addressed between the individual and his or her doctor rather than a payer.

Portability and Applicability of a Person-Centered Plan

MDHHS posed two questions to participants in regards to the portability and applicability of a person-centered plan. MDHHS asked participants about whether an individual's person-centered plan should be honored regardless of whether an individual switches providers or payers. The vast majority of participants confirmed that a person-centered plan should be honored regardless of payer, provider, location, or duration of services. Participants also noted that individuals should not have to re-establish a new person-centered plan every time that they move in and out of service. Participants also wanted the option to change their plan when requested. MDHHS also inquired about whether this requirement should also apply to physical health services. The majority of participants agreed that individuals should be able to take their physical health plans with them as well. Many participants confirmed that person-centered plans should be shared with physical health providers, but some participants expressed concerns about sharing non-medical information such as life goals with providers.

Transparency and Accountability in Governance of Publicly-Funded Entities

MDHHS asked participants several questions about the best ways to promote transparency and accountability in the governance structures of public entities. MDHHS asked participants about how much individual and family representation should be required on the boards of publicly-funded entities. A large number of participants advocated for having one-third to one-half of the boards of publicly-funded entities be reserved for individuals and families. Some participants also commented on the importance of having diversity and turnover on the boards of publicly-funded entities to incorporate new perspectives into governance. MDHHS also inquired about whether publicly-funded entities should

be required to comply with the Open Meetings Act and FOIA laws, and the vast majority of participants concurred with this concept.

MDHHS also asked participants for ideas on other ways that individuals and families can be represented in their communities. Participants identified several different strategies including surveys, focus groups, different types of local advisory boards or councils, social media, annual stakeholder meetings, public comment and internet forums. Some participants highlighted the importance on educating individuals about opportunities to participate and advocate for themselves and noted that families and guardians should have the same ability to participate.

Workforce Issues

MDHHS asked participants two questions in regards to recruiting and retaining a high-quality workforce for delivering health care services. The first question explored the characteristics that individuals value in treatment and support staff. Several participants noted the importance of staff treating individuals with dignity and respect. Some participants also highlighted the importance of staff who are empathetic and listen to the concerns and needs of individuals. Other participants emphasized the importance of longevity and stability in relationships between individuals and staff and voiced concerns about the adverse impact that staff turnover has on individuals. Finally, many participants noted that staff should be well-trained, competent, and knowledgeable about the needs of individuals.

MDHHS also questioned participants about strategies for encouraging staff to stay in the field and continue to work with individuals. The vast majority of participants emphasized the importance of improving wages, benefits, hours and job security for staff. Many participants also drew attention to recognizing the efforts and hard work of staff and creating a career path for individuals who stay in the field. Finally, some participants highlighted the importance of lower caseloads for staff and providing better training (including trauma-informed care).

Peer Supports

MDHHS asked participants to identify different ways that peers support individuals during the service delivery process. Participants noted that there are a wide variety of names for peers, which include peer specialists, recovery coaches, and health coaches. Many participants emphasized the unique ability of peers to understand the experiences of individuals. Participants explained that peers can provide incomparable support to individuals who are in recovery because peers have "lived experience." Several participants also noted that peers can help individuals with navigating the service delivery system and participating in the community. In addition, a few participants highlighted the ability of peers to link individuals to community resources to address issues such as housing, employment and education. However, some participants emphasized that peers should work in conjunction with clinical staff and case managers and should not be viewed as substitutes.

Person-Centered Planning and Trauma-Informed Care

MDHHS asked participants a series of questions in regards to the person-centered planning process. MDHHS questioned participants about whether individuals should be able to make decisions about the following aspects of the person-centered planning process: (a) choosing when and where planning meetings are held; (b) choosing who can attend the meeting; (c) choosing which services and supports one would receive and the people who would provide for them; and (d) choosing one's facilitator if the

person-center planning process is facilitated by someone. Virtually all participants agreed that these aspects are important. A few participants also emphasized the importance of being able to change the facilitator in the midst of a process. Other participants also noted that person-centered planning meetings should be facilitated by individuals who are independent of the service provider.

MDHHS also inquired about why participants believed these aspects are valuable. Several participants cited the importance of individuals being in charge of their own lives. Other individuals noted the importance of individuals feeling comfortable during the process and being empowered to advocate for themselves. Many participants emphasized that individuals have the best understanding of their health and wellness needs and that they should be able to present information and make recommendations during the process. Some participants also noted the importance of individuals being able to invite key people who are able to provide insight on crucial aspects of the individual's health and wellness needs. Finally, some individuals highlighted the importance of the pre-planning meeting to support the person-centered planning process.

MDHHS also asked participants whether it is important for individuals to be able to change their plan when they choose. Virtually all participants agreed on this principle. Many participants indicated the importance of the plan being adjusted as an individual's life, needs and goals changes. Some participants noted the importance of plans being updated at least on an annual basis and emphasized that supports coordinators should be included in this process.

Finally, MDHHS asked whether it is important that individuals who have experienced trauma are provided with services in a method that is trauma-informed. Virtually all participants concurred with this principle. Some participants emphasized that staff should only be involved in examining the causes of trauma if they are trained and know the individual. Some participants also noted that trauma should be identified and addressed as part of the person-centered planning process.

Health Information Sharing

MDHHS asked participants two questions in regards to the sharing of individual health information for care coordination. Both questions examined whether individuals were comfortable with providers sharing their care plan (9a) and person-centered plan (9b) to coordinate their services. The majority of individuals agreed with the importance of sharing health information between providers to improve the coordination of health services. Several participants noted that health information should only be shared on a "need to know" basis. Several participants wanted to provide written consent for any release of health information. Some participants seemed to have greater concerns about sharing the information within a person-centered plan as opposed to sharing the information within a care plan. Some participants were also comfortable with providers having access to information but expressed concerns about other individuals (such as employers or family members) having access to information.

Access to Substance Use Disorder Services

MDHHS asked participants to identify services that should be made available for individual who are recovering from a substance use disorder. Participants identified several types of services that included inpatient detoxification programs, long-term outpatient services, transition housing, job re-entry services, access to recovery coaches, access to support groups, counseling, medication-assisted treatment, case management, peer supports and 24-hour crisis services.

Participants also outlined several key principles for delivering substance use disorder services. Participants emphasized the importance of individuals being able to go to group meetings instead of CMHSPs deciding where they can and cannot go. Participants also highlighted the value of having more than one recovery pathway. Recovery pathways may include "professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches."[7] Several participants indicated that the system needs to have a greater focus on early intervention (especially for youth). Additionally, participants highlighted the importance of supports for families in addition to individuals.

Participants voiced concerns about service agencies forcing individuals to be discharged from inpatient services early despite clear medical needs. Additionally, participants also indicated that individuals who are in recovery need greater support when transitioning out of jail and prison. Finally, individuals were resistant to the idea that individuals need to stop abusing substances before starting treatment.

Services for Children, Youth and Families

MDHHS asked a series of questions in regards to services and supports for children, youth and families. The first question focused on the different types of early-intervention (pre-crisis) services that should be available for children, youth and families. Several participants highlighted the role of early intervention in preventing crisis, putting a person on the road to recovery, reducing suffering and avoiding more expensive and prolonged care. Many participants emphasized the importance of education for youth and families on what resources are available. Several participants also indicated schools could play a role in screening and early recognition of symptoms and diagnoses but noted that schools may need additional staff, training, and funding to play this role. Several participants mentioned the importance of starting to plan for individuals before "age out" of the system. The participants explained individuals "age out" of the school-based system and that transition planning needs to occur in advance to ensure the continuity of services for individuals who "age out." Several participants highlighted the value of providing respite for families and 24-hour crisis care.

MDHHS also inquired about other types of issues that need to be tackled for youth, children and families besides early intervention. Participants highlighted the importance of mentorship and peer supports for youth and education and empowerment of families. Participants also underscored gaps in service delivery including a lack of treatment facilities for children and difficulty with accessing services for children with serious emotional disturbances. Some participants emphasized the importance of providing counseling, education and job coaching for youth. Other participants indicated that diagnosis and treatment for children should be based on an objective assessment and not place blame on the family. Finally, some participants noted the importance of pre-planning for youth in terms of financial planning, housing options, work opportunities and vocational training.

Incentives and Outcome Measures

MDHHS asked participants several questions in regards to measuring outcomes within the health care system and providing incentives for providers to achieve desirable outcomes. The first question was in regards to the use of financial incentives for achieving outcomes in the person-centered plan. In general, participants expressed concerns about the use of financial incentives for this purpose. Some participants

[7] Del Vecchio, Paolo. "SAMHSA's Working Definition of Recovery Updated." SAMHSA Blog. SAMHSA, 23 Mar. 2012. Web. 09 Nov. 2016.

believed that financial incentives would encourage providers to only work with the easiest individuals and avoid individuals with complex health needs. Other participants noted that individuals may be working to maintain their current health status or may be working through recovery and that providers should not be penalized if individuals do not make progress. Some participants also felt that achieving good outcomes for individuals should be its own reward. Many participants expressed a preference for additional funding to be spent on care delivery instead of incentives.

MDHHS also asked participants about which outcomes of service delivery were most important to them. Many participants voiced support for using outcomes that reflect an individual's quality of life and overall health and wellbeing. Other participants advocated for using outcomes that reflect achievement of goals within the person-centered plan such as growth, independence, recovery, community participation and skill development.

MDHHS asked a final question in regards to outcome measures that should be used to measure the performance of the system overall and ensure accountability. Participants identified a wide range of potential measures. Some participants recommended the use of measures that reflect the quality of life of individuals and success in the person-centered planning process. Some participants suggested metrics that track reductions in hospitalizations, incarcerations, homelessness, suicides and substance use relapse. A few participants voiced support for using the National Core Indicators to measure performance.

Appendix 9: Summary of Affinity Group Feedback (Providers)

MDHHS has been exploring strategies for improving the coordination of physical health and behavioral health services. This initiative, which is known as Section 298, is based upon a legislative requirement in this year's budget. Under Section 298, the Michigan Legislature has directed MDHHS to develop a report with recommendations on this issue.

In late 2016, MDHHS facilitated a series of Affinity Group meetings for providers. The purpose of the meetings was to collect input, feedback and ideas on ways to inform the development of the policy recommendations for the legislative report. During the meetings, participants were given a set of questions to answer in regards to the delivery of physical health and behavioral health services in Michigan. MDHHS also provided individuals with the option to submit comments in writing outside of the Affinity Group meetings. This document summarizes the comments that were provided during the meeting and in writing.

Summary data on the number of Affinity group meetings, participants and respondents is included below.

Summary of Affinity Group Participation (Providers)	
Number of Affinity Groups	12
Number of Affinity Group Participants	286
Number of Written Comments	16
Estimated Number of Total Respondents*	302

** The number of total respondents is an estimate because some stakeholders participated in an Affinity Group meeting and separately submitted written comments.*

Coordination of Physical Health and Behavioral Health Services

MDHHS asked participants several questions about the coordination of physical and behavioral health services. MDHHS first asked participants to offer recommendations for the coordination of care for those individuals who want their behavioral healthcare and/or intellectual/developmental disability needs and physical healthcare needs coordinated by the CMHSP. Participants suggested streamlining processes and standardization of service delivery in a variety of policies and processes across the state. Some participants also suggested improving information sharing through a variety of methods, which included: (1) use of a standard consent form, (2) use of standardized electronic medical record or more robust health information exchange, and (3) expansion of CareConnect360. Participants also suggested embedding primary care providers into behavioral health settings and vice versa to ensure co-located, coordinated and bi-directional care. Finally, a few participants advocated for promoting the use of a health home model.

Some participants suggested that improvements in financial reimbursements could also help improve the coordination of services. Participants recommended allowing for reimbursement for services not currently covered like care coordination, care management and services covered through the health and behavior codes. A few participants also recommended using quality bonuses to incentivize better outcomes.

Participants also stressed the importance of education as a key component of successful coordination of care through the following methods. Participants recommended boosting education and training at all levels for individuals, providers, and health plans. Participants noted that plans and providers should be trained on person-centered planning, motivational interviewing and social determinants. Finally, participants recommended that individuals who use services should be educated on the importance of care coordination.

MDHHS also asked participants for recommendations on how to foster coordination of care for individuals who do not want their behavioral healthcare and/or intellectual/developmental disability needs and physical healthcare needs coordinated by the CMHSP. The participants offered the same strategies as listed in the first question with an additional item of encouraging the use of the Person-Centered Planning Process as a standard in primary care.

Finally, MDHHS asked participants for recommendations to improve coordination between behavioral health and primary care providers at points of service. Participants noted the importance of incentives for improved care coordination. Participants also emphasized the importance of eliminating barriers to sharing health information: participants recommended several strategies to this end, which included (1) addressing health information sharing restrictions in the Mental Health Code, (2) integrating Medicare and substance use disorder information into the clinical record, (3) developing and building upon mechanisms for real-time information sharing, and (4) encouraging participation of physical health and behavioral health providers in statewide health information sharing efforts.

Administration of Complaints, Grievances, and Appeals

MDHHS asked participants for recommendations to create a timely, easily navigable complaint resolution system in which providers and payers are not the ones who determine the validity of complaints. Participants generally supported creating an independent entity to review complaints and grievances. However, participants also voiced concerns about (1) whether there is sufficient evidence of issues with resolving complaints and grievances to justify creating a new entity and (2) how the costs for the new entity would be covered. Participants also expressed a preference to resolve the problem at the local level first. Participants expressed concerned about taking the complaint too far away from the source.

Participants suggested several strategies for improving the administration of complaints, grievances and appeals, which includes (1) improving data collection on grievances and appeals; (2) establishing a method for providers to appeal negative actions; (3) improving existing rights offices across the state; (4) increasing training; and (5) standardizing processes between PIHPs and MHPs.

Streamlining Processes

MDHHS asked participants for recommendations on streamlining administrative processes, reducing paperwork and creating uniformity across the states. Participants strongly advocated for eliminating duplication in administrative functions like credentialing and auditing. Participants also encourage the utilization of contractual mechanisms to clearly delineate requirements and promote additional uniformity across systems. MDHHS also urged the state to define and use best practices as a guide to standardize policies, processes, and procedures for MHPs, CMHSPs and PIHPs. Finally, some participants recommended enhancing and standardizing the technological infrastructure and capabilities across systems: a few participants advocated for potentially using universal or statewide systems.

Oversight and Administration of Health Care

MDHHS asked participants two questions about the administration and oversight of health care. MDHHS first asked participants what changes to the current system should be made to the current system to improve efficiency and efficacy of the administration and oversight of the CMHSP system. Participants advocated for reducing redundancies between CMHSPs, PIHPs and MHPs. Participants encouraged CMHSPs, PIHPs, and MHPs to develop uniform processes, procedures and performance metrics with the goal of reducing regulatory requirements. Participants also urged MDHHS to implement value and outcome-based payment models. Finally, some participants encouraged MDHHS and its partners to streamline the audit process.

MDHHS also asked participants to make recommendations to improve access to physical health and behavioral health services. Some participants advocated for allowing CMHSPs to provide services to the mild or moderate population. Other participants encouraged MDHHS to ensure that transportation is accessible by improving and aligning transportation policies across systems. Participants also recommended increasing access to integrated care settings and support these settings with the financial resources needed to assure sustainability: participants suggested consider incentives to improve coordination and individual outcomes as part of this effort. Participants also identified the need to equip providers with the skills or resources to complete behavioral health screenings in the primary care setting. Finally, participants noted the need to standardize processes, procedures and performance metrics across systems and counties.

Uniformity and Administrative Efficiency

MDHHS asked participants several questions about developing uniformity and creating effective quality improvement efforts. MDHHS first asked participants to make recommendations to develop uniform administrative, service and other policies, procedures and operational definitions for the entire public behavioral health system. Some participants recommended creating one system to administer the full behavioral health benefit versus bifurcating the system between mild/moderate and severe. Many participants suggested standardizing policies, processes, procedures and performance metrics across systems. Some participants urged MDHHS to consider a statewide system or, minimally, requirements that are uniform across responsible counties. In contrast, some participants suggested that geographical differences make uniformity difficult and, potentially, not ideal. Finally, participants suggested that MDHHS and its partners should review paperwork required of persons served to streamline, reduce unnecessary forms and develop uniform requirements.

Participants were asked to prioritize any of their recommendations. The most significant priorities identified by the participants were (1) focusing on the persons served and improving choice, access, and experience for individuals; (2) promoting integration at the provider level; and (3) simplifying and streamlining policies, processes and procedures.

Participants were asked for recommendations to enhance the uniformity and effectiveness of quality improvement efforts on a statewide level. Participants recommended considering uniform standards and performance measures for CMHSPs, PIHPs and MHPs: participants noted that these standards should be reviewed to ensure they align and promote outcomes valued in each system. Participants also emphasized the importance of improving coordination and communication across systems in regards to quality improvement efforts and measures utilized by the state to measure performance. Finally, some

participants encouraged MDHHS to use outcomes from pilots and the State Innovation Model to inform delivery system redesign and changes.

Governance, Transparency and Accountability

MDHHS asked participants two questions regarding governance, transparency and accountability. First, MDHHS asked participants how they would ensure the continuation of a strong individual and family voice (not merely advisory) in governance. Participants voiced support for continuing with at least one-third representation of individuals and families on CMHSP boards. However, some participants suggested greater representation for individuals on the board. Some participants also suggested actively recruiting individuals and their families to participate in meetings: participants indicated that steps should be made to facilitate individual participation in meetings if necessary.

MDHHS also asked participants for recommendations to foster transparency of information and operations. Participants recommended providing greater access to information online through the streaming of meetings and posting of materials online. Some participants also suggested updating the recipient handbook and other materials more frequently. One participant recommended strengthening the reporting requirement for payers.

Coordination at the Point of Service

MDHHS asked participants for recommendations for promoting coordination of care at the point of service delivery. Participant responses centered on providing flexible funding (i.e. something in addition to fee-for-service payment for specific services) to support local provider partnerships. Participants noted that partnerships should include expanding care team membership to include health professionals with multiple areas of expertise or implementing interdisciplinary service planning.

Workforce Issues

MDHHS asked participants for recommendations that would promote the recruitment, retention and continuity of quality staff, especially direct care staff and clinicians. Participants advocated for providing funding to increase direct care staff base wages and performance-related compensation in addition to improving fringe benefits. Many participants noted that this recommendation should be accomplished through higher reimbursement rates for services rendered. Participants also encouraged MDHHS and its partners to ensure that staff are paid to participate in ongoing training. Some participants also pointed to instituting loan forgiveness as a way to improve staff skills and recruit and retain staff. Other participants also suggested for greater flexibility for provider organizations in the application of disciplinary action to staff as a result of a recipient rights complaint. Finally, a few participants recommended developing strategies that increase engagement, provide meaningful recognition and reduce the incidence of staff burnout including making paid leave more widely available.

Peer Supports

MDHHS asked participants for recommendations to elevate the use of peer supports and peer voices (e.g. peer support specialists, community health coaches, community health workers, etc.) as a core element to be included in all service delivery options. Participants highlighted several strategies to reducing barriers to the use of peer supports. Participant recommendations included: (1) providing better pay and incentives for peer support; (2) improving billing/reimbursement practices for peer

support; (3) coordinating peer supports with an individual's care team; (4) offering localized training for peer support workers; (5) encouraging the implementation of evidence-based practices for peer supports; and (6) instituting contract requirements to promote or require use of peer support.

Person-Centered Care

MDHHS asked participants two questions regarding person-centered care. MDHHS started by asking participants for recommendations to foster the widespread use and integrity of person-centered planning (free from conflicts of interest). Participants offered several suggestions in various aspects of the process in developing person-centered plan, which included (1) encouraging the use of independent facilitation of person-centered plans; (2) reviewing administrative requirements and standards for person-centered plans; (3) re-emphasizing pre-planning meeting for person-centered plans; (4) reviewing reimbursement practices for person-centered planning activities; and (5) enabling person-centered plans to follow individuals across boundaries.

MDHHS also asked participants for recommendations to promote and improve access to and use of trauma-informed interventions. Participants suggested training providers and others community partners, such as schools and law enforcement agencies, on trauma-informed care. Participants also recommended following evidence-based practices in screening for trauma, which may include adverse childhood experiences. Finally, some participants suggested reimbursing trauma screenings through MDHHS policy.

Health Information Sharing

MDHHS asked participants for recommendations to foster the coordination of care across all provider systems and the sharing of electronic and hardcopy records. Participants emphasized the importance of expanding access for providers to the Michigan Health Information Network: participants highlighted opportunities for improving care coordination through the use of admission, discharge and transfer notifications. Participants also encouraged MDHHS to provide trainings on privacy laws for individuals and providers and reduce legal barriers to sharing data between providers. Finally, participants encouraged action to reduce cost barriers for technology upgrades for small practice providers.

Substance Use Disorder Services

MDHHS asked participants to make recommendations for changes at the state, regional and local levels to increase the scope and availability of substance use disorder services. Participants were particularly interested in expanding access to medication-assisted treatment and detoxification. Participants also emphasized the importance of increasing access to services at correctional facilities and schools. Participants also highlighted the importance of providing greater physician education and training on substance use disorder treatment. Participants also encouraged MDHHS to review payment rates and structure for substance use disorder services. Finally, participants advocated for increasing participation in health information exchange among substance use disorder providers.

Services to Children, Youth and Families

MDHHS asked participants two questions about services for children, youth and families. The first question focused on recommendations on changes at the state, regional and local levels to increase the scope and availability of early intervention (pre-crisis) services for adolescents. Participants suggested

providing early intervention by increasing greater access to care at schools. Participants highlighted the potential role of child and adolescent health centers and federally-qualified health centers in early intervention efforts. Participants also articulated the need to actively work to reduce stigma. Finally, participants recommended reviewing reimbursement practices for early intervention and trauma.

The second question focused on other recommendations (beyond adolescent pre-crisis) for meeting the needs of children, youth, and their families. Participants suggested providing greater education and training of primary care providers on behavioral health and trauma. Some participants also emphasized the need to improve coordination with the child or youth's care team. Finally, participants highlighted the need to improve coordination with the juvenile justice system.

Incentives and Outcomes Measures

MDHHS asked participants several questions about alternative payment models. MDHHS initially asked participants to recommend changes to foster the use of alternative payment models (not fee-for-service). Participants suggested developing mechanisms for cost savings that are generated as a result of more effective care. Participants noted that cost savings should be retained by payers and be shared with providers, ideally in a manner that can be implemented consistently across both physical and behavioral payer types. Some participants noted that models that feature partial financial risk for providers represent good opportunities.

For the second question, MDHHS asked participants to define and measure outcomes that should guide alternative payment systems with consideration given to the wide range of supports needed by eligible individuals. Participants suggested providing financial incentivizes to providers which successfully exceed performance goals. Many participants indicated measurement and goals should be centered on individual experience and engagement in addition to outcomes. Many participants also pointed out that social factors should be considered in developing goals so differing individual risks are addressed.

In the third question, MDHHS asked participants to give recommendations to guard against the system avoiding the most complex cases. Participants recommended consideration of the use of a tiered payment system for managing complex cases. Participants encouraged MDHHS to adopt payment approaches for complex/high-risk individuals to provide enhanced, upfront payment to address complex needs requiring higher intensity care. Participants also noted that outcomes incentives do not fully support more intense treatment and support services.

Standardizing Behavioral Health Screening, Assessment, and Treatment

MDHHS asked participants for recommendations for changes at the state, regional and local levels to incorporate behavioral health screening, assessment and treatment as a standard in primary care. Participants proposed various financial and training models towards standardization of behavioral health in primary care.

Participants first recommended developing direct reimbursement mechanisms for screening and intervention services rendered by primary care participants. Many participants suggested requiring Medicaid payment for associated codes. Some participants pushed for tying reimbursement to specific mandated screening tools and intervention strategies. Examples included (1) moving from screening towards using a specific Patient Health Questionnaire and (2) moving from brief intervention towards using the SBIRT model.

Participants also suggested providing training for primary care providers and other primary care team members on behavioral health screening and intervention. Participants recommended providing training on both direct intervention within primary care and developing primary care awareness of the broader mental health system and referral points or resources. Participants noted that training should be easily accessible and less expensive. Some participants pushed for free training and accompanying resources.

Finally, participants advocated for providing more flexible funding to support local provider partnerships and integration. Some participants mentioned using co-location models and asynchronous collaborative consult approaches and/or building behavioral health expertise into primary care teams. Some participants mentioned increasing the number of primary care practices employing behavioral health specialists directly.

Appendix 10: Summary of Affinity Group Feedback (Payers)

MDHHS has been exploring strategies for improving the coordination of physical health and behavioral health services. This initiative, which is known as Section 298, is based upon a legislative requirement in this year's budget. Under Section 298, the Michigan Legislature has directed MDHHS to develop a report with recommendations on this issue.

In late 2016, MDHHS work with its community partners to host one Affinity Group meeting for payers. The purpose of the meeting was to collect input, feedback and ideas on ways to inform the development of the policy recommendations for the legislative report. During the meeting, participants were given a set of questions to answer in regards to the delivery of physical health and behavioral health services in Michigan. MDHHS also provided individuals with the option to submit comments in writing outside of the Affinity Group meeting. This document summarizes the comments that were provided during the meeting and in writing.

Summary data on the number of Affinity group meetings, participants and comments is included below.

Summary of Affinity Group Participation (Payers)	
Number of Affinity Groups	1
Number of Affinity Group Participants	48
Number of Written Comments	9
Estimated Number of Total Participants*	57

** The number of total respondents is an estimate because some stakeholders participated in an Affinity Group meeting and separately submitted written comments.*

<u>Coordination of Physical and Behavioral Health Services</u>

MDHHS asked participants several questions about the coordination of physical and behavioral health services. The summary combines the responses for all of the questions in this section.

Several participants called upon MDHHS to define "care coordination," "care management," and "supports coordination." The participants mentioned the importance of aligning accreditation, regulatory and contractual definitions on this issue.

Several participants highlighted the potential role of health information technology in improving the coordination of care. The participants supported the use of telehealth and telepsychiatry services as well as a health information exchange. A few participants also called on the State of Michigan to improve and expand the functionality of several state-based health information technology applications. Some participants encouraged the State of Michigan to improve the Michigan Automated Prescription system by enhancing access to critical information and allowing for alerts. Other participants asked for MDHHS to accelerate Care Connect 360 efforts and extend access to include more providers.

Several participants encouraged the department, PIHPs and MHPs to standardize and improve different processes and policies across the state. Some of these process and policies included obtaining consent to share health information, accreditation, credentialing of providers and audits for providers.

Several participants also encouraged MDHHS to support the development of integrated service delivery models. Some participants advocated for the allowing either the MHPs or PIHPs to assume full responsibility for delivering physical health and behavioral health services to individuals. Other participants encouraged the department to pursue models such as accountable care entities, community care organizations or health homes.

Several participants suggested strategies for improving integration at the point of services. Suggestions included: (1) improving behavioral health screening, brief intervention and referral to treatment in primary care settings; (2) embedding direct care providers in CMHSPs; (3) providing funding to support the inclusion of nurses on care coordination teams; (4) promoting the use of wellness visits; (5) improving immediate, same day, and urgent referral participant times at CMHSPs and other behavioral health providers; (6) expanding the use of training and education on integration; and (7) requiring CMHSPs and MHPs to share assessment and care plans. A few participants emphasized the importance of breaking down barriers to integration such as National Correct Coding Initiative edits and same day services exclusions.

Several participants also called upon the department to clarify roles and responsibilities for different organizations within the system. Some participants focused on the need to clarify roles and responsibilities for physical health screening and referral. Another participant cited the importance of learning from the MI Health Link demonstration on this issue.

Several participants called upon the department to implement payment models and reimbursement changes that would incentivize care coordination and better outcomes. One participant encouraged MDHHS to consider how to include outcomes that are related to social determinants.

A few participants highlighted the importance of improving the experience of individuals who receive services. Some suggestions included offering choice in providers, improving the use of person and family-centered models and focusing on individualized care. Some participants also emphasized the importance of educating individuals on the benefits of care coordination and sharing health information across providers.

Several participants also highlighted the need for greater collaboration and coordination between MDHHS, PIHPs and the MHPs. Several participants highlighted the need for enhanced contractual relations and standardized outcome measures. Another participant suggested the possibility of integrating MDHHS administrative departments for physical health and behavioral health services.

One participant also encouraged the department to include the primary care physician's name and contact information for all Medicaid beneficiaries in MHP and PIHP enrollment files and ensure that this information is made accessible to CMHSPs and various types of providers.

<u>Administration of Complaints, Grievances and Appeals</u>

MDHHS asked participants two questions about the administration of complaints, grievances and appeals.

MDHHS asked participants for recommendations on creating a timely, easily navigable complaint resolution system in which providers and participants are not the ones determining the validity of complaints. Several participants advocated for the use of a statewide independent review process for

complaints. A few participants advocated for this responsibility being shifted from providers to either the PIHPs or a statewide entity. Other participants encouraged the department to leave the complaint review process at the local review but add a state-level external review option by an independent body. Several participants encouraged the department to align the complaint process for physical health services, mental health services and substance use disorder services and also ensure compliance with applicable federal regulations and accreditation standards. Several participants emphasized the importance of mandating that complaints be addressed within certain timelines. A few participants indicated the importance of educating individuals on the complaint process. Other participants emphasized the importance of ensuring individuals are involved at every level of the appeal and complaint system. Several participants called upon the State of Michigan to integrate the accreditation and contracting standards and processes for physical health, mental health and substance use disorder services across the state.

MDHHS asked participants about how potential changes to handling complaints, appeals and rights complaints would impact their work with the network of providers. Several participants highlighted potential benefits of these changes. Several participants noted a centralized system would minimize the duplication, increase accuracy and individual satisfaction and reduce bias and miscommunication. A few participants cited potential benefits for tracking of outcomes, public reporting and identification of opportunities for quality improvement efforts. One participant emphasized the potential improvements for the substance use disorder system and noted that the system currently does not adequately address provider compliance issues. One participant noted that it would relieve some of the burden on CMHSPs to fulfill this role and reduce conflict of interest concerns. Several participants highlighted some potential challenges for implementing these changes. Some participants mentioned the potential impact on administration rules and personal licensure.

Streamlining Processes

MDHHS asked participants for recommendations on streamlining administrative processes, reducing paperwork and creating uniformity across the state while remaining accountable to the public and meeting the requirements of the new federal managed care rules. Several participants emphasized the need to review reporting requirements, contractual requirements and other requests from MDHHS. Several participants highlighted the need to streamline reporting requirements and eliminate legacy reports. A few participants indicated the importance of aligning and standardizing quality reporting requirements. Several participants encouraged the department to look at previous recommendations that have been made on administrative requirements. One participant encourage the use of annual review and feedback process for requests made to the State of Michigan. One participant also suggested the possibility of integrating administrative departments at the State of Michigan. Several participants indicated that MDHHS should provide incentives for standardization and alignment with a particular emphasis on early adopters.

Several participants indicated that standardization could be achieved by reducing the number of organizations in the system or empowering entities such as PIHPs or MDHHS to establish uniform requirements. Some particular focus areas that were mentioned were credentialing, training, contracting, assessment, provider network, utilization management and audits. Several participants indicated that the department should provide incentives for standardization and administrative alignment with a particular emphasis on early adopters. Several participants encouraged the department to review opportunities to use electronic health information sharing or health information exchange in order to improve administration reporting. Several participants emphasized the importance

of defining roles and responsibilities for different organizations and also setting clear goals, timelines, definitions and expectations

Oversight and Administration of Health Care

MDHHS asked participants several questions about the administration and oversight of health care.

MDHHS asked participants how they would recommend improving efficiency in the CMHSP system. Several participants mentioned the importance of improving health information sharing between different entities within the system. Several participants highlighted the need to standardize and improve the credentialing and impaneling process for providers. Several participants emphasized the need to review reporting requirements, contractual requirements and other requests from MDHHS. Several participants highlighted the need to streamline reporting requirements and eliminate legacy reports. A few participants indicated the importance of aligning and standardizing quality reporting requirements. Several participants encouraged MDHHS to look at previous recommendations that have been made on administrative requirements. Several participants emphasized the potential for integration of different parts of the system to improve the administration and oversight of the system. Several participants recommended integrating physical health and behavioral health services into one contract. One participant suggested reducing the number of entities in the system. Another participant suggested opportunities for integrating administrative oversight and requirements across MSA and BHDDA. Several participants recommended clarifying roles for PIHPs and CMHSPs and identifying functions that can and cannot be delegated. One participant advocated for the use of incentives to encourage provider integration, co-location and quality performance.

Second, MDHHS asked participants how they would recommend improving access to health care and behavioral health services. Several participants recommended changes at the point of service to improve access. These recommendations included: (1) expanding the use of telehealth and telepsychiatry; (2) co-location; and (3) 24-hour access. Several participants encouraged the use of incentives to help improve access to services. Several participants emphasized the benefits of integrating physical health and behavioral health services delivery into one contract and ending the benefit carve-out for behavioral health services. Several participants emphasized the need to improve the availability and utilization of training for primary care providers and pediatricians in delivering behavioral health services. Several participants also mentioned the importance of improving the process for primary care providers to screen for behavioral health needs, conduct brief interventions and make referrals for behavioral health services. One participant advocated for implementing the SBIRT and Improving Mood – Promoting Access to Collaborative Treatment (IMPACT) models in primary care. One participant also highlighted the need to partner with universities to develop trainings on integrated care service delivery for behavioral health providers. One participant emphasized the need to have eligibility of determinations completed by an entity that does not have a conflict of interest. One participant emphasized the need to expand medical provider network that accepts Medicaid coverage and address provider shortages.

Uniformity and Administrative Efficiency

MDHHS asked participants several questions about developing uniformity and creating effective quality improvement efforts.

MDHHS asked participants for recommendations on developing uniform policies, procedures and definitions throughout the public behavioral health system. Several participants emphasized the need to review reporting requirements, contractual requirements and other requests from MDHHS. Several participants highlighted the need to streamline reporting requirements and eliminate legacy reports. A few participants indicated the importance of aligning and standardizing quality reporting requirements. Several participants encouraged the department to look at previous recommendations that have been made on administrative requirements. Several participants recommended the implementation of financing and reimbursement changes, which included standardizing the Medicaid Fee Schedule, ensuring that rates are actuarially sound and exploring alternative funding approaches to achieve outcomes. Several participants suggested strengthening service and provider network requirements for MHPs and PIHPs. Several participants also recommended that the department clarify which contractual functions can and cannot be delegated. Several participants emphasized the importance of improving the sharing of health information and other key data sets. One participant recommended expanding the use of evidence-based practices.

Second, MDHHS asked participants to prioritize their recommendations. Participants identified several potential priorities, which include (1) health information sharing, (2) integration of administrative departments at the state level, (3) improving the alignment of policy and contractual requirements, (4) reducing stigma, (5) standardizing the Medicaid Fee schedule, and (6) improving rules around access to services, complaints and appeals. One participant emphasized the opportunity to build upon the work that is already happening with the MI Health Link Demonstration.

Third, MDHHS asked participants for recommendations on improving the uniformity and effectiveness of quality improvement efforts on a statewide level. Several participants noted the importance of aligning contractual, accreditation and quality reporting requirements. Several participants emphasized the importance of achieving compliance and increasing alignment with certain guidelines such as National Committee for Quality Assurance (NCQA) and Michigan Quality Improvement Consortium (MQIC) guidelines. Several participants also encouraged the department to align quality reporting requirements and reduce the use of unnecessary measures or measures that are not meaningful to the individual. Several participants emphasized the importance of improving the transparency of the system through improving the public reporting of quality measures and requiring entities to abide by the Open Meetings Act. Several participants encouraged the department to leverage specific resources to enhance quality improvement efforts. One participant emphasized opportunities to use health information exchange and data analytics to support quality improvement efforts. Another participant noted opportunities to collaborate with colleges and universities to conduct health services research, support collaboration across the system and facilitate public reporting.

<u>Governance, Transparency, and Accountability</u>

MDHHS asked participants several questions about governance, transparency and accountability. Participants were asked how they would ensure individuals and families are given a strong voice in governance. Nearly all participant participants recommended including individuals on decision-making boards, committees and/or other decision-making groups. Several mentioned creating incentives or quality metrics based on board membership of individuals. Several participants recommended including individuals and advocates in the design and delivery of services. Specifically, several mentioned the importance of including individuals in the design of quality initiatives**.** Several participants

recommended improving training and education for participants, providers and individuals. A few recommended using advocacy groups for training and education.

MDHHS also asked participants about strategies for fostering transparency of information and operations. Most recommended improving public reporting of quality metrics in an understandable, easily accessible manner. Participants suggested several methods of communication such as report cards, online dashboards, policy handbooks, mailings, online member portals and member forums/advisory councils. A few participants recommended requiring all parties receiving public dollars to abide by the Open Meetings Act and making non-HIPAA information available to the public. Several participants expressed a need for clearer expectations about transparency and public reporting.

Coordination at the Point of Service

MDHHS asked participants about promoting coordination at the point of service. Nearly all participants recommended using incentives to promote integration between physical health and behavioral health providers. Almost all participants recommended improving health information sharing between providers. Also, many participants recommended creating incentives to promote the exchange of health information**.** Nearly all participants recommended using standardized protocols/processes such as screenings, referrals and consent between physical and behavioral health providers. Most participants recommended training providers on the importance of reducing behavioral health stigma and the benefits of care integration. Most participants recommended creating billing procedures/codes that allow for and incentivize integration. Several participants recommended promoting and utilizing co-location of behavioral health and primary care providers.

Workforce Issues

MDHHS asked participants about promoting the recruitment, retention and continuity of quality staff, especially direct care staff and clinicians. All participants recommended raising the wages and benefits of direct care staff. A few participants recommended redirecting potential savings from integration to wage increases for direct care staff. Almost all participants emphasized the need to improve the education and training of staff. Several participants recommended providing formalized training for direct care staff and working with schools to create a standard curriculum for direct care staff. Several participants recommended using more peer supports models for staff and providing advancement opportunities and recognition for quality direct care staff. Several participants also recommended incentivizing education and training for clinicians and quality staff through efforts such as student loan forgiveness and stipends. Several participants recommended expanding the utilization of non-clinical/limited license staff for non-clinical/limited-license duties. Several participants suggested expanding their utilization through changing contracts and billing procedures and codes.

Peer Supports

MDHHS asked participants about promoting peer supports and voices as a core element in service delivery options. All participants emphasized the need to create billable codes for these services. Almost all participants recommended improving and expanding training for these roles. Several participants

suggested using standardized certifications for these positions, including adopting national curriculum and training standards. Several participants recommended providing adequate opportunities for individuals receiving services to becoming peer supports/mentors.

Person-Centered Care

MDHHS asked participants to recommend ways to foster the widespread use of person-centered planning. Several participants recommended improving training for providers on the importance of person-centered planning. Furthermore, several participants recommended developing minimum standards for the person-centered planning process, including defining "conflict-free" and creating protocols for ensuring individual participation. Several participants recommended incorporating primary care providers and physical health services in the person-centered plan. Several participants also recommended contracting with an independent agency to facilitate the planning process and monitor the system/recommend improvements. Finally, several participants recommended separating the authorization function from service delivery.

MDHHS also asked participants how they would improve access to trauma-informed interventions. All participants recommended expanding the use of trauma-informed training across systems (providers, law enforcement, schools, etc.). Several participants also emphasized using training that implements evidence-based treatment such as standardized assessment tools and Mental Health First Aid. Several participants recommended improving public awareness about available services. One participant recommended using an independent agency to monitor trauma-informed interventions. Another participant recommended adding trauma-informed interventions to licensing requirements.

Health Information Sharing

MDHHS asked participants what recommendations they would make to foster the coordination of care across all provider systems and the sharing of electronic and hardcopy records. Almost all participants supported increased use of electronic health records to achieve better coordination of care. Most participants suggested working on developing a universal consent and developing clear statewide guidelines. Several participants recommended specific roles for the state in encouraging the use of electronic health records such as facilitating the sharing of data between the participants; maintaining a centralized data warehouse for electronic health records and information sharing; and developing contract incentives for use of electronic health records. In addition, most participants suggested that there be greater education efforts directed to participants, providers and the public on data sharing.

Substance Use Disorder Services

MDHHS asked participants what recommendations they would make for changes at the state, regional and local levels to increase the scope and availability of substance use disorder services. Payment was a common theme among the participants' recommendations. Most participants suggested reviewing payment systems, incentivizing providers and allowing additional reimbursable services. Another common recommendation was education. Many participants suggested increasing provider education and implementing an ongoing stigma reduction campaign. Many participants also suggested changes in

state administration of substance use disorder services. These changes include integrating administration at the state level, coordinating funding streams and updating laws and regulations to address this public health crisis.

Services to Children, Youth and Families

MDHHS asked participants two questions about services for children, youth and families. The first questions was on the scope and availability of early intervention (pre-crisis) services for adolescents. The second question was what recommendations they would make for support and services of children, youth and families (beyond pre-crisis). Most participants responded that more training was required in systems such as medical providers, law enforcement and schools. Many participants suggested expanding the use of Mental Health First Aid and Michigan Child Collaborative Care (MC3). Many participants also suggested looking at ways to integrate services for all those that may be in contact with adolescents. This recommendation includes medical providers, law enforcement and schools. Additionally, participants recommended that efforts should be made to reduce stigma.

Incentives and Outcome Measures

MDHHS asked participants several questions about alternative payment models. The first question was about fostering the use of alternative payment models. Most participants expressed a need for clear definitions from MDHHS and CMS on value-based payment. Several participants also suggested piloted models before implementation. In addition, several participants suggested coordination with other alternative payment models initiatives.

Second, MDHHS asked participants how they would define and measure outcomes for alternative payment models. Most participants recommended focusing on quality of life measures and social determinants of health measures. Most participants also recommended standardization of these measures across other programs.

Third, MDHHS asked participants for recommendations on preventing the healthcare system from avoiding the most complex or costly cases. Most participants suggested variable rates or weighted payments for complex cases. Most participants also recommended financial incentives for these complex cases. Some participants suggested penalties for those who avoided the most complex cases. Several participants recommended an even distribution of complex cases. Several participants suggested providing training on complex case management and ensuring adequate staffing of professionals experienced in these cases.

Standardizing Behavioral Health Screening, Assessment, and Treatment

MDHHS asked participants what recommendations they would make for changes at the state, regional and local levels to incorporate behavioral health screening, assessment and treatment as a standard in primary care. Several participants recommended increasing training for providers on behavioral health and screenings. Suggestions for this included expanding existing programs, such as MC3, and hiring case managers. Several participants suggested that these efforts be required or at least incentivized.

Appendix 11: Summary of Affinity Group Feedback (Tribal Health Organizations)

MDHHS has been exploring strategies for improving the coordination of physical health and behavioral health services. This initiative, which is known as Section 298, is based upon a legislative requirement in this year's budget. Under Section 298, the Michigan Legislature has directed MDHHS to develop a report with recommendations on this issue.

In late 2016, MDHHS facilitated an Affinity Group meeting for Tribal health organizations. The purpose of the meeting was to collect input, feedback and ideas on ways to inform the development of the policy recommendations for the legislative report. During the meeting, participants were given a set of questions to answer in regards to the delivery of physical health and behavioral health services in Michigan. MDHHS also provided individuals with the option to submit comments in writing outside of the Affinity Group meeting. This document summarizes the comments that were provided during the meeting and in writing.

Summary data on the number of Affinity Group meetings, number of participants and number of respondents is included below.

Summary of Affinity Group Participation (Tribal Health Organizations)	
Number of Affinity Groups	1
Number of Affinity Group Participants	12
Number of Written Comments	0
Estimated Number of Total Respondents*	12

** The number of total respondents is an estimate because some stakeholders participated in an Affinity Group meeting and separately submitted written comments.*

Access to Services for Tribal Members

The Affinity Group discussed challenges that Tribal members experience when attempting to access services. The Affinity Group participants explained that accessing services for Tribal members is complex and diverse with the first challenge being recognizing, acknowledging and understanding the government to government relationship that exists under current federal law and policy that recognizes Tribal sovereignty. The Affinity Group participants noted that each of the 12 federally-recognized Tribal nations is a distinct separate unit of government with designated service areas and specific service eligibility criteria. The Affinity Group participants explained further that there are non-federally recognized Tribal nations and urban Tribal organizations within Michigan that serve Tribal populations. Affinity Group participants concluded that a unique, customized approach is required to improve the delivery of health care services to Tribal citizens and noted that the unique needs and status of these groups needs to be taken into consideration by MDHHS.

The Affinity Group then discussed the numerous specific challenges and barriers that Tribal members have encountered with accessing behavioral health services. One priority and challenge that was mentioned was the need for Tribal members to have access to traditional medicine services and that traditional medicine services should be a viable state recognized service. Some Affinity Group participants explained that it is commonly misunderstood that Tribal health systems have unlimited

funds and resource capacity to provide the diverse health care that a Tribal member requires: many Tribal health systems must provide necessary services despite a substantial shortage of funds.

Some participants highlighted a few of the barriers that Tribal members experience with gaining access to case management or care coordination services through PIHPs. The participants described the importance of case management or care coordination services for addressing clinical needs as well as social determinants. Several Tribal programs also mentioned the high uninsured rate amongst Tribal members and noted the low levels of enrollment by Tribal members in the Healthy Michigan Plan in some parts of the state.

Financing and Reimbursement for Tribal Health Services

Several Tribal programs emphasized the need to increase state and federal funding for Tribal health services. One barrier to accessing state and federal funding is that many of the Tribal programs operate under Tribal government policies that restrict services to Tribal citizens; these policies often conflict with the state requirement to service everyone in their county or service area. Some participants noted the significant health disparities that Tribal members experience and emphasized the gaps in access to behavioral health services. A few participants mentioned the challenges that Tribal health organizations encounter with securing grant funding and described how volatility in grant funding creates significant challenges for delivering behavioral health services on a consistent basis. One solution that was proposed by the Affinity Group was to create a separate, specific funding identified for federally-recognized and non-recognized Tribal nations for their disbursement and access. A separate Tribal system would ensure equitable access to funds and quality services.

Several Tribal programs also described the importance of providing access to traditional medicine services for Tribal members and being able to have this as viable billable expense with insurance and state Medicaid. The participants explained that the majority of the funding for these services is currently dependent on the Access to Recovery grant, a SAMHSA initiative, which expires Sept. 30, 2017. The participants conveyed the negative impact that the expiration of grant funding would have on retaining providers and continuing delivery of vital traditional medicine services to Tribal members.

Barriers to Service Delivery and Opportunities for Collaboration

The Affinity Group discussed several barriers the Tribal health organizations have experienced with delivering behavioral health services and coordinating care with other parts of the health care system. Several participants discussed their experiences with working with CMHSPs and PIHPs to deliver services to Tribal members and receive reimbursement. Many participants struggled with connecting with the local CMHSP and PIHP and emphasized the need to improve collaboration between Tribal health organizations, CMHSPs and PIHPs. A few participants also discussed the challenges with the new required legislative accreditation mandate for health care organizations and how this would negatively impact service delivery by Tribal health organizations. One participant shared how the prohibition on same-day billing for behavioral health services and physical health services under the same diagnosis code creates an obstacle for delivering integrated care to Tribal members.

Provider Training and Readiness

The Affinity Group discussed the training and readiness of providers to deliver behavioral health services. Several participants spoke about the challenges of delivering trauma-informed care to Tribal

members and the importance of providing training to providers on this issue. One participant highlighted the need to increase physician training and readiness to participate in the delivery of behavioral health services especially in medication-assisted treatment. Several participants also indicated that services should be delivered in a way that is culturally appropriate and that providers should receive cultural competency training.

Data Collection and Aggregation

The Affinity Group discussed the importance of improving the collection and aggregation of data related to delivery of services to Tribal members. Several participants discussed the negative impact the inconsistent identification of Tribal status in data collection has on understanding the disparities and gaps in care that Tribal members are experiencing. Participants explained that the lack of clear and accurate data impacts the service utilization numbers that are necessary to document the need for additional funding: although the numbers of Tribal members may not be substantial compared to the whole population, this does not negate the seriousness of the disparities that Tribal members face.

Appendix 12: Summary of Comments on the Interim Report from Public Review

MDHHS has been exploring strategies for improving the coordination of physical health and behavioral health services. MDHHS developed an interim report for the legislature on this issue. The interim report was posted for public review from December 14, 2016, through January 4, 2017. MDHHS collected comments on the interim report through three types of methods:

- Web-based survey
- Written comments by mail or email
- Public forum on January 3, 2017, at the West Campus of Lansing Community College

This appendix summarizes the comments that were provided during the public review process. Summary data on the results of the public review process is included below.

Summary of Public Review Participation (Public Review)	
Number of Submitted Surveys	57
Number of Written Comments	36
Number of Forum Participants	71
Estimated Number of Total Respondents*	164

** The number of total respondents is an estimate because some stakeholders participated in the public forum and submitted comments through the survey or by email.*

Stakeholders who participated in the survey were also able to indicate their level of support for the different sections of policy recommendations. The summary data of the results is included below.

Summary of Support for Various Policy Recommendations				
Section	Number of Respondents	Agree	Neutral	Disagree
1	55	81.8%	5.4%	12.7%
2a	57	78.9%	17.5%	3.5%
2b	56	87.5%	8.9%	3.6%
2c	53	69.8%	28.3%	1.9%
2d	51	90.2%	7.8%	2.0%
3	52	73.1%	17.3%	9.6%
4	50	78.0%	20.0%	2.0%
5	55	83.9%	10.9%	3.6%
6	51	76.4%	17.6%	5.9%
7	53	86.8%	7.5%	5.7%
8	53	86.8%	11.3%	1.9%
9	53	88.7%	9.4%	1.9%
10	53	88.7%	9.4%	1.9%
11	52	78.8%	15.4%	5.8%
12	52	78.8%	13.5%	7.7%
13	53	71.7%	20.8%	7.5%

Section 1: Coordination of Physical Health and Behavioral Health Services

Stakeholders disagreed about whether changes should be made to the current publicly-funded system. A large number of stakeholders supported maintaining the role of the current publicly-funded system in delivering behavioral health and intellectual/developmental disability services. Some stakeholders emphasized that PIHPs/CMHSPs have local relationships that promote better care coordination with primary care and social safety net providers. Other stakeholders expressed concerns about continuing with the status quo and emphasized the various inefficiencies, fragmentation and layers that are inherent in the current system.

Several stakeholders suggested several financing options for improving the coordination of physical health and behavioral health services:

- A few stakeholders recommended getting rid of the PIHPs and allowing for direct contracting to the CMHSPs.

- A few stakeholders supported providing funding for physical health and behavioral health services to the CMHSPs and allowing CMHSPs to manage the whole health of the people served.

- Some stakeholders advocated for including safety net providers such as Federally Qualified Health Centers in the consideration of models of "other competent, public, risk-based configurations".

- Several stakeholders supported fully integrating the physical health and behavioral health systems and bidding out services.

- One stakeholder advocated for creating Regional Mental Health Authorities to deliver services. The stakeholder noted that MDHHS would negotiate and enforce contracts with providers across the state under this model, and the Regional Mental Health Authorities would deliver services in accordance with these contracts. The stakeholder noted that payments would also be issued by MDHHS with one, statewide risk pool.

Some stakeholders inquired about the possibility of improving the coordination of the mild to moderate benefit for 20 outpatient visits. Some stakeholders expressed concerns about whether CMHSPs are adequately using discretionary dollars to serve individuals with mild-to-moderate needs. One stakeholder advocated for changing the reimbursement rule that prevents CMHSPs from using Medicaid dollars to make up the differences between MHPs' fees for service and the CMHSPs' costs to deliver the services to persons receiving the MHPs' mental health benefit.

Stakeholders generally agreed with recommendation 1.2 but highlighted the importance of educating consumers and family members about different options for care coordination. One stakeholder also mentioned that the issue is primarily with interpreting and monitoring current contractual language rather than creating new contractual language.

Several stakeholders expressed concerns about the financing of behavioral health services. Several stakeholders emphasized the need to adequately fund the non-Medicaid budget for specialty behavioral health and intellectual/developmental disability services and supports. Other stakeholders noted that the major savings for improved care coordination is realized on the physical health side and that there

needs to be a mechanism to ensure that savings achieved through improvements are reinvested to behavioral health services and social determinants.

Section 2a: Substance Use Disorder Services

Some stakeholders supported the recommendations as written, but other stakeholders felt that the recommendations were too limited and did not fully address issues with the delivery of substance use disorder services. Several stakeholders noted the importance of addressing all drug dependencies. A few stakeholders noted that the recommendations were mostly silent on the integration of substance abuse prevention into primary care.

A large number of stakeholders advocated for eliminating barriers to accessing substance use disorder services and expanding the delivery of community-based prevention programs. Several stakeholders highlighted the need for greater funding but also emphasized the importance of supporting implementation through contractual requirements and guidance on best practices. One stakeholder also highlighted regulatory barriers that providers were confronting in administering harm reduction activities such as needle exchange programs.

A large number of stakeholders mentioned the difficulties of providing access to substance use disorder services on a statewide basis due to the challenges of recruiting and retaining providers in rural areas. Several stakeholders supported expanding the use of peer recovery coaches but noted that provider organizations are confronting challenges with the variation in contractual procedures in different areas of the state.

Several stakeholders supported the recommendation on value-based payment models but highlighted several concerns. One stakeholder noted that the model should not use the SAMHSA National Outcome Measures because they are not relevant based on the population served. Another stakeholder noted the importance of avoiding a one-size-fits-all program and emphasized the importance of ensuring that pilot programs are provided in a way that recognizes cultural and geographic variations.

Stakeholders generally supported the recommendation to expand the use of screening for substance use disorders. Some stakeholders emphasized the need for a standardized assessment tool. One stakeholder also encouraged MDHHS to evaluate the assessment process and determine whether the process and practices creates barriers to access.

Section 2b: Services for Children, Youth and Families

Stakeholders were generally supportive of the recommendations in this section. However, several stakeholders noted the lack of emphasis in the recommendations in regards to the physical health of children and adults: the stakeholders encouraged greater emphasis on promoting healthy behaviors and wellness to improve physical health.

Several stakeholders voiced strong support for the recommendation to allow Medicaid reimbursement for transition services for youth aged 18 to 21 years: the stakeholders noted particular challenges that youth face as they transition from services for a “serious emotional disturbance” towards services for a “serious and persistent mental illness”. One stakeholder raised concerns about whether CMHSPs are being held accountable for reaching and serving children and teens with serious emotional disturbances who can be readily found.

Several stakeholders emphasized the potential role of schools in improving the screening of children and youth for mental health conditions. One stakeholder recommended requiring mental health wellness checks as part of the physical exam that Michigan requires annually for school entry.

Some stakeholders advocated for recommendations to address services gaps for specific populations such as (1) children and youth in the juvenile justice system or child welfare system, (2) infants, or (3) LGBTQ youth. One stakeholder recommended adding another recommendation that is similar to Recommendation 2.b.5. to improve communication and coordination for early childhood programs serving children from birth through kindergarten.

A large number of stakeholders highlighted issues with the current availability of providers and service centers for children and youth. Several stakeholders drew attention to the statewide shortage of child psychiatric, acute care beds, and emergency crisis residential services for children and adolescents and advocated for addressing this issue. Several stakeholders supported the expansion of funding for Child and Adolescent Health Care programs. A few stakeholders supported opening Medicaid paneling up to clinicians outside of CMHSPs to improve access to behavioral health treatment for children.

Several stakeholders highlighted issues around the current utilization of specific services. One stakeholder advocated for expanding the use of family supports which includes peer supports. Another stakeholder recommended addressing the duplicative billing around the Individualized Education Program (IEP) process that prevents parent support partners and clinicians from providing services and support during IEPs. A third stakeholder inquired about the current methods and metrics that the state uses to monitor the use of the Early and Periodic Screening, Diagnosis and Treatment benefit.

Section 2c: Services for Tribal Members

Stakeholders generally expressed support for the recommendations and viewed the recommendations as a positive step forward in addressing the needs of Tribal members. Several stakeholders agreed that access for Tribal members to services needs to be strengthened while allowing for individuals to have a choice of providers within and outside of the Tribal health system. A few stakeholders also emphasized the need to improve the coordination of services and funding between CMHSPs and Tribal Health Centers. A few stakeholders supported the use of traditional health techniques but emphasized the need to provide training and ongoing support to ensure that these services are effectively delivered to citizens across the state. One stakeholder encouraged MDHHS to explore new federal reimbursement opportunities for Tribal services. The stakeholder also voiced strong support for the recommendation to improve data collection efforts for identifying the service needs of Tribal members. The stakeholder also highlighted the lack of a grievance procedure for contracted providers to resolve complaints.

Section 2d: Continuity of Services

Stakeholders were generally supportive of the recommendations in this section. Several stakeholders noted that continuity of services for individuals is essential and that policy should be designed to maintain relationships. Stakeholders emphasized that trust is developed between individuals and their providers over time and this trust is crucial during times of crisis and recovery. Stakeholders also noted that the loss of a provider can be highly traumatic and disruptive to individuals.

A few stakeholders raised concerns about the impact of service continuity when there is a dispute between a MHP and PIHP over responsibility for reimbursing the provider. Stakeholders noted that the creations of different silos for service delivery may impact the continuity of services. Other stakeholders emphasized the need to improve planning for care transitions between inpatient and community-based services. A few stakeholders also highlighted the disruption in service continuity that individuals experience with the current behavioral system when they move across county lines. A couple of stakeholders highlighted recent efforts within CMHSPs and PIHPs to strengthen provider networks by streamlining the contracting and credentialing process and increasing the consistency of rates.

One stakeholder suggested the following amendment to Recommendation 2.d.1.: "MDHHS, payers and providers shall make every effort to maintain existing provider and support relationships as long as the supported person desires or needs. Policy should be designed with a primary goal of maintaining and supporting existing relationships."

Section 3: Administration of Complaints, Grievances, and Appeals

The majority of stakeholders expressed overall support for the recommendations contained in Section 3, especially clear recognition of the important role that individuals and stakeholders will play and the emphasis placed on independence from conflicts of interest. A subset of stakeholders suggested that utilizing the recommended independent complaint infrastructure across both behavioral and physical health services would be preferred. A large number of stakeholders reinforced the importance of timeliness and the need for specific complaint resolution timelines to be maintained as independent complaint resolution processes are designed.

Several stakeholders also suggested that it could be beneficial for the independent complaint resolution infrastructure to support mediation (also called assisted negotiation) during the first plan / local service agency attempt to resolve a complaint. A small number of stakeholders also expressed support for the provision of no cost representation during complaints processes. A few stakeholders felt the availability of representation would lessen intimidation felt by some individuals during complaint processes.

However, numerous stakeholders expressed concern that the development of an independent complaint resolution infrastructure would be costly, potentially burdensome to manage and could be counter to reducing administrative layers in the system overall.

Section 4: Protections for Mental Health and Epilepsy Drugs

A large number of stakeholders agreed with the recommendation in this section. Several stakeholders offered suggestions that prescriptions reviews be conducted to ensure the appropriateness of the prescribing practices but reviews should be done after the prescription is filled to avoid delays.

Several stakeholders expressed concerns about this recommendation as currently written. A few stakeholders highlighted the impact that the high cost of care for behavioral health drugs has on the ability of the public system to deliver services to the broadest number of persons. One stakeholder noted that MDHHS and/or contractors should be required to make the full array of accepted treatments available and to minimize barriers to treatment but MDHHS and/or contractors must be allowed mechanisms to monitor access to some medications to ensure that effective treatments are being delivered in a cost-efficient manner. Another stakeholders noted that prior authorization and other

review mechanisms can serve an important purpose in minimizing doctor and pharmacy over-uses, dangerous polypharmacy and other negative consequences.

One stakeholder also suggested amending the recommendation as follows: "The Michigan Legislature should amend Public Act 248 of 2004 to prohibit both the department and its Medicaid contractors from requiring prior authorization (as defined in the act) of the following medications as they are defined and operationalized in the act: anticonvulsants, antipsychotics, antidepressants, non-controlled substance anti-anxiety drugs, and drugs to treat mental disorders; including non-controlled drugs to treat substance use disorder, epilepsy, and seizure disorders."

Section 5: Self-Determination and Person-Centered Planning

The vast majority of stakeholders voiced support for the recommendations. A few stakeholders voiced specific support for expanding the person-centered planning process to (1) incorporate education for individuals on the availability of physical health services and (2) include physical health providers in the person-centered planning process as desired by the individual.

Several stakeholders had specific questions about the recommendations. A few stakeholders asked whether guidance would be provided for person-centered planning for individuals with substance use disorders: the stakeholders highlighted specific issues with person-centered planning for individuals in the criminal justice system. Another stakeholder inquired about whether the state currently collects data on the extent of self-determination and independent facilitation arrangements.

A few stakeholders expressed concerns about the recommendations as currently written. A few stakeholders noted that the availability of services may be impacted by the location of where the individual lives. Another stakeholder emphasized that services should be delivered based upon medical necessity. A few stakeholders also expressed concerns about the cost of independent facilitation and self-determination and potential additional documentation requirements.

Section 6: Governance, Transparency, and Accountability

A large number of stakeholders voiced support for the recommendations as currently written. Stakeholders highlighted the importance of public meetings and public accountability.

Several stakeholders advocated for strengthening oversight of the publicly-funded system. A few stakeholders suggested increasing the role of the legislature in monitoring and providing oversight of the delivery of services and expenditures of public resources. A few stakeholders noted that boards should also be culturally diverse. A few stakeholders suggested that MDHHS should hold annual forums throughout the state to allow individuals who use services to provide feedback. Another stakeholder suggested using a mechanism similar to the Substance Use Disorder advisory committees to collect feedback. One stakeholder noted that entities that manage Medicaid benefits should be held to transparency and regulatory standards as outlined under the insurance code.

Section 7: Workforce Training, Quality, and Retention

The vast majority of stakeholders expressed support for the recommendations contained in Section 7, especially the component of the recommendation focused in increasing wages. A large number of stakeholders also suggested that the recommendation to increase wages should more specifically reflect

the need to ensure wages are sufficient to both attract and retain qualified staff in a competitive job market rather than simply be "above minimum wage." Numerous stakeholders indicated the importance of taking a broad view of the types of staff members included in the "direct support staff" group so that lower wage staff were not unintentionally excluded from needed wage increases.

The majority of stakeholders also advocated that wage increases, paid leave, paid training and other items contained in the recommendations will require Medicaid provider rate increases to be accomplished. A small number of stakeholders suggested that additional mechanisms, such as a student loan repayment program, could be combined with wage/rate increases to foster more competitive employment opportunities. Several stakeholders indicated that conclusions reached in the Section 1009 Report should be considered as additions to the recommendations contained in the draft Section 298 Interim Report.

A few stakeholders suggested additional issues that should be addressed by the recommendations. A few stakeholders suggested that a mechanism should be created to allow providers to appeal disciplinary actions against staff but not the actual findings of the complaint or grievance. Other stakeholders recommended increasing the extent of training for physicians on the delivery of mental health services.

Section 8: Peer Supports

The vast majority of stakeholders were generally supportive of recommendations. However, a few stakeholders expressed concerns around particular issues. Several stakeholders voiced concerns about the training and certification process. A few stakeholders noted that trainings and certification should be localized and not done by MDHHS. One stakeholder noted that not all peers need to be certified. One stakeholder suggested clarifying recommendation 8.1 to reference "all categories of peers across all systems of care".

Section 9: Health Information Sharing

Stakeholders generally were supportive of the recommendations and saw the value of health information sharing for improving the coordination and delivery of services. Several stakeholders emphasized the importance of educating consumers, providers and payers on the importance of sharing health information.

A large number of stakeholders expressed specific support for statewide efforts to align policy, regulatory, statutory and contractual requirements for sharing behavioral health information. One stakeholder expressed particular concerns about the impact of 42 CFR Part 2 on the sharing of behavioral health information and integration of care. Some stakeholders advocated for mandating the use of the behavioral health consent form and other standards for sharing behavioral health information.

Several stakeholders noted that information should only be shared on a "need to know" basis and that individuals should be informed when and why their information is shared. A few stakeholders emphasized the need for individuals to have control of how their health information is shared. A few stakeholders advocated for family members and caretakers to have increased access to health records.

Several stakeholders supported the creation of a statewide infrastructure or technology system to support health information sharing and service integration. A few stakeholders emphasized the need to accelerate work on developing a statewide approach for electronic consent management.

Section 10: Quality Measurement and Quality Improvement

A large number of stakeholders voiced support for the recommendations. Several stakeholders encouraged the alignment of quality metrics across the system and elimination of unnecessary metrics. Several stakeholders also urged MDHHS to reduce data gathering and documentation requirements.

However, several stakeholders noted that most performance measurement requirements have been established by federal or state statute, regulation, or contract and/or by national accrediting bodies. The stakeholders also mentioned that other measurements added are typically good faith efforts by payers and providers to improve their operations and results. Several stakeholders also cautioned against recreating standards that have already been created by other accrediting organizations.

Several stakeholders suggested particular opportunities to improve quality measurement across the state. One stakeholder noted that a large number of consumers and family members had supported the use of metrics that focus on quality of life and person-centered planning goals: the stakeholder encourage MDHHS to consider the use of these metrics. One stakeholder suggested using the workgroup for the Children's Special Health Care Service integration into managed care as a model for any new quality metrics workgroup. One stakeholder advocated for revising the annual needs assessment process and benchmarking CMHSP and MHP performance against the best available estimates of prevalence and incidence in the population.

Section 11: Administrative Layers in Both Health Systems

Several stakeholders supported studying the current administrative structure, requirements, and roles of the public behavioral health and physical health system to identify redundancies and inefficiencies in the administration of Medicaid services. Several stakeholders expressed concerns about the redundant, confusing, and burdensome requirements from accrediting bodies, payers and government entities. Most stakeholders supported developing uniform and consistent standards for the provision of behavioral and physical health services, including substance use disorder services. Several stakeholders expressed particular interest in the role of the workgroup that was referenced in the recommendation. One stakeholder suggested reinvesting savings from reducing administrative layers and inefficiencies directly into individual services.

Section 12: Uniformity in Service Delivery

A large number of stakeholders supported ensuring uniform, high-quality services regardless of where someone lives. While supportive of the goal, several stakeholders said the system needs additional funding in order to achieve it. Several stakeholders raised questions about the feasibility of achieving uniform access to services across Michigan with the level of geographic variation in the availability of providers. Several stakeholders were concerned that on-demand access to services across the state was not feasible. Several stakeholders also highlighted the large number of MHPs, PIHPs and CMHs as a reason for the lack of uniformity across the state.

Some stakeholders expressed concerns around the uniformity of availability of specific services. One stakeholder voiced concerns about whether MHPs have adequate panels of psychiatrists who accept new Medicaid patients and encouraged the department to monitor contractual requirements around network adequacy. Another stakeholder encouraged the workgroup to amend recommendation 12.1 to specifically reference crisis intervention for children and youth who are not currently enrolled in Medicaid services.

Section 13: Financial Incentives and Provider Reimbursement

A large number of stakeholders supported using incentives that are outcome-based, promote efficiency and quality care and are focused on the needs of the consumers. However, several stakeholders believed that the public health system should not use incentives. A few stakeholders were concerned incentives would not improve the quality of services. One stakeholder noted that families and consumers in the affinity group process generally were not supportive of incentives and that the public system should not need incentives to provide the best possible service.

Several stakeholders suggested strategies for improving the quality of care. Several stakeholders suggested focusing on improving reimbursement and expanding codes for providers instead of financial incentives. Several commenters suggested focusing on incentives that measure the quality of life and achievement of person-centered planning goals by individuals who use services. One stakeholder recommended that MDHHS convene a separate workgroup to help provide guidance on the use of incentives. Another stakeholder recommended piloting the use of incentives.

General Comments

The vast majority of stakeholders appreciated the efforts of the department and workgroup and commended both on their extensive engagement of stakeholders throughout the process.

The majority of stakeholders voiced support for reforming the system and improving the coordination of physical health and behavioral health services. A few stakeholders expressed concern that much of the report focuses on enhancements of the current behavioral health system as opposed to recommendations on improving the coordination of physical health and behavioral health services. A large number of stakeholders emphasized the need to preserve access to current specialty services. Several stakeholders expressed direct opposition to privatizing the system.

A few stakeholders expressed concerns about the development of new models and recommended that MDHHS should avoid implementing new models and learn from existing demonstrations. The stakeholders recommended that the workgroup should specifically review the successes and challenges of the MI Health Link Demonstration. Several other stakeholders emphasized the need to pilot changes to the system before implementing them statewide.

Several stakeholders expressed support for the mission, vision, and values as outlined in the report. A few stakeholders expressed concerns about potential conflicts in the values section between “Freedom of choice” and restrictions on where people live in the community. Several stakeholders expressed concerns about efforts to limit the choices of individuals in regards to the use of certain home and community-based settings.

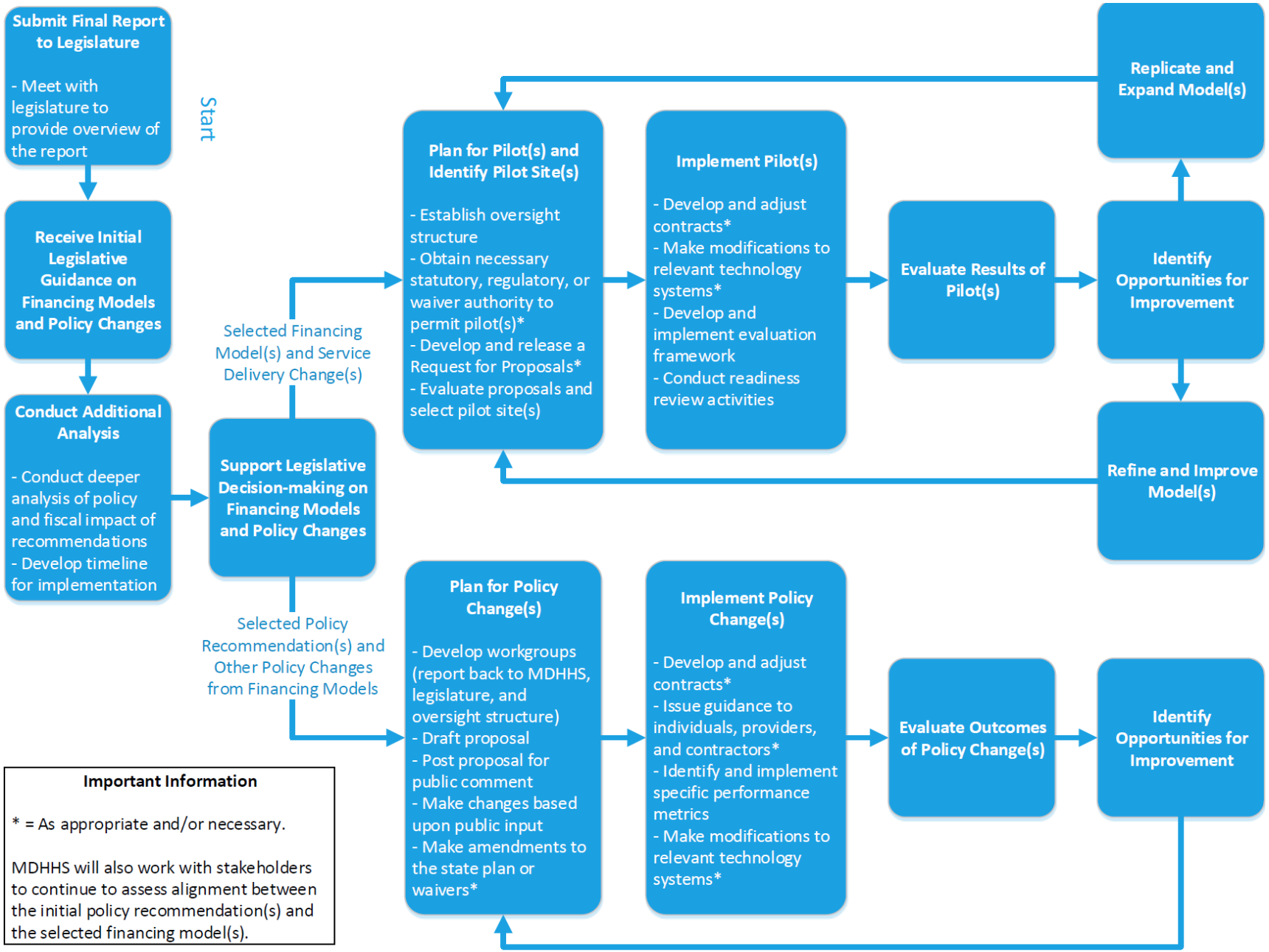
Several stakeholders asked about whether the recommendations apply to all behavioral health services or only Medicaid-funded services. Several stakeholders expressed concern about access to services for individuals who are not Medicaid eligible or are not currently receiving Medicaid services. A few stakeholders expressed concern about gaps in services for individuals who have private insurance or are enrolled in the Medicare program. Other stakeholders expressed concerns about individuals who lack any form of insurance or health coverage. One stakeholder recommended addressing Medicaid spend-down and the income disregard.

Several stakeholders highlighted sub-populations that face significant challenges with accessing services. Some stakeholders advocated for increased attention for specific populations such as veterans, individuals who are homeless, individuals with hearing disabilities. Several other stakeholders suggested seeking more feedback from individuals with experience and expertise in delivering substance use disorder services. One stakeholder emphasized the need to improve access to behavioral health services for individuals who are or were recently incarcerated. The stakeholder noted that individuals who are in jails may only receive CMH services if there is a contract in place or general funds are available. Another stakeholder highlighted the need to improve the availability of housing options, job development, and supported employment opportunities for individuals with serious mental illness.

A few stakeholders asked that clarifications should be made to the description of the current system in the current report. A few stakeholders noted that some CMHSPs provide mild to moderate services for individuals with mental health needs under contracts with MHPs: the stakeholders also noted that PIHPs who are participating in the MI Health Link demonstration also administer benefits for individuals with mild to moderate behavioral health needs. Other stakeholders encouraged the workgroup to clarify that MDHHS contracts with the 10 PIHPs who in turn contract with CMHSPs and other providers for multiple types of services. Another stakeholder noted that the description of the current system and the diagram in Appendix 3 should explicitly describe the MI Health Link Demonstration. One stakeholder noted that CMHSPs do not contract for the delivery of inpatient rehabilitation services and this issue should be corrected in the description section.

Several stakeholders commented on the overarching recommendation. Stakeholders were generally supportive of this recommendation. A few stakeholders specifically agreed with the need to conduct pilots of system changes before implementing them statewide. The Overarching Recommendation is clear and compelling. One stakeholder encouraged the workgroup to make it more explicit that the goal of the report is improvements in the physical health status of specialty behavioral health populations. Another stakeholder stressed the importance of conducting a legal and regulatory review of what demonstration projects are permissible under state and federal law.

Appendix 13: High-Level Process Map for the Section 298 Initiative



Appendix 14: Summary of the Workgroup Evaluation of the Financing Models

After the submission of the interim report, MDHHS and the 298 Facilitation Workgroup launched the next phase of the process, which focused on the development of recommendations for financing models. In order to generate concepts for potential models, MDHHS and the workgroup opened a statewide process for interested stakeholders to submit model proposals. MDHHS and the workgroup ultimately received 42 model proposals as part of this process. MDHHS submitted the 42 model proposals to the Michigan Legislature as a separate companion document to the final report for the purposes of public record.

MDHHS and the workgroup organized the 42 model proposals into six categories of financing models and one category of non-financing models. All seven categories are listed below.

- **Model Category #1:** Statewide Behavioral Health Managed Care Organization
- **Model Category #2:** CMHSP (Provider) Capitation
- **Model Category #3:** Modified Managed Care Approaches
- **Model Category #4:** Current Financing Structure Enhancement
- **Model Category #5:** Local/Regional Integration Arrangements
- **Model Category #6:** MHPHP or PIHP Payer Integration
- **Model Category #7:** Non-Financing Models

After the financing models were developed, the workgroup conducted an evaluation of five of the six financing model categories, which included categories 1, 2, 3, 4 and 5. The workgroup did not evaluate categories 6 and 7 for the following reasons:

- **Model Category #6:** In a 9 to 4 vote, a majority of the workgroup affirmed that model categories that do not align with the policy recommendations should not be evaluated by the workgroup. The workgroup determined the MHP or PIHP payer integration model category cannot adhere to Policy Recommendation 1.1 from the interim report. As a result, the workgroup did not evaluate this model category. However, MDHHS did complete a policy review for the model category, and the model category was posted for public input.

- **Model Category #7:** The Section 298 boilerplate language specifically focuses on the development of recommendations for financing models. All of the models within this category do not explicitly impact service financing. As a result, the model category will be included for reference only in the final report.

The workgroup evaluated the five financing models based upon the goals that were outlined in sub-section 2 of the Section 298 boilerplate language. The legislative language for Section 298 is included in Appendix 1 of the final report. As part of this process, the workgroup assessed whether each individual model category had strengths or challenges that would influence the ability of the health system to

achieve each boilerplate goal. The workgroup also identified whether each model category had issues that need to be resolved before the state government considers implementing the model category.

The workgroup also incorporated comments from the public input process into the evaluation of the individual financing model categories. The full results of public input are summarized within Appendix 16 of the final report.

Model Category #1: Statewide Behavioral Health Managed Care Organization

The workgroup believed that transitioning from 10 PIHPs to a single statewide behavioral health managed care organization may help improve the consistency of policies, procedures and processes for the delivery of specialty behavioral health services on a statewide level. The workgroup also believed that this model category could promote greater uniformity in service delivery but that uniformity across the state may be limited based upon the local availability of providers. The workgroup also noted that the model would preserve the public governance of the specialty services system. The workgroup believed that a single statewide organization could achieve greater efficiencies and economies of scale for the administration of specialty behavioral health services as opposed to having 10 separately administered PIHPs.

The workgroup also identified several potential challenges. The workgroup noted that transitioning towards the use of a single behavioral health managed care organization would not necessarily lead to significant improvements in the coordination of physical health and behavioral health services: the workgroup explained that the statewide organization would still need to coordinate with different MHPs in order to promote integrated service delivery. The workgroup also noted that the ability of the State of Michigan to achieve efficiencies in transitioning to a single statewide organization may be limited because the statewide organization would still have to possess adequate capacity and infrastructure in order to assume the former responsibilities of all 10 PIHPs. The workgroup emphasized the potential risk of having to rely upon one organization to administer all specialty behavioral health services when a suitable back-up organization may not exist in case of an emergency.

The workgroup outlined several potential issues that would have to be resolved if the State of Michigan transitioned towards contracting with one statewide behavioral health managed care organization. The workgroup inquired about whether creating a single statewide organization is a change that could be piloted. The workgroup also noted that the State of Michigan would also be required to delineate the differences in roles and responsibilities between (1) the CMHSPs and the statewide organization and (2) the statewide organization and MDHHS. Finally, the workgroup noted that the State of Michigan would have to navigate challenges with transitioning away from regional governance boards under the PIHPs and establishing a new statewide governance structure.

Model Category #2: CMHSP (Provider) Capitation

The workgroup highlighted several potential strengths for this model category. The workgroup noted that this model preserves local control and public governance for the delivery of specialty behavioral health services. The workgroup also emphasized that direct contracting between the CMHSPs and MDHHS would increase the amount of funds that are available at the local level, which could support greater access and flexibility in service delivery in local communities.

The workgroup also emphasized a series of challenges for implementing this model category. The workgroup noted that switching from 10 PIHPs to 46 CMHSPs would undermine consistency and uniformity of service delivery on a statewide level. The workgroup also noted that contracting with the CMHSPs directly would not automatically improve the coordination of physical health and behavioral health services: workgroup members explained that service delivery reforms would have to be pursued in conjunction with direct contracting in order to achieve greater service coordination. The workgroup noted that the elimination of PIHPs would not remove administrative requirements within the system: the workgroup explained that the administrative functions that were historically performed by the PIHPs would need to be assumed by either the CMHSPs or the State of Michigan. The workgroup noted that many CMHSPs may not have the staffing resources to adequately manage contractual and regulatory requirements that are currently required of the PIHPs. The workgroup also indicated that some CMHSPs may not have a sufficiently large population in order to assume full risk for managing the population. The workgroup explained that the transferring of responsibilities from the 10 PIHPs to the 46 CMHSPs would lead to increased costs due to all CMHSPs having to develop the same administrative capacity. The workgroup stated that implementing this model category would require the state to significantly expand its capacity and staffing to provide oversight of the 46 CMHSPs.

The workgroup identified several issues that would have to be resolved before MDHHS could pursue direct contracting with CMHSPs. The workgroup noted that the state government would need to establish a new regulatory framework for MDHHS to provide oversight of the CMHSPs in their new role. The workgroup also indicated that MDHHS would need to substantially amend and alter its contracts with CMHSPs in order to incorporate responsibilities for both parties.

Model Category #3: Modified Managed Care Approaches

The workgroup decided to evaluate the individual model proposals within this category as opposed to the category itself due to significant variation within the model proposals. The individual evaluations for the model proposals are outlined below. The workgroup also noted that all of the model proposals within this category advocated for the creation of new entities to coordinate services and that there would be a significant learning curve for the newly created entities regardless of model proposal.

Model 2: This model proposal called for the blending of CMHSPs and PIHPs into new regional health organizations that would assume some responsibility for managing and coordinating services. MDHHS would also assume significant responsibility for paying for services and providing system oversight. The workgroup noted that model proposal #2 could significantly reduce barriers to accessing services eligible individuals and that this model would also strengthen local control. However, the workgroup also noted the model proposal lacked mechanisms for ensuring coordination and accountability in service delivery in the absence of a managed care structure. The workgroup also expressed concerns about transitioning back to Fee-For-Service arrangements under this proposal, which may inhibit efforts to pursue payment reform and shift the focus of reimbursement from volume to value. Finally, the workgroup mentioned that this proposal would require a significant build-up in capacity and staff within the State of Michigan in order to provide monitoring and oversight of the newly created regional health service organizations.

Model 15: This model proposal called for the creation of ICOs that could have responsibility for managing and paying for behavioral health services. The proposal also called for the creation of a behavioral health accountable care organization to coordinate care at the service delivery level. The workgroup highlighted several potential strengths and challenges for model proposal #15. The workgroup noted that this proposal builds upon the MI Health Link demonstration in terms of

promoting integration between physical health and behavioral health services. The workgroup also indicated that this proposal combines improved integration and alignment at the payer level with service delivery level reforms through the creation of a behavioral health Accountable Care Organization. Finally, the workgroup specifically highlighted the emphasis on using health information exchange and health information technology as a strength of this model. However, the workgroup also noted that the creation of an ICO may not align with recommendation 1.1 of the interim report if the governance structure for the ICO is not public. Additionally, the workgroup questioned how the ICO would navigate differences in the administrative structure of both systems such as differences in the process for grievances, complaints and appeals.[8] Finally, the workgroup noted that the State of Michigan would need to fully explore the results and lessons learned from the MI Health Link demonstration before pursuing this model.

Model 31: The proposal called for the creation of a care integrator who would provide care management for a specific population (i.e. individuals with intellectual/developmental disabilities). The workgroup also identified several strengths and challenges for model proposal #31. The workgroup noted that the care integrator within this model proposal may be able to strengthen the coordination of physical health and behavioral health services at the service delivery level. Additionally, the workgroup stated that this proposal builds upon the experience of the organization with delivering specialty supports and services for individuals with intellectual and developmental disabilities. However, the workgroup questioned whether this model proposal was scalable beyond the initial community and identified sub-population: if this model is not scalable, the workgroup expressed concerns about whether it would undermine uniformity in service delivery.

Model Category #4: Current Financing Structure Enhancement

The workgroup highlighted several strengths for the Current Financing Structure Enhancement category. The workgroup noted that this model category promotes shared accountability and collaboration between the MHPs and PIHPs on improving outcomes for their enrollees. The workgroup also noted that this model builds upon the experience and strengths of the existing system and aligns with current initiatives such as the Shared Metrics initiative. The workgroup indicated partnerships between MHPs and PIHPs under this model category could use payment reform and other mechanisms (including incentives) to support reforms at the service delivery level.

The workgroup also identified several potential challenges for this model category. The workgroup noted this model category maintains the current bifurcation between the physical health and behavioral health financing. The workgroup also noted that this model category focuses on increasing alignment across payers at the statewide level and does not address integration at the service delivery level: the workgroup explained that the state may also need to pursue service delivery level reforms in conjunction with this model category. The workgroup noted that this model could strengthen the measurement of uniformity of service delivery across the system but does not directly institute any mechanisms to remediate identified gaps in uniformity on a statewide level.

The workgroup also outlined several issues that need to be resolved if the State of Michigan pursues this model category. The workgroup noted that the State of Michigan will need to determine which

[8] The 298 Facilitation Workgroup notes that the workgroup created recommendations in regards to the administration of complaints, grievances and appeals that can be implemented regardless of which financing models are pursued.

populations are included as part of this model (e.g. shared enrollees, specific specialty service populations, Fee-For-Service, etc.). The workgroup also indicated that the State of Michigan will need to design a governance structure that supports collaboration and accountability for partnerships between the MHPs and PIHPs. The workgroup also mentioned that the State of Michigan will need to strengthen contracts and quality measurement systems in order to hold MHPs and PIHPs accountable for collaborating across the system.

Model Category #5: Local/Regional Integration Arrangements

The workgroup identified several strengths for the Local/Regional Integration Arrangements category. The workgroup noted that this model category focuses on improving integration at the service delivery level, which most directly impacts the experience of individuals and families. The workgroup also emphasized the value of being able to pool resources at the local level: workgroup members explained that the pooling of resources enables the provider collaboration to be more flexible and innovative in meeting the unique needs of individuals and communities. The workgroup also indicated that this model category could be pursued without making changes to the overarching managed care structure for publicly funded services. The workgroup also mentioned the potential for provider collaborations to build on and align with other innovation initiatives in Michigan, which may include initiatives like the State Innovation Model and MI Care Team.

The workgroup also identified several challenges for this model category. The workgroup noted that physical health providers and behavioral health providers have historically had different philosophies about how services and supports should be delivered and that provider collaborations would have to address differences in culture. The workgroup mentioned that the provider collaborations under this category would be dependent upon the availability of providers within individual local communities who can meet specific service needs. The workgroup also noted that only individuals who are receiving services from providers within the collaborative would experience the benefits of greater coordination of services. The workgroup further explained that this model category by itself does not address uniformity or consistency issues at the statewide level. The workgroup indicated noted that many provider collaborations may require some start-up funding in order to develop key capacities and that delivering services through provider collaborations may initially cost more in the short run.

The workgroup outlined several issues that need to be resolved if State of Michigan pursues this model category. The workgroup noted that the State of Michigan would need to sort out how payers would participate in this model. On a related note, the workgroup also stated that the State of Michigan would need to articulate what respective roles and responsibilities of providers and payers would be within this model: workgroup members explained that the delegation of risk to provider collaboratives under this model may also involve the delegation of specific functions from payers to providers. The workgroup also indicated that the State of Michigan may also need to address how financing for the delivery of mild to moderate mental health services is impacted under this model. The workgroup noted that the State of Michigan would need to develop a strategy for replicating this model category outside of the initial pilot communities because the local availability of providers in different parts of the state may inhibit certain types of provider collaboratives. The workgroup noted that the State of Michigan would need to navigate specific issues with this model category in terms of governance of publicly funded services: workgroup members noted that this model category potentially involves partnerships between non-profit, public entities and for-profit or private entities, which creates unique challenges in terms of governance and stewardship of public resources.

Model Category #6: MHP or PIHP Payer Integration

The workgroup determined the MHP or PIHP payer integration model category cannot adhere to Policy Recommendation 1.1 from the interim report. As a result, the workgroup did not evaluate this category.

Appendix 15: Summary of the Policy Review of the Financing Models

If Michigan pursues any of the financing model categories, the State of Michigan may need to make changes to state law, policy, contracts, waivers or state plan as part of implementation. The potential changes that would be required to implement each model category are outlined in the table below.

Model Categories	Change to State Law	Change to Policy	Change to Contract(s)	Change to Waiver(s) or State Plan
#1: Statewide Behavioral Health Managed Care Organization	No	Yes	Yes	Yes
#2: CMHSP (Provider) Capitation	Yes	Yes	Yes	Yes
#3: Modified Managed Care Approaches	Yes	Yes	Yes	Yes
#4: Current Financing Structure Enhancement	No	Yes	Yes	No
#5: Local/Regional Integration Arrangements	No	Yes	Yes	No
#6: MHP or PIHP Payer Integration*	Yes	Yes	Yes	Yes

** The 298 Facilitation Workgroup determined the MHP or PIHP payer integration model category cannot adhere to Policy Recommendation 1.1 from the interim report. As a result, the workgroup did not evaluate this category.*

Similar Examples in Other States

MDHHS and the workgroup have also identified whether any other states are currently pursuing or have implemented similar models to each model category. Please note that the models that other states have implemented may differ from Michigan's model in several ways, which may include (1) what services and supports are available under the model, (2) what populations are served under the models, (3) whether the payers within the system are public or private and (4) whether the providers within the system are public or private.

Statewide Behavioral Health Managed Care Organization: Washington has a financing system that is based upon "carved-out" Behavioral Health Organizations, which are local entities (some public and some private) that assume responsibility and financial risk for providing substance use disorder treatment as well as mental health services that were previously overseen by the counties and Regional Support Networks. Pennsylvania, New York and California are examples of other states that have implemented similar models.

CMHSP (Provider) Capitation: Washington has a financing system that is driven by Behavioral Health Organizations, which are single, local entities that assume responsibility and financial risk for providing substance use disorder treatment as well as the mental health services previously overseen by the counties and Regional Support Networks.

Modified Managed Care Approaches: Arizona, Connecticut, Florida, Kentucky and Oregon have implemented some form of modified managed care approach. Examples of these approaches are outlined below:

- Arizona implemented an integrated physical and behavioral health program for Medicaid beneficiaries with serious mental illness for the whole state in 2015.

- Florida has launched a fully integrated specialty plan to manage Medicaid benefits for individuals with serious mental illness in 8 of 11 regions. This plan provides all medical and behavioral health services.

- Oregon funds behavioral and physical health services through local health entities called Coordinated Care Organizations (CCOs). CCOs have a single budget with fixed growth rate and are accountable for a defined set of population-level outcomes.

Current Financing Structure Enhancements: Alabama, Arkansas, Maine, Montana, North Carolina, North Dakota, Oklahoma, South Dakota and Vermont have implemented models that fall into this category. All of the preceding states operate a form of Primary Care Case Management or health homes, which fund behavioral health services primarily via contracts with primary care providers. This approach also pays a case management fee to providers in addition to regular Fee-For-Service payments; these payments are not risk-based and include performance-based risk/reward.

Local/Regional Integration Arrangements: Many states (including Michigan) have implemented local or regional integration arrangements. Examples of this model in other states includes Coordinated Care Organizations in Oregon. Examples of this model in Michigan include the MI Care Team initiative and the State Innovation Model.

MHP or PIHP Payer Integration: 15 states currently have some form of integrated contract for physical health and behavioral health services. The 15 states are Iowa, Kansas, Louisiana, Massachusetts, Minnesota, Nebraska, New Mexico, New York, Nevada, South Carolina, Tennessee, Texas, Vermont and West Virginia. Colorado is planning to integrate their behavioral health organizations and physical health organizations into one administrative agency.

Appendix 16: Summary of Public Input on the Financing Models

After the submission of the interim report, MDHHS and the 298 Facilitation Workgroup launched the next phase of the process, which focused on the development of recommendations for financing models. In order to generate concepts for potential models, MDHHS and the workgroup opened a statewide process for interested stakeholders to submit model proposals. MDHHS and the workgroup ultimately received 42 model proposals as part of this process. MDHHS submitted the 42 model proposals to the Michigan Legislature as a separate companion document to the final report for the purposes of public record.

MDHHS and the workgroup organized the 42 model proposals into six categories of financing models and one category of non-financing models. All seven categories are listed below.

- **Model Category #1:** Statewide Behavioral Health Managed Care Organization
- **Model Category #2:** CMHSP (Provider) Capitation
- **Model Category #3:** Modified Managed Care Approaches
- **Model Category #4:** Current Financing Structure Enhancement
- **Model Category #5:** Local/Regional Integration Arrangements
- **Model Category #6:** MHPHP or PIHP Payer Integration
- **Model Category #7:** Non-Financing Models

MDHHS posted the six financing models for public input. The public input process for the financing models lasted from February 16, 2017 through March 3, 2017. MDHHS established two opportunities to provide input on the financing models, which are described below:

- Stakeholders could complete an online survey to provide input on the draft financing models. As part of the survey, MDHHS asked stakeholders to identify strengths and challenges for each model category. The survey also included an opportunity for stakeholders to indicate whether they believed that each model category had the potential to improve the coordination of physical health and behavioral health services. Stakeholders could use a sliding scale from 1 (strongly disagree) to 100 (strongly agree) to express their views on this issue.

- MDHHS also hosted a public forum to gather comments on February 24, 2017, from 9 am to 12 pm. MDHHS held the forum at the Hannah Center in East Lansing.

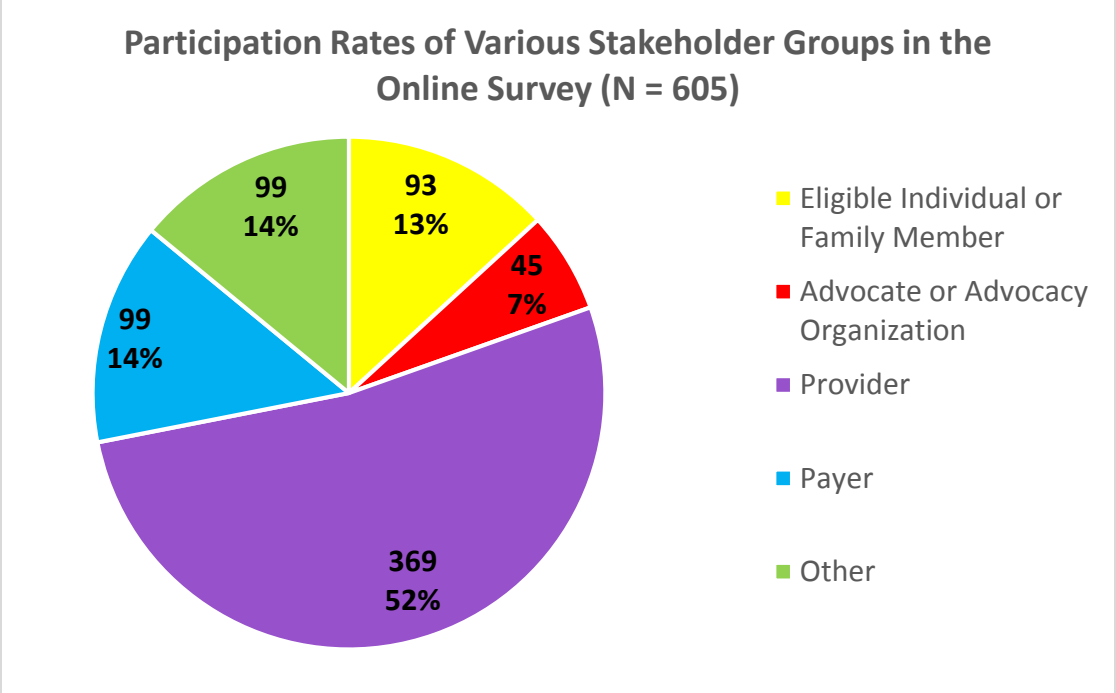
This appendix summarizes the comments that were provided by various stakeholders through the survey and through the forum. MDHHS and the workgroup used the comments from the public input process to refine and improve the evaluation of the individual financing models.

Summary of Public Participation in the Public Input Process

MDHHS developed this section to provide an overview of participation rates in the public input process. The table includes the number of completed surveys, number of forum participants, and estimated number of total respondents. The pie chart depicts the participation rates of various stakeholder groups in the online survey.

Summary of Public Input Process Participation	
Number of Partial or Fully Completed Surveys	705
Number of Forum Participants	62
Estimated Number of Total Respondents*	767

** The number of total respondents is an estimate because some stakeholders participated in the survey and participated in the forum.*



Model Category #1: Statewide Behavioral Health Managed Care Organization

Respondents identified several potential strengths of the statewide behavioral health managed care organization category. Many respondents believed that one statewide ASO could streamline the current administration of publicly-funded behavioral health services and reduce fragmentation across the system. Several respondents stated that using one ASO would also maintain and potentially strengthen public oversight and monitoring of the public behavioral health system. Respondents noted that creating one statewide ASO would promote greater consistency in policies, procedures, and programming for behavioral health services on a statewide basis. Some respondents also noted the potential for a statewide ASO to promote alignment amongst the CMHSPs on issues such as recipient rights, contracting, auditing and credentialing. Finally, several respondents also highlighted the potential

to achieve administrative efficiencies by reducing the number of PIHPs and redirect administrative funding towards service delivery.

Respondents also highlighted some potential challenges for transitioning towards the use of one statewide behavioral health managed care organization. A large number of respondents expressed concerns about whether reducing the number of regional PIHPs would lead to a loss of local control over the delivery of publicly-funded behavioral health services: respondents were particularly concerned about whether a statewide organization would allow for sufficient flexibility and innovation at the local level to meet the unique needs of individuals and communities. Respondents also voiced concerns that transitioning towards one statewide entity would prevent the state from recognizing geographic differences in service delivery between rural and urban areas. Several respondents also noted that this model category does very little by itself to (1) promote the integration of physical health and behavioral health services or (2) promote coordination at the point of service.

Respondents also identified several issues that still need to be resolved with this model. Respondents emphasized the importance of addressing local concerns within the governance model for the new statewide organization. Several respondents also indicated that the State of Michigan would need to make decisions about how funding for Substance Use Disorder Treatment and Prevention Services would be handled if the PIHPs are consolidated into one ASO. Respondents also indicated the importance of ensuring that local offices for recipient rights, customer services, and grievances and appeals are still available. Finally, respondents noted that the State of Michigan would need to develop a strategy for providing oversight of one statewide organization as opposed to ten regional PIHPs.

Model Category #2: CMHSP (Provider) Capitation

Respondents highlighted several potential strengths of the CMHSP (Provider) Capitation category. Respondents noted that this model category removes an administrative layer (i.e. the PIHPs) which could lead to greater administrative simplicity and free up funding for service delivery. A large number of respondents indicated that this model category would maximize local control and governance of publicly-funded behavioral health services. Several respondents also stated that CMHSPs have the capacity to manage funding for local populations and prioritize services that are more effective for addressing the needs of individuals and communities. Some respondents noted that pursuing this model category would give CMHSPs more flexibility to participate in other local/regional provider collaborations and pursue partnerships that strengthen the local safety net. Several respondents indicated that the State of Michigan could also ensure accountability and uniformity across the CMHSPs through the development and enforcement of contracts and standards.

Respondents also identified several limitations with this model category. Many respondents expressed concerns about whether eliminating the PIHPs and contracting with the CMHSPs would diminish uniformity and consistency across the system. Respondents noted that the behavioral health system had made significant progress towards enhancing consistency of policies, procedures, and programming and that implementing this model category may undo that work. Several respondents also noted that this model category does very little by itself to (1) promote the integration of physical health and behavioral health services or (2) encourage coordination at the point of service.

Respondents also outlined a series of challenges that would be created by the elimination of the PIHPs. Respondents noted that the elimination of PIHPs would not remove administrative requirements within the system: respondents explained that the administrative functions that were historically performed by

the PIHPs would need to be assumed by either the CMHSPs or the State of Michigan. Several respondents noted that many CMHSPs may not have the staffing resources to adequately manage contractual and regulatory requirements that are currently required of the PIHPs. Other respondents questioned whether smaller CMHSPs would have sufficient fund balances in order to manage risk for an entire population. A few other respondents expressed concern whether CMHSPs should be responsible for financial risk management and care coordination/direct service provision at the same time. Several respondents believed that the transferring of responsibilities from the 10 PIHPs to the 46 CMHSPs would lead to increased costs due to all CMHSPs having to develop the same administrative capacity. Finally, many respondents stated that implementing this model category would require the State of Michigan to significantly expand its capacity and staffing to provide oversight of the 46 CMHSPs.

Model Category #3: Modified Managed Care Approaches

Respondents identified several potential strengths with the Modified Managed Care Approaches model category. The vast majority of comments focused on the option of creating an ICO. Respondents noted that this option builds upon the experience and progress under the MI Health Link Demonstration. A large number of respondents emphasized the benefits of integrating physical health and behavioral health funding in order to coordinate service and supports for individuals with complex needs. Several respondents specifically highlighted opportunities for creating a continuum of care for individuals with mild, moderate, and severe mental illness. Other respondents voiced support for the model proposal's emphasis for allowing the individual to select their own coordinator. Several respondents also highlighted the option for individuals to choose whether they wanted to receive services from an ICO or whether they preferred to receive services through the CMHSP/PIHP system.

Respondents also outlined a number of potential challenges for this model category. A large number of respondents expressed concerns about whether this model category would create another administrative layer and not improve integration at the point of service. Respondents also voiced concerns about whether having multiple competing ICOs would drive up costs and lead to fragmentation of the system. A few respondents also stated that giving consumers multiple choices in terms of payers may be confusing. The respondents specifically noted that consumers may not understand that choosing a certain payer may affect their ability to access certain providers. Several respondents also questioned whether the governance structure for the ICO is public or private and whether the ICO would be able to align with recommendation 1.1 of the interim report. Finally, many respondents wanted to know more about the results of the MI Health Link demonstration in order to determine whether the model should be replicated in other parts of the states; some respondents also wondered whether this model could only be replicated in urban areas and may not be appropriate for rural areas.

Model Category #4: Current Financing Structure Enhancement

Respondents identified several strengths of the Current Financing Structure Enhancement category. Many respondents felt that this model category would improve collaboration, coordination, and accountability between the PIHPs and MHPs. Many respondents indicated that this model category mostly preserves the current system and would be the least disruptive for consumers and providers: several respondents noted that this model category could be implemented primarily through amendments to contracts. Respondents also stated that this model category allows for necessary regional variation. Many respondents voiced support for the use of incentives in order to encourage partnerships between the MHPs and PIHPs. Several respondents also indicated that this category builds

upon current progress under the Shared Metrics initiative and could also potentially align with other innovation initiatives such as the State Innovation Model and health home projects. Other respondents indicated that this model category could enable and be pursued in conjunction with integration efforts at the service delivery level. Finally, a few respondents noted that this category could also leverage statewide health information sharing efforts in order to support service coordination.

Respondents also identified several challenges with implementing this model category. Many respondents voiced concerns that this category maintains the current bifurcated system and does not achieve integration at the point of service by itself. Several respondents also expressed doubts about whether the MHPs and PIHPs could work productively together. Other respondents noted that this category primarily focuses on changes at the state or regional level and does not focus on integration at the local level. A few respondents also questioned whether implementing this category could add complexity to the system through new administrative layers or duplication of administrative services. Several respondents also highlighted the importance of addressing information technology compatibility issues and health information privacy issues in order to facilitate health information sharing. Finally, several respondents articulated concerns about the use of incentives: respondents specifically focused on the need to ensure that incentives are centered on improving the experience of the individual as opposed to financial management.

Model Category #5: Local/Regional Integration Arrangements

Respondents highlighted several potential strengths of the Local/Regional Integration Arrangements category. Many respondents emphasized that this model category would directly improve the coordination of physical health and behavioral health services at the point of service. A few respondents specifically highlighted the possibility of improving the coordination of the mild-to-moderate mental health services with services for severe mental illness. Many respondents also expressed support for the focus on this model on local control: respondents felt that this model category allows for local innovation and flexibility in order to meet the unique needs of individuals and communities. Several respondents stated that the flexibility in funding that would be enabled through these provider collaborations may allow providers to expand access to critical services. Other respondents highlighted the potential to implement shared savings arrangements that would permit providers to retain funding and reinvest in services if the providers met certain performance targets. Finally, several respondents indicated that model category could easily be piloted and would be less disruptive to consumers and providers during implementation.

Respondents also identified several challenges for implementing this model category. Several respondents expressed concerns about transferring risk for managing care to the provider level and questioned what the impact on the service delivery would be: respondents noted that performance metrics and outcome indicators would be needed to avoid inconsistencies in care. A few respondents also indicated that providers may experience difficulties with managing risk across a smaller population. Other respondents noted that many provider collaborations may require some start-up funding in order to develop key capacities and that delivering services through provider collaborations may initially cost more in the short run. Some respondents felt that this category did not make significant changes to the current system and that the time and costs that would be required to implement these changes would not be worth the investment. Some respondents also expressed concerns about how the State of Michigan would ensure adequate oversight and accountability for provider collaborations at the local level: a few respondents specifically wondered how the State of Michigan would ensure uniformity of access when a broad array of different provider collaborations could be created across various

communities. Finally, a few respondents highlighted the challenges of the State of Michigan in coordinating multiple integration initiatives at the same time: the respondents noted that the State would need to develop a strategy for tracking the results of all of the various pilots.

Model Category #6: MHP or PIHP Payer Integration

Respondents identified several different strengths for the MHP or PIHP Payer Integration Category. Several respondents believed that integrating the financing for physical health and behavioral health services would reduce administrative complexity and encourage payers to focus on the needs of the "whole person." Other respondents noted that this implementing this model category would simplify credentialing, paneling, billing, and payment for providers. Some respondents emphasized the potential of the model category to improve uniformity in the use of quality and outcome measures and support the effective use of incentives. Finally, some respondents emphasized the opportunity to reduce unnecessary service utilization through the implementation of this model category.

Respondents also highlighted a series of different challenges for implementing this category. A large number of respondents voiced concerns about whether MHPs would focus on maximizing profits instead of improving the quality of services: respondents questioned whether MHPs would employ different strategies to reduce costs such as rate reductions and service denials. Several respondents expressed concerns that consumer access and person-centered planning could be limited as a result. Several respondents also identified issues with ensuring public governance, local accountability and transparency if the state government transitioned towards using MHPs. A few stakeholders expressed concerns about whether competition between multiple competing health plans in one area could have a negative impact on the delivery of services. Other stakeholders inquired about whether MHPs have the experience and expertise to manage specialty behavioral health services. Finally, several respondents also indicated that the State of Michigan would need to make decisions about how local funding and funding for Substance Use Disorder Treatment and Prevention Services would function as the State of Michigan transitions towards contracting with MHPs for all services.

General Comments

Respondents provided several other comments as part of completing the survey and participating in the public forum. The set of more generalized comments from the public input process is outlined below.

A large number of respondents thanked MDHHS for allowing ongoing opportunities for public input as part of the Section 298 Initiative. Many respondents appreciated the efforts of MDHHS and the workgroup to facilitate a statewide discussion on the coordination of physical health and behavioral health services, and several respondents emphasized the importance of continuing to support a public discussion on this topic.

Several respondents expressed concerns about the focus of the Section 298 Initiative. Several respondents encouraged MDHHS and the workgroup to continue to focus on the needs of consumers while pursuing this initiative. One respondent noted that the original boilerplate focused on coordination and integration of services but that the interim report focused on system architecture, service quality, consumer experience; the respondent specifically emphasized the importance of improving the physical health outcomes of individuals who are currently being served under the specialty supports system. Another respondent advocated for the need to improve parity between physical health and behavioral health services. Finally, a third respondent articulated the need to

incorporate prevention strategies into efforts to improve the coordination of physical health and behavioral health services.

A large number of respondents debated whether the MHP or PIHP Payer Integration category should be considered as part of the final report. Several respondents encouraged MDHHS and the workgroup to evaluate and consider this model category as part of the final report. Other respondents expressed opposition to this category and voiced concerns about the impacts of implementing this category.

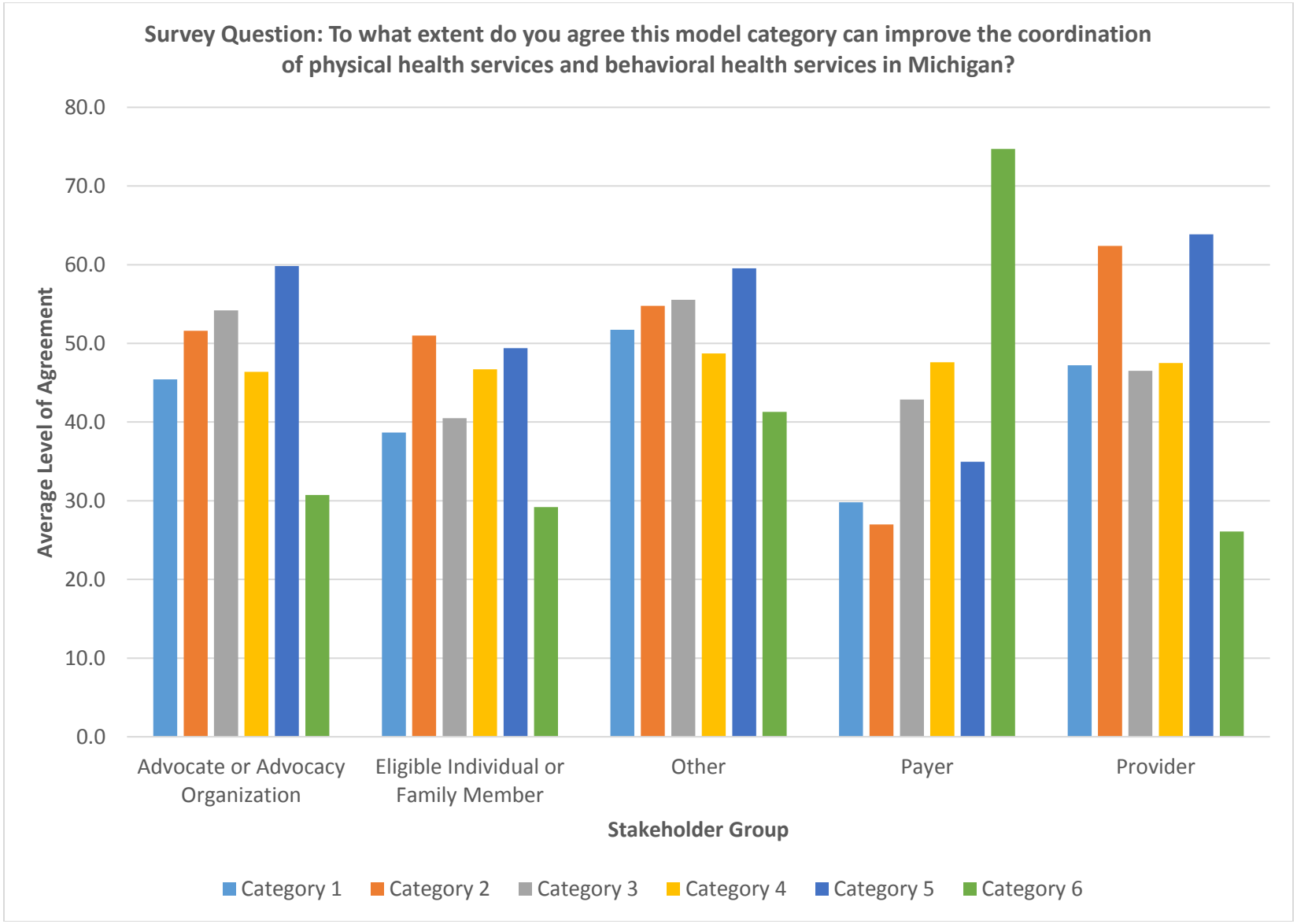
A wide variety of respondents also advocated for implementing models that focus on supporting integration of services at the local level. Several stakeholders argued against the view that system restructuring is necessary in order to achieve integration. One respondent noted that CMHSPs and other providers need sustained funding (not just grants) in order to support care coordination and integration activities. Another respondent advocated for reducing the administrative layers (i.e. PIHPs) and seeing how CMHSPs can operate when they are given clear incentives and penalties for shared outcomes with MHPs. In contrast, several other respondents noted the importance of allowing for some local flexibility but also promoting uniformity in access and outcomes on a statewide level.

Some respondents also commented on roles and responsibilities of different organizations within the current system and noted ways that different financing models should change roles and responsibilities. One respondent noted that PIHPs need to assume responsibility for addressing managed care functions without delegation to the PIHPs. Another respondent advocated for devolving the responsibility for managing substance use disorder services down to the CMSHPs. A third respondent articulated the need to create one statewide recipient rights office that is separate from the CMHSPs but that also stations staff locally. A fourth respondent raised concerns about delegating too much risk from payers to providers as part of new financing models.

Finally, many respondents raised concerns about various policy issues with the current system. Several respondents advocated for changes to policies around workforce issues with a specific focus on wages for caregivers, workforce development and university training programs and recruitment of mid-level clinicians besides social workers. Other respondents highlighted the need to address the social determinants of health such as housing and employment and articulated the need for changes to Medicaid policy that would allow for greater flexibility in meeting these needs. Finally, one respondent highlighted the need to address spenddown issues with the current eligibility process.

Overall Potential to Improve the Integration of Physical Health and Behavioral Health Services

The survey included an opportunity for stakeholders to indicate whether they believed that each model category had the potential to improve the coordination of physical health and behavioral health services. Stakeholders could use a sliding scale from 1 (strongly disagree) to 100 (strongly agree) to express their views on this issue. The chart on the next page depicts the average response for each model category by each stakeholder group.


Survey Question: To what extent do you agree this model category can improve the coordination of physical health services and behavioral health services in Michigan?
Average Level of Agreement
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Advocate or Advocacy Organization
Eligible Individual or Family Member
Other
Payer
Provider
Stakeholder Group
Category 1
Category 2
Category 3
Category 4
Category 5
Category 6

Appendix 17: Summary of the Recommendations for Benchmarks for Implementation

As part of the Section 298 boilerplate language, the Legislature directed MDHHS to develop "annual benchmarks to measure progress in implementation of any new financing model or policy recommendations." MDHHS consulted with the 298 Facilitation Workgroup on this issue, and the workgroup provided the following guidance to MDHHS. Please note that the word "performance metrics" is used interchangeably with "benchmarks" for the purposes of the recommendations.

- MDHHS should focus on identifying the following types of performance metrics:
    - Metrics that are currently being used in Michigan.
    - Metrics that span across all relevant populations that would be affected by potential financing models and policy changes under the Section 298 Initiative. Affected populations will include, but are not limited to (1) individuals with physical health needs, (2) individuals with mild-to-moderate behavioral health needs, (3) individuals with serious mental illness, (4) children with serious emotional disturbances, (5) individuals with intellectual/developmental disabilities, (6) individuals who are recovering from a substance use disorder, and (6) tribal members.
    - Metrics that represent outcomes for both health status and quality of life.

- MDHHS should give deference to metrics that are (1) derived from research, (2) feasible in terms of being able to be calculated annually, and (3) overarching to the extent that the metrics would synchronize with any potential financing models or policy changes that are implemented.

- The workgroup noted that the chosen benchmarks are minimum metrics that will apply across all financing models and policy changes, but each financing model and policy change will have more in-depth evaluative criteria that are inclusive of specific process and outcome metrics. The metrics may also need to be adjusted based upon which financing model(s) and policy change(s) are pursued by the Legislature.

- The workgroup concluded that all performance metrics should support the attainment of the vision as outlined in the Section 298 Interim Report and the final End Statement from July 2016, which is as follows:

  "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. 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."

Based upon this guidance, MDHHS and the 298 Facilitation Workgroup identified a series of potential performance metrics to measure the progress of implementing new financing models and policy changes. The recommended policy metrics are outlined below.

Benchmark Recommendations

MDHHS and the 298 Facilitation Workgroup note that the following recommendations are intended to be the basis for benchmark measurement in the context of the boilerplate requirements (i.e. measured and reported annually over a three-year time period). Recommended performance metrics reflect the vision of the Section 298 Initiative. Performance metrics for health and quality of life outcomes for each target population are outlined below:

Health Benchmarks

In order to identify performance metrics that effectively measure health outcomes, MDHHS and the 298 Facilitation Workgroup reviewed the metric sets for several current or planned statewide health care transformation initiatives. MDHHS and the workgroup found significant consistency across current sets of performance metrics and data stewards. In fact, MDHHS and the workgroup identified great overlap between the measures for Section 2703 Health Homes, Certified Community Behavioral Health Centers (CCBHC), MI Health Link, the Medicaid Health Plan Performance Monitoring Report (PMR), and State Innovation Model (SIM).

Based on these initiatives, MDHHS and the workgroup identified four measures that provide an optimal analysis of overarching health outcomes that are associated with the vision and goals of the Section 298 Initiative. Additionally, these metrics can be extracted from the MDHHS Data Warehouse for the various affected populations and stratify based upon specialty sub-population. MDHHS will use the data from MDHHS Data Warehouse and other sources to set baselines on health outcomes for each sub-population and periodically evaluate to identify whether progress is being made after implementing the pilot(s) and policy change(s). These measures include the following:

- Plan All-Cause Acute 30-Day Readmissions.
- Follow-Up after Hospitalization for Mental Illness.
- Ambulatory Care Sensitive Emergency Department Visits.
- MDHHS will explore metrics that can be used to assess progress on improving health outcomes for individuals with the following health conditions as part of the evaluation framework.
    - Diabetes
    - Chronic Obstructive Pulmonary Disease
    - Asthma
    - Hypertension
    - Congestive Heart Failure
- Inpatient Utilization.
- MDHHS will work with stakeholders to develop and deploy metrics to measure medication adherence and interactions as part of the evaluation framework.

MDHHS will explore opportunities to build upon recent progress that has been made with the Performance Monitoring Report process for Medicaid Health Plans. MDHHS will also continue to

monitor health outcomes and other program indicators to ensure that individuals with complex needs are not adversely impacted by the implementation of the evaluation framework.

Quality of Life Benchmarks

Performance metrics for quality of life are not as standard across populations, which therefore necessitates nuance in the recommendations for benchmarks. For this reason, the following list identifies quality of life metrics that are stratified by affected populations. Please note that data for some of the chosen metrics may be more difficult to collect on a regular and repeatable basis as part of evaluating specific financing models.

- Physical and Mild-to-Moderate Behavioral Health
    - SIM Population Health Data (see Tables 1 and 2 at the end of this section)

- Severe Mental Illness
    - Behavioral Health Treatment Episode Data Sets (BH-TEDS)
        - Employment/In School Full or Part-Time.
        - In Stable Housing/Living Situation.
        - MDHHS will work with stakeholders to develop and deploy metrics to measure level of functioning as part of the evaluation framework.
        - MDHHS will work with stakeholders to develop and deploy metrics to measure the diversion of individuals who have severe mental illness from the criminal justice system as part of the evaluation framework.

- Substance Use Disorder
    - BH-TEDS and Substance Use Disorder Treatment Episode Data Sets (SUD-TEDS)
        - Employment/In School Full or Part-Time.
        - In Stable Housing/Living Situation.
        - MDHHS will work with stakeholders to develop and deploy metrics to measure the diversion of individuals who are recovering from a substance use disorder from the criminal justice system as part of the evaluation framework.

- Intellectual/Developmental Disability
    - National Core Indicators
        - Chose Home.
        - Chose Staff 2012-13 and Beyond.
        - Has A Paid Job in the Community.
        - Engages in Regular, Moderate Physical Activity.
        - Helped Make Their Service Plan.
        - Uses a Self-Directed Supports Option.
        - MDHHS will work with stakeholders to develop and deploy metrics to measure the consistency and integrity of person-centered planning processes across the health system as part of the evaluation framework.
        - MDHHS will work with stakeholders to develop and deploy metrics to measure the diversion of individuals who have intellectual/developmental disabilities from the criminal justice system as part of the evaluation framework.

- Serious Emotional Disturbance
    - Child and Adolescent Functional Assessment Scale (CAFAS) for children who are ages 7 through 17 and Preschool Early Childhood Functional Assessment Scale (PECFAS) for children who are ages 4 through 6
    - Access Outcome
        - This metric measures access to PIHP/CMHSP services for children who (1) meet the criteria for serious emotional disturbance as defined in contract with MDHHS (Attachment P4.7.4) and (2) request services.
        - If MDHHS observes (1) a decrease in the statewide average intake CAFAS score for children ages 7 through 17 and the average intake PECFAS score for children ages 4 through 6 years who are entering PIHP/CMHSP services and (2) a total annual increase of the number of children (including those children birth to 48 months), this trend would indicate that more children who are eligible for PIHP/CMHSP services per the contract are given access to those services. MDHHS will also use other supplemental metrics to ensure that children with high levels of need are not adversely impacted by the implementation of the evaluation framework.
    - Performance Outcome
        - A reduction in total CAFAS score or PECFAS score demonstrates an improvement in functioning. The total CAFAS score or PECFAS score for children with serious emotional disturbance who receive PIHP/CMHSP services will drop from intake to exit of services indicating an improvement in functioning across relevant life domains that are measured by the CAFAS (School/Work, Home, Community, Behavior Toward Others, Moods/Self-Harm, Substance Use and Thinking) or PECFAS (Day Care/School, Home, Community, Behavior Towards Others, Moods/Self-Harm and Thinking).
        - An increase in the total protective factor score on the Devereux Early Childhood Assessment (DECA) for children birth to 48 months demonstrates an improvement in functioning. The DECA protective factor score will increase from intake to exit of services, indicating an improvement in functioning.
    - MDHHS, in concert with parents and parent organizations, will identify a tool that measures reduction in parent stress and improvement of quality of life.
        - MDHHS will work with stakeholders to develop and deploy metrics to measure the diversion of children with serious emotional disturbances from the criminal justice system as part of the evaluation framework.

- Tribal Members
    - MDHHS and the workgroup noted that MDHHS may be able to use the previously cited Quality of Life data sources to measure outcomes for tribal members.

Table 1: Quality of Care Health Outcome Measures*			
CDC A1c Testing	Chlyamydia Screening	Anti-Depressant Medication Management	CDC: A1c Control
CDC Eye Exam	Childhood Immunization	Follow-Up Care for Children Prescribed ADHD Medication	CDC: Blood Pressure Control
CDC: Attention for Nephropathy	Adolescent Immunization	Hypertension Prevalence	Controlling High Blood Presure
Colorectal Cancer Screening	Well Child Visits (15 Months)	Asthma Prevalence	Weight Assessment and Counseling for Nutrition and Physical Activity
Cervical Cancer Screening	Well Child Visits (3-6 Years)	Obesity Prevalence	Adult BMI Assessment
Breast Cancer Screening	Well Child Visits (Adolescent)	Lead Screening	Tobacco Use Screening and Cessation
Use of Imaging Studies for Low Back Pain	Use of High Risk Medications in the Elderly	Diabetes Prevalence	Screening for Depression and Follow-Up

Table 2: Utilization, Cost and Care Management Measures*			
All Cause Acute Inpatient Hospitalization Rate	Percent of Attributed Patients Receiving Care Management	Total PMPM Cost	30 Day Re-Admission Rate
Emergency Room Visit Rate	Timely Follow-Up with a PCP After Inpatient Discharge	Preventable Emergency Room Visits	Ambulatory Care Sensitive Hospitalizations

* Measures are subject to changes.

Appendix 18: Summary of the Recommendations on Financing Models

After the submission of the interim report, MDHHS and the 298 Facilitation Workgroup launched the next phase of the process, which focused on the development of recommendations for financing models. In order to generate concepts for potential models, MDHHS and the workgroup opened a statewide process for interested stakeholders to submit model proposals. MDHHS and the workgroup ultimately received 42 model proposals as part of this process. MDHHS submitted the 42 model proposals to the Michigan legislature as a separate companion document to the final report for the purposes of public record.

MDHHS and the workgroup organized the 42 model proposals into six categories of financing models and one category of non-financing models. The workgroup conducted an evaluation of the strengths, challenges, and issues to be resolved for each financing model category. The summary of the workgroup evaluation can be found in Appendix 14 of the final report. MDHHS and the workgroup also launched a public input process on the draft financing model categories. The summary of the public input process can be found in Appendix 15.

After completing the evaluation process and public input process, the workgroup considered 16 draft recommendations on financing models. The workgroup used an initial voting process (Round 1) to identify which draft recommendations would have sufficient support for approval if amendments were made. A draft recommendation was required to obtain a supermajority (two-thirds) of available votes in Round 1 in order to warrant additional discussion and potential approval. For the purposes of Round 1, a super majority was defined as 13 votes. Any votes that were cast in Round 1 shall not be construed as giving final approval to any recommendation for inclusion in the final report. Table 1 outlines the draft recommendations that were considered in Round 1 and the voting results for each recommendation.

Table 1: Round 1 Voting Results for Draft Recommendations

Number	Draft Recommendation in Round 1	Yes	No	Status
1.1	For inclusion among pilots/models to be tested, the workgroup recommends the expansion and broadening of jointly funded, staffed and operated programs between MHPs and the public behavioral health system for coordinating services to shared enrollees. This concept includes themes from certain proposals received in some of the workgroup's categories -- minimally, categories #5 (Current Financing Structure Enhancement); #6 (Local/Regional Integration); and #7 (Non-Financing).	16	3	Approved for Further Consideration and Amendment
1.2	The Workgroup recommends that Proposal 1 be targeted for implementation over time. Proposal 1 is suggested over Category 1 because it is the proposal within the category that is most clearly and directly consistent with the values and policy directions that have already emanated from the 298 process (Calley Workgroup, affinity groups, current MDHHS Workgroup). Any subsequent enhancements to Proposal 1 should remain	10	8	Did Not Obtain Sufficient Votes

	consistent with all 298 values and policy directions established to date.			
1.3	The Workgroup believes that integration of health care and specialty services and supports for people with disabilities happens primarily at the point of service and is driven by local coordination between providers, following consistent statewide contract language, rather than statewide integration of financing.	13	5	Approved for Further Consideration and Amendment
1.4	In the spirit of forming recommendations for pilots which use parts of a model or other information, I suggest a category of recommendations which covers coordinating the physical health care and behavioral health care through the CMHSP or CMHSPs for persons with a mental illness, SED and/or SUD who are vulnerable and at risk for issues of increased morbidity and premature death as well as persons who are high utilizers of emergency rooms and hospitalization. Under that category would be: • Contracted obligations to identify and serve such persons so as to coordinate their physical and behavioral health. CMHSPs and the responsible entities for physical health, whether a health plan or private physicians would be charged with accomplishing said coordination. • An ACO with funding from the health plan or fee for services, through the CMHSP, would be responsible for the provision of coordinated physical and behavioral care for these two groups. It could also include other entities. • Other plans to address the coordination of care at the local CMHSP(s) level, such as utilizing a supports coordination model rather than the case management model. • Utilization of a wraparound model for youth and children with SED that will better address their unique needs for integration of well child and preventive health care as well as behavioral health needs.	15	4	Approved for Further Consideration and Amendment
2.1	The workgroup recommends all model categories to the legislature for further review of short and long-term impact on integration and coordination of physical and behavioral health services, including possible implementation of pilot demonstrations testing model categories it deems appropriate based on this review.	10	9	Did Not Obtain Sufficient Votes
3.1	Adopt the Model Category of a creating a State-wide Behavioral Health Managed Care Organization with regional offices (category 1)	12	6	Did Not Obtain

	• Re-configure the regional offices to correspond with the Michigan Prosperity Regions (to be in better alignment with the Medicaid Health Plans); although with some consolidation where it seems appropriate, as to not move backwards.
	• Establish autonomy of the PIHPs from the CMHSPs and re-configure its existing governance, so that the CMHSP's CEOs are not solely running the PIHP (get the foxes out of the henhouse).
	• Establish standardized, state-wide with reciprocity:
	  ○ Provider contracts
	  ○ Outcome measures
	  ○ Audit & compliance guidelines & tools
	  ○ Recipient Rights processes
	  ○ Access Mgt/Utilization Management processes
	  ○ Credentialing and training standards
	• Establish clear parameters for regional offices to develop locally responsive service delivery systems and programming, while maintaining core standardization.
	• Maintain the SUD Advisory Board per PIHP, but be given greater authority (rather than just advise on PA2 spending)
				Sufficient Votes

3.2	Adopt a Current Financing Structure Enhancement strategy (category 4) • Further flesh out an operational model/infrastructure as outlined in Proposal 20 • Weave in as the operating expectations for the Statewide Single Behavioral Health Managed Care Entity • Create a Super-Board that has oversight between the SBHMC and the Medicaid Health Plans with consumer/patient/advocate and CMHSP/private provider representatives at the table. • Establish an Integration Innovation Venture Capital Fund, which is managed by the Super-Board and provides start-up capital for new cross-system initiatives. Could be an identified location for the re-investment of some systemic savings. • Establish a formula or methodology for the Medicaid Health Plans to retain a certain portion of identified system-wide savings for their economic gain. We need to honor that these are private businesses that have a different set of	9	10	Did Not Obtain Sufficient Votes

	operating guidelines and goals than public sector organizations. Otherwise, they have less of an incentive to participate or cooperate.			
3.3	Using an Integration Innovation Venture Capital Fund, provide opportunities for Local/Regional Integration Arrangements (category 5) • Much like Blue Cross/Blue Shield has done with the Michigan Health Endowment Fund, this fund can be used to be use to support, enhance or develop integration arrangements at the provider level. • This allows for real integrated service delivery at the community level, allows for the unique nuances of that region, and is the way to best impact a person and family's experience. • The success of healthcare integration is significantly impacted by the relationships held between providers. This is a local issue that can only be managed and facilitated at the local level. This allows the State to create the opportunities for willing, innovative partners without forcing structural changes based on external resources. • Allows the existing MHPs and the State-Wide Managed Behavioral Healthcare Organization to identify the various ways that they can braid funding and explore various funding methodologies while managing the risk pool. • Because of the advent of Medicaid Expansion and "ObamaCare," there is already a great deal of initiatives in place. This can serve as an incubator of integration that could not be achieved through a state-wide, macro-level policy.	13	6	Approved for Further Consideration and Amendment
4.1	All models shall to be evaluated against the CMS Managed Care Rule in its entirety, including those models in category six (MHP or PIHP Payer Integration).	11	8	Did Not Obtain Sufficient Votes
4.2	All models shall have a fiscal analysis evaluating potential impact to state and local financing.	11	6	Did Not Obtain Sufficient Votes
4.3	The workgroup should recommend model category six (MHP or PIHP Payer Integration) to the legislature for further review and possible pilot implementation.	8	11	Did Not Obtain Sufficient Votes

4.4	Specific recommendations should also include the following: a. Requiring that a contracted entity be at full risk and receive capitated rates from the State that are actuarially sound. b. Requiring that a contracted risk-bearing entities must maintain at least 1/3 Governing Board membership representing enrollees, and must form a specific enrollee Advisory Council focused on those with Behavioral Health or Substance Use Disorder needs. c. Contracted risk-bearing entities would have to licensed and regulated with the Department of Insurance and Financial Services for the purpose of maintaining complete financial transparency and solvency. d. Contracted risk-bearing entities would be required to contract with Community Mental Health Service Providers so as to avoid any disruption of services at the provider level for impacted enrollees. e. Recommending that the Legislature consider amending the Social Welfare Act to apply the performance bonus incentive requirements currently applicable to contracted health plans to all risk-bearing entities that contract with the State to provide medical services. f. Recommending that the Legislature consider amending the Section 190f of the Social Welfare Act to state that with the exception of pilot programs authorized by the Legislature through annual appropriations, the specialty services and supports shall be carved out from the basic Medicaid health care benefits package. This would allow the state to amend existing contracts with risk-bearing entities rather than needing new contracts specific to this benefit. g. Recommending that consumers be provided with choice of managed care organizations by ensuring that there are more than one MCO in all regions of the state except those who receive a rural exemption from CMS.	9	10	Did Not Obtain Sufficient Votes
5.1	MDHHS will develop a process for sanctioning implementation of model concepts that do not require policy or statutory changes to be implemented.	16	3	Approved for Further Consideration and Amendment

5.2	MDHHS, assisted by workgroup, will conduct more in-depth review and select desirable elements from models or proposals submitted to see if another set of model(s) might emerge (i.e., let the cream rise)	15	4	Approved for Further Consideration and Amendment
5.3	Workgroup will assist MDHHS in selecting up to X categories for feasibility analysis: a. Conduct policy and/or regulatory (federal and state) analysis of those chosen categories i. Eliminate any categories where federal or state regulations would create undue demand burden or specific barriers for implementation b. Conduct Fiscal impact analysis of remaining categories (i.e., categories where implementation is fiscal in policy/regulatory environment) i. additional costs and/or savings generated by categories over time c. Identify up to X categories for pilot and/or RFP	6	12	Did Not Obtain Sufficient Votes
5.4	The Legislature in conjunction with MDHHS will set milestones as opposed to timelines to allow for creation of more thorough, data informed, analytics-based recommendations.	9	9	Did Not Obtain Sufficient Votes

After the conclusion of Round 1 of voting, six recommendations had obtained sufficient votes to be considered for additional amendment and potential approval. A draft recommendation was required to obtain a supermajority (two-thirds) of available votes in Round 2 in order to be approved for inclusion in the final report. For the purposes of Round 2, a super majority was defined as 13 votes. Table 2 outlines the recommendations that were considered during Round 2 and the final voting results for each recommendation.

Table 2: Round 2 Voting Results for Draft Recommendations

Number	Amended Language for Recommendations in Round 2	Yes	No	Status
1	The workgroup recommends that MDHHS should develop a process for evaluating model concepts that do not require policy or statutory changes for implementation.	19	0	Approved Unanimously
2	The workgroup recommends that MDHHS, informed by stakeholders, should conduct a more in-depth review of model proposals that were submitted to see if other model(s) might emerge.	19	0	Approved Unanimously
3	For inclusion among models to be tested, the workgroup recommends the expansion and broadening of jointly funded, staffed and operated programs between MHPs and the local public behavioral health system for coordinating services to shared enrollees.	15	4	Approved by Super Majority

4	The workgroup recommends the development of consistent statewide contract provisions to encourage the integration of physical health, behavioral health and intellectual/developmental disability services and supports for all populations at the point of service, which should be driven by local coordination between providers rather than statewide integration of financing.	15	4	Approved by Super Majority
5	The workgroup recommends the use of models which improve the coordination of physical health and behavioral health services and supports through the local public behavioral health network for individuals with a mental illness, serious emotional disturbances, and substance use disorders. Within that population, the focus should be on individuals who are vulnerable and at risk for issues of increased morbidity and premature death as well as persons who are high utilizers of emergency services and hospitalization services. This recommendation includes the following elements: • The local public behavioral health network and the responsible entities for physical health, whether a health plan or private physicians, would be charged with accomplishing physical health and behavioral health coordination. • An Accountable Care Organization with funding from the health plan or fee for service, through the local public behavioral health network, would be responsible for the provision of coordinated physical and behavioral services for the affected populations. The Accountable Care Organization could also include other entities. • MDHHS should consider other strategies to address the coordination of care at the local public behavioral health network level such as using a supports coordination model rather than the case management model. • MDHHS should also consider using a wraparound model for youth and children with serious emotional disturbances that will address their unique needs for integration of well child and preventive health care as well as behavioral health needs.	14	5	Approved by Super Majority
6	The workgroup recommends the establishment of an Integration Innovation Venture Capital Fund, which would provide opportunities for Local/Regional Integration Arrangements. A fund should be established and used to support, enhance or develop integration arrangements at the provider level.	17	2	Approved by Super Majority

	• This recommendation allows for integrated service delivery at the community level, recognizes the unique nuances of each region and is the way to best impact a person and family's experience. • The success of integration is significantly impacted by the relationships held between providers. This is a local issue that can only be managed and facilitated at the local level. This recommendation allows the State of Michigan to create the opportunities for willing, innovative partners without forcing structural changes based on external resources. • This recommendation also allows the existing MHPs and PIHPs to identify different ways to braid funding and explore various other funding methodologies while managing the risk pool. • As a result of the advent of the Healthy Michigan Plan and Patient Protection and Affordable Care Act, there are already several integration initiatives in place. This approach could serve as an incubator of integration that could not be achieved through a statewide, macro-level policy.			

List of Model Proposals

Supplemental Document for the Final Report of the 298 Facilitation Workgroup

Section 298 Initiative

Michigan Department of Health and Human Services

Purpose of this Document: This document contains all of the model proposals that were collected as part of the development of the financing model categories for the Section 298 Initiative. This document is being included with the submission of the final report to the Michigan Legislature in order to provide additional reference materials for discussions on the integration of physical health and behavioral health services.

List of Model Proposals

Model #1

Section I: Model Name and Contact Information

Name of Model: Statewide Integrative Health Collaboration

Name of Submitting Organization: The ArcMichigan; Association for Children's Mental Health; Epilepsy Foundation of Michigan; Mental Health Association in Michigan; Michigan Disability Rights Coalition; Michigan Protection and Advocacy Service; National Alliance on Mental Illness-Michigan; UCP-Detroit; UCP-Michigan

Model Partner Organization(s): Michigan Department of Health and Human Services (MDHHS); a new Statewide Administrative Services Organization (ASO); Community Mental Health Services Programs (CMHSPs); Medicaid Health Plans (MHPs)

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services, (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/ payment mechanisms, and (5) how a competent, public body would be engaged in managing the model.

Six behavioral health advocacy organizations represented on the state's Section 298 workgroup, joined by the Epilepsy Foundation of Michigan and UCP (Detroit and Michigan), are collectively submitting this proposal to model a Statewide Integrative Health Collaboration. In advancing this proposal, our organizations recognize that the Interim 298 report has already recommended an overall financial model for behavioral health and other medical services – i.e., separately funded and managed services through the MHP and CMHSP systems. ("Behavioral health" in this proposal encompasses mental illness, emotional disorder, developmental disability, intellectual disability, and substance use disorder.) We further recognize that Recommendation 1.1 of the Interim 298 report – and this Request for Information document – call for the involvement of a "competent public body" in management.

We respectfully propose that services for persons served by CMHSPs and MHPs involve four key players: the Michigan Department of Health & Human Services; a new Statewide ASO; the CMHSPs; and the MHPs.

MDHHS would contact with a public entity to be the ASO (or, in effect, a statewide PIHP) for all Michigan CMHSPs, which in turn would sign Medicaid contracts with the ASO. (Over time, this could possibly be extended to involve all CMHSP public funds, irrespective of source.) MDHHS would also continue contracting with MHPs. The Department's contracts with the ASO and MHPs (and the ASO contracts with the CMHSPs) would require all parties to engage in collaborative activity to coordinate care for "dual individuals" (i.e., served by both CMHSPs and MHPs). Special targets for coordination would be shared enrollees at risk of severe health repercussions and those whose history indicates high levels of service utilization. The new ASO would also have oversight responsibility – through a special division separated by a firewall from other administrative work – for enforcement of CMHSP Medicaid expectations.

The ASO and MDHHS would have responsibility for developing incentives that would be offered to CMHSPs for administrative and/or service mergers. The ASO, MDHHS, the MHPs, and the CMHSPs would further be given responsibility to collectively analyze and come up with a recommendation for how the current MHP 20-visit mental health outpatient benefit would be handled in the future.

Among ASO functions would be:

*Design, oversee, and enforce contractual requirements for CMHSPs.

*Conduct analytics on claims and quality performance measures from CMHSPs.

*Establish and oversee uniform quality improvement policies for the CMHSPs.

*Reduce duplicate administrative functions at the CMHSP and service delivery level.

*Assume population-based risk in the public behavioral health sector.

*Analyze and advise MDHHS on performance outliers and population health status.

*Assist CMHSPs and MHPs in creating effective locally based coordination and identifying priority clients for coordination.

*Administer prepaid Medicaid capitation systems to CMHSPs (with possibility long-term for involving all CMHSP funding).

*Monitor, track, and measure performance of CMHSPs and their coordination/collaboration with MHPs.

The structure being proposed would have many benefits:

*Creating greater public mental health system uniformity.

*Fostering greater administrative efficiency in the public mental health system.

*Potentially creating cost savings via one ASO (rather than ten PIHPs) and future CMHSP mergers that may occur.

*Providing more effective oversight than can be given by MDHHS, with its staff limitations.

*Requiring that all involved parties work together on coordination of services.

*Assuring that the new ASO would be public.

Types of Services/Supports Offered

All services/supports available today could and would remain in place. Nothing in this proposal requires any reduction. And Medicaid health systems would be as able as they are today to incorporate new services that come to the forefront through research.

Organizations Involved in Providing, Coordinating, Paying

A single ASO would replace ten PIHPs. Medicaid money to the CMHSPs would flow through the ASO, while the MHPs would receive direct state funding. MHPs and CMHSPs (not necessarily in today's numbers forever) would remain and would continue to manage/work with provider networks. There is no need under this proposal to re-do the types of players involved in providing Medicaid services for behavioral health and other medical care.

298 Interim Report Recommendations and Core Values

This proposal does not contradict or interfere with any of the report's recommendations/values, excepting for the possibility of "PIHPs" (plural) becoming "PIHP" (singular). The model proposed can encompass all recommendations and values.

Model Financing

See subsection on "Providing, Coordinating, Paying."

Management by a Competent Public Body

The 298 Workgroup has already signed off on retaining MHPs and CMHSPs as key entities. The single ASO proposed here – the new piece involved – would be public. Why?

*Recommendation 1.1 in the Interim 298 report requires it.

*This Request for Information document requires it.

*Public entities have an extra layer of transparency and accountability.

*Private health care interests are not well-versed in modern behavioral health concepts such as recovery, resiliency, social supports, person-centered planning (PCP), and self-determination.

*Two of the three key entities with which the ASO would be involved (MDHHS and CMHSPs) are public. When it comes to behavioral health, DHHS has previously written that there is a "bi-lateral dependency" among public entities needed for success. More specifically, the Department said that "neither the simple market model, nor more complex forms of competitively organized exchange are applicable to (behavioral) contracts…the state must obtain an agent that is committed to the objectives of (community) integration and inclusion…without costly haggling that might delay (community) integration."

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

Enhancement of Care Coordination and Supports

The parties involved in the Statewide Integrative Health Collaboration would be required to foster and maintain strong collaborative relationships to provide joint care management services to shared enrollees. Special targets for coordination will be shared enrollees at risk of severe health repercussions and those whose history indicates that they are high utilizers of services. The state ASO will work closely with each CMHSP and MHP to identify shared enrollees with complex physical and behavioral health needs and jointly develop and implement (in concert with beneficiaries) processes to manage their care, eliminate inefficiencies, and improve health outcomes. Attention will not only be on treatment of health conditions, but will also include social services, housing, education/employment and other supports.

Consistent with Recommendation 1.2 of the Interim 298 report, a beneficiary could choose whether a CMHSP or MHP would be the lead party with respect to care coordination. A beneficiary could also elect to do his/her own coordination. In such cases, if meaningful care coordination is not resulting, beneficiary incentives may have to be created to stimulate acceptance of coordination assistance.

Promoting Greater Collaboration among Providers, Service Agencies, Payers at Service Delivery Level

Our model recognizes that better health care outcomes will be achieved for consumers through the development of an improved collaborative system of care between CMHSPs, Medicaid Health Plans, and community providers dealing with shared enrollees. This model supports development of an integrative health collaboration in all regions of the state, specifically designed to identify high-risk and high-utilizer individuals, and creating a defined process for coordinated care management that ultimately improves access to care and service coordination between the individual's primary care providers, specialty providers, and CMHSP and MHP overall systems of care. This model is intended to support all treatment providers by facilitating care coordination, information sharing, and shared treatment planning to aid individuals in meeting their goals and improving overall health. Once engaged for a shared enrollee, a Coordinated Care Plan (CCP) is developed in concert with the beneficiary. (Note: For individuals not already engaged with a behavioral health provider, their MHP network, based on age-appropriate behavioral assessment or other relevant circumstances, would determine if referral within the CMH system is necessary. As stated earlier, the parties in this new model would make a determination about future handling of what is now the 20-visit MHP outpatient benefit for behavioral health.) The CCP would supplement, not replace, an Individual Plan of Service, Person Centered Plan, or any other service-and-support documents developed and managed between a consumer and provider. A copy of the CCP is given to the individual and anyone s/he has designated for care coordination assistance. The individual and his or her approved care coordination entity provide regular updates based on established timeframes, and the plan is updated based on shared information between the parties. A care conference may be requested at any point to assist with resolution of issues that are preventing successful progress. The Statewide ASO will assure that each CMHSP has a signed Coordinated Care Memorandum of Understanding or contracts with MHPs and other community resources that come in contact with Medicaid beneficiaries, such as community hospitals, FQHCs, Rural Health Clinics, Tribal Health Services clinics, Veteran Affairs, and physician practices. These will describe services and reciprocal responsibilities including:

- Support ongoing communication and care coordination for shared consumers;
- Partner to develop and implement an action plan to identify, accept, and serve consumers with behavioral and other medical needs;
- Establish data-sharing protocols to support care coordination, including data on lab results, prescriptions and medication reconciliation, and other continuity of care concerns for shared consumers;
- Ensure that children, youth, and adults (including older adults) have access to age-appropriate screening and preventive interventions as may be required; and
- Other manners of collaboration to implement health intervention strategies for shared consumers.

The state ASO would also assure each CMHSP has standard policies in place to guide intake, assessment, risk levels presented, historical reviews, and referral assistance.

How would the model improve availability, accessibility, and uniformity of services (including medications) and supports? Promoting Availability, Accessibility, and Uniformity of Services and Supports

This model in no way subtracts from services and supports presently available. It would not be negatively impacted by the Interim 298 report recommendation on access to medications involving mental health and epilepsy. And, with one ASO instead of ten PIHPs, the likelihood of improved uniformity is strong.

This model can make additional improvement in care coordination, assuring that individuals are provided the opportunity for an integrative health path to assist them in making and keeping appointments, connecting with sources of service-and-support provision, and understanding their benefits. Consumers should also have the opportunity to work with a Peer Support Specialist (or the analogous position in the MHP field) who can provide outreach, support, encouragement, and basic health coaching. Such specialists have the flexibility to meet with individuals in their home as well as attend appointments.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train and retain clinicians, direct care staff and other key personnel?

Our model would strongly support and be prepared to implement the Interim 298 report recommendations for Workforce Training, Quality, and Retention. This, of course would depend on available resources. The same caveat would apply to Medicaid health care as we know it now in Michigan. (See previous subsection for commentary on Peers.)

Section IV: Rights, Protections, Service Continuity

Empowering Individuals to Make Decisions; Promotion of PCP, Self-Determination, and Choice

All Interim 298 report recommendations pertaining to these issues can and would fit under this model. CMHSPs (although there is room for improvement) have dealt with PCP and Self-Determination since 1995, and would be aided in building on what's needed by the ASO. Should Michigan determine to have MHPs more involved with PCP, Self-Determination, and Choice, the contract vehicle between MDHHS and the MHPs can be used for such purpose.

Affect Complaints, Grievances, Appeals?

This model would not affect these mechanisms, and could completely encapsulate where the related Interim 298 report recommendations would take Michigan, as well as the new federal rules on Medicaid managed care appeals/grievances.

Continued Access to Current Services, Supports, Providers

There would be no changes to what individuals currently experience, unless CMHSPs and/or MHPs were permitted and elected to make changes on their own, unrelated to this model, in these areas.

Section V: Governance

Governance Function; Transparency and Accountability

The new ASO would have an appointed Board of Directors, with at least 51% of the Board comprised of non-provider behavioral health consumers, family members of such consumers, and statewide non-profit citizen groups that advocate on behalf of behavioral health. The 51% of the Board representing such sub-populations would be appointed by leading and long-standing statewide behavioral health advocacy organizations. Meetings and actions of the ASO and its Board would be subject to FOIA and Open Meetings laws.

How would individuals, families, and community be engaged?

Persons with lived experience and their families would have to be included on the ASO Board. Other community interests could be included on the Board within the 49% that don't have to be consumers, families, or advocates. The ASO Board would likely have committees that can offer additional opportunity for diverse community involvement. The ASO could also hold community meetings/forums.

Section VI: Financing and Reimbursement

Changes to Financing Mechanisms for Payers

We propose continued use of Medicaid capitation rates. For the CMH system, in concert with the state's 1115 Medicaid waiver proposal, there would be the following points of emphasis:

*Capitation rates include all State Plan, 1915(b), and 1915(c) waivers.

*Capitation rate values developed using state ASO-submitted CMHSP encounter data and Medicaid Utilization Net Cost reports, and vary by benefit type and program code.

*Rate adjustment factors developed to reflect age, gender, and geographic region for each benefit category.

*The state ASO is the designated managing entity for all Medicaid beneficiaries within each CMHSP geographic catchment area.

Changes Needed to Provide Reimbursement under the Model

As noted immediately above, continued reliance on capitation. Also, instead of contracting with and supporting ten PIHPs, the state would contract with and support one ASO for CMHSP Medicaid.

What Incentives (Payer/Service Provider) Would Be Used? How Would They Be Designed?

As presented earlier, MDHHS and the state ASO would be expected to develop incentives for CMHSP administrative and/or service mergers. We suggest those two parties, in concert with CMHSPs and counties, are better suited to come up with mechanisms than we are in a list here. As also previously stated, some beneficiaries themselves may over time need incentives to accept formal care coordination assistance. But as far as payers and providers are concerned, given the negative feedback in consumer/family affinity groups to possible financial incentives for those entities, we suggest no other incentives for them. This does not preclude the executive and legislative branches, in concert with the state ASO, the CMHSPs, and/or the MHPs, from exploring payer/provider incentives and making the case with stakeholders and taxpayers that any identified as meritorious be considered.

Section VII: Quality Measurement

How would the quality of service be measured and continuously improved?

We do not present an extensive list of measures here because it's our understanding that MDHHS may be heading toward its own list of metrics and evaluation benchmarks through the 298 Workgroup process. We can say that, under our proposal, MDHHS would be responsible for evaluating the outcomes produced by the state ASO and the MHPs. And the ASO would be responsible for uniform quality measurement and improvement activities of the CMHSPs. We think some key metrics (if they fit what the state ultimately wants) would include hospital and ER usage; follow-up on hospital discharges; improvements in health status/functioning (including lowered severity risk); timeliness in development of care coordination plans; outcomes of care coordination implementation (including impact with high-utilizers); fidelity to PCP (including family-centered); access to primary care physicians; compliance with prescribed medication regimens; diverting persons from high risk of justice system involvement; community inclusion/participation opportunities; and beneficiary reports on their service-and-support experiences.

Define "success" for the model. How measured? What benchmarks?

This model will be successful if:

*There is greater uniformity and standardization in the public behavioral health system thanks to one ASO instead of ten PHPs.

*It can stimulate some CMHSPs to undertake administrative and/or service mergers.

*Administrative efficiencies generate savings that can go back into direct health care service.

*Beneficiaries receive the services they want/require in a timely manner.

*Shared enrollees who present high risk of health condition severity or have histories of high service utilization can be identified and helped to lower their levels of risk and/or utilization through care coordination.

(See related discussion under previous sub-section.)

Section VIII: Pilots and Other Considerations

Piloting?

This proposal calls for statewide implementation of a model. But it could be narrowed so that it is initially tried in part (but not all) of the state. If, for example, half the state were under the approach proposed here while the other state half still had multiple PIHPs, results from each half could be compared and contrasted.

Statewide Implementation?

This is a proposal for statewide implementation.

Regulatory Changes?

State law (minimally the Mental Health Code) would have to be revised for the existence, operation, and governance of one state ASO for the public behavioral health system.

Other States/Communities Using This Model?

We are unaware of its usage elsewhere.

Model #2

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: A Better Mental Health System (BMHS)

Name of Submitting Organization: Alliance for the Mentally Ill of Oakland County

Model Partner Organization(s): MICHUHCAN

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

See attached 4-page proposal docu,emt for a better description. Responses to above questions follow. (1) Services and supports as defined in current PIHP/CMHSP contracts. (2) The current system would be re-structured (see attached proposal document) with (a) MDHHS as primarliy responsible for leadership, operational performance, payor and owner of risk, contract management for all contract providers, and consolidated administrative functions including unified information systems for the public mental health systems, (b) an independent organization for oversight, needs and unmet needs assessment, disput resolution underutilization assessment, and reporting to the legislature for meanful governance, (c) consolidation of PIHP and associated CMHSPs/core providers into regional organizations responsible for professional services, meeting community needs and ensuring delivery of adequate and appropriate services within the scope of services as adopted for the budget adopted by the legislature, (d) contract service providers to deliver services prescribed by the regional organizations and billed to MDHHS. (3) The model is consistent with the core values and will provide an environment in which service providers are no longer driven to put cost control ahead of quality care. (4) Funding is by legislative appropriation consistent with objective needs assessment, funding limitations and publicly reported needs determined to be unmet by the appropriation considering Federal and state funding and availability of other health insurance. MDHHS to be payer for all services delivered without bundled rates or other mechaisms that would delegate risk from MDHHS to providers including regional organizations and criminal justice services for otherwise qualified recipients of metal health services. (5) MDHHS must have responsibility for management of the system with a significantly expanded staff as a resulto of consolidation of administrative functions as well as training, certifications, professional prectices, information systems, optimization of contract resources (including capacity that ensures timely access to services with reasonable, informed choice) and over-utilization management.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

The proposal document is based on services to persons with mental illness but (with appropriate adjustments) should be applied to all populations currently served by the public mental health system, and extended to address the addition of early intervention (rather than crisis-driven) and sustained recovery support. Separation of populations would result in loss of economies of scale and thus a loss of efficiency and response to change. A consistent level of services should be ensured independent of funding source including Medicaid, unninsured, Medicare, and private insurance.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

All services and supports currently addressed by PIHP/CMHSP contracts plus consideration of housing, transportation, socialization, employment and recreation must be addressed as essential to achieving and sustaining recovery.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

Choices of service providers would be expanded by enabling service providers to support multiple regional organizations under their MDHHS master contracts and through MDHHS support of a provider directory to ensure that recipients have appropriate information for a meaningful decision. No restrictions will be imposed on professionals or provider organiztions for the purpose of controlling budgets. Informed choice supported by an MDHHS provider directory, including performance and violations, will minimize coflicts of interest in selection of providers. MDHHS must ensure adequate provider capacity for timely access to and delivery of services across the state. Coordination of care is through collaboration of professionals, particularly doctors and case managers, with appropriate compensation for collaboration activities along with performance review of redundant or inconsistent services. Coordination of care must be with the informed choice of the recipient or their legal representative. All providers must be certified for the services offered, and all professionals and direct care personnel must be licensed or certified for their roles. MDHHS is responsible for certification management.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

Coordination of care occurs through collaboration of professionals with (authorized) access to shared electronic health records managed by the MDHHS information system. Professionals must be paid and evaluated for their support of coordinated care. Doctors as well as other professinals must be required and compensated to collaborate. Billings to MDHHS will reveal potential failures to coordinate for implementation of remedial action..

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

They must be paid to do the work of coordination and collaboration, and they must be evaluated for their effectiveness. They must be supported by appropriate information systems. The systems must be developed and managed by MDHHS so MDHHS is responsible and accountable for providing the needed support and identification of coordination failures.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

All services are under state/MDHHS master contracts that define them cosistently and hold them accountable. All services are available to all recipients within their provider capacity and their geographical service area, so access is not restricted to the contracts of the responsible

Regional (PIHP) organization or CMHSP. Medications are medical decisions by doctors with review for possible abuse or indiscration. That is what we educate and pay doctors for. Get the bureaucrats out of medical decisions. Case managers are resposible for continuoing oversight of individual recipeint needs and delivery of appropriate services as currently required in the case manager job description but corrupted due to conflicts of interest and inadequate funding.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

MDHHS becomes responsible for training and certification of all professionals and direct care staff and other key personnel. Definition and certification of services is part of the MDHHS management of master contracts. All personnel must be paid competitive wages/salaries so that quality staff are recruited and retained. All personnel must consider their first priority is adequate and approplriate care of recipients, not budget constraints. Appropriate services are deliverd and paid for without bundline or bureaucratic interference or prior authorization. Over-utilization is managed by MDHHS but determination of over-utilization is reviewed and authorized by the independent oversight agency. Under-utilization is assessed and corrective action enforced by the indepednet oversight agency. People will want to work for the mental health system because it is a rewarding job both in the ability to really help disabled people and the appropriate compensation for quality work.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

Providers are contracted, overseen, certified and accessible to recipients through direct access to provider information including perofrmance evaluations and records of misconduct, neglect, recipient complaints, etc. Case managers and other professionals are encouraged to provide adequate and appropriate services without managers trying to make their budgets look good. The risk of budget overruns belongs to MDHHS where the budets are developed with public disclosure of the persons in need who will be denied services and the persons who will not be qualified to receive certain types or intensity of services otherwise available. These restrictions must be translated to define the populations of unserved or underservde individuals by the indepndent oversight agency. Managed care has destroyed the mental health system by making professionals deny services based on financial risk and by creating staff shortages and underperforming personnel due to inadequate compensation and excessive workloads. Compensation and workloads should not be restricted by budgets since billing for services delivered must be honored by MDHHS.

Would this model affect the administration of complaints, grievances, and appeals?

Definitely. These would be addressed by the independent oversight agency that would have authoruty to prescribe corrective action and remedies for injured individuals. Investigations and appeals are a key basis for evaluation of system and provider performance and system assessments provided to the legislature.

How would the model support continued access for individuals to current services, supports, and providers?

Recipients have maximum opportunities for choice among providers under state master contracts based on capacity and geography and professionals available in/through their regional organiztion. Continuity of service provider would only be affected by relocation of a recipient to a geographical area not addressed by the provider. More providers would be available to each region since contracts are with the state not with the regional organization. An MDHHS directory would provide all appropriate information for informed choice.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

FOIA and open meetings would be required for organizations receiving a threshhold level of public funds direectly or indirectly. The independent oversight agency will provide objective assessment of performance and reports of misconduct, complaints, appeals, etc. Substantiated complaints will result in meaningful corrective action. Regional organiztions will be focused on serving their community and recipients rather than functioning as the cost controllers for budgets for which they have no authority or control.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

Regional organizations would actually be focused on and advocates for meeting the needs of communities and their citizens. Regional boards would start listening to complants and have the ability to correct problems instead of making excuses for failures and denial or inadequacy of services. Regional organizations as well as families and advocates will have a voice with the independent oversight agency to resolve problems and ensure legislators really uderstand how well the system is working or not. Professionals must be compensated for the time required to collaborate with families and significant others as well as their clients/patients.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

MDHHS is the payer and holder of the risk for a state-wide risk pool. Services are only limited by the qualifications of recipients and the scope of services defined for the budget. No more delegation of risk. No more bundled rates that result in denial of services to the more difficult or critically ill recipients. No more non-competitive wages or overloading of staff to impose inadeauate budget constraints. MDHHS, the

administration and the legislature are responsible for the governance and management of the system and they must be held accountable for the risk. MDHHS should also develop methods to manage the utilization of funding from multiple sources as appropriate to the funding restrictions including private insurance and Medicare. The fragmentation of funding sources should have minimal impac on the services available to an individual recipient.

What changes would need to be made to provider reimbursement in order to implement the model?

All providers bill MDHHS for the services they deliver under their state master contracts as prescribed for individula care by regional professionals. No more delegation of risk. No prior authorization. Timely access to services is more important than prior authorization.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

The incentives are standards of quality care and the satisfaction of helping disabled and vulnerable people. Independent oversight, performance evaluation and utilization review with appropriate corrective action including withdrawal of certification or licensing are incentives for quality care at reasonable cost. In the long term, cost will be saved by early intervention, doing it right the first time and sustaining recovery. All the efforts to cut costs have resulted in the need for more intensive services, shifting of costs to jails, prisons, hospitals, nursing homes and families and unecessary suffering and premature deaths of vulnerable people.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

This is a resposibility of MDHHS and the independent oversight agency. It involves leadership and qualified professional expetise, not prescriptive practices that defeat professinalism. These organiztions must work with the people who actually do the work to ensure a culture of professionalizm and integrity and develop methods of performance evaluation and oversight to reinforce quality care and correct inadequate capability or misconduct.

Define “success” for the model? How will the model’s success be measured? What types of benchmarks would be appropriate for evaluating the model?

More people receiving quality, adequate and appropriate services, early in the development of their disability and sustaind for a higher level of functioning the rest of their lives. Quality care can improve efficiency along with the efficiencies of consolidations for economies of scale. IN particular, the jail and prison population should be significantly reduced resulting in savings of the cost of incarceration over the cost of incarceration. At the same time, a reduction of negatives--fewer rights violations, fewer complaints, fewer incarcerations, fewer crises, fewer premature deaths (mentally now have 25 years shorter life expectancey), parents believe their ill/disabled family member will continue to receive quality care when the parents die. The average cost of Michigan incarceration of a person with mental illness is reported as $95,233 per

year compared to the cost of the average prisoner of $35,233. Proper community care of these people should be significantly lower, along with fewer crminial acts the currently cause the incarceration.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Certain apects can be piloted immediately, others involve larger scale transformation. There is no real need to pilot consolidations of administrative functions other than phasing them in one or more region and one or more business function at a time. The independent oversight agency should also be rolled out rather quickly with takeover and integration of the local recipient rights organizations. This proposal is not a bunch of tweaks, it is substantial and will have major impact, but a piecemeal approach will have serious problems transitioning organizations and employees. The transforation requires commitment and orderly but timely changes. Consolidations and elimination of a level of contracting will be more difficult the longer it takes. Consolidation might be approached as tranfer of the operation of a preferred regional functional organization to MDHHS followed by incremental expansion of that operation as it absorbs the workload of each successive regional organzation and CMHSP. There will be many persons adversely affected because the savings from economies of scale come from staff reductions and efficiency improvemets, particularly those in administrative roles reduced through consolidation. Opposition will prompt recipient fears of loss or disruption of services. The system will be fragmented until the transformation is completed, resulting in inefficiencies and challenges for both recipients and providers. The goal should be to substantially achieve the organiztional changes in two years, with several more years to adapt to new roles and transform operational details. This must be managed, not just allowed to happen. A formal project team and steering committee, including participation by the independent oversight agency, must be committed and authorized to make it happen.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

It must be implemented state-wide to realize economies of scale and equity of care. Much of it involves changes of roles and responsibilities to existing organiztions. See the attached proposal that puts it all together.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

Yes there would be a number of changes, many of them related to changes in roles and responsibilities and creation of the independent oversight agency. For example, (1) MDHHS responsibility for the state-wide risk pool and payment processing; (2) Consolidation of recipient rights organizations in the independent oversight organizaiton and processes for compaints and appeals; (3) MDHHS contract management for all service providers; (4) management of certifications for all providers and direct care personnel not covered by licensing; (5) FOIA ad Open Meetings application to all mental health agencies receiving a threshhold level of funding from public dollars; (6) limitation on governmental

immuity to ensure accoutability of service providers for damages to recipients; (7) extablishing a true entitlement to Medicaid services as well as services authorized for funding under the statemental health budget; (8) elimination of gaps in services resulting from fragmented sources of funding; (9) Consolidation of CMHSPs into regional organizations (based on PIHPs) and responsiblities for treatment planning, oversight and authorization of services under provider master contracts with MDHHS; (10) Clarification of the regional organization (formerly PIHP) for providing responsive mental health services to the community including early intevention, outreach, collaboration with schools, law enforcement, and other community organizaiotns, board representaton of community interests (rather than cost control), and so on.

(Optional) Are you aware of any other states or communities which have implemented this model?

No, there are not any. Mental health care is a problem in all states as evidenced by the populiations of persons with mental illness in jails and prisons, homeless and suffering death 25 years earlier than the general population. It is long past time to change direction. Privatization is a common cop out. Managed care is a disaster driven by financial interests to avoid cost and risk. It has driven us to this crisis and is responsible for the need for more intensive services and more unserved and underserved vulerable and disabled people as a result of cost cutting, unpaid, underqualified and overworked personnel and demands to minimize access to services. Michigan has the opportunity to lead the way out of this crisis.

Model #3

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Rural Health Integration Public Partnership (RHIPP)

Name of Submitting Organization: AuSable Community Mental Health Authority, CentraWellness Community Mental Health Organization, North Country Communtiy Mental Health Authority, Northeast Michigan Community Mental Health Authority, and Northern Michigan Community Mental Health Authority

Model Partner Organization(s): Region 2 consists of the Northern Michigan Regional Entity (NMRE) Prepaid Inpatient Health Plan (PIHP) and five Community Mental Health Service Programs (CMHSP), AuSable Valley Community Mental Health Authority, CentraWellness Community Mental Health Organization, North Country Community Mental Health Authority, Northeast Michigan Community Mental Health Authority and Northern Lakes Community Mental Health Authority. The twenty one (21) counties are rural and provide unique challenges to improving the coordination of physical health services and behavioral health services and supports. Region 2 has a number of programmatic and structural assets that provide the foundation for the model that we propose. Two of the five CMHSPs are currently participating in the third year of the Section 2703 Health Home Pilot. One CMHSP is in the third year of a SAMHSA Primary and Behavioral Health Care Integration Grant (PBHCI). One CMHSP functions as a MI Choice Waiver Agent, participates in the Senior Reach Pilot and the Non-Emergency Medical Transportation pilot. All five CMHSPs are involved in various stages of integrating physical and behavioral health services and are collocating primary care services on a CMHSP site and/or collocating behavioral health staff at primary care sites. Several of the CMHSPs participate in Mental Health Block Grants. The NMRE CEO and two CMHSP CEOs are on the Steering Committee of the Northern Michigan Community Health Innovation Region (NMCHIR) and one CEO serves on the advisory board of the Northern Lower Regional Center, Michigan Area Health Education Center (MI-AHEC). The region has utilized telepsychiatry in some of its counties and this proposed model enhances the existing regional resources by proposing this Rural Health Integration Public Partnership (RHIPP) model operating as a regional Accountable System of Care (rASC) that provides an additional telehealth option for the people we serve. The Rural Health Integration Public Partnership (RHIPP) model operates as a regional Accountable System of Care (rASC) designed to ensure that Michigan' s most vulnerable citizens receive high quality, locally available, and well-coordinated integrated whole health care. RHIPP takes full advantage of three public systems dedicated to improving the health and welfare of the citizens living in rural areas through the collaborative and coordinated provision of a variety of direct treatment, environmental, safety net, educational, and prevention activities. In addition, all existing local relationships with private physical health providers will be sustained. Community Mental Health Service Providers, District Health Departments, and State Universities exist to serve the citizens of the state. The RHIPP inclusion of these public partners will ensure that those citizens living with Intellectual/Developmental Disorders, Serious Mental Illness, Serious Emotional Disturbance and Substance Use Disorders experience an enhanced sense of health, welfare, and quality of life. To this end the combination of talent, knowledge, and resources brought together by the RHIPP, in forming a rASC creates a unique safety net to provide physical health

services in remote locations to the underserved. The RHIPP rASC is a platform from which to launch a campaign to overcome the challenges of providing first rate fully integrated health services across Michigan's rural regions thus ensuring that Michigan's most vulnerable and underserved citizens are that no longer. In the RHIPP rASC the CMHSP is responsible for care coordination leadership and integrated service development and operations. CMHSP staff has frequent contact and the great familiarity with the specialty population which leads to a heightened understanding of specialty populations needs in general, and the specific needs, dreams, desires, and preferences of the person seeking care, treatment and supports as they progress on their recovery journey. This model directly engages providers and funders in care coordination teams thus avoiding the expense and inefficiencies of a middle layer of management coordinating care. A care coordinator becomes a person who works with people, not a concept applied to cases. The RHIPP will provide a network of providers who will not deny services because of the presences of behavioral health symptoms. All persons will be fully embraced as they present, will be screened for behavioral health, physical health, and substance use and receive care that is consistent with their needs (R 2.a.1 & R 2.a.2)*. Whereas the method and location of services may vary to meet a person's present circumstance, a CMHSP led rASC will ensure that essential primary health and behavioral health services are provided uniformly across the continuum of care . * References in parenthesis denote 298 recommendations

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

RHIPP will offer clinic-based and virtual, via a telehealth delivery model, physical health services, utilizing existing private clinics, public health clinics, and newly created health clinic settings where needed to ensure that integrated health services are uniformly available in each participating county. The standard array of CMHSP services will be available (including telepsychiatry) across the RHIPP region. Health education, wellness education and activities, and prevention services will be available in person or via tele and/or video conferencing consistent with individual recovery plans. Substance Use Disorder and co-occurring treatment services will be uniformly available. Facilitated by the CMHSPs' varied "Tele" technologies, this will allow for interdisciplinary care coordination teams, inclusive of providers and funders to huddle and discuss care. This system will also support a robust system of specialty provider referrals via tele-consultation. Simply, whole person comprehensive care, in all counties, delivered by an integrated and coordinated accountable system of care, provided in vivo or via "tele" technologies.(2)Where brick and mortar clinics exist within the RHIPP rASC, existing staff provide treatment: this includes DHD clinics. Where no clinic is physically located in a county or where staffing does not currently permit adequate physical health care opportunities, the CMHSP and or the DHD will expand the scope of care or develop clinical space appropriate for providing physical health services (in vivo and telehealth). And, when staffing shortages occur in existing clinics, the telehealth system will be available to fill gaps while replacement providers are recruited. All designated locations will have telehealth/teleconferencing capabilities. RHIPP physical health clinics will be staffed by DHD nurses and university nurse practitioners and CMHSP staff. The virtual clinic will be open daily and in-location services with nurse practitioner present, will occur two days per month in each location. Care coordination teams will be facilitated by CMHSP care coordinators (nursing staff) and include all pertinent members of the clinical team and the funder. The care coordinator will facilitate the interdisciplinary care coordination team to ensure that best practices are applied to achieve valued outcomes and economic efficiencies. To this end, the "Triple Aim" becomes the mantra of the system.(3) Whereas the RHIPP rASC is a model designed to meet the total health and welfare needs of the specialty population, the RHIPP will promote provider choice, and support the individual with care coordination, case management, and support services regardless of the provider of choice being a part of the RHIPP or not. The RHIPP will employ a Person Centered Planning model that will include health goals and supports. Participating individuals will have choice of provider and choice of service delivery format (in vivo or telehealth). The RHIPP model ensures that in every county there will be in vivo (locally based clinic) and a telehealth option affording choice and ensuring uniform availability of services. Through tele technology applications, the person served may select from any of the care coordinators available, as their involvement can occur "virtually" if they are otherwise not geographically proximate. Relationships with hospitals are regionally established and through the use of teleconferencing and telehealth, making access to specialist locally available (virtually) and more frequently available.(4) Governance will depend largely on the state funding model selected from the recommendations discussed in this model

proposal below, which is intended to be a "regional accountable system of care" similar to that described in the State Innovation Model. Alternatives for organization could include the Intergovernmental Contracts Act (MCL 124.1), the Urban Cooperation Agreement Act (MCL 124.501), or use of Regional Entity provisions in the Mental Health Code (MCL 330.1204b), with necessary modifications to the law to include primary health care services. In the Intergovernmental Contracts Act and with the use of the Regional Entity law, the governance board would include members from the behavioral health entities statutorily charged with the oversight of services to the "Priority Populations" as described in the Michigan Constitution and subsequent laws. The member organizations would oversee the regional accountable system of care efforts in both physical and behavioral health for the priority populations, regardless if the funding from MDHHS (State) is strictly for behavioral health or both behavioral health and physical health services. In the use of the Urban Cooperation Agreement Act, the Board would be comprised in a fashion similar to that specified in the current Regional Entity law 330.1204b (1)(b) . It is extremely important to note that in any model selected governmental immunity must be maintained. The use of non-governmental entities in fiduciary arrangements to assist priority populations serves governmental immunity as well as supports the necessity of individual, family, and other community member engagement which, in any final model is essential for its success.(5) Where brick and mortar clinics exist within the RHIPP rASC, existing primary care clinics and their staff will continue to provide treatment: this includes DHD clinics providing health care (R 2.d.1). Where no clinic is physically located in a county or where staffing does not currently permit adequate physical health care opportunities, the CMHSP and or the DHD will expand the scope of care or develop clinical space appropriate for providing physical health services (in vivo and telehealth). And, when staffing shortages occur in existing health clinics, the telehealth system will be available to fill gaps in service availability while replacement health providers are recruited. All designated locations will have telehealth/teleconferencing capabilities. RHIPP physical health clinics will be staffed by DHD nurses and university nurse practitioners and CMHSP staff (R 12.1)(R 12.2). The virtual clinic will be open daily and on location services with a nurse practitioner present, will occur two days per month in each location. Care coordination teams will be facilitated by CMHSP care coordinators (nursing staff) and include all pertinent members of the clinical team and the funder. The care coordinator will facilitate the interdisciplinary care coordination team to ensure that best practices are applied to achieve valued outcomes and economic efficiencies. To this end, the “Triple Aim” becomes the mantra of the system.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
RHIPP rASC will serve any and all qualified members of the Specialty Population in the catchment region, including all Medicaid eligible persons living with Substance Use Disorders, including Co-occurring disorders.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
The RHIPP rASC creates a rural network of providers, with far reaching telehealth, telepsychiatry, and teleconferencing capabilities, bringing together the full force of the public health and community mental health service array, vastly expanded by the inclusion of private practice groups, while expanding the treatment of individuals and health education possibilities through the university partnership. No single service already available via public health or community mental health will be lost and with reliance on “tele” technologies, the local availability and array of services is greatly expanded. This approach brings more providers to underserved locations rendering services more available in a more convenient and consistent manner. “Tele” technologies change the paradigm of care from bringing the individual to the practitioner and to

bringing the necessary knowledge and service to the location of the individual in need. The rASC further promotes access to care with centralized telehealth scheduling that will foster more timely access to services regardless of the location of the person to be served. This brings unprecedented efficiency by make a single practitioner available to a population across a rural region, in a time sensitive framework, regardless of location.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

RHIPP rASC will contract with competent providers/ coordinators not otherwise affiliated with RHIPP to encourage persons in the specialty population to remain in the rASC, by allowing the individual to keep their current providers (R 2.d.1). If not, they may opt out and continue to participate in their current arrangement, including self-determination and or finical intermediary arrangements, (R 5.7 & 5.8) with independent care coordination/services would revert to the funder.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

The RHIPP rASC brings together both physical health and behavioral health services, and all ancillary services provided under the auspices of the three public partners: CMHSPs, DHDs, and university nursing programs. This system includes existing providers already engaged with CMHSPs, and creates a safety net of services to fill voids in the system stemming from areas being underserved, or where no provider is available, or when temporary staffing shortages occur. All participating providers aligned with the rASC must participate in care coordination teams. The fundamental premise for the RHIPP is to only offer services from a comprehensive, integrated, coordinated framework. It is not care coordination as a concept, but as the basic tenet of service delivery, that makes the model truly person centered, as the person served is a part of the care coordination team (R 5.3). The care coordination process will be respectful of and shaped by the person's desires and goals. Care coordination can only be truly beneficial if it includes the person and holistically addresses the full range of health needs within the context of the person's current situation and life goals. . Additionally, RHIPP makes all services locally and readily available in rural areas that are typically underserved and where transportation and weather adversely impact access to care. In this model the "tele" technology advantage is the use of equipment that can allow "house calls" when needed for direct care, education, and planning and coordination functions, effectively reducing barriers to care. Finally, reliance on "tele" technologies in the provision of services reduces costs associated with drive time and missed appointments. A person who cancels or no shows for an appointment with a nurse practitioner in Mio, Michigan does not cause the services opportunity to be wasted, as it can be re-allocated to a person in Lake City, Michigan with an emerging need.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

The RHIPP brings together the operations of three public service institutions, university nursing programs, DHDs, and CMHSPs in a coordinated fashion to jointly operate clinics (in vivo and "tele") featuring a comprehensive service array. These clinical operations will complement the services already in place and create choices for individuals and options when provider shortages occur or when the individual decides to opt for a different care provider. All professionals and clinics will operate in concert with the lead mental health agency. They will operate as a team from the start, with the CMHSP providing leadership in care coordination. The acceptance of the Universal Consent for Care Coordination will be a required element for provider participation (R9.3). Coordination is not possible if behavioral health and physical health services are not available in an area. RHIPP addresses and resolves that issue through the reliance on telehealth technologies. The model establishes care teams, which in concert with the person seeking care provides for whole-health needs. The collaboration is in the model: all care and all providers affiliated with the RHIPP will have access to real-time information because the electronic health record will be generated by those working in support of the person served. Specific training will be provided initially and on an ongoing basis to educate all participants in the best practices to use in working with persons living with a mental health, I/DD or SUD condition. Mental Health First Aid classes will be available for all clinical staff and affiliated personnel.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

The model will use existing relationships with private and public providers where they exist and supplement where needed with telehealth clinics and in vivo clinics in underserved areas or to create provider choice opportunities for individuals. The model establishes access to health care and behavioral health care in every county in which RHIPP operates through minimally telehealth and telepsychiatry services, and more expansively through the availability of nurse practitioners available for in vivo services in counties without an existing health clinic two days per month per county. The reliable availability of providers and appointments, in vivo or through telehealth, will lead to more consistent care being provided and enhanced treatment outcomes even for those living in the most rural of settings. The addition of university partners and their students will allow for greater attention to the health management and education needs of individuals living with chronic health conditions. As services progress, the advanced understanding of how to address the needs of a person living with minimally two chronic conditions will grow, and the need for expensive care in urgent care or emergency departments will be reduced. Tele-consultation abilities will reduce individual uncertainty regarding what to do when there is an unanticipated change in condition. Peer support workers participating in consultations and care coordination meetings will effectively serve as a second set of ears to help with understanding and follow through regarding care instructions. A commercial pharmacy will be engaged to provide remote dispensing on a timely basis where other options do not exist. This does not replace relationships with existing pharmacies, but rather extends the safety net, by making rural dispensing an option when there are no other timely options available. This in turn may avert unnecessary visits to emergency departments when care has been provided, the prescription has not been filled and the condition being treated worsens given the timely lack of medication.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

The use of "tele" technologies will reduce professional travel, fatigue, and enhance the reliability of staff in providing service often interrupted by distance and weather conditions. Specialized staff, both behavioral health and physical health may more frequently participate in case conferences and care coordination meetings across a vast area in a more efficient manner. Overall this will allow more service to be available using existing staff. Such technologies allow persons with more immediate needs greater access to care, as they can walk into a clinic and be provided telehealth services even when the practitioner is not on site. In addition, staff will be available to assist individuals who can participate in consultations over the phone seeking advice as to what steps to take next in addressing an emerging medical development. The participation of the university nursing programs in RHIPP provides expanded opportunities for clinical training for nurses, and enhanced exposure to and familiarity with behavioral health populations, rural medicine, and telehealth applications. Staff at all levels has the opportunity to participate in "grand rounds" using "tele" technologies to enhance learning, professional development, and discuss clinic questions. All this advances the network of knowledge and helps staff to be better prepared to respond effectively to issues as they emerge in the future. This community of practice will further advance the benefits of multidisciplinary practice and further care coordination objectives. The team approach using "tele" technologies also allows for more flexibility in scheduling consults, care coordination meetings, and access to care, thus reducing missteps and missed opportunities. The use of tele technologies will make it more practical for staff at all levels, i.e. recovery coaches, peer CLS workers , peer mentors, community health workers, and parent support staff, to more readily participate in care coordination meetings regardless of location, and provide supports to individuals engaged in care. In particular, the use of peers who are culturally aware can advocate to help all practitioners consider alternative methods, options, and treatment points of view, thus enhancing the likelihood of positive treatment outcomes. Their ability to ask questions, share insights, and make suggestions to better support the individual on their recovery journey is a valuable support to the varied practitioners aligned with the RHHIP.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

Individuals who have only a single option or no option in respect to their health care have no decision to make. The RHIPP rASC brings health care choice into play by allowing individuals to first have a care provider, and second to have a choice in provider. The individual has an active role in the care coordination process, which goes beyond person centered planning, and places the individual in the ongoing discussion with professionals providing and funding care. RHIPP promotes the model, not the provider, and in this spirit is committed to fashioning internally a fitting set of providers consistent with the individual's needs, or contracting with providers preferred by the person, and beyond, allow the person to contract for funding to create their own team of providers.

Would this model affect the administration of complaints, grievances, and appeals?
The RHIPP rASC will comply with current statutory and regulatory requirements using existing systems. To the extent that RHIPP is a partnership of public providers, complaints against any provider will be addressed within the frame work of CMHSP systems and the existing Recipient Rights system.

How would the model support continued access for individuals to current services, supports, and providers?
The RHIPP rASC is outcome driven not provider driven. The primary outcome is access to care for all members of the specialty population and Substance Use Disorder services. To this end, there is no person who for whatever reason, not welcome to participate in the services.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?
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How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?
Governance will depend largely on the state funding model selected from the recommendations discussed in this model proposal below, which is intended to be a "regional accountable system of care" similar to that described in the State Innovation Model. Alternatives for organization could include the Intergovernmental Contracts Act (MCL 124.1), the Urban Cooperation Agreement Act (MCL 124.501), or use of Regional Entity provisions in the Mental Health Code (MCL 330.1204b), with necessary modifications to the law to include primary health care services. In the Intergovernmental Contracts Act and with the use of the Regional Entity law, the governance board would include members from the behavioral health entities statutorily charged with the oversight of services to the "Priority Populations" as described in the Michigan Constitution and subsequent laws. The member organizations would oversee the regional accountable system of care efforts in both physical and behavioral health for the priority populations, regardless if the funding from MDHHS (State) is strictly for behavioral health or both behavioral health and physical health services. In the use of the Urban Cooperation Agreement Act, the Board would be comprised in a fashion similar to that specified in the current Regional Entity law 330.1204b (1)(b) . It is extremely important to note that in any model selected governmental immunity must be maintained. The use of non-governmental entities in fiduciary arrangements to assist priority populations serves governmental immunity as well as supports the necessity of individual, family, and other community member engagement which, in any final model is essential for its success

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?
The financing system and mechanism can take different forms while maintaining the spirit of the RHIPP rASC model. The following options span a spectrum that would include: 1) maintaining the current major funding systems, (Medicaid, General Funds, MI Choice, Senior Reach, Non - Emergency Medical Transportation, Adult Mental Health Block Grants, Substance Use Disorder Block Grants, Liquor Tax Funds and 2703 Health Homes) with contractually specified care coordination between the CMHSPs and the Medicaid Health Plans similar to what has been implemented with the current MDHHS contract. 2) enhancing the current major funding systems with reimbursement codes for care coordination supported by financial mechanisms for shared financial incentives to promote integrated behavioral and physical health care, and 3) altering the current Medicaid and General Funds flow by carving out the physical health care funds and directing them to the CMHSPs, as has been done in the state of Arizona, while maintaining a contractual collaborative, mutually incentivizing system to promote behavioral and physical health care integration with the MHPs for physical health care services.

What changes would need to be made to provider reimbursement in order to implement the model?
Option 1 would leave the current provider reimbursement models in place. Option 2 would establish care coordination reimbursement codes and incentive pools where the CMHSPs and MHPs would benefit financially if savings are achieved with a portion of the savings used to expand services. In Option 3, the Medicaid and General Funds for both behavioral and physical health care would flow to the CMHSPs that could in turn either contract with the MHP for some or all of the physical services or could contract directly with PCMHs, PHOs or ACOs.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
Incentives at the payer and/or service provider level could take many forms. Establishing incentives at the level of the individual Health Home, PCMH or PHO would include the achievement of utilization and quality targets (e.g. HEDIS, Ambulatory Sensitive Conditions, Hospital utilization, etc.) and would reflect a value based purchasing approach that would incentivize all parties particularly the person served. Options 1-3 are summarized above and can include a variety of incentives that can be drawn from the PCMHs, Section 2710 Health Homes, Federal ACO models and the payment and incentive models that emanate from the State Innovation Model (SIM). The SIM payment reform initiatives that are to be developed by the Northern Michigan Community Health Innovation Region (NMCHIR) in prosperity Region 2 will contribute to the mechanisms for value based purchasing.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?
One advantage of having university partners is the ability of the RHIPP rASC to avail itself of the research acumen of the faculty and leadership involved. The model will establish core data sets to study the satisfaction of persons served with the model, the clinical effectiveness of the

model, and the economic effectiveness of the model. Annually, the model will analyze the data collected and sustain successful practices and thoughtfully implement business and practice variations to enhance and improve outcomes.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

The simplest measure of the success of any model is that there remains a consistent and perhaps growing participation in the model by individuals in need of care, providers, and funders. Secondarily, the overall health and welfare of the person's served remains stable and is addressed predominantly via routine and planned activities versus urgent, emergency, and extended hospital care episodes. Third the care delivered is consistent with the person's goals and is in support of person's achieving and living the life they choose: a life lived that is more about the person than the care provided. Consequently, the "successful" outcome is that members of Michigan's most underserved and vulnerable population are living a life where that distinction becomes irrelevant.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Yes. The formalization of the RHIPP rASC will require a considerable amount of work depending on prevailing state and federal decision regarding Medicaid waivers, funding, and regulations. That can be achieved and negotiated. The Clinical models are in place and operational in various parts of the rural area familiar to the writers of this model. That knowledge gained based on these experiences and from others involving partners and collaborators will hasten the essential aspects of clinical service, data collection and information sharing. The common hurdle will be the training and incorporation of a true and meaningful care coordination model. Here the immediate and prudent use of incentives will be essential to entice participation. A projected timeline requires 6 months to create and have approved the rASC at all levels: federal, state, regional, local. The clinical model and clinical protocols will be ready within the same time frame. The pilot itself should run for a minimum of 24 months and ideally 36 to allow stability of operations over time to ensure that data collected reflects a stable operation that meaningfully uses data to refocus its operations and models to promote desired outcomes. The pilot will not measure if the model as initially envisaged is beneficial, but rather that the model is capable of producing better outcomes based on data based modifications. Truly the model at the end of the pilot should be meeting goals, producing outcomes, and not look as it did in the beginning.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

It is not recommended for statewide use. The life style of those living in the northern 21 counties of Michigan whose boundaries extend north of Highway US 10 to the Mackinaw Bridge is fundamentally different than that experienced by those living below US 10. Population density is less, vast areas are considered medically underserved, and in general medical service is not a matter of choice of provider, but one of discovering if there is a provider that will take a Medicaid covered, person with multiple chronic illness. This is a rural safety net model: a well-

crafted quilt of small pieces of medical skill sewn together to cover a region. It is an option that will work rurally, but may not be applicable in urban areas.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

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(Optional) Are you aware of any other states or communities which have implemented this model?

Click here to enter text.

Model #4

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: **Integrated Physical and Behavioral Health care in Community Mental Health Service Programs (CMHSPs)**

Name of Submitting Organization: **Bay-Arenac Behavioral Health**

Model Partner Organization(s): **N/A**

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

The Michigan Department of Health and Human Services (MDHHS) should expand its contracts with its county-based CMHSP partners to require the delivery of integrated physical and behavioral health services for all existing Medicaid Specialty Behavioral health services and supports (also known as state plan mental health, B3 mental health and habilitation supports waiver services), Healthy Michigan, Substance Use Disorder Services, Autism Spectrum Disorder services and existing services through both the Children's and Serious Emotional Disturbance Waivers. These services would be enhanced through the integration of primary health care services delivered at the specialty behavioral health and substance use primary provider locations. The lead organization in providing and coordinating services would be Community Mental Health Services Programs (CMHSPs) and its overlapping community partners for primary health care and substance use services in its medical trading area.

The model would actualize further implementation of the core values in the interim 298 report by building on existing state mental health safety net systems that are already founded on the key principles of persons-centered planning, recovery, trauma-informed care, employment and self-determination. The CMHSP system, with its statutory-defined accountability to local communities and persons/families receiving services, is uniquely qualified to further the policy goals of the 298 report. The model would primarily by financed by MDHHS through consolidation of current public behavioral health resources within existing state and county funding mechanisms for CMHSP services. This will include affirmative efforts by CMHSPs to establish financial incentives and shared reward mechanisms with downstream healthcare providers to improve health outcomes and offset public funding through available primary and secondary payer obligations.

The model will be implemented within existing Michigan Mental Health Code requirements for CMHSPs, county governments and the state mental health authority. This includes a publically-appointed CMHSP board of directors accountable to a democratically elected county government and subject to existing state laws regarding municipalities and governmental entities. The board of directors are elected for staggered terms, include representatives of persons/families receiving CMHSP services and are

composed of representatives of mental health providers, agencies and occupations with a working involvement with mental health services and the general public. These governance obligations, CMHSP accreditation requirements and targeted oversight from the state mental health authority through Administrative Rules, Medicaid policy, CMHSP Certification and Annual Submission requirements ensure a competent engagement of the public in the delivery of mental health services.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
The model would be implemented for all populations currently eligible for PIHP/CMHSP specialty behavioral health services under existing Medicaid waiver authorities including adults with severe mental illness, children with serious emotional disturbances, persons with autism spectrum disorders, persons with intellectual/developmental disabilities and persons with substance use conditions.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
These changes would apply to all Medicaid specialty behavioral health services and supports, including state plan services, B3 services, habilitation supports waiver services, substance use disorder services, Autism Spectrum Disorder services and existing services through both the Children's and Serious Emotional Disturbance Waivers. This would include the full range of community-based services including inpatient psychiatric services, outpatient services, targeted case management services, nursing services, assertive community treatment, home-based services, applied behavioral services, supports coordination services, peer-delivered services, community living supports and supported employment services. Many of these services would be enhanced through the integration of primary health care services delivered at the specialty behavioral health and substance use primary provider locations.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?
This model retains the current model of separate structures for the management and delivery of Medicaid physical healthcare and specialty behavioral health care as recommended in the Interim 298 report. This includes the existing provider choice requirements established for the Medicaid Health Plans (HPs) and PIHP/CMHSP service populations. The primary change is the incorporation of primary health care services in CMHSP locations. The model acknowledges that CMHSPs are required to offer

choice of providers to the maximum extent possible depending upon the local provider market. This provision would extend into the primary healthcare services embedded in CMHSP service locations. In some situations, CMHSPs can offer out of network options to individuals that prefer an alternative provider organization. In some cases, Medicaid policy and existing HP and PIHP/CMHSP coordination agreements encourage transfer between both systems if in the best interest of the individual receiving services. This mechanism could also be used to support any individual preferences to pursue primary health care outside of the CMHSP system.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
The model would directly enhance coordination of physical health and behavioral health services for individuals by embedding primary health care services (physician, nursing, pharmacy, and laboratory) directly in specialty behavioral health and substance use disorder primary service locations. CMHSPs would serve as the lead organization in providing and coordinating integrated behavioral health care services for the specialty populations with its overlapping community partners (i.e. hospital systems, emergency rooms, physician groups, Federal Qualified Health Centers) for primary health care and substance use services in its medical trading area. This will ensure that both health care and specialty behavioral health services are available and delivered at the same point of service location.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

CMHSPs would implement strategies, i.e. Health Homes, Certified Community Behavioral Health Clinics (CCBHCs), that embed primary health care services (physician, nursing, pharmacy, and laboratory) directly in specialty mental health and substance use disorder primary service locations. This will ensure that nearly all primary and specialty behavioral health care is available and delivered at the same point of service location. This will encourage a consolidated health team, shared electronic health record, shared technology, shared professional resources and more effective communication of assessment, diagnosis, treatment and follow-up of health care decisions at the point of service. These developments have been identified as factors that will improve the health outcomes for persons with complex health and behavioral health conditions.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

The model would integrate primary health care services into CMHSP service locations thereby improving the availability and accessibility of these services for persons with mental illness, serious emotional disturbances, substance use disorders and intellectual/developmental disabilities. CMHSPs would implement physical health services in a manner consistent with integrated healthcare and/or national accreditation requirements that would increase the uniformity of these services.

The model assumes existing availability, accessibility and uniformity requirements for all other Medicaid specialty behavioral health services will continue to be enforced by MDHHS. The model recommends no changes to the existing carve-out for certain prescription drugs covered by Medicaid including anti-convulsants, anti-psychotics, anti-depressants, non-controlled substance anti-anxiety drugs and medications to treat mental disorders, epilepsy and seizure disorders.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
The model does not directly address workforce issues related to the delivery of specialty behavioral health services and supports; however, it is recommended that MDHHS consider implementation of the Direct Support and Peer Support Workforce Development Model (DS-PS Workforce Model) that has been adopted in similar forms in other states including Alaska, California, Massachusetts, Minnesota, New Mexico, Ohio, Virginia & Washington. The DS-PS workforce model is consistent with previous legislative initiatives related to direct care staff and would improve CMHSP efforts to recruit, train and retain staff that are so critical for the delivery of community living services and supports.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?
The model is founded on the empowerment principles of recovery, trauma-informed care, person-centered-planning and self-determination. These are philosophical and policy expectations inherently aligned with the delivery of CMHSP Medicaid behavioral health services and supports. These affirmative policy requirements ensure that specialty services and supports are delivered in an amount, scope and duration predicated on the needs and preferences of the individual person and/or family. This

foundation establishes the exceptional nature of the MDHHS/CMHSP partnership as compared to commercial and private sector healthcare systems and the traditional medical model of service. In addition, individuals will continue to have the option to retain an independent facilitator for person-centered planning activities, participate in self-determination arrangements that transfer control to the individual for allocation of specialty care resources and use of a fiscal intermediary to supplement self-directed approaches to care. This model would extend the principles of person-centered planning and self-determination into the physical health primary care services that will be embedded in CMHSP service locations. This will ensure that all primary and specialty healthcare services for persons with serious mental illness, severe emotional disturbances, substance use disorders and intellectual/developmental disabilities are also delivered in a manner consistent with the principles of recovery and trauma-informed care. These changes will reduce the impact of stigmatization and discrimination toward these vulnerable populations by the traditional health care sector and continue to empower individuals to assume more direct responsibility for their health care resources.

Would this model affect the administration of complaints, grievances, and appeals?
This model would support existing federal and state requirements related to complaints, grievances and appeals. CMHSPs would use existing recipient rights and customer service protections to manage individual complaints, grievances and appeals in compliance with MDHHS requirements. All persons receiving Medicaid services would continue to have access to MDHHS state fair hearing processes. The MDHHS Office of Recipient Rights could serve as the independent state-wide infrastructure identified in the Interim 298 report to provide oversight and resolution to complaints, grievances and appeals not successfully resolved at the CMHSP level.

How would the model support continued access for individuals to current services, supports, and providers?
The model does not change any current service arrangements for individuals receiving specialty behavioral health services.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?
CMHSP governance is vested in a 12 member board of directors appointed by the county government. The CMHSP and its board of directors are ultimately subject to oversight of the county via board member removal and CMHSP dissolution proceedings as allowed for under the MI Mental Health Code. As a result, the local community and its elected county officials are some of the

most important stakeholders for CMHSP services. In addition, the CMHSP board of directors has specific duties prescribed in state law including oversight of the CMHSP executive director, annual budget, performance improvement systems, and are subject to all laws governing public entities including the Open Meetings Act and the Freedom of Information Act. These requirements ensure that CMHSP governance processes are held open to the public, documented, subject to reconsideration and ultimately responsible to local communities.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

The person-centered planning process is the foundation for the delivery of all CMHSP services and supports. This ensures that the preferences of the persons/families receiving services are paramount in the individual decision-making regarding public services and supports. This principle is supported by the availability of self-determination arrangements that empower individuals to more directly manage their service resources. In addition, all CMHSP boards of directors must include 1/3 membership by persons/families receiving services including at least ½ of those members must be primary consumers. In addition, CMHSP board of directors are expected to include representatives from mental health providers, agencies and occupations with a working involvement with mental health services and the general public. In addition, CMHSPs routinely obtain feedback from consumers, providers and other community agencies through satisfaction surveys and needs assessment processes.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

MDHHS would finance these services through allocation of related Medicaid and substance abuse resources in a manner that augments existing CMHSP state/county funding mechanisms for the local geographic service area. MDHHS would develop a funding methodology for the HPs and CMHSPs that supports expanded primary health care in CMHSP service locations and redirects future actuarial savings related to integration of physical and behavioral health care into expanded service options. This could be accomplished by directing a portion of Medicaid primary health care capitation to the CMHSPs for the specialty service populations and establishing a shadow withhold for identification of future health care savings for reinvestment into the community-based services as identified in the Interim 298 report. The CMHSPs would manage the risk corridor for these populations either through a state-wide risk pool, continuation of internal service funds via existing PIHP/CMHSP mechanisms or purchase of re-insurance for financial liability.

What changes would need to be made to provider reimbursement in order to implement the model?
There will be minimal changes to provider reimbursement apart from the overall capitation changes and incentives addressed above and below, respectively. However, CMHSPs would assume payment responsibility for some primary health care services delivered in CMHSP service locations and would need to implement additional coordination of benefit practices that offset public funding through available primary and secondary payer obligations.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
CMHSPs will implement innovative efforts to establish financial incentives and shared reward mechanisms with downstream healthcare providers that have been enlisted to support persons receiving services. The incentives would be a combination of enhanced payments to providers for meeting specific integrated health practice requirements and a shared reward pool for collective network accomplishments related to integrated health outcomes. These developments may serve as the foundation for the next evolution in integrated physical and behavioral health care through the development of larger accountable care models that may align all CMHSPs, community hospitals, physician practice groups, public health services and similar local providers with shared financial risk shared populations and communities of care.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?
The model would continue the existing quality assessment and performance improvement standards required in the existing PIHP/CMHSP contracts and extend them to the additional primary health care services in CMHSP locations. This includes standards related to customer services, access systems, customer satisfaction measures, substance use services and related service delivery outcomes. These considerations would be enhanced upon adoption of the state-designed Quality Rating System (QRS) required by federal Medicaid policy. This can include measures that evaluate physical and behavioral healthcare integration either directly or through related outcome measures available through national benchmarks such as HEDIS, NQF, CCBHC.

Define “success” for the model? How will the model’s success be measured? What types of benchmarks would be appropriate for evaluating the model?
The model will be considered successful based on the performance of CMHSP service delivery against the measures of integrated physical and behavioral health care adopted in the state QRS noted above. These improvement will also translate into healthcare savings for the Medicaid programs. It will be important for MDHHS to develop evaluative methods to identify and monitor the

extent of related HP Medicaid savings to avoid assumption of these accumulated resources into overall healthcare or plan expenses.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?
Yes, this model could be piloted in specific areas of the state prior to a larger implementation. It is recommended that any pilot be first considered in CMHSPs with established mechanisms for the delivery of integrated services or in existing PIHP regions that demonstrate sufficient interest and competence to ensure a successful transition.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?
Yes, the model could be implemented state-wide as it is based on existing CMHSP service operations covering all 83 counties in Michigan. It is recommended that state-wide implementation include an initial readiness phase (similar to the transition to Medicaid managed care from 1998-2002) to ensure sufficient opportunity for underserved areas to develop the required physical health care service components.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?
There are no changes to existing state statutes required to implement this model. However, there may be some adjustments to state appropriation language necessary to move implementation of the model forward.

(Optional) Are you aware of any other states or communities which have implemented this model?
Some variations of this model have been implemented in Missouri, Ohio, Maine, New Jersey, Oklahoma and Rhode Island.

Model #5

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Crisis stabilization and integrated care for adults with mental illness and co-occurring disorders

Name of Submitting Organization: Beacon Specialized Living Services, Inc.

Model Partner Organization(s):

- **Mackinac Straits Health System (ER/ED medical treatment);**
- **Mackinac County Sheriff Department (to reduce law enforcement calls and supervision of admitted patients);**
- **Drug Court of Mackinac County (to provide alternative program support for offenders with mental illness or substance use disorder);**
- **Great Lake Recovery Centers & Behavioral Health Services (for substance use counseling and Addiction Treatment);**
- **Pinerest Medical Care Facility (Psychiatric services);**
- **Upper Peninsula Health Plan (potential data support, care coordination and physical health reimbursement);**
- **Community Mental Health Organization(s) and PIHP(s) (for mental health and substance-use payments for new models of care afforded by bundled rates to cover residential, behavioral and care coordination services they need.**

Beacon Specialized Livings Services is a statewide provider of Specialized Adult Foster Care facilities providing residential, behavioral, physical and mental health supports to adults in Michigan for over 18 years. Beacon currently serves over 300 consumers throughout the state, providing a variety of programs and facilities matched to the needs and acuity of each consumer. Beacon currently holds contracts with 28 CMHSPs and 7 PIHPs and has developed an outstanding reputation for effectively managing some of the most challenging populations with the greatest mental and physical health needs and behaviors.

Today a majority of our residents have serious mental illness and co-occurring substance use disorder. Many of these consumers have, in the past, represented a threat to themselves and/or the community at large. Additionally, they average 4.9 chronic conditions each day, and it is difficult to secure providers willing to meet these consumers' significant needs. To that end, Beacon spends over $500,000 annually providing clinical and medical care for these consumers. Very few, if any, of these services are reimbursed due to Michigan law that precludes Beacon from billing Medicaid or Medicare directly as a non-medical enterprise.

Thus, we have had to innovate and coordinate all the care that each consumer needs directly using telemedicine and by bringing the providers to our residents.

Through these challenges, Beacon Specialized Living Services has gained valuable insights and competencies, which ultimately resulted in the development of the St. Ignace Crisis Stabilization and Independent Living Readiness Center models described herein. By providing a cost-effective alternative to institutional treatment and fragmented care, we successfully stabilize consumers in a warm, compassionate, and supportive home environment. Through coordinated care and targeted resources, our consumer engagement and corresponding outcomes of lower utilization, medication compliance, behavior improvement and consumer satisfaction have become a reality.

The models being proposed here have been a work in progress for over two years, and through planning and an investment of more than $1.5 Million, Beacon Specialized Living Services successfully opened the St. Ignace Shores Crisis Stabilization and Independence Readiness Center. With sufficient financial support, Beacon Specialized Living Services will expand on this integrated and coordinated physical and mental health service for consumers with severe mental and chronic illness, and co-occurring substance abuse disorder.

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

St. Ignace Shores Crisis Stabilization and Independent Living Readiness Center ("St. Ignace Shores") is a newly renovated 18,750 square foot, single story facility situated on 5.4 acres of land, purchased from the former St. Ignace County Hospital. The facility now offers 28 Specialized Adult Foster Care (AFC) licensed beds, with each room offering a spacious 200 square feet each. This is a newly furnished facility with recently purchased amenities that include sofas, beds, linens, closets and artwork throughout the home. Rooms are connected by spacious double-wide hallways that provide easy access to three family rooms and lounges. There is a new

cafeteria, large dining room, and grooming rooms with newly installed showers. This facility also features two outpatient counseling rooms, group meeting areas for peer support programs, a nursing station, medication vault and dispensing room, and administrative offices directly adjacent to all living spaces. All rooms have easy access to beautifully landscaped courtyard (spring and summer). Parking is directly adjacent to the building, and all doors are connected to a state of the art security and safety system.

Goals of St. Ignace Model

- To better serve adults in the Eastern Upper Peninsula (EUP) who have serious mental illness and substance use disorder (SMI/SUD) and exude high risk behaviors, over-utilize emergency department, public safety and justice resources and who fail to respond to traditional and current services and benefits.
- To offer expanded access to cost effective and integrated clinical alternatives to emergency department (ED) triage or inpatient psychiatric services that address the "whole person" including mental, behavioral, emotional, physical, spiritual and social needs.
- To improve consumer engagement and ensure that patient and consumer rights are protected and that self-determined care plans include choices for addressing housing, employment, school performance, family stability and avoidance of involvement with criminal justice system.
- To better use public funding to address the needs of adults with serious mental illness (SMI) and substance-use disorder (SUD), one of the highest cost population segments to serve, by reducing transitions of care, hospital boarding due to insufficient referral options, and increased use of programming that addresses the root causes for individual consumers' costly use of services.

- To improve continuity of care by forming a specialized network of providers serving the EUP who have agreed to collaborate and deliver improved person centered care, assuring comfort and convenience to the consumer in a home-like and therapeutic environment vs. an institutional bed where community care has proven ineffective.
- To provide each consumer an adequate array of services focused on stage-based and evidence-based treatment modalities and comprehensive assessments that better assess cognitive functioning, intellect and readiness for change. This readiness is imperative for the consumer to develop and implement appropriate and sustainable solutions.
- To create a consumer experience that improves engagement and enables them to learn and maximize new independent living skills that can be sustained based on their abilities.
- To provide a HIPAA compliant collaborative care applications and utilize a global consent form for each consumer admitted to St. Ignace Shores so that information can be shared and service coordinated better for the consumer. This will allow the providers in our specialty network to access PHI and contribute to each consumer's care plan. We will collect, analyze and report de-identified demographic, condition, medication compliance, engagement, and other KPMs for the consumers served at St. Ignace Shores. Over time, we will contribute to any state-directed data sharing initiatives or with HMOs/Health plans directly to share our data for assessing and demonstrating the impact of our programs against other comparative cohorts and their respective claims (total cost of care).
- To leverage existing payment methods from CMHSPs, PIHPs or SSI for mental health, substance-use or living services respectively. Additional incremental funding will be pursued from mental health and SUD payers from savings generated from reduced recidivism. Beacon Specialized Living Services will also initiate a plan to recover care costs from HMOs/health plans to cover the costs of more intensive staffing, coordination of integrated care, data systems and

management, security, transportation, and the coordination of integrated care. We will ask payers to reinvest in these services from savings realized from lower utilization, administration, pharmacy, and social service support costs.

St. Ignace Shores is organized by three stages of care, depending upon the referred consumer's acuity and needs at the time of admission.

1. Crisis Stabilization Unit: Once medically cleared by their attending physician, consumers experiencing psychiatric crisis and/or intoxication with severe behaviors would be transferred to the Crisis Stabilization Unit from local hospitals or inpatient facilities. Stabilization includes consumer observation and continuation of medical treatment per the attending/referring physician's care plan, including treatment for substance use disorder.

- Estimated Length of stay on this unit is 2-5 days, depending on the complexity of the presenting issues.
- This unit would provide stabilization for emotional health needs through physical and psychiatric care, including assistance with withdrawal management (detox) and physician-directed Medication Assisted Treatment (MAT) if required. (Partners: Great Lakes Recovery and Behavioral Services; PCP and MAT administration by Mackinac Health System; in-patient supervision, monitoring and administration by Beacon nursing staff).
- If they are cognitively and emotionally prepared, consumers begin to explore skill building groups and various recovery groups such as Smart Recovery, 12-steps Life Ring, Women in Recovery, Double Trouble and Native American recovery. Beacon will have a crossed trained and multidisciplinary team of coaches and counselors and will coordinate local peer support groups in our programming.
- Once the consumer has achieved physical stability, is coherent and in remission from any imminent psychological risks such as suicidal or homicidal ideation, hallucinations or delusions, or other condition that prevents them from committing to program planning and full participation in treatment, they can be moved to the second stage of treatment. It should

be emphasized that consistent with self-determination best practices, consumers must be willing to commit to program planning and participation to proceed to Unit 2.

- Payment Methods: Beacon Specialized Living Services is submitting a plan to the local PIHP (Northcare) to support their strategy to utilize Medicaid funds to provide residential crisis services for 16 of St. Ignace Shores beds. Crisis Residential services have established per diem rates and coverage for up to 14 days and can be extended upon the recommendation of the multidisciplinary care team. Due to the high acuity and chronic nature of difficult behaviors associated with these consumers we intend to serve, Beacon will work with the regional PIHPs, CMHSPs and UP Health Plan for payments above the per diem to offset staffing and administrative costs related to the coordination of primary care, specialty care, community resources, and Medication Assisted Treatment. All physical health and Medication Assisted Treatment services will be provided by non-Beacon physicians and providers in our specialty network, with each billing for their respective services directly to Medicaid, Medicare or Commercial health plans. (Some patients may have commercial insurance and Beacon will work to become a network provider in order to receive payments. Until this agreement can be established, these patients must seek alternative services or pay out-of-pocket).

2. Assessment Unit: Once consumers are medically stabilized and demonstrating sufficient levels of engagement, this unit provides a comprehensive clinical and behavioral team to assess the consumer to determine if there are other contributing factors for their behavior.

- A multi-disciplinary team of medical, behavioral and psychiatric experts collaborate to uncover critical information about the consumer to help identify root causes, triggers or deficiencies in the consumer's aptitude and skills required for successful recovery.

- Comprehensive psychological and/or intellectual assessments will be administered to assist in determining and developing personalized counseling, treatments and supports.
- At this stage, consumers become heavily involved in developing and implementing their respective evidenced based treatments including mental health groups, SUD treatments, and individualized interventions focusing on issues such as trauma, family dynamics, skill deficits etc.
- There is also an available team of Certified Peer Support and/or Recovery Coaches available to assist individuals in entering their recovery journey. This important service allows people who have experienced mental illness or substance use to come alongside their peer (the consumer) and provide hope and guidance as they examine ways to begin their own journey to recovery.
- Regular case management and individual therapy will also occur at this stage to assess strengths and deficits. Again, all programming is driven by the consumer to maximize engagement at each step of programming and treatment. Once consumers are exhibiting sufficient functioning, engagement and comprehension of their self-directed plan, they are ready to move to Unit 3, the Independent Living Readiness Unit.
- Payment Methods: The services provided in the Assessment Unit will be covered by the Crisis Residential per diem but will require additional per diem funding for staffing, the administration of assessments, and the collaborative care planning tool. Per above, a multidisciplinary team will determine the plan of care based on needed services extending beyond the 14-day standard benefit. It is anticipated that some residents will leave once they are stabilized; some will stay through the assessment phase; others may require a transfer to in-patient psychiatric services or inpatient recovery services. We will work with the PIHP and CMHSP case workers to negotiate appropriate plans of care prior to admission for Medicaid beneficiaries. We will also work with the UP Health Plan for payments related to their beneficiaries that have significant physical health and/or mild to moderate mental illness and/or SUD.

3. Independent Living Readiness Unit: Once primary stressors are identified and the consumer's choice of recovery options is discussed and negotiated, the consumer begins to engage in new behaviors and assume new responsibilities. The goal of this unit is to instill an individual with the right set expectations, activities, and supports necessary for successful recovery and more independent living. Here, improved function and readiness for more independent living is supported and demonstrated, and living options are matched to each consumer's abilities and living choices. Each option is discussed and assessed with the consumer, guardian, or family to assure meaningful and personalized case coordination. The readiness unit provides the following supports.

- Strengthen gains made by the consumer to avoid reentering the crisis cycle and resulting inappropriate use of the emergency department.
- In addition to therapy, Independent Living Readiness unit assists people with SMI or long term SUD with nonmedical services, such as income support, vocational training, housing assistance, as well as assistance managing day-to-day activities. These services are provided on an individualized basis to assure these services are addressing specific root causes.
- Assist consumers in returning home or to another appropriate community based environment. If it is determined the consumer has too limited capacity for independent living, arrangements can be made for continued supportive living in an AFC or other supportive residential program. If the consumer is not able to become stable and/or refrain from substance use, they may be placed in a sober living facility until the consumer is better positioned to gain benefit from this program.
- Payment Methods: We will accept the standard Specialized Adult Foster Care per diems plus SSI payments for eligible consumers transferred or admitted to the Independent Living Readiness Unit. Additional per diem payments will be required to cover the costs of increased staffing, residential assessments, placement and transfers, and for monitoring the consumer's need for ongoing supports for 90 days following discharge from St. Ignace Shores. We believe this is

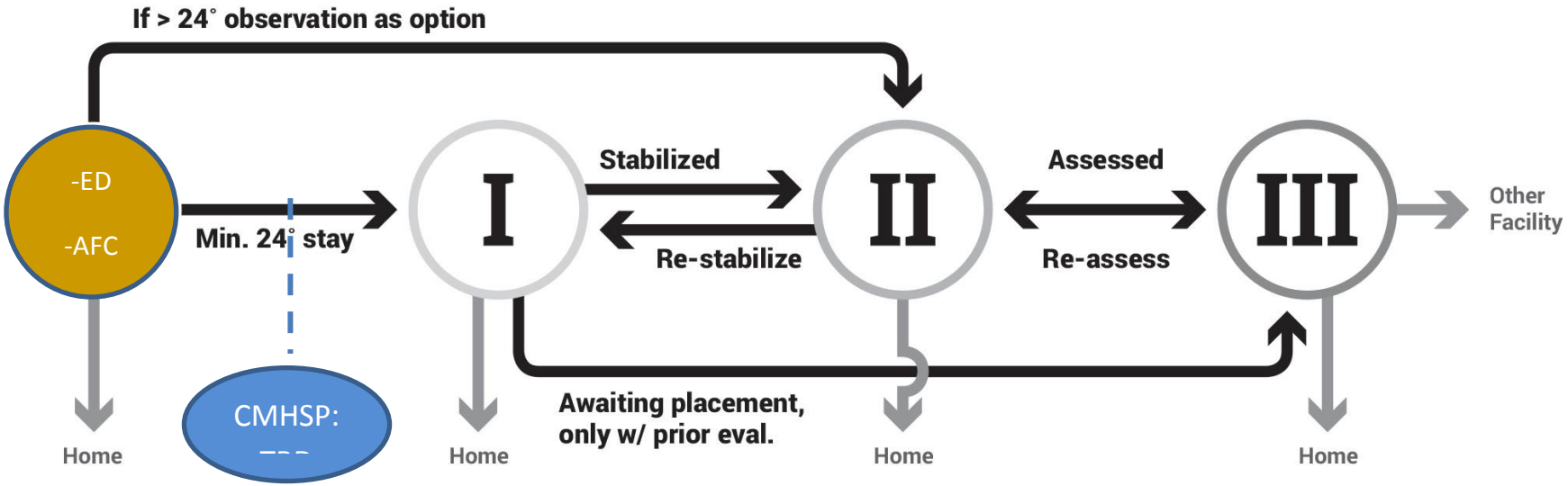
critical for achieving sustainable results. We will work with PIHPs, CMHSPs and UP Health Plan where applicable, to establish pricing for these extended special services.

Our programming is voluntary, and we believe these highly effective, evidenced program offerings will lead to a high engagement rate among consumers. We believe the opportunity for consumers to work on serious issues for both themselves and their community while removed from a chaotic environment that contributes to increased emergency department utilization will hold significant appeal to properly supported and motivated consumers. Unlike traditional crisis programs, the consumer will be the driver of programming decisions. Services are individualized and tailored to the consumer's needs and wants. A thorough consumer history is taken and assessments are focused on determining the root cause of behaviors and recidivism, and consumer's contributing deficits or mitigating strengths. A treatment plan relevant to the consumer's specific needs and desires is developed and coordinated with treating physicians, psychiatrist's treatment team and community supports.

Through this program, we are serving those consumers who have previously been unsuccessful at community levels of care, have misused emergency departments and are all too often unwanted customers of the criminal justice system. Beacon Specialized Living Services believes that the best hope for consumers with serious mental illness and co-occurring substance use disorder is to receive targeted treatment programming that addresses all domains of their life; physical, mental, environmental, and spiritual, and strives to provide consumers better care for a lower total cost. While Programming is individualized, a sample of services is included below:

- Meetings with a case manager
- Meetings with Psychiatrist
- Meeting with a Primary Care Physician
- Meeting with a Masters Level Therapist trained in both SUD and mental health issues

- Specialized evidenced based mental health skill building groups or SUD groups (examples could be Seeking Safety Groups, Wellness Action and Recovery Planning Groups, Helping Men Recover, Dialectical Behavior Therapy, Matrix Model)
- Individualized needs/services programming set through shared decision making
- Daily Monday-Saturday Co-occurring Disorders psycho educational group as needed
- Continued recovery peer support groups



Payment Model

Bundle fees based on treatment, services, programs and LOS matched to patient's needs for recovery and stabilized living.

Value Prop: Break the cycle of recidivism

Develop plan and provide on-going supports that results in long-term recovery and independence.

Gaps in the current system

Inpatient treatment, recovery and skills building. Community repatriation services.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

This project will specifically focus on costly consumers with serious mental illness and co-occurring substance use disorder. This population, more than any other mental health group, represents an opportunity for improved and enhanced services that ultimately reduce the cost of serving this population. As previously noted, the strength of our model is that it serves a multitude of impaired populations who overuse emergency services, simply because there are no other alternatives. . Consumers with substance use disorders combined with mental illness, complicated by untreated or undertreated physical co-morbidities will benefit from these services. While those with intellectual and developmental disabilities would not be excluded from this model, many of these consumers are currently in stable living situation and their physical health care needs are already met through readily available programs. We hypothesized that these individuals would not be served by the proposed pilot program as often as those with serious and persistent mental illness and substance use disorders.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

The model we are proposing targets those who have been unsuccessful in maintaining stable relationships with community providers. This project represents a **fully integrated care model** provided in a residential setting where a close working relationship with consumers can ensure compliance and coordination required to improve engagement, treatment, recovery and long-term health and well-being improvement. The following services and supports would be incorporated in the implementation of our model.

- Primary Care
- Specialty Care for Chronic Illness or Injuries (Diabetes, hypertension, CHD, COPD, etc.)
- Medication Assisted Treatment
- Mental Health (Psychiatry)
- Behavioral Health (Psychologist and Group therapies)
- Social Services (Assessment and coordination of housing, food, transportation, work, etc.)
- Case Management
- Care Coordination.

This includes primary care physicians, case managers, therapy providers and often includes maintaining a home environment that supports positive changes that the individual may make to achieve recovery. We know that some people are not at a place in their stage of change or behavioral health diagnosis where they are responsive to community based interventions. Least restrictive in a community based setting is the gold standard for care. However, we know that for a small segment of this population, there is a failure to respond to community level of care and that the other gold standard under which we operate "individualized care" must be applied.

Therefore, our model would include an opportunity for individuals to participate in and select from a variety of services, depending on where their deficits may impact their lives. Generally, programming will begin in a crisis residential format offered in three phases. Psychiatric stabilization and/or withdrawal management would be offered in level 1. Referrals for ongoing Medication Assisted Treatment (MAT) which may include Buprenorphine, Naltrexone and Acamprosate, among others. In Phase 2, residents begin to identify what they want to work on and accomplish, what they believe are barriers to their success, and how they will persevere and move forward. Services offered to assist the consumer can include such things as formalized assessments

(Intellectual, Personality, Trauma, etc.), psycho-educational groups, evidenced based practices in the areas of trauma, substance use disorders, wellness, and recovery. In addition to these services, Beacon will assure each consumer has individual therapy and case management service. An additional important component of this treatment model is community living supports to address skill deficits as identified by the consumer

Reconnecting the consumer back to the community focuses on remediating gaps in physical health care services and/or repairing broken relationships that may have occurred as a result of the consumer's behavior. If a consumer is already receiving services in the community and wishes to continue with them, the program will focus on maintaining open communication between Beacon, the consumer, and additional providers.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

Access to this program would require a voluntary referral from the emergency department and/or court system, with approval from the CMHSPSP or PIHP, if the consumer agrees that this is the right level of care for them. Once enrolled in the program, the consumer would also participate in selecting the best programming and services to meet their needs. Often this population has an engagement or should have an engagement with a mental health Service program. Beacon has a long history of working closely with many service programs around the state of Michigan, and would continue and build on these strategic relationships. Beacon has served individuals with some of the most challenging diagnoses and behaviors in the state. Through these partnerships, Beacon will collaborate and establish an enhanced standard for inter-agency cooperative care for our consumers. This same approach will be applied to consumers with significant physical health conditions. Beacon has new leadership who are very experienced in administering Medicaid Health programs which positions our organization well to take on the changing landscape of merging physical and behavioral health.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

This program is designed to target those with behavioral health conditions who are too often presenting at the emergency department, which is not adequately staffed to treat co-occurring disorders. While many of these consumers may also have legitimate underlying physical health concerns, it is difficult to ascertain what the true presenting issue is (often due to legitimate pain, psychic pain, withdrawal, a chaotic life, and depression). These consumers may present with pain or other health related issues, which due to the frequency of visits, manner of presentation, reputation among the medical community, or a combination of these factors, is attributed to behavioral a health issue. Our programming will look at the whole person and address their needs as they occur. We intend to work with all providers with the expectation that they also address the consumer's needs holistically.

Care Integration occurs at a local level where people live, where providers are, and where services occur. True Integration focuses on the active and meaningful participation of the consumer, family, providers and community. Policy support for this integration is what is needed, though this likely does include a more seamless blending of funding of mental health and substance use disorder services within the same building/service. Our model proposes to blend funding through billing mechanisms by charging both physical and behavioral for the care provided and involving both in the coordination of the care. Additionally, through the use of electronic tools (Careconnect 360) we can assure that all providers having been involved in the consumers care can be involved in the coordination and in the development of a care plan.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

The model we are proposing is a bundled payment model for coordinating services of a specialty network, blending substance use disorder dollars and Medicaid specialty service dollars. We are proposing that since all dollars flow through the PIHP initially, the percentage of contribution from each funding source for this service be negotiated and arranged for by the PIHP's. Because this model aims to take some of the most difficult to serve consumers and provide them services, which may include housing, this offers multiple service agencies not only an opportunity to provide some long-term stability for these challenging individuals, but to devote resources to others in the community who may be of a more moderate need level. Achieving success with these difficult consumers can restore confidence that services do work and recovery does happen.

Additionally, this model has a structure that is very similar to a Patient Centered Health Home or an Accountable Care Organization where multiple services may be coordinated under one organization. This will lead to a comprehensive network, generating better services for the consumer. It is also an important effort toward bringing together the physical and behavioral health payers. As previously noted, collaboration occurs at the local level when payers and providers come together to benefit the consumer. This fiscal and clinical integration effort could be a model easily replicated for the benefits of the most seriously ill.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

While it is a voluntary program, it is anticipated there would be a pathway that permits the most severely impaired consumers to have the option of receiving this program followed by housing assistance. This would result in the less severely impaired having a uniform benefit distributed across the Northern region, and ideally across the state if the programming expanded and replicated. There are times when those with the most serious and chronic of disorders have difficulty finding care. They may have missed multiple appointments and are no longer allowed back, they may not have been treated well by office staff or they may simply lack the skills to schedule and attend appointments and thus become chronic users of the emergency department. This model can help

to remedy these issues by helping to identify the root cause of the behavior, assisting the most impaired in achieving stability and providing consumers the opportunity to rebuild broken relationships with family, friends, and community.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

Given the magnitude of coordination required for the pilot program, Beacon has already initiated an aggressive recruiting campaign to identify a senior leader for St. Ignace Shores. Furthermore, multiple meetings have taken place between the partnering organizations to discuss specific individuals and teams that must collaborate in order to execute effectively. Beacon has also made significant investments to improve workforce quality and retention by increasing base rates for care staff, improving health care benefits and defining career pathways within the organization. This program would, also, likely positively impact the relationships among providers, direct care workers, nurses and physicians. It would provide an opportunity to positively demonstrate the use of a multidisciplinary team across the medical and mental health fields. Specifically, the opportunity to have clinical staff who are cross trained for both mental health and substance use disorders, Psychiatrists, primary care physicians, nurses, case managers, Certified Peer supports, and Recovery Coaches all working together as a multi-disciplinary team sets an example of what good care should

look like. If we are to integrate our treatment, it should include members of these disciplines. Not only will the consumer receive the best possible care, but this also provides an opportunity for staff to learn from one another.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

Central to the very core of this model is enhancing an individual's ability to make decisions about their services. From choosing to enter the program, to determining which evidenced base curriculums best suit their need, to helping the therapists identify what barriers have really prevented them from moving into recovery, consumers are the driver of their treatment. A central theme of moving from phase 2 to phase 3 is determining independence, consumers have a measure of control in making these decision and following through successfully with treatment. Taking extended time away from an environment which may have contributed to the chaotic cycle puts them in the position for making and investing in good life decisions.

It is essential that consumers involve their family/ guardian and other community supports as the move through this treatment process. This innovative model not only provides for this, but requires the consumer look at their natural support network to determine how they want to live their life.

Would this model affect the administration of complaints, grievances, and appeals?

This model would not affect the administration of complaints, grievances, and appeals.

How would the model support continued access for individuals to current services, supports, and providers?

There would be no negative impact on supports and services under this model. This model would expand services as it would open new options for people not currently seeking services or not seeking services other than crisis situations. This would provide another opportunity for consumers who may have previously been contemplative about making changes an opportunity to seek services. Additionally, it provides an opportunity for those individuals whose chaotic level of functioning prevented them from participating in needed assistance an opportunity for services. This model also draws together physical health providers due to its intensity of services and the commitment to whole person services. A strength of this model is that it also brings together emergency department and law enforcement from whom consumers may have been getting services sporadically that may not have been therapeutic in nature and directs all energies and activities towards consumer centered desires to change. We hope to end the boarding in emergency rooms of those with mental illness and SUD or the use of jails as alternative psychiatric institutions.

Additionally, the model provides for coordination with traditional safety net services so that all services and supports can be maximized, duplication and redundancy can be eliminated and an improved service delivery model can be launched. All of this will occur while honoring the consumer's treatment desires and within a person centered planning process. Often time's consumers aren't intentionally duplicating services, but are merely just looking in multiple places for help. Due to their illness or lack of knowledge, they may be disorganized in their methodology and have not been successful in receiving the right type of assistance to address their particular needs. Our programming can help them truly look into what it is they want and need and how to go about getting this. Through our plan to use multiple funding sources such as physical and behavioral health, we can assure that all parties charged with providing support to individuals with high risk needs are able to be involved with their care.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

Beacon will work with partnering organizations to develop a structured process for overseeing, monitoring and reporting on the performance of coordinated services in the context of the consumer experience. Beacon Specialized Living Services' residential programs are organized regionally. These regional residential programs include Central, Lakeshore, Southwest, Northern Lower Michigan and the Upper Peninsula. We currently service residents from 28 counties which encompass 7 of the 10 PIHP's. Each of these falls under the aegis of Beacon Specialized Living Service's Executive Director of Operations and supporting leadership including the company's Chief Financial Officer, Chief Compliance Officer and Executive Director of Human Resources who in turn reports to the organization's Chief Executive Officer. Beacon Specialized Living Services Board and administration commits to ensuring transparency and accountability in the delivery of these services. Beacon will assure reasonable access to organizational financial information relevant to this project. Accountability of this project will be assured by Beacon Specialized Living Service's emphasis on staff training, policy driven decision making and a system conducive to staff empowerment and responsibility. Beacon Specialized Living Services will institute an advisory group populated by consumers, family members, community leaders, community members, and service providers. The purpose of this advisory group is to provide a vehicle for community input in the development and implementation of this program. This advisory group will meet monthly, and will make recommendations directly to the organization's leadership and board of directors. Currently active in St Ignace is a group of community leadership referred to as the FOCUS group. Membership in this group includes law enforcement, courts, the hospital, citizens, etc. This groups was the driving impetus behind the opening of the St. Ignace facility. This group would become part of the governance structure for the St. Ignace facility. Should expansion be able to occur, most communities have a similar multi-purpose collaborative body such as this that could also be incorporated as a part of the governance structure. This level of accountability to the community and families is an essential part of Beacon's identity

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

As previously noted, a bundled rate payment consisting of Medicaid/Block Grant Substance Use Disorder funds and the Medicaid Specialty Services dollars is the initial suggested for the funding of this project. This payment could be made through a negotiated contract rate through the PIHP(s) who have a first touch relationship with the dollars. However, we would also plan to seek additional reimbursement through the Medicaid Health Plans as they would ultimately see significant savings from this programming through a reductions in unnecessary emergency department visits and a reduction in inpatient admissions through coordinated health care for chronic conditions. We will develop a plan to recover care costs from HMOs/health plans to cover the costs of more intensive staffing, coordination of integrated care, data systems and management, security, transportation, and the coordination of integrated care. We will ask payers to reinvest in these services from savings realized from lower utilization, administration, pharmacy, and social service support costs. The sharing of the fiscal responsibility for this high risk population and ultimately the sharing of the savings for their improved condition is the type of financial integration is reflective of the changing nature of our systems and the roles of the health plans and behavioral health providers within it. Providing both the service packages found in the 1115 waiver for Behavioral Health and Intellectual/Development Disability Services using the care coordination models that were central to the Certified Community Behavioral Health Homes and the patient centered Health Homes provides an opportunity to merge in a simple yet effective way, a variety of transformative initiatives that exist today

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

As noted, Beacon is committed to consumer and family voice in all that it does. The use of advisory boards made up of consumer and family voice as well as the use of community groups as part of its governance structures is critical to the foundation of the service. Services designed **around** those we serve will fail. Services designed **with** those we serve are the only way to be successful. Consumer and family voice and choice are a fundamental in the redesign of the system. This is not true only of the programming that we are proposing, but of the system as a whole. Who better to speak to what works than the individuals for whom the receipt of the services has been a reality, not just a concept. Advocacy groups such as NAMI have a voice to offer as do individual families. Reaching out to advocacy groups, peer run recovery centers, 12-step programs, specialty courts just to name a few, are all avenues to reach out and solicit the voices of those who need to be engaged in the system design and who Beacon will be using to form our services.

What changes would need to be made to provider reimbursement in order to implement the model?

For this program, we would need to be able to bill one entity, (the PIHP) for both the SUD portion of the treatment and the mental health services. This could include all the necessary encounter codes but would be submitted to the one entity who could then determine which funding source to charge them to and which counties allocation these dollars would be withdrawn from. The PIHPs and CMHSP's are all funded by the Behavioral Health and Development Disabilities Administration (BHDDA) department of the Michigan Department of Health and Human Services and have a history of working together closely and cooperatively together. Additionally, there is only one PIHP in the Upper Peninsula so to launch the pilot using this formal would be a relatively simple endeavor. As noted previously, we would also be seeking reimbursement from the Upper Peninsula Health Plan to cover the medical portions of the care and to recoup some of the additional care coordination, physical health, and information technology.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

N/A

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

As noted, there would be a stakeholder group and feedback will continuously be sought from this group and adjustments made to programming and performance based on this feedback. A part of the success measurement satisfaction surveys will be given to consumers but they will also be sent to other stakeholders such as referrals sources, payers, and partners and adjustments to performance will be made based on this. Additionally, as all services offered will be evidenced based but are varied, (therapy, case management, psycho-education groups, peer supports, housing supports) data will be tracked based on which services are preferred by the consumers, which are most effective and what interventions they believe are additionally needed. This data will be result in programming changes as needed. Additionally, we would request access to Care Connect 360 so that we can achieve a baseline understanding of where our consumers have been and where they are going. We will collaborate with managed care payers to measure HEDIS and/START quality measures for consumers served under these programs. We want to have access to all providers of our consumers and use progress on their care plans as one evaluation measurement. Upon discharge, we would continue to monitor our success through monitoring ongoing primary care physician visits through Careconnect 360 and ensure no unnecessary ED visits through the same.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

For this project, success is based on an overall reduction in the total cost of care including the costs of social services. Moreover, in the short term we will work with our partnering organizations to measure a reduction in number of psychiatric hospitalizations for

those completing the program; a reduction in the percentage of non-emergency, Emergency Department visits for those completing the program; a reduction in the percent of incarcerations for those completing the program; Consumer Measured Satisfaction Surveys for those completing the program, and maintenance of stable housing or movement into supportive housing.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

The model as proposed is a pilot, as it is currently offered in only one facility. If through implementation, this service proves to be as successful as it is anticipated to be it is readily transposable to a variety of communities. Its current location in the Upper Peninsula was selected at the request of the community but there are many regions in the state where there is significant overutilization of the emergency department by those who have failed to respond to traditional offerings of the behavioral health system and whose needs put them at high risk. Addressing high utilizers of the emergency room aligns with national and state initiatives

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

Yes. While the model is a proposed pilot in one facility in the Upper Peninsula designed to take those consumers living in the Upper Peninsula and Northern Michigan Initially, as noted above the model could easily be replicated in any area of the state. In fact, because it targets high/super utilizes of the emergency room and can divert those who would otherwise be arrested for behaviors that likely stem from their mental illness or substance use disorder there are multiple communities in which both the emergency departments and jails would likely welcome a program such as this. The ED boarding of this population or the turning of jails into de-facto psychiatric holding centers is expensive, ineffective but sometimes cannot be helped when you have a population that won't or is unable to commit to community services. Our programming structure offers the intensity needed for that small

percentage for whom community services are not enough and who we wish to avoid institutionalization. With the cooperation of the PIHP, CMHSP and Medicaid Health Plans, this model can be set up in virtually any county in the state.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

What would be required to facilitate this model is greater cooperation amongst the physical and behavioral health payers. A recognition of whole person treatment from the payer side is critical to launch innovative programs. While the service being proposed is one that is generally classified as a "behavioral health service", the greatest savings financially occurs to the physical health side. This is in terms of reduced emergency department visits, reduced inpatient stays, longer term better health outcomes when consumers begin preventative health care and begin receiving screenings and treatment for chronic conditions. Therefore, it would be necessary that the physical health side, specifically the HMO's/Medicaid Health Plans support the reimbursement of the model in partnership with the PIHP's, CMHSP's. This is consistent with the idea of integrated funding, offering a broader array of benefits and PIHP's and Medicaid Health Plans entering partnerships to serve high risk consumers.

(Optional) Are you aware of any other states or communities which have implemented this model?

Not this model specifically, but components of this model are based on elements of the Housing First model. The Housing First Model posits that you need to have people in a safe and secure environment before beginning to work on any of the other presenting issues. This is a foundational element of our treatment hypothesis. It is essential to remove these consumers from their triggering environment long enough to assist them in achieving stability and make community connections if they are to be candidates for independent living. Additionally, in San Antonio, TX there is a program called the Restoration Center funded in large part by state and Medicaid dollars that works in conjunction with an agency called Haven for Hope. The Restoration Center is

funded in part by local hospitals and allows local law enforcement to drop off those with substance use disorders or those experiencing acute psychiatric crisis to one of several units which include a sobering unit, a detox unit and a crisis residential unit. Those deemed in need of longer term care are able to transfer to it through the Haven of Hope. One of the main objectives is to avoid incarcerating people with mental health concerns or Substance Use Disorders rather than treating them or tying up valuable resources at the local emergency department. Elements of both the San Antonio and Housing First programs can be found in our design. Taking what works and finding a way to make it work for Michigan residents is what Beacon Specialized Living has stood for since it opened it 1998. We have consistently served those with the most challenging disorders in the most innovative ways and we plan to continue doing so at this time. Our continual search for excellence, improvement and meeting the needs of consumers and the community led us to opening the St. Ignace facility which we believe will be a cost effective, clinically effective solution to those with serious behavioral health disorders misusing the emergency department.

Model #6

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Integrated Health Care Management Model

Name of Submitting Organization: Blue Cross Complete of Michigan, LLC

Model Partner Organization(s): Not applicable

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

Blue Cross Complete of Michigan, LLC (Blue Cross Complete) is one of the Medicaid health plans (MHP) serving Michigan residents through the Comprehensive Health Care Program. We have developed and are proposing an Integrated Health Care Management Model based on our understanding of Michigan's integration needs, as well as the experience of our affiliated companies, which deliver physical health, behavioral health, intellectual disability, substance use disorder (SUD) treatment, and pharmacy services to vulnerable enrollees across the country. Currently in Michigan, specialized behavioral health and SUD treatment services are carved out of the Comprehensive Health Care Management Program. These services are provided by community mental health service providers (CMHSP), which are contracted and paid by prepaid inpatient health plans (PIHP). Collaborative efforts between MHPs and PIHPs to coordinate member care are currently in place, but do not fully accomplish the goal of integrated health care management. With claims data and care plans split across multiple payers, neither entity has a complete picture of the member, which inhibits the ability of both entities to effectively coordinate services in a holistic manner to meet all of the member's needs and maximize cost efficiency.

Further complicating the situation, the Michigan PIHPs and CMHSPs have a high degree of latitude in the services they provide and the policies for accessing those services. This lack of uniformity negatively impacts members and providers. As documented in the summary of the April 11, 2016 Behavioral Health Section 298 Workgroup meeting, "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." This lack of uniformity also affects behavioral health medications, as there is no standard, statewide formulary for all physical and behavioral health drugs.

Nearly 25 percent of Medicaid enrollees have behavioral health diagnoses and substance use disorders. This population is very demographically diverse, as well as diverse in terms of the types of disorders and types of medical treatment needed. Integrated care — the systematic coordination of physical health, behavioral health, SUD treatment, and pharmacy benefits — often produces the best outcomes and is the most-effective approach, from both medical and cost perspectives, to caring for people with complex health care needs. Integrated health care management also helps manage the growing costs of Medicaid programs by providing enrollees with the right support at the right time and in the right setting to manage their health care needs. Almost every state has a different integrated care model — the model we are proposing for Michigan is designed to improve health outcomes and quality of life by streamlining the financing mechanism and enabling MHPs to cover the full range of services and supports Medicaid managed care members need. Blue Cross Complete's affiliated companies have utilized a similar Integrated Health Care Management approach, which has been effective in addressing and improving on some of the shortcomings in Michigan's current model. We are confident that our proposed model can successfully address the goals of Michigan stakeholders in caring for the behavioral health population.

Through the Integrated Health Care Management Model:

(1) **All Medicaid physical health, behavioral health, SUD treatment, and pharmacy services would be accessed by Comprehensive Health Care Program beneficiaries through their selected MHPs.** This includes specialized behavioral health services and behavioral health medications. Integrating these benefits through the same payer entity will enable MHP care management and key providers to better coordinate care for enrolled members. Managing the pharmacy benefit is critical to the model, as it will support improved medication adherence, safer drug regimens, and ultimately lower inpatient and emergency room utilization. The effect on member safety will have an immediate impact as drug reconciliation will be easier to perform.

(2) **MHPs would coordinate and pay for all available services through directly contracted and credentialed provider networks.** In order to fully integrate and coordinate care, MHPs would be responsible for building a behavioral health network and staffing care management teams with trained and qualified behavioral health specialists. In addition to their existing behavioral health provider networks, MHPs would contract with the Community Mental Health Centers (CMHC), which are currently providing and coordinating care to Medicaid members, and partner with community service agencies to support access to services and supports, improve health outcomes, and quality of life.

(3) **Care coordination would be person-centered, family-driven, and youth-guided and would encourage self-determination and member choice across the state.** Members, or their chosen representatives, would have complete control over the participants on their integrated care team, which could include family members, caregivers, key physical and behavioral health providers, external care managers, and pharmacists. The care team would help the member develop a person-centered care plan that addressed their personal goals and preferences. Members would have the option to choose providers from across the MHP's network, without regard to county of residence. The MHP would leverage partnerships with community service agencies to help address members' social determinants of health, including housing and employment.

(4) **MHPs would receive Medicaid funds for included services and providers would submit claims for services rendered.** We propose that MDHHS would pay the MHPs an all-inclusive per-member per-month (PMPM) capitation rate that incorporates funds from Medicaid and waivers

for individuals with a serious and persistent mental illness and members with serious emotional disturbances. Creating a combined funding stream would enable MHPs to mitigate many of the access disparities across the state, creating equity of care, services, and supports across the state. MHPs would contract with providers throughout their service areas, using a variety of payment structures; providers would then submit claims or encounters to the MHPs. As part of their provider reimbursement strategies, MHPs would create value-based contracting opportunities for behavioral health providers to reward improvements in member outcomes and other quality measures.

(5) **MDHHS would continue administering the Comprehensive Health Care Program.** MDHHS would expand the current oversight of MHPs to incorporate additional quality improvement initiatives, measures, and outcomes related to behavioral health treatment and management. Overall success of the integrated model would also be measured and reported. In addition to state oversight, MHP performance against national standards is measured annually by the National Committee for Quality Assurance (NCQA) as part of the accreditation process. Behavioral health Healthcare Effectiveness Data and Information Set (HEDIS) measures are included in this assessment.
Additional considerations accounted for in designing this model include:
(6) **Members, their families, and providers would benefit from a streamlined system.** Enabling MHPs to manage all Medicaid covered services would create a more seamless system of care to address member needs, including social determinants of health. Members and their families would have a single point of contact to address all service, support, and care coordination needs Providers would not have to submit claims related to a single member to different payers. Additionally, reducing payers streamlines program administration so that more public resources reach direct services rather than used for administration of the program.

(7) **Consolidating data improves the effectiveness of care management.** With all data related to physical health, behavioral health, SUD treatment, and pharmacy (including behavioral health medications) services, MHP care management staff can develop a complete picture of the member's service activity. This makes it easier to identify when additional care coordination or care management support is needed. Access to this utilization data will also enable MHPs to improve population management efforts around prevention and early intervention.

(8) **Regulatory requirements for risk-bearing entities are increasing.** The Centers for Medicare and Medicaid Services update to the regulations for Medicaid risk-bearing entities, including the PIHPs, will now require entities to, by 2018: be accredited by a national organization such as National Committee for Quality Assurance; support a technology platform capable of supporting real-time multi-stakeholder information sharing and care planning; and, have experience in financing models that support Patient-Centered Medical Home (PCMH) concepts. These key elements must be present in any model in order to assure quality, financial stability, member-centric benefit administration, and cost efficiencies/savings. The MHPs in Michigan already have these capabilities, accreditation, and experience.

Blue Cross Complete is committed to supporting integrated care in Michigan. We will continue working with the PIHPs and CMHSPs to address member needs and identify opportunities to improve care coordination and integration efforts across the state.
Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
The Integrated Health Care Management Model is designed to provide existing Medicaid managed care enrollees with all physical health, behavioral health, pharmacy, and substance use disorder services they need in the amount, scope, and duration defined in each member's

person-centered care plan. Mirroring the populations outlined in the current Comprehensive Health Care Program, the populations affected by this model would include:

– Children in foster care.

– Families with children receiving assistance under the Financial Independence Program.

– Persons enrolled in Children's Special Health Care Services (CSHCS).

– Persons under age 21 who are receiving Medicaid.

– Persons Enrolled in the MIChild Program.

– Persons receiving Medicaid for the aged.

– Persons receiving Medicaid for the blind or disabled.

– Persons receiving Medicaid for caretaker relatives and families with dependent children who do not receive FIP.

– Pregnant women.

– Medicaid eligible persons enrolled under the Healthy Michigan Plan.

– Supplemental Security Income (SSI) Beneficiaries who do not receive Medicare.

 Voluntary enrollees:

– Migrants.

– Native Americans.

– Persons with both Medicare and Medicaid eligibility.

The following Medicaid-eligible groups would be excluded from this model:

 Children in Child Care Institutions.

 Deductible clients (also known as Spenddown).

 Persons authorized to receive private duty nursing services.

 Persons being served under the Home & Community Based Elderly Waiver.

 Persons diagnosed with inherited disease of metabolism who are authorized to receive metabolic formula.

 Persons disenrolled due to Special Disenrollment or Medical Exception for the time period covered by the Disenrollment or Medical Exception.

 Persons in PACE (Program for All-inclusive Care for the Elderly).

 Persons in the Refugee Assistance Program.

 Persons in the Repatriate Assistance Program.
Persons in the Traumatic Brain Injury program.

 Persons incarcerated in a city, county, State, or federal correctional facility.

 Persons participating in the MI Health Link Demonstration.

 Persons receiving long-term care (custodial care) in a nursing facility.

 Persons residing in a nursing home or enrolled in a hospice program on the effective date of enrollment in the Contractor's plan.

 Persons with commercial HMO/PPO coverage.

 Persons with Medicaid who reside in an Intermediate Care Facility for individuals with developmental disabilities or a State psychiatric hospital.

 Persons without full Medicaid coverage.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

Services and supports to be incorporated in the model — All behavioral health and substance use disorder (SUD) services, including specialized behavioral health services, are included in the model alongside the existing physical health benefits included in the Comprehensive Health Care Program. This includes:

 Applied behavior analysis.
 Assertive community treatment.
 Crisis interventions and residential services (behavioral health and SUD).
 Health and home-based services.
 Individual, group, and family therapy (behavioral health and SUD).
 Inpatient psychiatric and SUD hospital admissions.
 Intensive crisis stabilization services.
 Nursing facility mental health monitoring.
 Occupational, physical, speech, hearing, and language therapy.
 Outpatient partial hospitalization services.
 Residential and intensive outpatient program treatment for SUD.
 Personal care services.
 Psychosocial rehabilitation programs.
 Substance use disorder treatment.
 Targeted case management.
 Telemedicine.
 Transportation.
 Treatment planning.

MHPs would also be responsible for administration of a common formulary for all physical and behavioral health medications.

How the model affects services and supports — Integrating the funding and management of the physical and behavioral health benefits will positively affect member and provider experience. Consolidating care coordination, care planning, and provider networks to a single entity enables MHPs to use a "no wrong door" approach to helping members access the services and supports they need, rather than referring them to another entity. Similarly, providers benefit from a streamlined approach to quality management, claims submission, and utilization management processes, only working with a single payer for each patient.

MDHHS can that ensure access to these services and supports is minimally affected by defining provider network access standards for behavioral health clinicians, direct care staff, certified peer support specialists, and other key personnel. MHPs have established provider network access standards for physical and behavioral health providers, and compliance with these standards is audited on an annual basis. As part of the proposed Integrated Health Care Management Model, MHPs would contract with Community Mental Health service programs that are currently providing these services to preserve continuity of care and funding to these crucial community supports. These contracts could include provisions for providing:

 Crisis stabilization and response, including 24/7 crisis emergency services.

 Case management services, including:
– Identification, assessment, and diagnosis to determine member needs.

– Planning, coordination, and monitoring to assist members in accessing services.
 Specialized mental health and SUD treatment, including clinical interactions.

 Prevention activities.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager? Overall, the Integrated Health Care Management Model would increase member choice by eliminating disparities in service availability from region to region and increasing the homogeneity of benefit administration and care management approaches. The full complement of available benefits and community supports would be accessible to all members, consistent across the covered geography. Members, or their legally authorized representatives, would have the freedom to choose the services and supports received under this model, from inclusion in the person-centered care plan to the setting in which they are received.

All providers within the MHP network would be available to the member, including Community Mental Health Centers (CMHC) and medical/behavioral health homes, to provide services and supports. There would be no county or region restrictions. MHPs are currently required to provide access to out-of-network providers if the service cannot be provided in-network; this same contract provision would be included under this model.

Members, or their legally authorized representatives, will also have the power to determine whether the MHP's care manager or an external case manager leads their care team, as well as whether external case managers/service coordinators coordinate their care. For example, if the member has chosen a health home or PCMH, the member may choose to have service coordination staff from that entity coordinate their care. Regardless of who leads, the MHP care manager, either a Registered Nurse, Licensed Master Social Worker, Nurse Practitioner, or Physician's Assistant, would play an integral role in the care team. This includes documenting:

 Medical, behavioral, and socioeconomic assessments.

 Person-centered care plans developed by the integrated care team.

 Other critical information.

The MHP care manager also makes this documentation available to the integrated care team, in accordance with member preferences and consents, through a centralized portal, e.g., the MHP's provider portal, CareConnect360, or MiHIN.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
Consolidating responsibility and data to a single payer, the MHP, will improve care coordination and member experience by:

 Speeding up identification of members who need behavioral health services — Screening for behavioral health needs and SUD is already a key component of the MHP assessment process. Primary care providers also screen for mental health and SUD needs, as well as developmental disorders, autism, and trauma in children. Under the Integrated Health Care Management Model, MHPs would continue working with primary care providers to train and support their ability to screen for behavioral health comorbidities.

Having all of the member's physical health, behavioral health, pharmacy, and SUD data combined into a single, centralized health record would enable the MHP's care management team to identify service trends that indicate a need for additional care management or more specialized care. Furthermore, MHP data analytic tools can analyze this consolidated data to better stratify members in accordance to the complexity and acuity of their care needs, enabling care managers to quickly engage high-risk members who would benefit from enhanced care management support.

 Increasing transparency and simplifying prescribing for physicians — At the urging of the provider community, MDHHS established a common formulary for medications used to treat physical health conditions. Rather than access a different formulary for each MHP, prescribers now have a common set of medications covered by all MHPs. Drugs from every class are represented in the formulary, which was vetted by a committee of state and MHP medical and pharmacy directors. Currently, prescribers must access multiple formularies if a patient needs physical and behavioral health medications. Under the proposed model, behavioral health medications would be added to the common formulary, and behavioral health medical and pharmacy directors would join the advisory group to provide input about the medications included in the integrated common formulary.

 Removing barriers to accessing care — As these needs are identified, the MHP's care management team can provide direct pathways to appropriate specialty providers, rather than refer the member to the regional behavioral health entity for further screening and subsequent care coordination. Under this model, outpatient treatment would not need authorization, and MHP's would leverage a "no wrong door"

approach that enables members to access care by reaching out to the MHP or directly contacting the physical or behavioral health provider. For services included as part of the patient-centered care plan, no authorization or referral would be required.

- **Enabling care coordinators to assist members with all service needs** — Under the current model, care connectors and community health navigators can help members identify and schedule appointments with physical health providers. For behavioral health needs, however, members are referred to the PIHP/CMHSP to coordinate behavioral health services. Additionally, MHPs receive a data file from the state that details prescriptions for carved-out medications filled by enrolled members, but there may be a several-day delay between when the prescription is filled and when the information is received and loaded into the population management application and the plan or care. The proposed model would allow the care management team to coordinate provider appointments and arrange transportation, all in a single phone call. The lead care manager would arrange for all services, including assertive community treatment, Clubhouse, peer support, and in-home services, as identified in the person-centered care plan. To best support members with specialized behavioral health needs, MHP care management teams would employ trained and appropriately licensed/certified care coordination support staff.
- **Establishing a single point of contact for all service needs** — A key component of Blue Cross Complete's care management approach is building strong, trusting relationships with our members and their families, caregivers, and/or legal representatives. These relationships are critical to successfully helping members manage their care and encouraging them to proactively reaching out when they need help. Under the current service management and delivery model, members and providers must manage two relationships, and the MHP's care management team can only provide so much help before referring the member or provider to the PIHP/CMHSP. Through the proposed model, members, their representatives, and their providers could reach out to one entity, the member-selected MHP, to address all service and support needs holistically.
- **Bringing key care team participants together on a single, integrated care team and creating a single, holistic plan of care** — While there is some joint care management for members with complex illness under the current model, there is no systematic approach. The Integrated Health Care Management Model would enable a single, integrated care team to operate in a treatment environment that improves understanding, communication, collaboration, and coordination. Members, or their legal representatives, would select the participants for their care team, which could include physical health and behavioral health providers, as well external care managers, caregivers, or pharmacists. This care team would then create a single person-centered plan of care that holistically addresses all of the member's clinical needs, driven by the member's goals and preferences.

The MHP's population health management platform would provide a systemic approach for capturing all member-related data, including completed medical/behavioral/ socioeconomic assessments, the care plan document, and other ongoing documentation. The MHP care manager would be responsible for sharing this data, in accordance with member consent, with the care team to help address a member's clinical needs, goals, and desires through a seamless and ongoing case conference environment. Information would be transmitted electronically through a centralized portal, e.g., the MHP's provider portal, CareConnect360, or MiHIN.

Care teams would be in place for all members, with care team meetings scheduled based on the stability of the member's health, the member's ability to comply with the plan of care, and the complexity of the member' health conditions. At these meetings, the integrated care team would assess the member's progress on the plan of care and identify additional services and supports that are needed.

 Leveraging combined data to effectively address member needs — The current model is limited by data-sharing constraints, which makes implementing a systematic approach to managing care for all shared members a challenge. Under the Integrated Health Care Management Model, the MHP would receive all data related to physical health, behavioral health, SUD, and pharmacy (including behavioral health medications) services, enabling care management staff to develop a complete picture of the member's service activity.

With this data, MHPs would be able to identify disconnects between the management and treatment of physical and behavioral health conditions, including medications, which can then be brought to the member's care team to revise the care plan. It could also inform the care team about additional providers who are working with the patient and all medications the member is taking. Better access to pharmacy data would enable the care management team to identify members who have not refilled medications, drug interaction alerts, and a comprehensive medication reconciliation program.

For example, under the current model, a member with family history of cardiomyopathy and hypertension could visit the emergency room several times in a short period for palpitations and shortness of breath. Each time, the member could present with no medications and not disclose information related chronic anxiety and depression. When the MHP received the emergency department admission through MiHIN, neither the hospital's nor the MHP's member record would have the antianxiety or antidepressant medication paid for by the state's pharmacy benefit manager. As result, the member receives a full cardiac work-up with every visit. With a consolidated medical, behavioral, and pharmacy service data feed, the MHP could identify this trend earlier and engage the member's care team to identify ways the member could better manage his/her anxiety disorder, as well as address medical issues identified in the cardiology evaluation, as communicated through the MiHIN data exchange.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?
Through the Integrated Health Care Management Model, collaboration between providers, service agencies, and MHPs would be improved and increased in the following ways:

 Participating on an integrated care team — Through the integrated care team, behavioral health providers and key service agencies would work directly with the member, MHP, and physical health providers, as well as other parties selected by the member, to develop a single person-centered plan of care. This care plan would be accessible to all providers and service agencies on the integrated care team through the MHP's provider portal, CareConnect360, or MiHIN.

 Sharing data with the care team — With the MHP receiving all data for an individual member, it becomes possible to develop a systematic approach to share data so that care team participants can use it more effectively. One way this information could be more effectively used is to design critical incident alerts — e.g., missing a medication refill, psychosocial crisis, emergency room visit, inpatient admission. As data is

processed through the MHP's population health management platform, a critical incident alert would trigger if one were to occur, informing the team that an intervention was needed.

For example, if data received by the MHP indicates that a member has not refilled their antidepressant by the due date, a critical incident alert would trigger. The MHP's care manager can quickly deploy a community-based care management team member (e.g., a community health worker) to deliver the medication to the member's home, as well as assess and mitigate any barriers to future refills of critical medication.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

The current model is based in part on regional funding through a variety of grants, county funds, block grant dollars, and other means. This model results in significant variations in availability, accessibility, and administration of behavioral health benefits across the state. Available services depend on what funds are available in a given region, as well as the types of providers in the regional CMHSP's network, and therefore vary across the state.

Incorporating the available dollars into one funding stream, managed by the MHPs, would reduce state administrative costs and help eliminate, or at least mitigate, many of these disparities by streamlining and standardizing program administration. Additional methods that could be used include:

- Adopt industry-standard assessment tools and evidence-based clinical practice guidelines that would be used statewide to increase uniformity in service delivery.
- Implement a shared, statewide formulary for all drugs, including psychotropics, to minimize confusion among providers and increase consistency in the administration of the benefit statewide.
- Establish behavioral health provider network access standards, including provider-member ratios, to increase member choice and improve service accessibility.
- Standardize reporting requirements to increase uniformity and transparency of program administration.
- Establish and publish behavioral health outcomes measures on a regular basis using industry benchmarks and audited data to increase payer accountability for improving access and quality.

Support and possibly incentivize MHPs to increase availability and accessibility of services and supports, including through the use of telehealth, telemonitoring, and teleconferencing programs.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

Strengthening the workforce — Through this model, MHPs would be required to contract with or hire certified peer support specialists, recovery coaches, certified community health workers, peer mentors, youth peer support, parent support partners, and other key providers and personnel to support continuity of care and ensure members have access to high-quality services and supports. MHPs would need to establish contracting and credentialing processes that comply with MCL 500.3528, MCL 500.3529, and NCQA credentialing standards. As part of this model, codes and fees would be added for care management services and non-clinical staff services, such as Certified Community Health Workers, and included in the MHP payment. Minimum rate thresholds for behavioral health services and supports could be established to attract high-quality staff and improve the quality of care provided by peer support and direct care staff.

Recruiting, training, and retaining staff that support behavioral health services — We recognize that integrating care is largely accomplished at the point of care. MHPs have a contract requirement to train PCPs in Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify SUDs, mental health needs, and, as part of ESPDT, any developmental, autism, or trauma issues. MHPs can support development of certification programs for non-clinical community partners (peer support, peer mentors, recovery coaches) and funding for training and certification of non-licensed community support staff through administrative cost savings. Medical cost savings, realized through the integrated care approach, can result in increased payments to providers through shared savings programs.

MHP Community Care Management Teams that conduct in-home assessments and care planning currently include a nurse, Licensed Master Social Worker (LMSW), and community health workers. These teams would be leveraged to provide assessments, care management interventions, schedule appointments, and arrange transportation for members with primary behavioral health diagnoses. These teams would be expanded to include other certified, non-clinical community support staff to support members' behavioral health needs and deployed as appropriate to address socioeconomic issues affecting the member's ability to remain in compliance with the care plan and enjoy a better quality of life.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

Members, or their legal representatives, would have ultimate control and decision-making power over their care team (including who leads it), person-centered care plan, choice of network providers, and services received. MHPs would support person-centered planning, self-determination, and choice by developing a model of care that incorporates the following:

Using the member's goals and preferences to drive the services and supports included in the person-centered care plan, empowering members to control their health and wellness.

 Providing easy-to-understand information about the health plan's provider network, care management programs, quality initiatives, and available community-based supports (e.g., support groups, food banks, housing assistance) to help members make informed choices about the services and supports they receive.

 Implementing and promoting culturally competent services and supports by:
– Establishing quality improvement programs that ensure members' cultural needs (including race, ethnicity, and language) are being met.

– Collecting and reporting on member-provided race, ethnicity, and language information.

– Attaining the NCQA Multicultural Health Care Distinction.
 Training care management staff in the evidence-based, person-centered practice of Motivational Interviewing, an empathetic clinical approach that helps people make positive behavioral changes to improve their health and wellness.

Would this model affect the administration of complaints, grievances, and appeals?

The Integrated Health Care Management Model would use the complaints, grievances, and appeals administration practices currently in place for MHPs. Existing MHP contracts include requirements for handling complaints, grievances, and appeals related to service and medical benefits. Appeals on adverse benefit determinations are monitored through the Department of Financial and Insurance Services in accordance with the Patient Independent Review Act. These appeals can also rise to the level of State Fair Hearings, as an additional level of the appeal process. MDHHS could also explore the use of an ombudsman to ensure member concerns, complaints, grievances, and appeals are appropriately addressed. This approach is used in other states, as well as in Michigan for residents living in long-term care facilities.

How would the model support continued access for individuals to current services, supports, and providers?

All existing services and supports provided under the current model would be continued in this proposed model. MHPs would be held to provider network access requirements for specialized behavioral health services to ensure access across the state, and MDHHS could implement requirements around contracting with the providers who are currently providing these services to affected members. Compliance with these provider network requirements would be measured and reported through GeoAccess reports and access and availability surveys. MHPs would also be encouraged to use telehealth technology, e.g., telepsychiatry, to expand access to services into underserved areas. MHPs would expand their provider networks, prioritizing behavioral health providers who are currently providing services to members, such as the CMHCs and SUD treatment providers.

State and NCQA requirements currently mandate that MHPs have continuity of care policies in place when new members transition into the plan. These policies allow members to continue receiving services included in pre-established/prior authorized treatment plans, including medications, as well as from providers with whom they have established relationships. Similar to the MI Health Link program, we would propose that continuity of care timeframes be specified for the following:

- Existing provider relationships.
- Existing medication regimens.
- Existing plans of care and prior authorizations.

Throughout the transition period, and on an ongoing basis, the MHP's integrated care management team would help coordinate access to services and supports, from helping members find and schedule appointments with providers or specialists to arranging transportation to appointments.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

Under the proposed model, MHPs would operate the same way they currently do, with contract requirements that promote transparency and accountability for the delivery of services and supports. We propose that MDHHS expand its current oversight of MHPs to incorporate quality improvement initiatives and measures related to behavioral health treatment, management, and outcomes, as well as the overall success of the integrated model. This could specifically be accomplished by:

- Expanding the MHDDS Consumer Guide algorithm to include HEDIS and CAHPS measures related to behavioral health outcomes, access to and satisfaction with behavioral health providers, and utilization of behavioral health services.
- Expanding the MDHHS HEDIS and CAHPS Aggregate Report and publically publishing a consumer-friendly summary of results.
- Collecting standardized consumer grievances and appeals data from MHPs related to access to and satisfaction with behavioral health care services, and publically publishing a consumer-friendly summary of results.

In addition to state-led actions, the annual NCQA accreditation process would also hold MHPs accountable through the rigorous auditing process, the results of which are publicly reported on an annual basis through the NCQA Health Insurance Plan Ratings and the MDHHS Consumer Guide.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

As part of NCQA's accreditation standards and the existing MHP contracts, MHPs must have a Quality Improvement Committee structure that includes participation of members, community partners, and providers in the governance of quality, service, credentialing, and health management programs. The Quality Improvement Committee structure should include, at a minimum, Quality of Service, Medical Policy, Credentialing, Member Engagement or Advisory Council, and Integrated Health Care Management Advisory Council Committees.
Under the model, MHPs would implement an integrated physical and behavioral health advisory council with smaller, community-based focus groups, as part of the Quality Improvement Committee structure. These councils would include members, family members, caregivers, community agencies, and advocates with the goal of gathering input on quality initiatives, medical policies, member materials, adequacy of the network (including composition, accessibility, and availability), clinical/population management programs, health disparity/cultural issues, and upcoming MHP changes that may significantly impact members. The Member Advisory Council would also provide a forum for constituents receiving physical and behavioral health management from the MHP to listen and learn from each other, reducing the stigma that may exist due to their medical or mental condition through increased understanding of the other members' experiences.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

To finance this model, MDHHS would create a fully capitated managed care system that includes behavioral and physical health care services, using Medicaid funds, CMH/SA Block Grants, and §1915 and §1115 waivers that are currently financing the behavioral health services provided through the PIHP/CMHSP delivery model, as appropriate/possible. Actuarially sound rates would be developed and revised annually, based on the complexity and acuity of the membership. MHPs would receive monthly capitation payments that reflect the composition of enrolled membership for that month. In addition to capitation payments, MHP contracts would include a Pay for Performance (P4P) program that provides incentive payments based on behavioral health managed care outcomes to promote better health and better care at lower costs. More details are included in response to the payer incentive question.

To minimize MHP's financial risk, we recommend that MDHHS establish High-Cost Risk Pools. MHP encounter data would be used by the Department to identify the high-cost members during a 12-month period. MDHHS will reimburse the MHPs for costs exceeding the threshold amount, as defined by MDHHS, for each member.

What changes would need to be made to provider reimbursement in order to implement the model?

In addition to their existing behavioral health provider networks, MHPs would contract with behavioral health providers, including CMHCs/SUD treatment providers, under the proposed model. Various reimbursement strategies could be negotiated through the contracting process, such as case rates or bundled payments, to appropriately compensate providers for the services they deliver. In the interest of protecting the financial viability of behavioral health providers, MDHHS could establish standard rates for specialized and/or community-based behavioral health providers.

To be reimbursed, providers would submit claims in accordance with state and federal regulations. As needed, MHPs would be required to configure variable funding streams in their information systems and demonstrate their capability to appropriately adjudicate claims during a readiness review process. MHPs would also need to demonstrate commitment to working with specialized behavioral health providers, service agencies, and other key personnel to develop their ability to correctly submit claims.

To support integration at the clinical level, MHPs would have enhanced payments for behavioral health homes and patient-centered medical homes that demonstrate commitment to improving outcomes for members with physical health and behavioral health comorbidities. This could be accomplished through a shared savings reimbursement model that rewards providers for reducing readmission rates and/or increasing follow-up visit rates. Through the Integrated Health Care Management Model, MHPs would be able to more-effectively leverage service data to support value-based contracting initiatives related to behavioral health.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

Payer incentives — MDHHS currently has a well-established Pay for Performance (P4P) program for MHPs, wherein a significant withhold from MHP premiums is used to fund a bonus pool, payments from which are determined based on a complex scoring algorithm that compares each plan' performance to state standards and national benchmarks. In the proposed model, clinical outcomes, access to services, and member/provider satisfaction measures related to behavioral health care would be added to the template.

In 2017, MHPs and PIHPs now share two P4P measures that reflect outcomes of shared care management and discharge planning between the MHP and PIHP, such as timeliness of an outpatient mental health appointment following an inpatient mental health admission. Under the proposed model, the following performance outcomes could be incorporated in the P4P program:

- Provider network access and adequacy.
- Adoption of evidence-based practices, measured through HEDIS results.
- Consumer satisfaction.
- Compliance.
- Efficiency, measured through cost savings and attainment of service level standards.

 Care coordination and continuity of care provisions.
Coordination with social services and supports.

 Address members' cultural and language needs.

 Clinical and recovery outcomes.

Provider incentives — As part of this model, MHPs would be required to establish value-based contracting arrangements that start with upside-only potential in order to introduce providers to value-based contracting, while simultaneously ensuring meaningful program outcomes. Over time, providers can move to risk-sharing programs as their ability to manage that risk increases.

These incentive programs could include:

 Shared savings arrangements or quality improvement incentives related to key behavioral health HEDIS measures, as well as reduction of preventable emergency department utilization.

 Enhanced capitation rates to PCMHs and behavioral health homes that provide integrated care management services.

 Payments for new services that promote more coordinated and appropriate care that are traditionally not reimbursable.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model? Click here to enter text.

Measuring the quality of service delivery — MDHHS contract requirements and NCQA accreditation standards include numerous measures designed to assess MHP service quality, care management effectiveness, member and provider satisfaction, operational efficacy, and provider network accessibility and availability. Key areas and/or tools include the following:

 Access and availability to physical and behavioral health providers.

 Coordination of care between levels of care.

 Coordination of care between medical and behavioral health providers.

 Coordination of care between primary care and specialty care.

 HEDIS reports.

 MDHHS Performance Monitoring Report, including the CMS Adult Core measures.

 Member satisfaction through adult and child CAHPS surveys.

 MHP P4P bonus measures.

 NCQA accreditation standard compliance.

Provider satisfaction.

 Satisfaction surveys conducted by MDHHS on plan-specific performance for special populations (e.g., CHSCS, Healthy Michigan Plan).

Continuously improving quality of services — MHPs design and implement clinical and non-clinical quality improvement initiatives to improve performance on these measures, as they influence consumer plan choice through the MDHHS Consumer Guide performance and are tied to financial incentives and the auto-assignment algorithm. Many of these measures are also used for NCQA Accreditation scoring.

MDHHS considers significant public health issues, such as preterm births, low birth weight babies, blood lead poisoning, and inappropriate use of the emergency room, for MHP-required quality improvement initiatives. Under the Integrated Health Care Management Model, the following initiatives could be focused on to improve the quality of services:

 HEDIS measures related to integrated care management, including: Antidepressant Medication Management, Follow up Care for Children Prescribed ADHD Medication, Follow Up After Hospitalization for Mental Illness, Diabetes Screening for People with Diabetes and Schizophrenia, Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia, Adherence to Antipsychotic Medications for Individuals with Schizophrenia, and Metabolic Monitoring for Children.

 External quality review performance improvement project focused on a behavioral health topic affecting the state.

 Participation with the MSMS Physician-Payer Quality Collaborative (PPQC).

 Incorporating HEDIS measures and other core measures into provider incentive programs.

MHP participation with MiHIN will increase performance on targeted measures if hospitals are required to submit admission, discharge, and transfer data on psychiatric admissions to the data hub. This would be an additional requirement under the model. The integration of psychiatric medications to the MHP management responsibility would also improve health outcomes, as demonstrated by improved performance on these measures which require real-time access to MHP, behavioral health, and pharmacy data. As described in the PPQC, data for those measures are submitted by provider organizations to MiHIN, and MHPs have a systematic approach for accessing and reviewing that data for HEDIS gap in care outreach and P4P initiatives.

Define “success” for the model? How will the model’s success be measured? What types of benchmarks would be appropriate for evaluating the model?

If implemented, the success of this model should be measured in a way that respects the many stakeholders involved, including members, MDHHS, and providers. This includes:

- Increasing the number of practices that can deliver both behavioral and physical health services.
- Improving member satisfaction with accessing care, satisfaction with providers, and satisfaction with MHP services.
- Improving provider satisfaction related to eligibility checking, claims submission and processing, and MHP care coordination support.

- Improving member health outcomes.
- Decreasing potentially preventable events such as emergency room visits and readmissions.
- Decreasing costs by reducing the service duplication that occurs under the current model.
- Improving health outcomes and member safety by increasing medication adherence.

Benchmarks for evaluating the model should be implemented after baseline performance has been established.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Yes, MDHHS could implement this model as a pilot. Our recommended pilot approach would be to identify a CMHC willing to partner with one or more MHPs in that region to test the Integrated Care Management Model. As previously stated, the MHPs would contract with the CMHC as the key service provider and establish mutually agreed upon rates for services. In order to mitigate risk to both the CMHC and the MHP, we recommend that the pilot occur in an area with a moderate population size.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

This model could be rolled out statewide in two possible ways:

Full statewide implementation — MDHHS could expand this model statewide all at once. Using this approach, having a sufficient readiness period would be essential to the model's success. The pros and cons of this approach include:

 Pros

– This approach would enable MHPs and MDHHS to implement system changes all at one time, increasing administrative efficiency.

– Statewide implementation would provide the opportunity to realize benefits of integration sooner, as well as create uniformity of benefits across Michigan.

 Cons

– This approach would impact the entire population at one time.

– Depending on the timeframes allowed, provider contracting may not be complete in all areas, especially those with existing provider shortages.

Phased approach by prosperity region — MDHHS could expand this model statewide using a phased approach by prosperity region. The pros and cons of this approach include:

 Pros

– A smaller number of beneficiaries would be impacted, making any operational challenges more manageable.

– A slower implementation would allow the model to be tested on a larger scale than the pilot, giving stakeholders the opportunity to evaluate outcomes before expanding statewide.

– With the regional approach, provider contracting activities and community partnership creation can be focused in one region at a time.

 Cons

– MDHHS, MHPs, CMHSPs, and PIHPs would need to maintain the management information system configuration for the existing model while implementing the new model, creating administrative inefficiencies and increasing the costs of implementation.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

To improve consistency and quality of services provided, the following community-based providers should be required to obtain certification, meet defined qualifications, or receive appropriate training before being contracted/credentialed:

 Community health workers.

 Peer mentors.

 Recovery coaches.

 Youth peer support.

 Parent support partners.

Public Act 248 of 2004 will require amendment to allow both the Department and its Medicaid contractors to use prior authorization (as defined in the act) of the following medications as they are defined and operationalized in the act:

 Anticonvulsants.

 Antipsychotics.

 Antidepressants.

 Non-controlled substance anti-anxiety medications.

 Medications to treat mental disorders, epilepsy, and seizure disorders.

Optional) Are you aware of any other states or communities which have implemented this model?

This model, where all physical and behavioral health services are provided by a single managed care organization, has been used successfully in many states. Blue Cross Complete affiliates operate in many of them, including:

 Louisiana, Healthy Louisiana — In December 2015, Louisiana carved-in behavioral health services, allowing Medicaid managed care program enrollees to receive mental health and SUD treatment through participating managed care organizations. This change enabled approximately 980,000 Medicaid enrollees were able to begin receiving physical and behavioral health services through one health plan. Behavioral health services covered by the managed care organizations include mental health, SUD, outpatient therapy, peer support, Community Psychiatric Supportive Treatment, residential care, and psychiatric in-patient services.

 South Carolina, Healthy Connections Choices — South Carolina's Medicaid managed care program operates in all 46 counties of the state through five managed care organizations. Starting April 2012, professional and facility charges associated with Medicaid-covered behavioral health services were included in the Medicaid managed care benefit. Rehabilitative behavioral health services were added to the program in July 2016.

 Iowa, IA Health Link — In April 2016, the majority of Iowa's Medicaid programs were consolidated into a single managed care program called IA Health Link. Physical and long-term care services are managed through three managed care organizations. Behavioral health services were kept carved out and delivered through Magellan Behavioral Health as the sole managed care organization for the Iowa Plan. Beginning January 01, 2017 the behavioral Health, as well as substance use treatment programs would be managed by the four MCOs in the state.

 Florida, Managed Medical Assistance — In 2011, the State of Florida created the Statewide Medicaid Managed Care program, which includes the Managed Medical Assistance program and the Long-Term Care program. Starting in 2014, behavioral health services were carved in to the Managed Medical Assistance program.

Additional programs (not all inclusive) that use this model include:

 Texas, STAR and STAR+PLUS — On May 20, 2013, the Texas House of Representatives passed Senate Bill 58 to improve mental health outcomes statewide by coordinating behavioral health services through managed care. On September 1, 2014, Texas carved-in targeted case management and mental health rehabilitative services for Medicaid-eligible individuals with mental health conditions though the existing STAR and STAR+PLUS managed care programs. Sixteen health plans administer behavioral health and substance abuse services through the STAR and STAR+PLUS programs across 254 counties in Texas.

 Kansas, KanCare — In January 2013, Kansas launched an integrated health plan named KanCare to provide physical and behavioral health services to Medicaid-eligible residents. Managed care services are administered by three health plans to more than 415,000 enrollees. Behavioral health services covered by the managed care organizations include mental health, SUD, outpatient therapy and medication management, targeted case management, crisis response, peer support, and inpatient behavioral health services. All Medicaid fiscal and contract management functions were consolidated into the Kansas Medicaid agency; however, a newly formed, separate Department for Aging and Disability Services is responsible for behavioral health policy direction, licensing, and waiver program management.

Illinois, Integrated Care Program — In May 2011, the Illinois Department of Healthcare and Family Services implemented the Integrated Care Program for senior and persons with disabilities who are eligible for Medicaid but not eligible for Medicare. The Integrated Care Program originated as a pilot and has expanded to operate in 29 counties across five regions. Members of the program receive one of three service packages, all of which include behavioral health and SUD treatment services are available:
– Service Package I is comprised of standard Medicaid physical and behavioral health services.

– Service Package II was phased in approximately two years after Service Package I. It provides coverage for nursing facility services and some home- and community-based service waivers.

– Service Package III, phased in after Service Package II, includes services outlined in the state's three developmentally disabled waivers.

(Optional) Are you aware of any other states or communities which have implemented this model?

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– Service Package III, phased in after Service Package II, includes services outlined in the state's three developmentally disabled waivers.

Model #7

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: **CCBHC Plus**

Name of Submitting Organization: **Community Mental Health and Substance Abuse Services of St. Joseph County, Saginaw County Community Mental Health Authority, West Michigan Community Mental Health**

Model Partner Organization(s): **Any CMHSP sites that are certified as CCBHCs and are interested in partnering; PIHPs and/or MHPs in regions of participating CCBHCs who are interested in partnering to advance model.**

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

All populations currently served in MI CMHSP system would be served under this model, called **CCBHC Plus**. **CCBHC Plus** would expand populations served in Michigan to include populations covered under CCBHC Standards and Guidance with additional Michigan specific variation. Under CCBHC coverage is guaranteed to Tribal members, Veterans, mild-to-moderate populations, persons with full array of substance use disorders, and persons with private insurance, Medicare, and Duals. In the CCBHC Plus model, services would be further expanded include individuals with intellectual and developmental disabilities.

No populations would be excluded from **CCBCH Plus**.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

All current services delivered by CMHSPs would be included in the **CCBHC Plus** model implementation, but services would be expanded. Specifically, participating CCBHCs in **CCBHC Plus** would be expected to provide services to persons in all levels of care for all populations served plus expanded CCBHC service populations and service expectations/standards.

Service expectations for CCBHCs participating in **CCBHC Plus** would include expectations for various models of colocation (CCBHC colocation in primary care, FQHCs, schools, justice system and corrections, homeless shelters, community resource networks, teen health centers) to better meet the needs of Medicaid persons served in the CCBHC and in the safety net for the local community. This includes creative models of joint funding that are used in CCBHC and CMHSP communities now to further expand benefits and services to meet the needs of all Michigan citizens. Colocation settings provide unique opportunities for MH/SUD screening,

prevention, consultation, and brief screening that expand the expertise of the CMHSP provider network and system beyond the traditional Medicaid population to enhance overall health of communities. In addition to improving coordination and access for the traditional Medicaid population, the presence of CMHSP/CCBHC expertise in non-CMHSP/CCHBC Settings, colocation provides mild-to-moderate and private insurance populations with access to:

- community health workers;
- care coordination expertise that attends to healthcare and wellness obstacles;
- pathways to access a broad array of local safety net resources that CMHSPs/CCHBCs understand and have established relationships with including community healthcare and social service partners; and
- evidence-based practices for prevention and treatment.

Models of colocation supported by **CCBHC Plus** expand access to primary care and behavioral health services for individuals with traditional Medicaid who may have limited access to primary care or who have bad primary care experiences (e.g., fired from primary care because of Behavioral Health condition, noncompliance, or "dirty drops"). Furthermore, colocation of services within the CCBHC also expands access to all types of whole person health care services for persons with mild-to-moderate behavioral health conditions, substance use disorders, persons with Medicare (and Medicaid/Medicare) and persons with private insurance.

Models for funding of colocation currently in use within the CMHSP/CCBHC system range from shared public/private funding, to contracted CCBHC and primary care resources, to host providers using private insurance. CMHSPs and CCBHCs with experience in these various types of colocation efforts have extensive experience in working with third-party payers (Medicaid, Medicare, and other private insurance types) and third party administrators, and have established mechanisms within these models to share supervision (e.g., host provider), leadership (e.g., medical director), and expertise.

CCBHC Plus service delivery would also allow further expansion beyond the CMHSP model and Federal CCBHC definition to include contracted CMHSP Network providers (including SUD providers). These tightly held contractual arrangements with Network Providers would be characterized by benefits limited in the national demonstration to DCOs (Designated Collaborative Organizations) under CCBHCs but would instead promote them as providers of CCBHC Core Services. Contracted network providers under **CCBHC Plus** are extenders of the CCBHC to allow for both increased consumer choice but also to build/ maintain service capacity and responsiveness of the local network to community demand. The resulting local service delivery structure is the CMHSP as the certified CCBHC network hub leading transformation of network operations.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

Care would be coordinated and delivered in concordance and compliance with standards and expectations of CCBHC with enhancements of complex care coordination using Collaborative Care Model (referenced in 1115 (i) Pathways to Integration Waiver Application (pending; see page 10/ Strategic Focus 1: Physical Health Integration and Care Coordination Design).

Individuals being served within the **CCBHC Plus** model would be guaranteed informed choice of care coordinator and choice of provider within the model. Like the principle of "informed treatment", *informed coordination* would call out CC360 data on all paid claims for all health related episodes; behavioral health as well as physical health care services with special focus in Emergency Department (ED) utilization and readmissions. This data, which 1) describes utilization history, and 2) informs the conversation with consumers/families about heath care needs, obstacles, and care coordination needs, could then be optimized to support informed choice regarding where care coordination occurs.

One of the core tenets of CCBHC is that services are delivered without geographical (i.e., county) boundaries. To the extent possible, this notion would be preserved across CCBHC sites under **CCBHC Plus**. Where funding barriers exist, CCBHC partners would work with fellow CMHSPs and providers to ensure consistent access. Arrangements would be made to coordinate services with organizations outside the **CCBHC Plus** Network in order to ensure maximum choice.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

Please see extensive description of Colocation and Care Models within **CCBHC Plus** described in Section II Above. Of important note, these are models of on the ground integrated delivery and coordination that are in place now in CMHSPs and CCBHCs across the state. Expansion of services under **CCBHC Plus** would further allow proliferation of these models to all certified CCBHCs sites and providers within their defined network.

CCBHC Plus encompasses the standards, expectations, and principles of CCBHC Model outlined by the Federal government, but departs from the model to expand services in some critical and foundational ways that support integrated care delivery. Specifically, **CCBHC Plus**:

1. Expands focus from the original CCBHC requirements on a comprehensive behavioral health network that is facilitated and managed by the CCBHC. It is an integrated network of local providers operating in the context of local communities and their related resources;
2. Creates strong electronic connections that support delivery of integrated care:
    a. Highly efficient for communication of critical information,
    b. Allows for coordination of care for individuals on Medicaid in and out of the carve-out,
    c. Integrates CCBHC, Meaningful Use, and MACRA quality metrics, expectations, and standards;
3. Promotes support and outreach to consumers to obtain insurance, maintain enrollment and purposeful consumer engagement activity.
4. Expands target populations to include:
    a. ID/DD population,
    b. Mild-to-moderate (for service needs beyond 20 visits or less that don't meet SPMI definitions) population,
    c. Substance Abuse Disorder populations (for service needs beyond 20 visits),
    d. Reintegration of SUD treatment and prevention providers into local community care networks to enhance coordination of care at the point of service delivery;
5. Establishes a local compiled focus of leadership for specialty behavioral health and intellectual and developmental disability services to promote leverage in the local health care landscape and centralized planning expertise for local community population health related initiatives;
6. Allows for development of a more robust and creative payment methodology than that specified around PPS1 and PPS2 in Federal guidance;
7. Expands emphasis on integrated whole person health care and supports increased emphasis on coordination of care that further supports care transitions:
    a. Use of CC360, CC360 supportive analytic technology, HIE, Meaningful Use Certified EHRs, and ADTs,
    b. Puts electronic coordination mechanisms for real coordination closer to the delivery of care;
8. Would establish Standards of Care for chronic health conditions across the sites for Diabetes, Hypertension, COPD, Asthma, Hepatitis, HIV, etc.;
9. Allows for core services of CCBHC to be delivered by most competent providers within tightly held contractual arrangement if they meet high standards and expectations of CCBHC:

    a. Allows for more diversity of CCBHC Sites, including fully competent CMHSPs who were determined unable to apply,
    b. Allows flexibility for CCBHC sites in their relationships with the rest of health care nuanced by local resources and start-up initiatives;
10. Eliminates the complicated relationships described as DCOs in the Federal Guidance for CCBHCs but preserves the contractual and financial integrity of those DCO relationships by allowing those tightly held contractual providers to benefit from the incentives and funding structures associated with CCBHC sites themselves;
11. Establishes clear linkages between CCBHC, SIM, CPC-Plus, 1115, and MiPCT models:
    a. Fully supports Collaborative Care Model delineated in 1115 application,
    b. Supports creative and innovation relationships between diverse providers, payers, and ACOs to enhance coordination of care at the point of service delivery.

A true complex care coordination and integration model was not well defined in the SAMHSA Guidance to CCBHCs but can be inferred by the CCBHC metrics. This model would suggest that through **CCBHC Plus** the CCBHC Enhanced sites have an opportunity to fill unique spaces in the health care/community landscape where health of consumers would be attended to, informed by CC360 data and related analytic tools like Zenith including:

1. Co-location of CMHSP/CMHSP Network Providers in primary care and other community locations;
2. Co-location of primary care inside CMHSP Centers;
3. Collaborative Care Model (built off AIMs Center's Collaborative Care Model at University of Washington). In Michigan CMHSP/CMHSP Providers would act as complex care managers for defined consumer/patient populations with multiple chronic health care conditions tracked in a registry with measurement based practice and treatment focused on targeted metrics of change in health conditions that address the Quadruple AIM;
4. CMHSP networks would be enhanced by the addition of care extenders like Medical Assistants to collect biometrics and community health workers for assistance with social determinant of health concerns (housing/ housing quality, social service connections and so on), particularly for those with mild-to-moderate behavioral health episodes who are not currently likely to experience the deep end Carve Out service array (i.e., currently not a part of the benefit);
5. This model would also suggest the expansion of ancillary health discipline scope for PTs/OTs/ RDs and health educators to address physical health conditions beyond psychiatric diagnosis. Special emphasis on pain management for consumers with Opioid addictions.

CCBHC Plus would further delineate ~~a~~ managed care structure specific to supporting the integrated care expectations of CCBHCs. This structure would be built upon core principles of governance and integration delineated in CCBHC standards PLUS includes the

latest knowledge about high functioning managed care organizations of the future. Clear components of Oregon's CCOs, Washington SIM, and Michigan SIM structures would be foundational to the development of the managed care structure. The **CCBHC Plus** managed care structure would be built "from the CCBHC up" to support integrated delivery of care closest to the consumer. It would take into account and support components such as:

- Comprehensive Network of Contractual Providers (managed directly by CCBHCs; common language, performance metrics, reporting mechanisms, could be developed jointly by CCBHCs and MCO for **CCBHC Plus** and shared across CCBHC sites);
- Multi-payer facilitation such as supporting the ability of CCBHC Sites to hold and maintain contracts with necessary payers to support their provider network (could be done by MCO);
- Facilitation of Care Coordination Agreements across the CCBHC Network, particularly for system-wide partners that touch and interface with multiple CCBHC sites across the **CCBHC Plus** (MCO support could efficiently address a standardization of language and terms of agreements across the CCBHC sites);
- Expanded role of CCBHC Leadership to inform local physical health system partners , community population health planning, and community health improvement plans;
- Relationships with Regional Veterans Administration Medical Centers (VAMCs);
- Relationships with Tribal Entities;
- Mechanisms for innovative payment that maximize dollars to services and enhanced scope of services.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

CCBHC Plus would permit the turning on of billing codes not currently available to the behavioral health specialty system, for care coordination and for select health care extenders. **CCHBC Plus** will create financial incentives for sites already involved in care coordination with physical health care providers and extend enhanced service to new sub populations of persons not currently served by CMHSP networks as they do not have behavioral health condition serious enough to gain access to the carve out benefit but would be well served in this model. Moving all of a communities' need for behavioral health to a single local CCBHC for network coordination and management means a complete view of the behavioral health needs of each community, clarity for the physical health care provider community concerning behavioral health leadership, as well as the promotion of collaborative efforts in work force development and training.

In addition **CCBHC Plus** would bring SUD providers and provider networks back into local networks where they can more fully participate in integrated care with the players of local community health care networks. This will eliminate artificial silos between

SUD and mental health care that are created by our past and present structure of service delivery. This was a core tenet of CCBHC service expansion for persons with SUD and will be more fully realized under **CCBHC Plus** modeling.

CCBHC Plus supports the development of comprehensive provider networks in concert with the local CCBHC Site that flexibly and creatively meet the local, diverse, and specific needs of communities. It allows for flexible use of community dollars and resources within the realms of allowable funding mechanisms while creating local community solutions to local community challenges. **CCBHC Plus** further creates learning communities amongst CCBHC Sites and their provider networks that facilitate knowledge transfer and extensive communication and learning to support success of the whole. When local solutions are not available, the MCO for **CCBHC Plus** can serve as a resource for studying how communities outside of its CCBHCs and outside of Michigan have met similar challenges head on with success.

Building upon the existing relationships most CMHSPs/CCBHCs have with their local FQHCs (e.g., colocation and other contractual arrangements), **CCBHC Plus** could further welcome FQHCs into the behavioral health networks and partnerships within local communities. Once expanded, these relationships and networks could support and further work to sustain funding for projects like the two year FQHC MI Care Project for depression and anxiety as well as additional joint expansion projects that maximize public dollar resources in service of the safety net.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

CCBHC Standards and expectations applied to ALL populations would be the common set of standards among the participants of the MCO for **CCBHC Plus**, including all standards for access, service array, and Evidence-Based Practice implementation. Only sites that are willing to meet the expanded service array and population expectations are eligible to participate. As other organizations within the state determine a desire to meet those service and populations expectations, they may apply to be part of **CCBHC Plus** and similarly certified. The MCO for **CCBHC Plus** and its CCBHC entities will work with those potential new sites to expand service array, face development challenges, and grow to meet the certification expectations and requirements. **CCBHC Plus** would anticipate preserving the current formulary as articulated in policy recommendations as well as expanding that formulary access to mild-to-moderate populations.

The inclusion of the responsibility for the mild-to-moderate behavioral health population and those consumers with substance use disorders will, for the first time, promote the standardized use of screening and assessments. This will not only inform care processes but also enhance treatment data, inform population needs and planning, and work to improve standards around

consistent benefit administration. These changes are also likely to serve as case finding for persons that should have access to the specialty service array to both meet presenting treatment needs but to also intervene with evidenced based treatment earlier in the disorder/illness process.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

CCBHC standards are extremely high for engagement of peers in service delivery for all populations and expectations for quality training and competency. **CCBHC Plus** further acknowledges that there is a significant opportunity to engage a diverse workforce of individuals with lived experience in the integration of care and coordination of care efforts on the ground, closest to the consumer and delivery of services. The expectation for all types of these workers is not the same, nor is the scope of delivery, training, and supervision consistent. **CCBHC Plus** would consider adopting well researched community health worker models where total health care reductions have been realized through implementation (e.g., Pathways for Better Health, an evidenced based and manualized program). In its initial year of implementation, CCBHC Sites who implement such evidence based practices will be supported financially in development and incentivized for early adoption. Further into implementation **CCBHC Plus** will consider outcome or value-based payments for CCBHC Sites who have achieved enhanced care outcomes and total health care savings where these peer positions have been implemented.

To support the development of the workforce overall in its readiness to deliver care to expanded populations, **CCBHC Plus** will support its sites in development of training and skill sets to become culturally and linguistically competent in meeting the needs of its diversified consumer population. Specific attention will be focused toward developing competency of workforce in person-centered planning, self-determination, trauma-informed care, motivational interviewing, meaningful care coordination, care transition planning, and health literacy. In order to enhance cultural competency related to expanded service populations, **CCBHC Plus** will support CCBHC Sites in meaningful training in cultural factors specific to treatment and coordination of care for:

- Veterans (including current and former service members and families of service members);
- Persons who are members of tribal communities;
- Persons of all gender identities, sexual orientation;
- Persons of diverse racial and ethnic origins.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

Person-centered planning, self-determination, and choice are core to the values of CCBHC. Additionally, the **CCBHC Plus** model expands access to person-centered planning, self-determination, and choice to the mild-to-moderate population, to Private Insurance populations (including Medicare), dual eligibles, and to others in the safety net who do not currently have access to these core services and values reflected in the Carve Out and the CCBHC. Within the CCBHC Sites and expanded CCBHC provider network supported by **CCBHC Plus**, consumers would have increased opportunities for choice among providers delivering an expanded Medicaid service array and honoring a very high federal standard for quality of care, consistency of benefit, and improvement in health outcomes.

Would this model affect the administration of complaints, grievances, and appeals?

The **CCBHC Plus** model easily accommodates existing requirements and could readily support changes in policy and practice as defined under the new State workgroup issuing guidance on policy changes in this area.

How would the model support continued access for individuals to current services, supports, and providers?

Persons receiving services through **CCBHC Plus** or CCCBHC Sites would not be expected to experience reductions to services, supports, and providers as a result of **CCBHC Plus** model change. Persons could expect expansion of services in key areas such as SUD treatment, improved coordination, and increased access to peer workforce. New sub populations such as those with mild-to-moderate behavioral health needs would gain access to provider and community resource networks not previously available to them in their recovery. Their experience of care might differ significantly from previous care approaches in:

- its focus on whole-person recovery;
- consumer support to establish and maintain medical home for primary care
- ability to support and address social determinants of health;
- enhanced access to evidence-based practice;

- ability to access care through a highly mobile workforce that supports their ongoing engagement in community and work activities;
- access community health workers indigenous to their local communities and peers with lived experience that are uniquely positioned to understand their concerns and issues as well as culturally competent and connected to community resources.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

CCBHC Standards of governance exceed the expectations and standards of the Michigan Mental Health Code for representation and transparency. The expectation under **CCBHC Plus** is that all CCBHC sites and the MCO for **CCBHC Plus** would meet these higher CCBHC expectations for governance and public transparency and accountability.

Governance structure would be built upon core principles of public governance and integration delineated in CCBHC standards PLUS and include the latest knowledge about high functioning managed care organizations of the future. Clear components of Oregon's Coordinated Care Organizations (CCOs), Washington SIM experiences, and Michigan SIM structures would be foundational to the development of the managed care structure.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

Family members, community members, and persons served are all required representatives in CCBHC governance standards, which exceed the standards of the current Michigan Mental Health Code. These principles of representation would further be applied to the governance standards of the MCO for **CCBHC Plus**. Governance additionally would incorporate (per CCO and future health plan Models) contracted network provider representation.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

For CCBHCs sites engaged in **CCBHC Plus**, payment would be received through the MCO for **CCBHC Plus**. In initial year of implementation, while governance structure and agreements are being established, resources for CCHBCs would go through their normal PIHP and MHP paths under a capitation/sub-capitation methodology. ISF and savings would need to move to the CCBHC Site as well in order for sites to bear the burden of new system transformation costs and risk associated with new payment model, newly developed shared risk arrangements, and service expansion. Transformational infrastructure cannot be developed without the pooled resources of all the partners necessary to support full expansion of services and population. This requires the PIHP and the MHP partners of CCBHC Sites within the **CCHBC Plus** to bring their dollars to the pooling table as well**.**

Similar to that Alternative Payment Model (APM) progression which was submitted in Michigan's 1115 Pathway to Integration Proposal (pending; page 11), **CCBHC Plus** would support a progressive path towards value-based purchasing. Unlike the continuum outlined in the Pathway to Integration, however, the **CCBHC Plus** continuum toward APM would recommend learning from the findings of New York's DSRIP implementation. New York's DSRIP implementation identified a series of additional steps that are more successful in advancing safety net providers along the APM continuum. This movement occurred in similar types of time frames to that proposed in the Pathway to Integration model. Unlike many privately funded providers, most safety net providers lack adequate reserves or cash resources to immediately move to risk-based modeling. Safety net providers may have excellent expertise and ultimate ability to achieve desired outcomes of APM models, but can lack the depth and breadth of capacity to support the rapid implementation necessary to demonstrate improved performance in short timeframes. New York found that with a few additional steps and some initial supportive resources invested early in the continuum, safety net providers can rapidly adopt and implement enhancements necessary to achieve enhanced outcomes and improved efficiencies. This progression is described in more detail under the question regarding "incentives" below. Additionally, **CCBHC Plus** would engage the tightly held provider networks of the CCBHC Sites in the APM transitions, comprehensively supporting the entire provider network in achieving the enhanced outcomes and efficiencies anticipated from value-based purchasing models. Quality incentives are one of the common elements along the continuum that ultimately, as in the Pathway to Integration proposal, would result in implementation of value-based purchasing**.**

PPS1 and PPS2 would be used as guidance where appropriate as component of development of payment mechanism, but **CCBHC Plus** would not limit itself to either structure directly due to the challenges with these models with the existing Michigan managed care models. A smooth transition from Michigan's current payment models to an APM approach would be better achieved through the mechanisms articulated in this recommended model than via PPS1 or PPS2.

It is important to note that a challenge to implementation in advance of private/public payer mix opportunities and with/without a pooled payment structure, is the lack of availability of General Fund resources to support the expanded benefit to previously unserved populations. The ability to sustain the CCBHC benefit for uninsured or underinsured populations is extremely challenging, particularly when in Michigan, CMHSPs are at risk for inpatient for this population. One critical component of implementation of **CCBHC Plus** will be to define a sustainable benefit under CCBHC for these populations and/or to determine adequate funding necessary to sustain that benefit.

What changes would need to be made to provider reimbursement in order to implement the model?

Within the **CCBHC Plus** model, CCBHC sites and their comprehensive provider networks are payed under the same payment structure as CCBHC sites themselves. This would include opportunities for performance and quality incentives, value-based payments, tiered payment structures, shared savings, and shared risk within the CCBHC Provider Network.

Please see description below on "incentives" for description of how **CCBHC Plus** would recommend implementing the APM transition, including in support of the comprehensive provider network.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

Incentives and incentive structure would be based on best practice modeling in places like Oregon's CCO Model and New York's DSRIP. Successful transition to APMs is a gradual process to support providers in managing increasing levels of risk.

In the DSRIP implementation in New York, the APM progression was slightly different than those utilized with large scale private hospitals or private provider networks. New York developed a revised model for their safety net system providers that allowed for rapid progression towards APM change. They found that, regardless of type of provider (private, public, and/or safety net) rapid movement to APM could not begin without extremely well defined performance measurement structures and expectations. This included both operationalization of measures as well as benchmarks and population parameters and scope for each outcome expectations.

Once these performance structures and expectations were established, support was offered to provider in the form of ***incentive payments*** and support resources to establish the necessary mechanisms to implement necessary tools for outcome data collection and monitoring (e.g., dollars and on-site staff resources sent to sites from the funding source to facilitate transition to new data collection expectations and troubleshoot process issues). This learning was then utilized with other sites along the path to

continually enhance the quality of the process and to facilitate rapid cycle implementation. For organizations that chose to be early adopters, additional incentive payments were available to support implementation. Once operationalization and first step implementation had begun across providers sites within the network, the MCO offered *bonus payments* for providers who met early standards for implementation (e.g., >= 90% accuracy on first month data sharing; or >= 90% completion rate for baseline outcome tools). The next developmental phase along the APM continuum is beginning implementation of *shared savings*. Shared savings are essentially pooling resources and dollars saved (i.e., through pooled payment structure) from advanced outcome implementation to support ongoing enhancements to care delivery that support improved behavioral and physical health outcomes (e.g., evidence-based practice implementation, additional staff training, caregiver wage increases, improved access to community health workers). Once the process of sharing savings has begun across the network and resources are flowing more fluidly to the system for care enhancements, the continuum is ready to add in the component of *at risk payment methodologies*. In at risk payment arrangements, providers are given clear expectations to improve some key outcome or component of care and some portion of dollars are withheld until that outcome is achieved. If the outcome is not achieved, the MCO provides additional supportive resources to guide the movement towards the outcome and then sets a new bar for achievement. Outcomes may differ across providers, based upon areas of outstanding performance or areas where performance needs to be enhanced to reach the acceptable bar of the network. Finally, in *value-based purchasing*, some agreed upon and clearly defined portion of resources are set forth in advance in some form of pooled capitation and the remainder of the dollars are paid out to the provider based on achievement of care outcomes and expectations for each population served.

Of note, in **CCBHC Plus**, all phases of the transition to APM are heavily data driven, based in Continuous Quality Improvement (CQI) and Rapid Cycle Improve (RCI) Principles, and require substantial broader collaborations across networks of providers to manage down-side risk.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

National CCBHC required measures would be the foundation for the quality measurement. Additionally, quality standards and model metrics would be based upon Meaningful Use and MACRA/PQRS/MIPS metrics. The MCO for **CCBHC Plus** would facilitate and support CCBHC Sites in developing mechanisms to understand support these enhance reporting requirements. Through knowledge transfer groups within **CCBHC Plus** and MCO and work with outside entities, to obtain necessary information to develop these capacities and competencies which would be jointly developed under pooled funding support.

CCBHC Sites and the MCO for **CCBHC Plus** would be prepared to incorporate and be responsive to additional metrics based upon:

- Pilot metrics;
- New State metrics;
- Metrics used by states involved in Federal CCBHC Demonstrations.

The **CCBHC Plus** model will further incorporate metrics and measures for carefully defined populations that will measure total cost of healthcare at baseline and at each successive year of pilot. Furthermore, **CCBHC Plus** will incorporate a double-blind study on specific subpopulations (e.g., ED high utilizers) in and out of the **CCBHC Plus** model and measure change in cost and outcomes over the three year pilot period. Specifically, for a defined population, did **CCBHC Plus** improve outcomes and did it decrease total cost of care?

CQI process is a critical set of standards required by CCBHC Sites. The MCO for **CCBHC Plus** would support the CCBHCs in developing capacity and in implementing common operational definitions for metrics to enhance and support outcomes for consumers receiving services through **CCBHC Plus**.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

Success would be defined by, at minimum, the following metrics:

- High satisfaction of consumers served within the CCBHC Sites;
- High satisfaction of CCBHC Coordination partners in coordination efforts;
- Improved performance (from baseline) on quality metrics (see above);
- Functional governance board comprised of consumer, payer, and provider involvement;
    - Characterized by high degree of transparency and accountability
    - Publicly appointed
- Ability over 3 years to create pooled savings;
- Ability over 3 years to disseminate shared savings back into service expansion;
- Ability over three years to support new system transformation costs;
- Improved access to services for consumers in CCBHC site (include expanded population access).

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

CCBHC Plus would initially be implemented with a handful of CMH Sites that were certified as CCBHCs in Michigan under the CCBHC Planning Grant period. Once the MCO Structure for **CCBHC Plus** was created, other CCHBC Certified sites could apply to be part of the **CCBHC Plus** model. If the model was successful during the pilot period, other sites (CMHSP or other) in Michigan interested in becoming CCHBCs could apply to be certified and be evaluated by **CCBHC Plus** for ability to meet expanded CCBHC Standards and expectations for outcomes, delivery, and integration.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

If **CCBHC Plus** is successful, other sites (CMHSP or other) in Michigan interested in becoming a CCHBC could apply to be certified and be evaluated by **CCBHC Plus** for ability to meet CCBHC Standards and expectations. The model includes a mixture of urban and rural CCBHC sites. The MCO for **CCBHC Plus** would include a variety of public and private members, including substantial consumer, provider, and community membership. Existing PIHP and MHPs could support MCO functions if organization was:

1. willing to perform managed care functions in a way that supported care delivery and integration model expected of CCHBC Sites as described above; and
2. competent to perform those functions.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

The **CCBHC Plus** governance structure, depending on how it is constructed, may need to have special waiver or dispensation to perform its governance acts and appropriate managed care functions during the pilot period.

(Optional) Are you aware of any other states or communities which have implemented this model?

CCBHC Plus is based upon CCBHC which is in demonstration status across the country. The governance structure is based upon some principles primarily of Oregon's CCOs, Washington SIM, and Michigan SIM. The payment model would be an enhancement

over the PPS1 and PPS2 structure offered in CCBHC. It would understand, reflect, as well as build upon Michigan's existing managed care structures and experiment with mechanisms for pooled funding, Incentive Payments, Bonus Payments, Shared Savings, Dollars at risk for performance, and ultimately Value-based purchasing.

Model #8

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Local Accountable System of Care using the Contract Model

Name of Submitting Organization: Centra Wellness Network

Model Partner Organization(s): None

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

The model being purposed was in existence from 1998-2000 and makes use of current laws already on the books in Michigan and it included all current behavioral health (BH) service dollars with the exception of Substance Use Disorder services (SUD). Services in this model would not only include the Michigan Department of Health and Human Services directly contracting with the Community Mental Health Programs (CMHSPs) already statutorily in existence for BH and SUD services (Intergovernmental contracts act MCL 124.1), but would contractually bind the CMHSPs to work with the local health care markets via localized accountable care organizations or cooperatives (Accountable Systems of Care {ASC} as they are the experts of physical health) to ensure effective integration of services to maximize efficient and effective treatment to those that are "High Utilizers of Care". ASC's would organize with the use of the various federal non-profit status or other common business joint ventures.

1) The types of services and supports offered in the model are already in existence in the Medicaid Manual, Mental Health Code, and the 1115 Waiver with the Federal Government Centers for Medicare and Medicaid (CMS).
2) The organizations providing the services are the current behavioral health providers under CMHSPs and all health care providers under an ASC arrangement.
3) The core values and recommendations included in the interim 298 report would be encapsulated in contractual agreements with the provider organization mentioned in 2 above.
4) Payments to the behavioral health system would be directly from the MDHHS to the 46 local county based community mental health boards. Payments to the ASC's would go directly to their health markets oversight board for distributions to providers based on a case rate arrangement. Incentive payment to both behavioral and physical health would go to providers in a health market showing a success in achieving state established goals. This would include the $200 +/- million dollars currently going to the PIHP behavioral health as well as funds currently going to the state Medicaid managed care administrative system less contractual enforcement administrative dollars to assist the MDHHS in carrying out the states policy directives for all health care in Michigan.

5) The competent-public body would manage the system using a robust contract compliance and technical assistance program organized under the auspices of MDHHS the entity in Michigan charged with assuring the overall health and welfare of the state's citizens with the ultimate oversight of MDHHS being the elected officials of Michigan, whom are direct representatives of their jurisdiction.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

All populations vis-a-vis a cooperative arrangement between health and behavioral health providers. No populations should be excluded.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

All individuals involved in services must be afforded the ability to choose his or her own provider according to federal regulations and this would be ensured via a robust grievance and appeals system tied to contract performance and public oversight.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

All individuals involved in services must be afforded the ability to choose his or her own provider according to federal regulations and state contract language. As mentioned above, this would be ensured via a robust grievance and appeals system tied to contract performance and public oversight.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

This model would contractually bind health providers and behavioral health provides via incentives to reduce state and regional outliers. What is important to note is that this model is going to utilize the current $200+/- million dollars currently tied up in the Pre-Paid Inpatient Health Plan and state managed care entities administration to firstly bolster the Michigan Department of Health

and Human Services contracting and contract enforcement staff and secondly to enhance services and provide the financial incentives to achieve many state aims including coordination.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

Because of shared goals via financial and contractual incentives between health care and behavioral health providers in a particular health market, providers will seek out other "specialty services providers" to ensure that their service delivery and the patient experience is as best as it can be. The inability of any provider to perform in a health market would lead to the providers being slowly and eventually marginalized within that market. Private organizations that are ineffectual may eventually fade away in favor of the more astute providers. Unresponsive public providers will be relegated to basic statutory functions at best. In any model the state develops it is important to have a public safety-net provider for the purposes of governmental immunity and access to state provided services.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

Because of the contractual and fiscal incentives addressing these topic area's public and private providers in a health market or regional area will work together to insure availability, accessibility, uniformity of service, medications and supports. Medications should be managed in accordance with the Social Welfare Act and those not requiring statutory protections should be managed with saving from the MCO administration by the MDHHS as it once was. Centralizing medications allows the State to purchase in bulk and have a greater negotiating position with pharmaceutical companies. Keeping medication usages in check (within appropriate ranges) and within budget would be a part of the behavioral and physical health markets contractual obligations and tied to financial incentives.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

This model with the built-in incentives to collaborate and maximize use of resources towards service delivery will lend organizations to work with each other as well as educational institutions to assist with greater use of interns and would include taking advantage of tuition re-imbursement programs for underserved area's such as urban, rural, and frontier areas of the state.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

Self-determination has been at the core of what the behavioral health industry has worked with for many years. The issue is, it becomes fragmented when health care and behavioral health providers are unable to work together to address the hopes, needs, and desires of the person they are jointly serving. With bi-furcation of the system comes frustration and anxiety. By having a strong contractual co-dependent relationship between all service providers the individual will have increase power to direct care and whom that care will be provided by.

Would this model affect the administration of complaints, grievances, and appeals?

Initial complaints would continue to be resolved locally with the providers of care via compliance officers or liaisons with the aim of improve service delivery to mitigate any potential delays in services. However, different from current practices where individuals appeal to local CMHSP boards, or the managed care entities, in this model we suggest a deviation from current practice in that appeals would be handled by an entity such as the state or an ombudsmen outside of the local CMHSP or health care provider. Otherwise, the use of current practices allow for quick resolution and less disruption in consumer care.

How would the model support continued access for individuals to current services, supports, and providers?
Access would be enhanced from current level. Appeals being handled by an organization outside of the local CMHSP would lead to uniformity of access and service standards especially if appeals results were widely published giving CMHSPs and health care providers further guidance as to state interpretation of access and service levels.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?
The transparency that is currently ensconced in law particularly with state and federal laws in the area of mental health and medical health (HIPPA etc…) would continue unabated. All statues would continue and be enhanced via good contract enforcement. There are a myriad of individual protections and all policy decision would be discussed at the governing boards of the associated CMHSPs and/or the accountable systems of care collaborations, etc…

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?
Currently family members and person's served are appointed the CMHSP board as a matter of law, so the composition of the behavioral health network would remain unchanged. In this model the ASC collaborative would be required to have community members on its oversight board in order to be awarded a state contract.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

Payments to the behavioral health system would be directly from the MDHHS to the 46 local county based community mental health boards. Payments to the ASC's would go directly to their health markets oversight board for distributions to providers based on a case rate arrangement. Incentive payment to both behavioral and physical health would go to providers in a health market showing a success in achieving state established goals. This would include the $200 +/- million dollars currently going to the PIHP behavioral health as well as funds currently going to the state Medicaid managed care administrative system less contractual enforcement administrative dollars to assist the MDHHS in carrying out the states policy directives for all health care in Michigan.

What changes would need to be made to provider reimbursement in order to implement the model?

Payments to the CMHSP system are well established and would continue under a sub-capitated arrangement based on actuarial review. The CMHSPs would be at full risk: they would procure re-risk insurance such as it was available from 1998 to 2002 from the Michigan Municiple Risk Management Authority or Lloyds of London, with the ability to withhold up to, but not exceed 5% of budget. Further, CMHSPs would only be allowed operating reserves (based on appropriate health care business levels) to ensure

services are provided vs savings. However, payments to providers involved in ASCs would be based on a case rate system and all providers would be allowed to retain funds should they come under the case rate due to efficiency and effectiveness and are at full risk as well. Both sets of providers (CMHSP and ASC) would be paid additional incentive funds when state goals are obtained as described above.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

Yes, this is the key to collaboration. Incentives would be firstly to "actively collaborate" show a good faith effort that the local health system is trying to improve access and care. Future incentives would be built around state identified issues in that local health market. Issues such as diabetes etc… payments would be made out on a census model divided into state funds available for "incentives". Any incentives not paid out in a given year would be held by MDHHS towards future projects either to provided technical assistance to health markets that did not achieve state objectives, new projects, and/or enhance awards/incentives in successful areas. In other words, at the discretion of MDHHS for the purposes of enhancing overall health care in Michigan.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

As mentioned above several areas would be address at a minimum: The rate of grievances and appeals, fiscal stewardship, health indicators (e.g. diabetes, inpatient usage, etc…), and review of data bench marks as is already readily available.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

The model will be measured and deemed a success if bench mark indicators established after the first year for each health market by MDHHS are steadily improved over the course of no more than 5 years. If each CMHSP and ASC in a given health market or region show improvement the state as a whole will improve. Areas that hold down overall state bench marks will in this model be afforded meaningful technical assistance and support in an effort to bring them to state expectations.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Yes, this model could easily be piloted using the Governors currently existing enterprise zones, natural health markets or trading zones, or even identified insurance markets. However, statewide implementation would have far quicker and greater results.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

It is preferred that this model be implemented state wide as a vast majority of the state's land mass is rural and in order for this model to have maximum effectiveness on the overall integration and health of Michigan's citizens then all of the state should be included in an effort to work together towards better health care. It would be preferred that this model be effective at the start or near the start of the governmental fiscal year, that is October 1, 20xx.

This model could be rolled out in the state and by prosperity zone etc. as mentioned above, but should be done so in rapid order in order to ensure that MDHHS can ramp up contract and technical staff at the same time. The state could be taken in sections either starting with the Upper Peninsula and working down or the inverse of this over an 18 month period. However, it is important to note that the running of dual or in this case multiple systems is very taxing on the State of Michigan's resources both in terms of funds and staff, thus I believe some of the problems the state faces now (i.e. State behavioral general funds for CMHSPs, Medicaid behavioral funds to PIHPs, and Medicaid health funds to MCO's) . The state attempted to move to a regional PIHP/MCO model forgetting it needs to also be cognizant of state laws (i.e. CMHSPs must be funded with all funding sources, etc….).

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

With regards to financing, other than taking a look at the funding model on the Medicaid health side of the ledger to see if entities other than managed care organization can be used as the funding vehicle and if so to change it to ASC's, I believe that Michigan can build this construct around the currently approved 1115 waiver with CMS.

Changes in the appeals process would require a change in Chapter 7 of the Mental Health Code to move it to either the state or an ombudsman.

Otherwise, as mentioned throughout this document, this model is built upon already existing laws and constructs that were previously utilized successfully in years past.

(Optional) Are you aware of any other states or communities which have implemented this model?

There are 22 county based systems of care throughout the United States in Utah (the ECHO model), Oregon, New Jersey (the Camden Model), California, Missouri, and Pennsylvania. Dr. Ron Manderscheid from the National Association of County Behavioral Health and Developmental Disabilities Directors is a good resource to access details from other states.

Model #9

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Comprehensive Care Excellence (CCE) Model

Name of Submitting Organization: Community Mental Health Authority of Clinton, Eaton and Ingham Counties (CMHA-CEI)

Model Partner Organization(s): Sponsoring/Primary partners: Ingham County Health Department, McLaren Health Plan, Sparrow Health System, McLaren Greater Lansing, Mid-Michigan Health Department, Barry-Eaton District Health Department. Additional Prospective Partners: PIHPs, Health Plans, Hayes Green Beach Memorial Hospital, Clinton County Medical Center, Eaton Rapids Medical Center, Michigan Works!, Peckham, E-Tran (Eaton), CATA (Ingham), Clinton Transit, Dean Transportation, Mid-Michigan Recovery Services, Volunteers of America

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

Introduction: Community Mental Health Authority of Clinton, Eaton, and Ingham Counties proposes a unified delivery system for the Clinton, Eaton, Ingham County Prosperity Region. The proposed model is guided by individuals served and provides a united, seamless, and coordinated service plan that includes behavioral health (integrated mental health and substance use disorder services) and physical health along with social determinants to fully address needs, provide a multitude of options, and informed choices. (1) The proposed Comprehensive Care Excellence (CCE) model aligns services into a comprehensive coordinated care organization. It is predicated upon cooperation between its sponsoring partners to provide inpatient, ambulatory intensive care, physical healthcare (primary care and specialty care), behavioral health care (including prevention and treatment of substance use disorders) in a multi-organizational care-coordination approach to ensure comprehensive care is provided to address all health needs, including social determinants of health through collaborations with housing, transportation and employment agencies. The model has elements of Totally Accountable Care Organizations (TACO), Systems of Care, and Certified Community Behavioral Health Centers (CCBHC). (2) The initial sponsoring members include a Medicaid Health Plan, a Community Mental Health Service Program, Federally Qualified Health Centers, and Hospital Systems. (3) The CCE Model aligns with the values and recommendations of the "Interim Report of the 298 Facilitation Workgroup" to improve care while maintaining publicly-governed oversight and accountability and recognizing the need for specialty care for Michigan's most vulnerable citizens. (4) In order to effectively leverage funds to maximize community benefit, CMHA-CEI proposes to contract directly with the state for all specialty behavioral health services, including substance use disorder services. CMHA-CEI proposes to receive the Medicaid PEPM (currently administered by the PIHP) SUD block-grant and local PA2 resources directly from the state across all populations served. Alternatively, CMHA-CEI would propose a direct pass-through from the PIHP with the ability to reinvest any savings into local services. The initial financing model with community partners would rely on existing capitated payments, with the potential of risk investment and pooled resources/shared savings on the part of participating entities through a joint operating agreement as the model develops. (5) The proposed pilot is built on a partnership arrangement with key representatives forming a Governance Committee chaired by the public entities per the 298 Interim Report recommendations. Additional partners may be added as planning and development continues. CMHA-CEI and the primary partners will identify key performance, satisfaction and outcome measures to evaluate the models efficacy, including an evaluation of cost and savings factors.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

In addition to the provision of CMHA-CEI's current array of specialty services, this model of community partnership allows the entities to focus together on defined high-risk, high-cost individuals and develop innovative, flexible supports leveraging the resources and expertise of all community partners. In the initial pilot under this model, CMHA-CEI proposes to begin by focusing on Medicaid consumers, served in Clinton, Eaton or Ingham Counties that have a serious mental illness, severe emotional disturbance, intellectual/development disability, substance use disorder OR have visited the emergency department six or more times in the past 12 months. The SUD population, in particular, has had limited access to primary care, utilizes the emergency department (ED) at higher than normal rates, and could benefit from this proposed coordinated care approach. Other high-risk, high-cost populations will also be considered as agreed upon jointly by the community partners (e.g. improved care coordination of persons having 1 or more chronic conditions, co-occurring behavioral health conditions, etc.)

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

The proposed CCE Model involves a much higher level of coordination between partners, with treatment teams and shared treatment planning between behavioral and physical health providers. In addition, the array of specialty services currently available through CMHA-CEI will include the implementation of recommendations outlined by the 298 Facilition Workgroup including innovative and substantive roles for peer support across all systems of care, transition services for youth, universal application of SBIRT protocols, support for independent facilitation of person centered plans, integrated partnerships with schools for true collaboration, care coordination, and screening. Under the proposed CCE Model, a consumer selected care manager/coordinator will be responsible for facilitation of team-based coordination with partners, making and tracking needed referrals (housing support, peer support specialists, healthcare coaches, psychiatric services, employment support, etc.) The model will rely heavily on evidence-based engagement models, peer-support and recovery coaches, and would embrace a Housing First approach. Service Prioritization Decision Assistance Tools will be used to assist in determining an individual or family's acuity and to identify areas in the individual's/family's life where support may be needed to prevent housing instability. Existing housing and transportation services will be used (such as peer supports, CMHA-CEI Housing Specialist, Mid-Michigan Recovery Services- Cooperative Agreement to Benefit Homelessness [CABHI] programs, E-Tran (Eaton), CATA (Ingham), Clinton Transit, Dean Transportation, and local taxi cab services.) Creative collaboration would consider means of creating on-demand housing and transportation opportunities to better meet the needs of individuals served. In addition, Mobile Crisis Team capacity would be enhanced to include a broader definition of “crisis” which would allow social determinants to be addressed in our Mobile Crisis Team model which aims to quickly engage consumers when and where they request it, stabilize situations and link individuals to the appropriate service.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

Under this model Individuals with a substance use disorder will be engaged and encouraged to opt-in to be part of the initial pilot of CCE but will not be automatically enrolled. Individuals with six or more ED visits over a 12 month period will be enrolled, but may opt-out. Individuals would initially be enrolled in care management/coordination services through CMHA-CEI. Each individual meeting eligibility criteria would be provided with information upon their first service visit following enrollment in the CCE pilot, and offered an opportunity to change which organization

provides their care management/coordination (i.e CMHA-CEI, FQHC, or a hospital health system). This is in keeping with Section 298 recommendations for each individual having the ability to choose where services are coordinated at the point of service delivery. Of note is that community based services may be the first post-model contact, and will offer advantages over those enrollment points that require engagement of clinics or hospitals. Individuals would be required to sign a consent to share information. Beneficiaries will have the opportunity to participate in or be removed from the CCE pilot at their discretion. Throughout the course of the CCE Pilot, individuals will be encouraged to be an engaged participant in their healthcare team and direct decisions affecting their own health and social supports, and may choose to eliminate themselves from the CCE pilot. This will not limit their ability to continue to receive services from individual partner organizations for which they are eligible.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
Interdisciplinary care teams would meet to address the needs of complex cases using online collaboration tools and shared treatment plans, recognizing that successful collaboration must include the person being served as well as family members when appropriate. When entering into an agreement to participate in the CCE pilot, participating organizations agree to utilize existing communications and technologies to engage a team-based approach to care communication and coordination for individuals. For the pilot, appropriate technologies and HIT interchanges would be used to improve care coordination. This may include one of the partner entities providing a coordinated care delivery platform for interdisciplinary information sharing. Participating organizations may use direct messaging, exchange of Transition of Care Summary/Continuity of Care Document and /or Admission, Discharge and Transfer feeds. Recognizing the importance of healthcare data and rapidly changing data and integration needs, data sharing agreements will be completed by the participating organizations. CMHA-CEI is in an excellent position to amend the data set and reporting capabilities as needed, based on the capabilities, and needs of the other participating organizations. This model will implement processes to promote the use of Care Connect 360 or other shared platform by all community partners.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?
Care coordination within the CCE model is predicated on communication around the individual's service and support needs. For example, the individual eligible for the pilot may lack care coordination across treatment silos, and have statistically higher emergency department utilization than population norms. The engagement of the CCE pilot offers an opportunity to coordinate the intermingled needs of behavioral and substance use care with physical health care and other social determinants to improve the overall population health of CCE pilot participants, improving their care experiences, and reducing higher-cost services.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?
The CCE model would improve the accessibility of services by providing a "no wrong door" approach. All partnering organizations will provide a facilitated referral (and warm handoff when possible) to any of the services included in the pilot. This enhanced referral will include tracking of referrals and outreach/engagement efforts targeted at those individuals that don't follow-up on referrals. Screening, Brief Intervention and Referral to Treatment (SBIRT) will be utilized by all partners to ensure that individuals' needs are identified and addressed. This model will assist

in the identification of individuals with high ED utilization whose unmanaged behavioral health needs may cause underutilization of routine, outpatient care, resulting in more frequent emergency department or other acute levels of care. A primary objective is to determine if highly coordinated care between community partners that engages social supports will help improve utilization of medically-necessary health and human services while lowering utilization of more high-cost services, thereby improving functioning and quality of life. Prescribers will continue to adhere to the principles of availability, accessibility and uniformity of services through thorough inter-organizational coordination to ensure no unnecessary delays occur in the provision anticonvulsants, antidepressants, antipsychotics, non-controlled substance anti-anxiety drugs, and other medications used to treat mental disorders, epilepsy and seizure disorder.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
Education and training will be the primary initial impact on the workforce. An introduction, community awareness, process and training plan involving physical (both primary and acute/specialty care providers) and behavioral health professionals, peer support specialists, finance, social support agencies would be forged, and hosted at CMHA-CEI in an initial kick-off, with subsequent shared learning and training opportunities among peers. The training plan will be created with input from all primary partners. The model would also leverage existing resources including Hospital Grand Rounds, morbidity and mortality education/awareness, coordination of care dinners, online learning, CMHA-CEI Clinical Excellence Committee Trainings, and shared learning through in vivo team meetings.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?
Throughout the course of the CCE Pilot, individuals will be encouraged to be an engaged participant in their healthcare team and direct decisions affecting their own health and social supports, and may choose to eliminate themselves from the CCE pilot. CMHA-CEI Customer Service staff are Certified Peer Support Specialists (CPSS) and available to assist with that choice. Customer Service, CPSS staff are trained in person-centered planning facilitation, self-determination and choice as core values and are available to assist in orientation of consumers to the service array and service delivery options.

Would this model affect the administration of complaints, grievances, and appeals?
To support the ability to promptly resolve issues at a local level, Customer Service, CPSS staff who have been trained in the complaint process of all the agency partners will be available to assist in the facilitation and navigation of individuals with complaints and concerns. Complaints,

grievances and appeals would be handled by existing systems during the initiation of the pilot. Oversight and monitoring of complaints, grievances and appeals for pilot model participants will be provided by the CCE Governance Committee.

How would the model support continued access for individuals to current services, supports, and providers?
The augmentations of care coordination between participating entities and the engagement of social support agencies will be offered in addition to the core service array. Customer Service, CPSS staff are available to provide support and navigation through every part of the service array, including access, orientation, person centered planning and other points of choice, and the ushering of complaints, appeals and grievances through CMHA-CEI and agency partners.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?
Partners will maintain their existing governance bodies however, oversight and monitoring of the proposed CCE model would be facilitated through the formation of the CCE Governance Committee, made up of representatives of sponsoring organizations responsible for assuring clinical, financial and administrative responsibility. It would be co-chaired by two of the participating public entities, ICHD and CMHA-CEI. Additional committees would be established reporting to the Governance Committee. While a Totally Accountable Care Organization model would normally precipitate the formation of a legal entity, the nature of this 298 pilot will first determine efficacy and be agreements-based rather than requiring formation of a new legal partnership/organization. If successful, it could potentially warrant a the creation of a community-based TACO. The CCE Governance Committee would include at least 30% representation of individuals receiving services from the partnering organizations and/or their family members/legal representatives. Administrative, Information Technology, and Clinical Committees will also be an integral part of the oversight of the model.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?
As the CCE Governance Committee would be co-chaired by public entities, meetings of the model partnership would be subject to both Michigan's Freedom of Information Act, and Michigans Open Meetings Act, thereby affording the opportunity for individuals to have awareness of progress, design considerations, challenges, and to be afforded input through public comment. Opportunities will be provided for public comment before and after meeting, public forums will be utilized to solicit feedback, and a consumer advisory council will also provide regular feedback.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?
The initial iteration of the CCE pilot is predicated upon existing financing and risk corridors of the sponsoring partners. For CMHA-CEI to effectively leverage funds to maximum community benefit, we propose to contract directly with the state for all specialty behavioral health services, including substance use disorder services. CMHA-CEI proposes to receive the Medicaid PEPM (currently administered by the PIHP) and SUD block-grant resources directly from the state. Alternatively, CMHA-CEI would propose a direct pass-through from the PIHP with the ability to reinvest any savings into local services. The benefits of direct payment is: Greater level of investment in service delivery, the ability to carry out care management functions at a lower overhead cost than is currently paid; thus allowing for more dollars to be employed in service delivery- Integration of services and network across the full mental health service array: the ability to receive SUD dollars directly from MDHHS, in the form of Medicaid and HMP SUD funds, PA2, and federal block grant dollars, thus fostering integration across the MI, SED, IDD, and SUD systems and networks - Improved access to capital to foster greater innovation and partnering; the ability to take on and finance prudent clinical and fiscal ventures, including the financing of and the capturing of savings resulting from partnerships and integrated care arrangements, by being able to hold and deploy, directly, Medicaid and HMP risk reserves in the form of Medicaid/HMP savings and ISFs. The initial financing model with community partners would rely on existing capitated payments, with the potential of risk investment and pooled resources/shared savings on the part of participating entities through a joint operating agreement as the model develops.

What changes would need to be made to provider reimbursement in order to implement the model?
While future iterations of the CCE Pilot Model would be predicated upon blended funding and shared savings/risk arrangements, including the potential of utilizing paneled providers of each participant's network, the initial iteration maintains all existing provider reimbursement models without change. Under this pilot, CMHA-CEI would become paneled as a provider of mild-to-moderate behavioral health services, presuming that reimbursement rates can be negotiated to adequately cover the cost of care.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
The sponsoring partners in the proposed model would identify the target population, agree on shared metrics of quality, cost savings and individuals experiences of care. Upon achievement of the agreed-upon metrics, cost savings from this model would be realized and reinvested into community services. The pilot would allow for a percentage of the shared savings (50 - 70%) to be awarded to partner organizations that met the financial, quality and customer satisfaction criteria.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?
The CCE pilot will identify a portfolio of measures that will align with national initiatives (such as those quality measures required within the CCBHC model (see page 63 of CCBHC Criteria), CMS set of Quality and Utilization Measures, and/or NCQA's patient centered medical home

standards) and existing sets of measures (such as the measures included in the NCQA Health Plan Report Card reports) to allow for comparison of performance with other providers in the state and nation. Measures relevant to the specific needs of the local population served will be identified and included in the portfolio. The measurement portfolio will be agreed upon by all primary partners.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

Success will be measured against the goals this pilot is attempting to meet, including: true consumer choice, use of peer supports, combined coordination of physical and behavioral health care, engagement of housing resources and others.The primary success of the model will be a reduction in preventable emergency department visits and access to appropriate ambulatory/outpatient care (such as the underserved SUD population.) Patient satisfaction will be assessed using Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys (the same beneficiary satisfaction surveys used by health plans and providers across the nation.) For CMHA-CEI, this could require a change from the current MDHHS required surveys to the ECHO Survey (for adults and children who have received behavioral health services.) Other performance targets will be jointly set by the primary partners.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Yes, the model could be piloted as written, with subsequent iterations based on proof of success to include formal development of a jointly-owned legal entity that could ultimately serve as a Totally Accountable Care Organization (TACO) pending approval and agreement by the State. If agreed upon, the development and approval of a State- and TACO-defined PMPM for CCE model participants in a shared savings/reinvestment arrangement by the risk-bearing entities (providers and payers) would afford the best opportunity to move forward.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

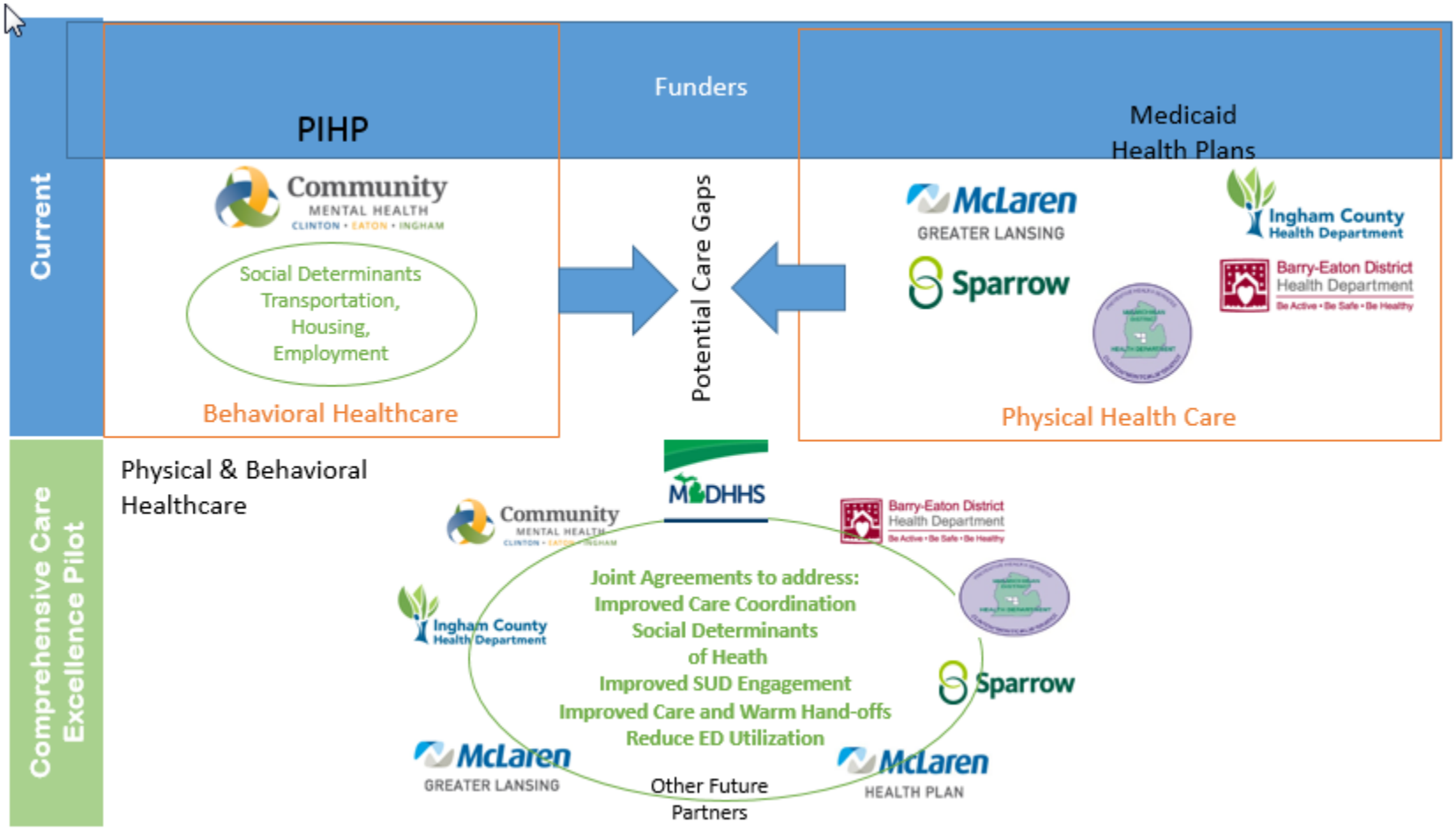
Yes. As there are health plans (MHPs, PIHPs), CMHSPs, hospital systems and FQHCs located throughout the State, similar collaborative, cooperative, and publicly-lead arrangements could be developed to afford all a stake in improved care for Michigan's Medicaid-covered citizens.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

Information-sharing consents for individuals receiving treatment for substance use disorders would be compulsory to participate in this model. Generally, such consents cannot be a barrier to service. Ideally, all community partners would have the same level of protected healthcare information on shared consumers, which may require changes to allowances for access to CareConnect 360. A mature pilot model that predicates development of a TACO may require changes to allow for PIHPs/CMHSPs to participate in their sponsorship.

(Optional) Are you aware of any other states or communities which have implemented this model?

Elements of this model are based on Totally Accountable Care Organizations, Systems of Care, and the elements of Certified Community Behavioral Health Centers.


Current
PIHP
Funders
Medicaid Health Plans
Community Mental Health Clinton • Eaton • Ingham
Social Determinants Transportation, Housing, Employment
Behavioral Healthcare
Potential Care Gaps
McLaren Greater Lansing
Sparrow
Ingham County Health Department
Barry-Eaton District Health Department
Physical Health Care
Comprehensive Care Excellence Pilot
Physical & Behavioral Healthcare
MDHHS
Community Mental Health
Barry-Eaton District Health Department
Ingham County Health Department
Joint Agreements to address:
Improved Care Coordination
Social Determinants of Heath
Improved SUD Engagement
Improved Care and Warm Hand-offs
Reduce ED Utilization
Sparrow
McLaren Greater Lansing
McLaren Health Plan
Other Future Partners

Model #10

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Direct Support and Peer Support Workforce Development Model (DS-PS Workforce Model)

Name of Submitting Organization: Community Mental Health for Central Michigan

Model Partner Organization(s):

Michigan Department of Health and Human Services
Michigan Association of Community Mental Health Boards
Advocacy Organizations
Community Mental Health Services Programs and CMHSP Providers
Pre-paid Inpatient Health Plans
Clinically Integrated Networks
Educational Service entities (e.g., High Schools, Intermediate School Districts, Community Colleges)
Michigan Works!
LARA and contract with Prometric (e.g., administers tests and maintains the Michigan CNA Registry)
MDHHS CHAMPS Adult Home Help Registry

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

In 2016, Lt. Gov. Calley challenged the Public Mental Health System to reimagine the system design if $2.4 billion dollars were to wash ashore. The following reflects the modernization and fiscally responsible realignment of roles, responsibilities, development, and funding to continuously improve the quality and reduce the costs for residential services and community supports for Michigan's most vulnerable citizens.

(1) The Direct Support and Peer Support Workforce Development Model (DS-PS Workforce Model) would include provision of the full range of residential services and community supports (e.g., Community Living Supports, Skill Building, Personal Care, Adult Home Help, Peer Supports, Pre-vocational, and similar supports and services). Scope, service boundaries and supervisory provisions for each of these services will require further development to maximize outcomes, avoid duplication and assure continuity of consumer experience. This model is consistent with the recommendations and scope of services noted in the MDHHS 2016 Report to the Michigan Legislature: Recruitment and Retention Challenges for the Workforce Delivering the Most Frequently Used Supports and Services (required in PA84 of 2015, Article X, Section 1009).

(2) Organizations involved would include:
   a. MDHHS and MACMHB in collaboration with advocacy groups, PIHPs, CMHSPs, and clinically integrated networks (CINs) to develop best practice statewide DS-PS workforce curriculum delivered by authorized educational providers in (2)b below with online refresher trainings made available at www.improvingmipractices.org.
   b. High Schools, Intermediate Service Districts, and/or Community Colleges to provide enhanced standardized educational services to develop key DS-PS personnel (i.e., direct care and peer support occupations) while in school, entering the workforce, or changing careers.
   c. Centralized entity (e.g., Bureau of Community and Health Systems, Prometric) to coordinate the certification process and registry of certified workers similar to the state Certified Nurse Aide (CNA) Model and/or CHAMPS Adult Home Help registry.

d. CMHSPs and their contracted providers for services and supports delivery, monitoring and reporting, and to form best practice recruitment and retention councils responsive to local economies and resource development.
e. PIHPs to provide funding for training, services and supports delivery, and collaborative care outcome incentives.

(3) Services and supports will be provided by key personnel (e.g., direct care and peer support occupations) who receive certification for standardized enhanced training delivered uniformly statewide to include best practice specialized care and supports protocols for person-centered medical, behavioral, and psychosocial plans, as well as best practices for assisting with the social determinants of health. The DS-PS Workforce Model would transform the development and growth of the paraprofessional behavioral healthcare workforce in keeping with values of behavioral and physical health collaboration for all populations at the point of service.

(4) The DS-PS Workforce Model is consistent with the 298 Interim Report recommendations to retain system structures for Medicaid funding of specialty behavioral health and intellectual/developmental disability services through the PIHP/CMHSP system. The DS-PS Workforce Model will be funded through reinvested administrative savings and legislative actions such as:
a. Elimination of redundant service provider DS-PS training resources statewide;
b. Consolidation of most efficient best practice principles from multiple workforce training versions and approaches
c. Reduction in provider overhead costs through uniform and reciprocal standardized DS-PS workforce development and collaboration strategies;
d. Behavioral health carve in of Adult Home Help (AHH) and Model Payment program funds into the PIHP capitated funding mechanism;
    i. Elimination of redundant oversight and divergent appeal mechanisms for AHH in behavioral health settings
    ii. Alignment of AHH workforce compensation models and worker payment complicated by multiple payers
    iii. Consolidation of CLS, AHH, and Model Payment processes within one person-centered planning approach
e. Medicaid savings from lower healthcare costs such as the reduction of unnecessary emergency department utilization through improved staff competency incorporating clinical pathway protocols in the DS-PS workforce curriculum; and
f. MDHHS DS-PS workforce wage appropriations, Medicaid rate setting reflecting minimum wage increases (PA268 Sec. 920(1)-(2)), and certification reimbursement funding similar to the state CNA Certification Model and/or through tuition funding programs such as Michigan Works!.

(5) The CMHSP will assure continuity of care with local oversight of performance following statewide uniform standards and the PIHP will provide oversight to assure alignment to the state Medicaid requirements.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

(1) This model impacts all behavioral health populations eligible for residential services, community supports, and similar peer services. Investment in this model has value-added implications for addressing Michigan's needs for a wide range of populations not part of the 298 scope including older adults, traumatic brain injury, and other disability groups.
(2) No populations would be excluded that are eligible for residential services and community supports.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

(1) All services and supports currently provided by the DS-PS workforce as listed above would be included in this model with enhanced training to increase competencies for collaborative medical, behavioral, psychosocial and social determinant pathways within the scope of supports and services. Existing provider and support relationships can be maintained as the existing workforce moves to certification. The DS-PS workforce enhanced curriculum covering best practice person-centered plan roles and responsibilities including physical healthcare plan protocols, post-discharge care plan assistance, personal care, home help, behavior plan implementation, skill building, coaching, and assistance with goals and objectives, are at least as comparable to the roles and responsibilities required in the state Certified Nurse Aide (CNA) Curriculum.
(2) Services would be affected though a statewide standardized curriculum that supports reciprocity, uniformity, continuity of care, choice and self-determination.
    a. This model would generate a ready and qualified applicant pool oriented to the 298 core values and would be appropriate to any living or work arrangement requiring DS-PS workforce assistance including support for successful self-determination arrangements.
    b. An 'on-demand' ready pool of applicants can be promoted on a services registry such as the CNA Model Registry or MDHHS AHH registry.
    c. The DS-PS workforce curriculum would be offered in high schools, ISDs, or other authorized community educational service to increase the applicant pool through preparation and awareness of this health occupation.
    d. The behavioral health field as a whole would further gain from the early hands on experience through the career progression from certification to possibly two-year, four-year, and Masters-level preparation with certification reimbursement like the MDHHS CNA Model.
    e. Adult Home Help services would be provided by the same worker for the same compensation as opposed to different payers paying different rates for comparable work.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

(1) The Adult Home Help (AHH) registry could be expanded for consumer choice for matching needed services to certified paraprofessionals (e.g., direct care, personal care, recovery coach, peer supports, and similar occupations). Ideally, the website that manages the certification process for CNAs would be expanded for the DS-PS workforce and have a lookup function for consumers and employers instead of the less user friendly AHH phone tree (800-979-4662).
(2) The DS-PS Workforce Model supports the identification of staff for self-determination and home and community based settings. This model does not infringe on consumer choice of provider or care coordinator/manager.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

In partnership with clinically integrated networks that exist to improve the quality of healthcare and reduce costs, this model raises the bar on DS-PS workforce competencies to incorporate standardized best practices for a stratified array of health concerns for the populations served such as protocols for diabetes, asthma, COPD, heart conditions, and medication adherence. Uniform best practice protocols for in-home services and community supports would include standardized approaches to preventive health supports, safe use of medical equipment (e.g., wheelchairs, walkers, Hoyer lifts, sleep apnea machines, communication devices), and fall risk reduction for a consistent consumer experience in healthcare across the state.

Uniform protocols would be included in the DS-PS Workforce curriculum to support access to appropriate healthcare settings in order to reduce non-urgent use of emergency departments (CMCS Bulletin, Jan. 16, 2014). Close adherence with best practice post-acute level of care transition plans could help improve efficacy of care, mortality, and consumer experience and reduce readmissions and healthcare costs. These best practice care plan protocols can connect individuals to a regular physician, support regular maintenance of health and wellness regimens, provide key instruction for post-acute care supports, and connect consumers to appropriate community resources and benefits.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

The DS-PS Workforce Model calls upon all stakeholder organizations to collaborate on best practices knowledge in the DS-PS Workforce curriculum to assure a common foundation and alignment with physical and behavioral services and supports to increase quality while reducing costs. Aligning protocols for 'treatment to target' and critical incident and risk event reduction using best practices encourages collaborative teaming and knowledge sharing at the individual and network levels. This model anticipates the

necessity for complementary training for care coordination and case management in support of the DS-PS Workforce who carry out the whole health oriented person-centered plan.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

(1) According to the Bureau of Labor Statistics, the projected job growth rate for Home Health Aides and Personal Care Aides from 2014 through 2024 is projected at 38% and 26% respectively which is much faster than the average of 7% for all occupations. Early workforce development, credentialing programs, and commensurate wages will be necessary to meet the increased workforce demand to support public mental health core values such as continuity of care, choice of provider, and self-determination. Availability of DS-PS workforce will improve with a regular stream of certified personnel developed through authorized educational service agencies and a strong promotional campaign of this important work by MDHHS.
(2) Accessibility and choice of certified key personnel is enhanced with a registry that allows for matching to services on demand utilizing mechanisms similar to the current registry for CNA and/or the MDHHS AHH Registry.
(3) Uniformity is made possible through a statewide standardized curriculum and use of existing educational service mechanisms such as High Schools, vocational technical centers, and community colleges. Partnerships between educational services and CMHSPs can be formed to incorporate lived experiences to identified topics including peer supports and self-determination. Uniformity is also assured through online refresher trainings overseen by a DS-PS Workforce Development Workgroup. Many Michigan CMHSPs utilize robust but varied monitoring and delivery systems that would be explored for the most cost effective means to deliver and monitor continuing education including www.improvingmipractices.org.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

(1) The DS-PS Workforce Curriculum provides a broad-based whole health career foundation to serve a greater purpose in transforming Michigan's health services culture and acknowledges that physical and behavioral comorbidities must be managed together at the point of service where individuals live and work in order to grow communities where all individuals experience fulfilled lives.
(2) Certification provides a goal for professional growth and is foundational to career development in collaborative health. Promotion and commensurate compensation of DS-PS workforce certification respectfully recognizes the scope of responsibilities and encourages the workforce toward further career development. Training and the continuous

improvement of service delivery would become uniform across the state, providing opportunities for potential specialties in residential, vocational, and peer supports for all populations.

a. The DS-PS Workforce Model provides the State flexibility to recognize varying levels of competency similar to National Alliance for Direct Support Professionals' model to provide higher definition to the DS-PS career path and underscore recruitment and retention strategies. A DS-PS Workforce Workgroup could recommend intermediate credentialing levels in the DS-PS career path such as DS-PS Registered, Certified, and Specialist credentials to correspond with progressive responsibility and wages (see www.nadsp.org).
b. In a randomized controlled study, research has shown that when DS-PS's complete a comprehensive training, there was a 16% decrease in turnover rates. While a 16% decrease in turnover appears small, the financial implications quickly add up with a DS-PS workforce approximating 44,000 Medicaid funded positions. Any reduction in the loss of service delivery relationships would reduce potential trauma due to job turnover.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

The DS-PS workforce curriculum will assure uniform orientation and application of principles of person-centered planning best practices, self-determination, recipient rights, and choice to empower individuals served to exercise their rights and respecting their personal preferences in services and supports.

Would this model affect the administration of complaints, grievances, and appeals?

This model does not impact the current or recommended 298 concepts for complaints, grievances and appeals. The DS-PS Workforce curriculum would have an orientation to the approved dispute and complaint systems to equip the DS-PS workforce in assisting individuals served to freely access these systems.

How would the model support continued access for individuals to current services, supports, and providers?

The DS-PS workforce curriculum would include an orientation of uniform services available statewide to assist access to services.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

(1) The DS-PS Workforce Model does not impact the 298 governance membership recommendations.

(2) Primary and secondary consumers on a governing Board would speak to quality issues related to the DS-PS Workforce curriculum under consideration in support of full transparency. Public forums would provide another avenue for transparency in feedback on coordination of physical and behavioral healthcare provided by the DS-PS workforce.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

The DS-PS workforce curriculum must include consumer participation in development and curriculum delivery.

Accountability and transparency on the DS-PS Workforce Model can be furthered by enhanced uniform satisfaction surveys and site reviews that monitor for coordination of care, home and community based care, and community inclusion principles.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

Medicaid rate setting would incorporate the certification wage to be commensurate with the CNA wage market. MDHHS would include contractual assurances that the certification wage factor translates to actual wages for achieving DS-PS Workforce Certification. The DS-PS workforce (http://milmi.org/datasearch, SOC311011 - $10.68, SOC399021 - $10.39) roles and responsibilities are at least commensurate with CNA roles and responsibilities and CNA wages (http://milmi.org/datasearch, SOC 311014, $13.46/hr.). The DS-PS Workforce work requirements are comparable to CNA roles and wage structures for complexity, judgment, communication, responsibility, and accountability.

Commensurate wages recognizing comparable work would directly support retention efforts by serving as a direct offset to the recruitment and onboarding costs. A very conservative estimate of the cost of recruiting and providing minimal pre-service training for a single Direct Service Professional is $2500 (Seavey & Salter, 2006-2010). Applying the $2500 conservative estimate to a turnover rate of 37% in the approximately 44,000 Michigan DS-PS workforce (MDHHS 2016 Section 1009 Report), the DS-PS estimated replacement cost aggregates to $40 million annually.

Changes in payer financing mechanisms need to be made to support collaborative (i.e., behavioral, physical, and social determinant) delivery of services and supports at the point of service. PIHPs would need the mechanism to act as payer for comorbid conditions or realize shared savings from collaborative care for comorbidities and reduction of overutilization of physical healthcare services. Costs attributed to DS-PS workforce wages commensurate with CNA wages can be recovered from shared savings from reductions in emergency department utilization and hospital readmissions due to best practice care plan protocols, uniform best practice fall reduction protocols, and preventive health strategies delivered in community living arrangements and pre-vocational/work settings.

What changes would need to be made to provider reimbursement in order to implement the model?

The cost of certification reimbursement and ongoing online refresher courses require financing mechanisms at the provider level for implementation of the model. The DS-PS Workforce credentialing program would mirror the opportunities afforded to CNAs through NATCEP certification reimbursement program sponsored by the MDHHS. Mirroring NATCEP rules, the DS-PS workforce would be reimbursed for their training and testing costs by the provider and the provider would be reimbursed by Medicaid. The state could also utilize Michigan Works! to support individuals seeking certification in the DS-PS workforce.

The DS-PS Workforce Model will realize system efficiencies that also support commensurate wages and educational services by converting multiple CMHSP-level administrative DS-PS training oversight systems and non-uniform DS-PS workforce training models into one statewide standardized DS-PS workforce credentialing program. DS-PS credentialing would be monitored centrally in a registry available to consumers and providers similar to the CNA Model, and potentially utilizing www.improvingmipractices.org for ongoing refreshers to maintain certification.

The MACMHB and MDHHS currently share responsibility for maintaining www.improvingmipractices.org and funding for enhancements could come through MDHHS project-based grants. Training certifications for refresher courses could also be monitored on this website.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
Incentives would be used in this model. PIHPs would need MDHHS allowable parameters on value-based payment models to incentivize CMHSPs and providers for achieving risk reduction outcomes such as reduced critical incidents and risk events in an upside risk model encouraging innovation and not compromising dollars needed for services.

Another incentive would be certification reimbursement to providers similar in design to NATCEP as outlined above to encourage statewide integration at the point of service with a DS-PS workforce curriculum that has a person-centered whole health focus.

Pass through wage incentives for providers could also be designed within PIHP/CMHSP contracts to encourage early adopters and ongoing provider participation in credentialing programs for single or multi-level DS-PS workforce credentialing to support recruitment and retention efforts. Additional recruitment and retention incentives would be designed by the DS-PS Workforce Workgroup to address the burgeoning need for the DS-PS workforce projected by the Bureau of Labor Statistics.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

Ultimately, it's quality of outcomes and service that matters. The available research on the impact of credentialed programs has a direct correlation to improved consumer outcomes. In a recent randomized controlled study, Hewitt, Nord & Bogenshutz (in press) found that when DSPs were supported by organizations to complete a comprehensive training program, the individuals who received services from trained DSPs experienced more improvement in outcomes such as employment, social relationships, inclusion and health and safety than their peers supported by DSPs who did not receive the comprehensive training. The study found that DSPs felt more valued by their supervisors and participating providers had a 16% decrease in turnover rates.

Consumer satisfaction would be measured using a standardized measure statewide with plans for improvement addressing consumer feedback, suggestions, and first-level complaints locally with the CMHSP and aggregately with the PIHP. Quality of service methods would include CC360 and ADT data trends to monitor for overutilization and high risk comorbidities to inform the person-centered planning process including collaborative care plan development. Stratification methods would be employed to identify systemic service and supports trends that inform improved practice and protocols for the curriculum. Existing monitoring systems such as critical incidents, and risk events would provide feedback on systems interventions to course correct for better outcomes.

PIHP Quality Improvement Council would identify systemic opportunities for continuous improvement using aggregate data. CMHSPs would address individual and local trends for improvements employing continuous quality improvement methods with consumer involvement on quality improvement committees.

Define “success” for the model? How will the model’s success be measured? What types of benchmarks would be appropriate for evaluating the model?

“Success” for the DS-PS Workforce Development model is defined as upholding core values while improving the consumer experience, improving population health, and reducing the cost of care.

Success measures could include higher consumer satisfaction, higher consumer engagement, lower emergency department utilization, fewer hospital readmissions, lower critical incidents/risk events, lower staff vacancy rate, lower overall DS-PS turnover, high enrollment in the DS-PS workforce curriculum, and increased staff retention.

Annual benchmarks through September 30, 2020 for each of the proposed success measures would be recommended by the DS-PS Workgroup as applicable upon establishing physical and behavioral health baseline information.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

The DS-PS Workforce Model could be piloted but once a DS-PS workforce curriculum is adopted it makes the most sense to roll it out for early adoption rather than withhold standardized best practices from statewide use for the benefit of all consumers.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

(1) The DS-PS Workforce Model is designed for statewide implementation regardless of location given the variety of entities that could be authorized to provide educational services.
(2) A training model coordinated by an MDHHS-MACMHB arrangement would enable broad-based implementation quickly once the curriculum is established and for ongoing training refreshers. Given the many current versions of DS-PS workforce curriculum, a training consulting firm is recommended to efficiently move the DS-PS Workforce curriculum development agenda along. Certification reimbursement incentives, wage improvements for a certified workforce, and PIHP incentives for improved service outcomes will be motivating factors for a quality training product.

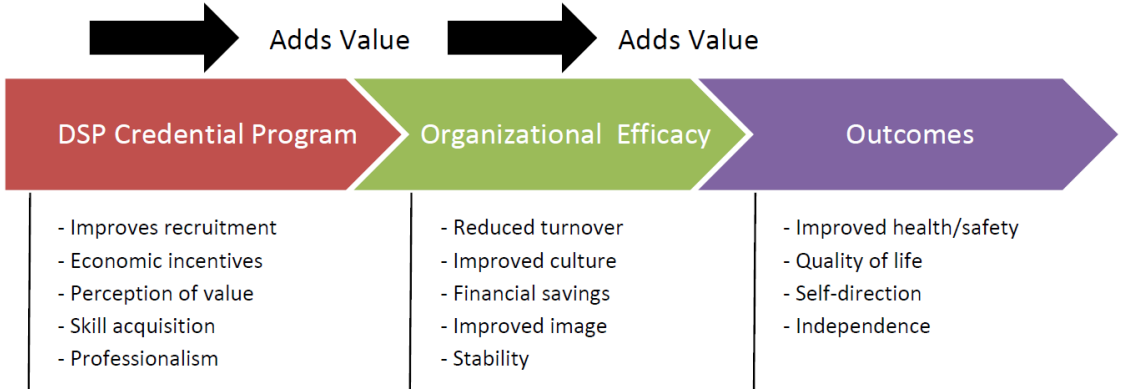
(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

(1) Legislatively require the DS-PS Workforce Workgroup to develop by date certain an implementation plan of the DS-PS Workforce model.
(2) Legislatively require by date certain a promotional campaign with MDHHS funds to build public awareness and appreciation of people with disabilities and those who chose a career to support them. The campaign should build off the system's mission of inclusion and stigma elimination. MDHHS, the PIHPs, employers, direct support staff, and people with disabilities should participate in the creation and execution of the campaign. (Reference: 2016 Section 1009 Report to the Legislature)
(3) Legislatively require with date certain the creation of a DS-PS Workforce Workgroup charged to develop a curriculum leading to state coordinated certification and incorporates best practice specialized care and supports protocols for person-centered medical, behavioral, and psychosocial plans, as well as best practices for assisting with the social determinants of health.
(4) Application of the DS-PS Workforce Model authorized certifications to the NATCEP reimbursement model to providers.
(5) Inclusion of the DS-PS Workforce Model authorized certifications as options in the CNA registry for on demand consumer choice in self-determination arrangements and for provider recruitment.
(6) Inclusion of DS-PS workforce certification as a factor in the Medicaid rates and/or a mechanism for DS-PS workforce wage pass-through for achieving certification.
(7) Contractual assurances with PIHPs/CMHSPs that wage corrections commensurate with CNA wages are received by the certified DS-PS workforce.
(8) Combine MDHHS Adult Home Help (AHH) and Model Payment systems into the PIHP Medicaid managed care financing structure including a review of MDHHS Adult Services Manual AHH wage calculation regulations and disparate AHH regional wage rates.

(Optional) Are you aware of any other states or communities which have implemented this model?

(1) At least 16 states have centralized DS-PS credentialing programs including Alaska, Arkansas, Arizona, California, Georgia, Idaho, Massachusetts, Minnesota, New Hampshire, New Mexico, North Dakota, New York, Ohio, South Dakota, Virginia & Washington (source: web search).
(2) The 2017 NACBHDD Strategic Directions refers to several national direct support credentialing programs available for a DS-PS Workforce Workgroup to review and make recommendations at NADSP.org (list of accredited organizations).
(3) The graphic below shows the value proposition for the DSP credentialing initiative in South Dakota:

If there is any reason alone to create a DSP credential program in SD, quality outcomes is at the base. While they have always been an element examined by regulators and accreditation organizations – they are the reason for the existence of CSPs. People receiving services come first in this field, and developing a DSP credential program is the foundation for quality outcomes! In many ways, such a program is a value added approach to service delivery. Figure 1 illustrates the concept.



(4) New York reviewed the following recommendations in 2016 for Direct Support Professional Credentialing: https://opwdd.ny.gov/sites/default/files/documents/CredentialExecutiveSummary.pdf, page 8:
"Recommendations to the [NY] Legislature and OPWDD: NY DS Career GEAR Up Credentialing Program

1. Make a long-term structural commitment to a statewide DS credentialing program and strengthening the DS workforce. Phase in the program statewide by FY 21/22 achieving the credential for 20 percent of this workforce.
2. Create a state statutory requirement for OPWDD to offer a statewide voluntary credential with incentives for participation through salary increases for targeted enrollments.
3. Develop and implement a mechanism to pay for the DS credentialing program by ensuring NY uses Medicaid to offset the costs through federal medical assistance plan (FMAP).
4. Implement and publicly fund the NY DS credential program beginning FY 16/17.
5. Build the DS credentialing program into the HCBS rule community transition implementation plan ensuring the content of the credentialing program is consistent with the systems changes created by the transition plan.
6. Build upon the statewide DS Core Competencies by moving this credentialing program forward.

7. Ensure that the DS credential program is built into managed care contracts for long-term services and supports.
8. Ensure the DS workforce is comprehensively included in the NY State and OPWDD “transformation” agenda.
9. Establish an independent representative advisory council for the DS credentialing program that is formed by OPWDD to advise and oversee the administrative body.
10. Be certain that the credential program is accessible, applicable and relevant for individuals and families that self-direct in the state of NY.
11. Develop and solicit responses to a request for qualifications (RFQ) for an independent entity to manage the DS credential administration no later than July 1, 2016.
12. Conduct systematic evaluation and improvement of the DS credential and make modifications to the program based on the evaluation results.
13. Mandate systems to ensure the credential program gets updated regularly to reflect the service system and changes in the field of long term services and supports to people with intellectual and developmental disabilities.“

Model #11

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Coordinated Care Organization Model for Michigan

Name of Submitting Organization: Community Mental Health Partnership of Southeast Michigan

Model Partner Organization(s): Community Mental Health Partnership of Southeast Michigan, Lenawee County Community Mental Health Authority, Community Mental Health Authority of Livingston County, Monroe County Community Mental Health Authority, Washtenaw County Community Mental Health

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

The Community Mental Health Partnership of Southeast Michigan has been the Prepaid Inpatient Health Plan (PIHP) for Lenawee, Livingston, Monroe, and Washtenaw counties since 2002. However, the development of the relationship began in 1997 with regular meetings among the Community Mental Health Services Programs (CMHSPs). The model described below is based on the Oregon model of Coordinated Care Organizations (CCOs) builds on the Medicaid Managed Care experience in Michigan and also the experiences and successes of the CMHPSM's 20 year partnership as well as research that describes the types of care coordination needed to partner with consumers in improving their health, quality of life, and in reducing future healthcare costs.

In Oregon, ninety-percent of Medicaid recipients receive coverage through a CCO, which is a risk-bearing locally-governed provider network that works together to serve Medicaid consumers. Although the Oregon CCO model provides fully integrated behavioral and physical health care through CCOs, a health home model with close collaboration between consumers, their medical homes, and behavioral health providers as well as between the PIHPs and MHPs could accomplish much to improve the health and wellbeing of consumers while managing/reducing health care costs. The coordinated care model is built on care management and coordination, shared responsibility for health, performance measurement, paying for outcomes and health, transparency, and a sustainable rate of growth.

Each CCO must have a governing board with the majority of representatives coming from the entities that share financial risk in the organization. Although in the Oregon CCO model board members must represent the community's health care delivery system, health care providers and community members, consumers and their families should have adequate (at least 1/3) representation on the board.

While the CCO's budget cannot grow more than 3.4% per year, each CCO has significant flexibility regarding what it pays for. In addition to paying for traditional health care services, the CCO may use capitation dollars to pay for "flexible services," non-medical services that support health outcomes and cost containment.

The CCO model was established via a Section 1115 waiver demonstration, through which the Centers for Medicare and Medicaid Services (CMS) provided an initial investment of $1.9 billion to establish the new program. In exchange, Oregon committed to reducing the growth rate of Medicaid expenditures by 2 percentage points, while maintaining health care quality and access. The Oregon Health Authority (OHA) contracts with 16 CCOs, which vary in size (from around 11,000 members to more than 243,000 members), geography, and how they organize care. Different types of CCO contracts cover a different mix of services. While initially some CCOs did not integrate coverage for behavioral health or dental care, now they include these types of care." (Note: this model description is included in a report written by HMA for the MACMHB)

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

All people with Medicaid eligibility who have a mild/moderate or moderate/severe behavioral healthcare needs would be served, not just those enrolled in Medicaid Health Plans. In addition to individuals with mental illness, substance use disorders, or intellectual/developmental disabilities; this includes people with Medicaid spend-downs, those who have dual eligibility for Medicaid and Medicare, and those with retroactive eligibility. Many of the individuals in these groups of Medicaid recipients who are not enrolled in MHPs have chronic health care needs that are not managed by the Medicaid Health Plans. The full behavioral health benefit, including the Medicaid outpatient mental health visits for Medicaid recipients with mild to moderate conditions should be included in the population served under this model. Many individuals receiving behavioral healthcare through the MHPs have co-occurring substance use disorder (SUD) treatment needs that can require SUD specific treatment that is included in the benefit managed by the PIHPs.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

- The model shall include the values of the 298 Workgroup including consumer empowerment; opportunities for self-directed care; community based care; positive consumer outcomes and satisfaction with care; equitable statewide access to care; access to a full array of effective care driven by the person's needs and desire; a coordinated, seamless and trauma informed system

of care; public oversight and accountability; maximization of resources reaching direct services; and provision of the highest quality of care delivered by the best trained and most experienced workforce.

- All current Medicaid behavioral health services covered under all the existing 1915 waivers and HMP and all services and supports included in the proposed 1115 Waiver would be provided. This includes Block Grant SUD treatment and prevention services.
- The responsibility and funding for behavioral health services (mild/moderate as well as moderate/severe) would be transferred to the PIHP/CMHSP systems and the mild/moderate population would be included in the overall health care integration/care coordination activities and collaboration with Patient Centered Medical Homes(PCMHs) and MHPs. MHPs would continue to manage the physical health benefit for Medicaid recipients.
- The model would follow the four principles of effective care identified by the SAMSA-HRSA Center for Integrated Healthcare Solutions (CIHS) which are Person-Centered Care, Population-Based Care, Data-Driven Care, and Evidence-Based care. Person-centered Care is based on the individual's preferences, needs and values. The individual is a collaborative participant in healthcare decisions and an active, informed participant in treatment. Population-Based care uses strategies for optimizing the health of an entire client population (based on a particular condition, set of characteristics, practice/provider group, or other parameter) by actively and systematically assessing, tracking, and managing the group's health conditions and treatment responses. Data-Driven Care uses strategies that entail collecting, organizing, sharing, and applying objective, valid clinical data to guide treatment. Evidenced-Based Care uses the best available evidence to guide treatment decisions and delivery of care, including preventive and health promotion services, screening, assessment, treatment, and relapse prevention. (Behavioral Health Homes for People with Mental Health and Substance Use Conditions, the Core Clinical Features; SAMHSA-HRSA Center for Integrated Health Solutions, May 2012)
- The focus of care management is on consumer participation and education, care coordination, and – when working directly with a treating provider – monitoring the consumers' participation in and response to treatment….For care managers working in the public system, telephone contacts are often easier because consumers may find it difficult to travel on a frequent basis due to transportation or child care challenges….(Behavioral Health Homes for People with Mental Health and Substance Use Conditions, the Core Clinical Features; SAMHSA-HRSA Center for Integrated Health Solutions, May 2012)
- Intensive Integrated Healthcare Coordination has been occurring in the PIHP/CMHSP system statewide, but not as a distinct, MDHHS recognized model. A recent survey conducted by the Michigan Association of Community Mental Health Boards, (MACMHB) identified over 750 healthcare integration efforts, of a wide variety associated with the PIHP/CMHSP system. As a "new service model" Intensive Integrated Healthcare Coordination it is not unlike targeted case management or Assertive Community Treatment (ACT) for individuals with mild to serious/severe SUD/MH (MI, SED, I/DD, SUD), but has a greater focus on care coordination and collaboration for those individuals with or at risk of developing chronic health conditions. It is a

strengths based, recovery focused model that would support an individual in improving their quality of life. This model would build on the integration efforts already underway and would move those efforts forward. It could be structured after the CIHS Health Home models that include close local partnerships with PCMHs. The PIHPs and MHPs would continue collaboration through existing Care Coordination activities to coordinate care at the systems level for the highest risk mutually served individuals. Interdisciplinary teams (physician/prescriber, nurse, masters/bachelors CSM, CPSS, PRC) would partner with consumers in accessing needed physical health and behavioral health care for:

  - Preventative and wellness care to reduce risk/prevent chronic health concerns;
  - Active engagement in wellness activities and access with PCMHs for consumers determined by existing health factors to be at a higher risk of developing chronic health conditions;
  - A moderate level of Care Coordination for consumers with chronic medical conditions who are not high utilizers, but are at ongoing risk of needing more intensive medical care
  - Intensive Care Coordination with consumers who have chronic medical conditions and who are high utilizers of ED and Inpatient care
  - Provide a wraparound approach to care delivery that moves away from episodic care to longitudinal relationships

- The model should be trauma informed and person centered. It should be welcoming, strengths based, and promote engagement. It should be recovery oriented for those with mental illness and/or SUD; resiliency focused for children, youth and their families; and focused on enhancing independence, self-sufficiency, and quality of life for individuals with intellectual/developmental disabilities. The model should respect the uniqueness of individuals, celebrate their diversity, and their right to "dignity of risk".
- The model should incorporate elements from the State Innovation Model (SIM) initiative that has the vision of "A person-centered health system that is coordinating care across medical settings, as well as with community organizations to address social determinants of health, to improved health outcomes; and pursue community-centered solutions to upstream factors of poor health outcomes." The SIM focuses on the involvement of health systems that include hospitals, PCMHs, PIHPs, CMHSPs and local safety net providers in creating a more seamless system of care locally and regionally. The focus is on communities providing care management across the spectrum of needs for individuals with chronic health conditions and high utilizers of ED and inpatient connecting the individual with resources for housing, employment, entitlements, specialty care (both physical health and behavioral health). Shared savings would be re-invested in support of promoting health and wellness across the region.

- Elements of the Certified Community Behavioral Health Clinic model can be included also. Specifically, statewide development of 24 hour mobile crisis response teams, crisis stabilization programs; more peer support/family support services; development of collaborative relationships between local outpatient primary care clinics and PCMHS as care coordination begins provider to provider at the consumer level; and access to intensive, community-based mental health care for members of the armed forces and veterans. Each of these elements has specific challenges.
    - It is difficult to establish and maintain local mobile crisis presence and a crisis stabilization programs in more rural communities with a smaller population base. These services, however, can be established and maintained by a PIHP and as a regional approach, would address the capacity and cost issues.
    - The PIHP/CMHSP system has been recruiting and retaining Certified Peer Support Specialists (CPSSs), Parent Support Partners (PSPs), and Peer Recovery Coaches. To increase capacity the required trainings should be available locally using an established curriculum rather than at the state level.
    - Development of collaborative relationships with local outpatient clinic primary care clinics and PCMHs for screening and monitoring of key health indicators and health risk and to further the development of a more integrated system of care. This care coordination occurs provider to provider at the consumer level. The role of the PIHP is to assist/support the CMHSPs in developing those relationships when needed.
    - Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration. The PIHP/CMHSP system should use the MDHHS strategic plan for Veteran's Services to develop closer relationship with the VA.
- Early intervention and jail diversion for people with MI, I/DD, and SUD so that the treatment needs are assessed and provided to prevent incarceration when possible
- PIHP would provide or oversee administrative Medicaid managed care functions and also provide support for a common data set for regional metrics and management reports and EHR, population health metrics, PIHP/CMH reporting functions both across the PIHP region, with MHPs and PCMHs, and with MDHHS.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

Individuals would select their PCMH and providers for their CMHSP services/supports. Care Coordination between the PIHP and MHP systems could be provided by any of the entities that offer individuals that resource. Individuals would have the option to have their MHP or PCMH be the lead entity in coordinating their health care and the PIHP/CMHSP would support the plan developed with the lead entity. Or the PIHP/CMHSPs could be the lead. An individual could also select their local Provider to fill that role.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

Care Coordination is a key element in achieving the Triple Aim. Multiple funders and providers have roles in fulfilling these tasks. Both PIHPs and MHPs have mutual and shared obligations in care coordination for Medicaid beneficiaries. Over the past year, the PIHPs and MHPs have worked closely MDHHS to create mechanisms for enrollee identification and stratification for care coordination; and process, content and format for care coordination care team documentation, available to registered members of the care team. Much effort has resulted in promising practices and emerging benefits in beneficiary satisfaction, quality of life and improved health status, and medical cost offset opportunities.

This model includes identification and removal of barriers to shared savings alignment agreements amongst and between PIHPs and MHPs and their networks. It expands efforts in healthcare system health information exchange and healthcare data analytics

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

The impact of Social Determinants on the health and wellness of individuals and families is immense. To better address the needs of the individuals and families served by the public behavioral health system, PIHPs function both as conveners and participants in region wide safety net systems of care.

Organizations represented in regional safety net collaborations include entities such as local CMHs; local MDHHS offices; SUD providers; health plans, hospitals, and physical healthcare providers; social service provider organizations; local Veterans' Affairs offices; and local government including courts and law enforcement. The involvement of local PIHPs/CMHs in projects aimed at

increasing the availability of safe and affordable housing, access to public transportation and participation in initiatives such as the State Innovation Model (SIM), CCBHC and related initiatives is critical. These projects and other similar opportunities promote better care coordination at the systems level as well as for individuals served by or in need of service from safety net organizations.

PIHPs should continue to work with local CMHs to identify and explore opportunities to address gaps in the safety net system of care as identified in local and regional community needs assessments. This can be accomplished by PIHPs and CMHs jointly reviewing community needs assessments and identifying areas in which the PIHPs can participate. PIHPs should be partners in local SIM initiatives and promote the same conversations in communities within the PIHP region that are not SIM demonstration sites.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

- Establish statewide metrics that are not processed based relating to the number of days before a consumer receives services, but instead the number of denials of one or more services and the results of a clinical peer review to determine whether or not the denial was appropriate. Aggregate results from peer reviews could be used to evaluate uniformity of access across a region and statewide. This would create a monitoring system that would identify areas where access in not uniform
- Prohibit requiring prior authorizations for anticonvulsants, antipsychotics, antidepressants, non-controlled substance anti-anxiety drugs, and drugs to treat mental disorder, epilepsy, and seizure disorders.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

The recommendations of the Section 1009 Group for Direct Care Worker Wage Fairness should be implemented. There should be statewide collaboration to assure retention and recruitment of a high-quality workforce through investment in professional development, adequate compensation, appropriate credentialing, scope of practice, and career ladders. This collaborative effort should include PIHPs/CMHSPs and their provider networks, MDHHS, community colleges, trade and technical school and universities to identify and plan for workforce development in the following areas: direct care workers, peer support specialist, recovery coaches, psychiatry, and social work/psychology.

Implementation of the Section 1009 Group will require MDHHS categorical funding and involvement. Improvements in administrative efficiencies through standardization across PIHP regions and statewide in network management activities such as standardized contracts, training reciprocity, standardized provider monitoring standards and processes, provider monitoring reciprocity, and network capacity assessment tools and processes will help providers reduce their administrative burdens and associated costs. Providers should be allowed to re-invest savings from administrative cost savings back into workforce recruitment, retention, and training.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

N/A

CMHPSM region has centralized ORR through the Washtenaw County Community Mental Health as all CMHs contract directly with Washtenaw for Recipient Rights.

Would this model affect the administration of complaints, grievances, and appeals?

N/A

How would the model support continued access for individuals to current services, supports, and providers?

A model similar to the Oregon CCO model would incorporate the existing service delivery networks and if administer by a version of the PIHP/CMHSP would also maintain the community linkages that are at the consumer level.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

The governance of the public system should remain public. The CMHSPs and the PIHPs are created through local units of government. They are subject to the Open Meetings Act and the Freedom of Information Act. The creation of the Boards of the CMHSPs and the PIHPs includes consumers, usually with lived experience of the public mental health system, and community members. It is essential that consumers of services and their families continue to have a strong presence on these boards or any future board that oversees these or similar entities. Consumer empowerment and voice and necessary to the optimal functioning of a system designed to serve those at risk of becoming or who are the most vulnerable of Michigan's citizens.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

There must be consumers with lived experience and their family members on the governing boards of the entities that manage and provide the behavioral healthcare provided to Medicaid recipients. In addition there should continue to be other avenues available at the local and regional level to advise the governance boards, provide input on the types and quality of services that are available and received, and to represent the very unique interests of the individuals who receive services through the public behavioral healthcare system (and also the public physical healthcare system). At least annual community meetings such as forums and town hall meeting should be held to include the community voice especially as relates to gaps in services, barriers to services, and ideas for innovative thinking that would lead to ongoing improvements.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

- The full behavioral health benefit, including the Medicaid outpatient mental health visits for Medicaid recipients with mild to moderate conditions should be included in the population served under this model. Many of these individuals have co-occurring substance use disorder (SUD) treatment needs that can require SUD specific treatment already included in the benefit managed by the PIHPs.
- Create payment models that incentivize care coordination and outcomes
- Create payment arrangements for care coordination activities that are not face to face
- Include CPT codes for RNs, case managers, and peer support professionals (for each population) to capture care coordination activities—both direct and indirect
- PIHPs/CMHs to share in the savings MHPs experience resulting from the care coordination activities done by PIHPs/CMHs
- Share per eligible/per month care coordination rate between PIHPs and MHPs
- PIHPs to be able to retain savings and pass down to CMHs and providers to reinvest in services
- Savings lose Medicaid identity so they can be reinvested in local safety net services and/or to develop and support programs that may not be Medicaid funded but are connected with the social determinants of health and address the needs of the at risk/high utilizer population. MHPs could contribute savings to these safety net services, also.

What changes would need to be made to provider reimbursement in order to implement the model?

PIHPs/CMHs to develop contracts with MDHHS/CMS approved language to allow contractors to keep savings to reinvest in their workforce and/or to develop new services.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

Yes. Incentives would be based on pay for performance, value based purchasing arrangements as written in contracts

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

Established sets of common metrics within the PIHP region and with MHPs and PCMHs would be implemented to monitor access to care, consumer engagement with care providers including the PCMHs and the CMHSPs, consumer specific outcomes, and population health trends. Consumer specific outcome measures should include consumer recovery on a continuum. Metrics would measure the efficacy of the model, identify gaps or barriers to engagement and positive outcomes, for performance improvement, and include pay for performance percentages that are required to be reinvested in services.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

Success would be determined by meeting Key Performance Indicators (KPIs) for each year over the first 5 years as reflected in the Triple Aim for Health Care—Better Care for Individuals, Better Health for Populations, and Lower Per Capita Costs.

HEDIS measures and/or National Outcome Measures (NOMs) would be incorporated into the metrics that would be used along with others that would support statewide and/or national benchmarking for consumer outcomes and satisfaction with services and costs.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Yes, the Oregon CCO model could be piloted in an existing PIHP region. Key initial elements include PCMHS or other health home structures, the participation of local/regional health systems including hospital systems, the participation of the local community or regional safety net organizations and of course the PIHP/CMHSPs. In regions with SIM initiatives many of these elements already exist or are in the process of development.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

Yes with support from MDHHS. Many aspects of this model are SIM like especially the focus on population health, concern for the health and wellbeing of the most at risk populations, emphasis on cross systems communication and collaboration, the integration of physical and behavioral health, the importance of PCMHs the involvement of healthcare systems, and the involvement of the safety net providers.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

Changes to the Insurance Code to allow for the inclusion of the mild to moderate benefit in the Medicaid benefit currently managed by the PIHPs.

(Optional) Are you aware of any other states or communities which have implemented this model?

Oregon has similar model.

Model #12

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Mediation in Behavioral Health

Name of Submitting Organization: Dispute Resolution Education Resources, Inc. (DRER)

Model Partner Organization(s): Community Mental Health Authorities, Community Dispute Resolution Program centers

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.
DRER proposes to pilot, at no cost, the effective use of voluntary mediation in resolving behavioral health care disputes. The proposal is based on the recommendation in Section 3.1 of the Interim Report. The recommendation supports the creaton of an independent dispute resolution entity with mediation as one of the available options. The pilot project is intended to inform further MDHHS and stakeholder work on the dispute resolution system. DRER recognizes that Section VIII of this form addresses pilots, but respectfully requests to begin the discussion here because of mediation's implications for the system as a whole.

(1) The pilot project will provide information about and access to mediation services, trained meditors, data collection, progress reporting and evaluation. (2) The pilot will be coordinated and managed by DRER, a Lansing nonprofit, 501(c)(3) organization. DRER will provide informational materials, mediator and intake training, data collection and progress reporting services. Partners will include CMHs that agree to refer cases to mediation and corresponding centers, all nonprofits, that belong to the Community Dispute Resolution Program.

(3) The pilot project will support the core values of individual self-determination and access to local services. Individuals in mediation continue to pursue their goals while working through disagreements with providers and payers. They do not sacrifice this role to outside parties unless they choose to use another form of dispute resolution. The project will make use of local mediation services with long experience mediating individual and family-related disputes with social service agencies.

(4) The pilot will be conducted at no cost to MDHHS or project participants. Long-term, mediation might be funded in several ways, including government grants and contracts, foundation support and fees paid by the parties. One consideration in determining the appropriate approach is mediation's cost compared to other dispute resolution processes. Numerous studies report that mediation costs less that traditional hearings and investigations and presents a potential savings to the agencies that use it. A second consideration is whether the source of funding will inject bias or the perception of bias into the mediation process. These considerations require further MDHHS and stakeholder review.

(5) Pilot project outcomes would be reported to MDHHS and stakeholders as information to be used in further planning for the indiependent dispute resolution system.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
The pilot project will affect individuals, providers and payers involved in disputes that arise from person-centered plans and those that arise from an individual's relationship with a provider or payer. The latter might include allegiations of disrespect or unfair treatment. The project will have the capacity to mediate issues related to Medicaid Fair Hearings if the MDHHS wishes to include them. This has been done successfully in North Carolina. The project will excluded cases involving abuse and neglect and those involving state hospitals.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
In terms of services, DRER will provide informational materials, mediator and intake training, data collection and progress reporting for the project. Partcipating CMHs will refer disputes to their local community dispute resolution centers. The centers will provide intake, mediation and scheduling services. Wayne State University will be asked to provide independent evaluation services. The centers will provide supports that enable parties to fully participate in the mediation process.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?
The pilot project will make information about mediation available to individuals through participating CMHs, local mediation centers, and disability rights organizations. This information will help individuals determine whether mediation is right for their circumstances. Individuals will be able to request mediation by contacting a participating center and will be free to work with any such center. Although mediators are generally assigned, individuals will be able to choose a mediator among those trained for the program by mutual agreement with the other parties involved in their dispute.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
The pilot project will address coordination to the degree the issue arises in mediation. If the issue is that coordination is lacking, the parties will be able to collaboratively develop a remedy that strengthens the system for the individual involved in the dispute

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?
The model will promote collaboration at the problem solving and service delivery levels. Mediation is a collaborative process for resolving disputes. Parties in mediation will communicate, negotiate and share information about the causes of and potential solutions to their disputes. They will succeed when they mutually agree to a solution that works for all concerned. Service delivery solutions may call upon several parties to coordinate activities for the benefit of the individual.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?
Mediation will provide a forum for participants in the behavioral health system to collaboratrively develop remedies to system shortcomings. In a mediation involving a specific incident, the individual, providers and payers will share their perspectives on the problem and find a solution that improves the system for the affected individual. (Where system problems affect a number of individuals similarly, mediation and other collaborative processes can be used to find more comprehensive solutions.)

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
The model will provide training by experts in the behavioral health and mediation fields for mediators and intake specialists. The model could strengthen staff by including training in collaborative planning, communication and conflict resolution skills.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?
Mediation engages the parties in communicating and negotiating with each other with the help of a neutral third party, whose chief role is to promote constructive interaction between them. It empowers individuals by supporting self-determination even when there is conflict, rather than transferring their decision-making role to outside third parties, such as investigators or administrative law judges. Mediation encourages individuals to assert their needs and help generate options – i.e., create choices – to meet those needs. If the other parties mutually agree, the individual will have furthered his or her interests and goals. Somewhat paradoxically,

the individual can also assert self-determination by rejecting the mediation option or the options created in mediation if they do not further his or her interests. Other dispute resolution options that better serve those interests will be available.

Would this model affect the administration of complaints, grievances, and appeals?
Mediation can be used as a case management tool to reduce backlogs or heavy caseloads as long as due process protections are in place. When used early and successfully, mediation can obviate the need for further dispute resolution. When used as an alternative to pending hearings or investigations, it can reduce or eliminate the issues to be heard or investigated. When all such issues are resolved by mediation in a given case, the complaint or grievance can be withdrawn.

How would the model support continued access for individuals to current services, supports, and providers?
The model will support continued access to the degree that it becomes a solution to an issue in mediation. Mediation will have no affect on access where it is not at issue.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?
MDHHS may wish to create a small stakeholder group to monitor the project, with DRER providing regularly scheduled progress reports. DRER will be responsible for ensuring that mediation services are provided in a professional, timely manner, and that pilot project results are shared with the MDHHS, stakeholders and the public. Training materials; referral, intake and scheduling procedures; mediator standards of practice and outcome data will be made publicly available. DRER will WSU for an independent evaluation of the pilot, the results of which will also be made public. Service delivery concerns may be directed to the stakeholder group or DRER, which will investigate them. It should be noted that mediation discussions themselves will be confidential.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?
Individuals, family members and community members can participate in establishing standards of practice for mediation. They would work with other stakeholders to define the goals of mediation, its appropropriate use, and the appropriate practices and behavior of mediators. Reaching a consensus would promote confidence in and acceptance of the mediation process.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?
As noted above, the pilot project will be conducted at no cost. Long-term, given the multiple ways of funding mediation, further discussion among stakeholders would be necessary to determine the best approach and its impact on current funding mechanisms.

What changes would need to be made to provider reimbursement in order to implement the model?
For the pilot project, none. Long-term, please see the preceeding response.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
As noted above, government funds are sometimes used to alleviate the cost of mediation for parties, whether individuals, providers or payers. The theory is that saving the parties the expense will encourage use of mediation and help agencies avoid the greater cost of more formal, time-consuming and resource-intensive dispute resolution processes. This will need further analysis in the behavioral health care context.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?
Service quality will be measured through data relating to the speed with which mediation services are delivered, the duration of mediation sessions, the overall agreement rate, the estimated cost savings in relation to other forms of dispute resolution, and user satisfaction with the referral, intake and mediation processes. Key elements of user satisfaction will include assessments of mediator understanding of the issues, mediator impartiality, whether an agreement was reached and whether the parties would recommend mediation to others.

Define “success” for the model? How will the model’s success be measured? What types of benchmarks would be appropriate for evaluating the model?
The pilot project will be deemed successful by posting an overall agreement rate of 70 percent and a user satisfaction rate of 85%.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Please see the above.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?
The model can be replicated throughout the state through the CDRP, which is comprised 18 local dispute resolution centers. The centers have extensive experience mediating issues relating to families and individuals with disabilities. The centers are particularly responsive to government programs that establish operational guidelines and targets for success.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?
The Michigan Mental Health Code's mediation provision (MCL Sec. 330.1788) would need to be changed to allow mediation before an investigation is conducted. In the event the model icludes the mediation of Medicaid Fair Hearing issues, the appropriate arrangements with MDHHS and MAHS would be necessary.

(Optional) Are you aware of any other states or communities which have implemented this model?
In 2008, North Carolina piloted a program to mediate Medicaid service reduction and termination appeals. The state office of hearings referred appeals upon receipt to the North Carolina Mediation Network, a group of nonprofit conflict resolution centers. The project posted a mediation agreement rate of 83% savings of nearly 20 times the expenditure for the process. The program became permanent.

The closest program to the model proposed here is the Michigan Special Education Mediation Program, which is operated by DRER for the Michigan Department of Education Office of Special Education. The federal Individuals with Disabilities Act requires that mediation be available to parents and schools as a dispute resolution option. It requires the state to pay for mediation services. The regulations at 34 CFR 300.506 establish standard practices for special education mediation, including due process protections. Michigan's program, as well as New York's, use their state CDRPs to provide local mediation services.

Model #13

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Community Based Provider Integrated Health Home
(A Physical/Behavioral Health - Community Behavioral Health Clinic (CCBHC) Like"/Value Based Payment (VBP) Model)

Name of Submitting Organization: Easterseals Michigan

Model Partner Organization(s): Oakland Integrated Health Network (OIHN), Oakland County Community Mental Health Authority (OCCMHA). The concept is supported by OIHN and we are in discussion with OCCMHA. Due to the short time of this request, we are yet to meet as a group.

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

Overview

For nearly 100 years, Easterseals Michigan has been an indispensable resource for people and families challenged by a special need and/or disability. As our country faces a broad range of new issues, we continue to make major, positive, life-changing differences in the lives of people and families challenged by behavioral and development disabilities. Now in the 21st century disabilities have become increasingly complex, going beyond the physical to include emotional, intellectual, social and educational challenges and we are committed to continually evolving and innovating to better serve those in need.

The health care systems recognition and desire to focus on social determinants of health is welcoming. It is our proposal that to best address social determinants and health care needs, partnerships between the Health Systems, funders and Community Based Providers/Organizations are vital.

Presently some of the more innovative payors and health systems have discovered and begun to contract with community-based organizations/providers (CBPs) that offer the ability to coordinate, support and provide services in an efficient, effective and holistic approach. Our proposal is centered around developing and maintaining partnerships that can care coordinate on mutual cases, refer for seamless access to either primary or behavioral health care and use health information technology to drive patient centered care.

The proposed model builds on where the public mental health system has evolved in developing partnerships with community based organization to enhance current offerings to be fully inclusive of all and providing a full continuum of care.

Easterseals Michigan (ESM)was founded on caring for and supporting the whole person including the family's needs and always, always with an eye on "social determinants". As we have evolved over the years we continually develop strong partnerships with foundations, donors, private and public payors and those we serve, who have continually challenged us to be innovative. Moreover, our strongest partner the Public Mental Health system has allowed us to jointly apply our shared values to meet the ever-changing needs of the community. This public/private partnership affords us the ability to leverage our respective strengths and talents to maximize public resources, while adding other resources and funding (not accessible by public entities) to be more innovative, efficient, creating new best practices and meeting unmet needs.

While many health care systems have long had relationships with CBPs, through referrals, many have not formally integrated them into a comprehensive, unified care plan. Our model proposes to leverage public/private partnerships, while adding a no wrong door approach and serving all populations utilizing elements of the Certified Community Behavioral Health Center Model and Primary Care/Patient Center Medical Home Model (PCMH) to create a community resource that is inclusive of all aspect of one's health. ESM was one of twelve organizations certified by the Michigan Department of Health and Human Services (MDHHS) this past year as a CCBHC program. The CCBHC model focuses on a set of core standards of practice for all behavioral health populations mild, moderate and severe with promotion of seamless, timely access to initial and ongoing services, person/family centered assessment, treatment planning and monitoring; crisis management, care coordination across multiple settings including child welfare, courts and juvenile justice, American Indian Health Settings, hospitals, etc. Furthermore, the CCBHC model emphasizes defining evidence based treatment teams and care coordination standards including the use of health information technology to promote real time health data exchange for care planning. In addition, the CCBHC model concentrates on defining the core programs that would be available for all populations regardless of residence, diagnosis, or ability to pay. ESM would utilize these core standards as the common framework for delivery of service under the proposed model. Michigan's values align strongly with the CCBHC model but the financial model did not fit with Michigan funding structures as well. ESM would propose with the aid of MDHHS a new value based funding structure to coincide with achieving core metrics.

Primary care providers are of the utmost importance to health care delivery for all populations. The model would include their important role as a primary care patient centered medical home (PCMH), but emphasize the unique strengths of Community Based Providers (CBPs) for serving not just the most chronic, frail and medically complex individuals but all groups. In creating our CBP Integrated Health Home (CBPIHH) program, it is important to note how it differs from an historical PCMH model. While PCMHs are well suited to coordinate medical care, they typically do not have the capacity to perform the full continuum of care including variety of levels of care from the low to intensive care coordination involving the extensive non-medical systems issues and behavioral health needs of

individuals with complex care issues (particularly serious behavioral health conditions). Our CBPIHH model would therefore incorporate and expand upon the PCMH physician-led medical care team through extensive complex care management services for enhanced coordination of medical and behavioral health care with needed social support resources for optimal health outcomes.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

- All populations served – All ages from birth and beyond, such as:
    - Mental Health, Substance Use, and Co-occurring regardless of level of care: Mild/Moderate/Severe
    - Intellectually and Developmental Disabled
    - Autism
    - Complex Medicaid Cases as defined by:
        1. Have 2 or more chronic conditions
        2. Have one chronic condition and are at risk for a second
        3. Have one serious and persistent mental health and/or substance use condition

  (Qualifying chronic conditions for a Medicaid Health Home include: mental health, substance abuse, asthma, diabetes, heart disease and being overweight. Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval).

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

Services and supports we envision within the CBPIHH include:

- Full continuum of Medicaid State Plan Services defined by benefit plan based on acuity (individual, family, group, etc.), excluding long term care
- Full continuum of SUD services
- Primary Care- FQHC Partner
- Medical Rehabilitation
- CARE Management is key and of utmost importance.

Services and supports would be affected by creating more efficiencies with providers that can integrate versus silos of service and funding buckets currently in place. The focus would be on prevention at the earliest stage of access to health care through primary

care visits to more specialized, early intervention, treatment, habilitative and rehabilitative arrangements for individuals with complex needs.

Core service elements of our proposed Integrated Health Home Model are:

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
4. Individual and family support, which includes authorized representatives;
5. Referral to community and social support services if relevant; and
6. The use of Health Information Technology (HIT) to link, refer and coordinate services through care coordination portals or health information exchange options as feasible and appropriate.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

Individuals will be able to select from a list of CBP's under contract with the PIHP/Managed Care Organization (MCO) within the network. The CBP's will be located in a specific geographical area or statewide. Individuals will utilize the Person/Family-Center-Planning process to access and determine medically necessary services. Services will be delivered by the providers that are part of the PIHP Network or if Self-Determination is utilized, by providers selected by the individual served who then will be paneled within the network.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals? Health Home Model – admin of both physical and behavioral health through a single care manager/coordinator that includes full scope of health care needs.

CBPIHH case managers will provide intensive, coordinated, care management that is person/family centered, strengths oriented and culturally sensitive. Individuals served and their families will be at the center of developing treatment goals and services provided. Moreover, care planning will be strength-based focusing on individual and family capacities (resiliency) as well as culturally sensitive

and responsive. Furthermore, integrated service plans will encompass other engaged care partners and community resource/service agencies for greater coordination of care, reduced service duplication and optimal care outcomes. Primary care partners will be an individual's PCMH/primary care physician, primary behavioral health provider and other involved social support/community resource service organizations.

Other key care coordination/ supports service features of the CBPIHH program will include access to:

a. high-quality health care services informed by evidence-based clinical practice guidelines;
b. preventive and health promotion services, including prevention of mental illness and substance use disorders;
c. mental health and substance abuse services;
d. chronic disease management, including self-management support to individuals and their families;
e. education and educational support services
f. individual and family supports, including referral to community, social support, and recovery services;

Enhancement efforts would include a creation of a continuum of care through strategically establishing formal functional relationships with select funders/providers to secure high-quality, cost-competitive services.

Partnerships and/or joint ventures with community based provider/nonprofit and FQHC as well as other contract approaches. To be successful, execution of an effective community based strategy will demand that health systems not only ensure access to high-quality services with competitive cost profiles, but also effectively manage the patient across the continuum. Our care management for all populations including the most at risk will the community and redesign of care delivery outside of the acute setting through this model.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

Proposed funding VBP model forces all of us to collaborate. Expectations and metrics to track outcomes would be defined around care coordination, communication, and ability to share HIE using a state wide consent module.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

It would be a community resource, health home and include pharmacy and other nontraditional services. The current system of care is fractured as PIHP/CMH requires eligibility to prove need to access services. In the proposed model, we are recommending a CCBHC/FQHC framework where there is no wrong door to receiving services in a timely manner. If you are certified CCBHC you are required to provide screening and assessment for services regardless of residence or ability to pay within a timeframe dependent on your acuity/severity of symptoms.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

The CBIHH would have adequate management staff to ensure that their organizations have the capacity, appropriate licensure and scope of practice to provide high quality services to Michigan residents. The current system ensures the highest quality of evidenced- based services are available under the current public pre-paid inpatient health system. This proposal would continue to leverage those initiatives. The CBIHH will ensure specific credentialing, staffing, training and culturally informed operational plans that builds upon the current Public Mental health requirements currently in place. It builds upon the current model of care but uses a holistic approach. Instead of saying 'integrated', it is all encompassing health care.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

This model empowers individuals to make decisions about services delivery through a better understanding of the relationship between their behavioral and physical health care needs. This is accomplished via utilizing a care manager that provides care coordination inclusive of both their physical and behavioral health. The basis of the model is the person/family -centered planning, self-determination, and choice processes ensured by a value-based purchasing arrangement.

Would this model affect the administration of complaints, grievances, and appeals?

We propose that as the model evolves after the pilot period, there are fewer PIHP's (potentially 1-3). This model affects complaints, grievances, and appeals by eliminating the conflicts that exist in the current system where the CMH could acts as both funder, provider, and administrator in many regions. This model would clearly define the role of the PIHP and moves complaints, grievances, and appeals to either the PIHP level or a newly created organization at the state level.

How would the model support continued access for individuals to current services, supports, and providers?

As earlier stated we would use CCBHC/FQHC framework that would provide universal access regardless of residency, level of care or ability to pay. We would create a virtual access/contact center in order to access the full continuum of care through leveraging health information technology.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

Governance would be streamlined as after the pilot we would propose that 1-3 PIHP's/MCO's remain. Proposed model includes metrics from value based contracts and reported to the public and DHHS.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

The individual/families served remain central as the key decision makers. Continued emphaisis on Person/Family Centered Planning. Individuals and their families will be actively engaged in decision-making via the local needs assessment requirements of the PIHP, participation in satisfaction surveys and membership on ARE Consumer and Family Advisory Boards

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

Enhanced payment opportunities for advanced care planning, chronic care, and transitional care management support the role CBPs play in population health management and risk mitigation as part of this model. Additionally, this model will create significant value for PIHPs and position providers to participate in the value created. The expansion of efficient, effective, and compliant community-based practice will address the quadruple aim of improved patient experience, better outcomes, lower costs, and greater provider satisfaction. Clinically integrated community-based medicine will enhance delivery of care to those at greatest risk of fragmented care and high costs.

Interoperable EHR systems and enhancing staff competencies to serve all populations will leverage existing staff skills that are used to care for the most chronic and serious to adapt to all other populations.

Sources of funding will include:

- All Medicaid Fund sources (autism, SED waiver, etc.)
- General Funding
- SUD Block Grant
- Healthy Michigan
- MI Child

Medicaid financial support for the CBPIHH program is available. States pursuing an MA eligible Health Home program may request federal planning funds at their medical assistance service match rate for health home program design. In addition, the CBPIHH pilot program could receive Federal funding for Medicaid – Medicare eligible individuals served (requires an approved Medicaid state plan amendment by CMS).

What changes would need to be made to provider reimbursement in order to implement the model?

Proposed alternative financing model including a value based purchasing arraignment. Braids existing funding streams. This would need continued evaluation amongst all parties involved and the DHHS. We envision an enhanced complex care management payment system that will have three levels of descending intensity:

- Transition (Highest Need)
- Stabilization (Moderate)
- Reoccurring (Low)

Model would require a changes to funding to the PIHPs and then PIHP would subcontract with CBIHH.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
Yes, that is at the core of the model as it uses value based payment arrangements. Moreover, cost savings from early intervention (e.g. reduced expensive hospitalizations, emergency room visits) and unnecessary duplication of services (e.g. tests, multiple intakes) would be reinvested into further program – service enhancements. This will be accomplished through using the existing system of care that ensures the best interest of the public vs. a privatization model where savings are converted to profits.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?
Begin with a benchmark (funding neutral) year for organization that takes a set of core standards/metrics i.e. HEDIS, MIPS, and add state wide quality improvement projects. Each subsequent year, organizations would have to improve or be penalized financially.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

HEDIS Measures
The evaluation methodology for the CBPIHH would utilize both processes and outcome measures to assess overall program value and the efficacy of any one of the program's elements. Program evaluation and continuous quality improvement metrics will therefore include both efficiency measures (service delivery process/costs) and quality of care measures (program participant wellness outcomes). Program outcomes regarding optimizing the "well-being" of individuals and families served will be assessed

using accepted standardized physical, behavioral, educational and social evaluation tools such as HEDIS measures and other psychometric tools i.e. Daily Living Assessment (DLA); Audit; Assist; CAFAS; SIS; to name just a few.

Moreover, the CBPIHH program will be evaluated to assure it meets the following 11 mandatory core Health Home Program standards per the Affordable Care Act with modifications based on Michigan needs and incentive targets that meet both BH and Primary Care standards:

1. Quality-driven, cost-effective, culturally appropriate, and person/family-centered health home services;
2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
4. Coordinate and provide access to mental health and substance abuse services;
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
8. Coordinate and provide access to long-term care supports and services;
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot? Yes

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

Yes, but would need assistance in areas where the current provider is the PIHP, CMHSP and provider.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model? Our proposed Integrated Health Home (IHH)Model with a VBPS could be established via "braiding" existing programs, services and funding sources. A State Plan Amendment could be sought though to support financing of our proposed IHH via Medicaid. States have flexibility in designing payment methodologies and may propose alternatives to CMS. An approved SPA would allow for a 90% enhanced Federal Medical Assistance Percentage (FMAP) for the specific health home services in Section 2703 (see The enhanced match doesn't apply to the underlying Medicaid services also provided to people enrolled in a health home. The 90% enhanced FMAP is good for the first eight quarters the program is effective. A state can get more than one period of enhanced FMAP, but can only claim the enhanced FMAP for a total of eight quarters for one enrollee (see healthhomes@cms.hhs.gov for more information).

(Optional) Are you aware of any other states or communities which have implemented this model? As of July 2016, 19 states and the District of Columbia have a total of 28 approved Medicaid health home models, including Michigan (see CMS State-by-State Health Home State Plan Amendment Matrix - https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-spa-at-a-glance-jul-2016.pdf). One highly developed Integrated Health Home model is The New York State Health Home (NYHH) Program. NYHH is a collaborative effort between The New York State Department of Health, the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Office of Children and Family Services. The NYHH program is a complex care management service model where all of the professionals involved in a member's care communicate with one another so that the member's medical, behavioral health and social service needs are addressed in a comprehensive manner. It is anticipated that the provision of appropriate care management will reduce avoidable emergency department visits and inpatient stays, and improve health outcomes. With the member's consent, health records will be shared among providers to ensure that the member receives needed Health Home services will be provided through a State Designated Health Home, defined as partnership of health care providers and community based organizations. Health Homes are responsible to facilitate linkages to long-term community care services and supports, social services, and family support services.

Model #14

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Michigan Complete Health Integrated Pilot for Managed Long-Term Services and Supports

Name of Submitting Organization: Fidelis SecureCare of Michigan, Inc.

Model Partner Organization(s): Managed Care Organization

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

Overview: Services and Supports.

Fidelis SecureCare of Michigan, Inc. (Fidelis) is pleased to have the opportunity to share with you our proposal for an integrated model that incorporates all services and supports for populations currently accessing long-term services and supports through fee for service. Currently, individuals receiving long-term services and supports (LTSS) in Michigan are excluded from managed care, as their Medicaid benefits are covered by the state's Medicaid program through fee for service (FFS). Through our Michigan Complete Health (MCH) product, we propose a pilot to transition those eligible populations receiving services for behavioral health (BH), developmental disability (DD) or LTSS through Medicaid FFS into a single managed care pilot program. We believe that Michigan will achieve the best outcomes by fully integrating the physical health, behavioral health, LTSS benefits. Through our pilot we will utilize an Integrated Care Team approach that provides Participants with a single point of contact and accountability for coordinating all needed services to ensure seamless, continuous, and appropriate care and services across the care continuum. MCH's Care Manager (CM) will be that single point of contact and will facilitate the care planning process, coordinating among the Participant, caregiver/supports, all providers and others planning and monitoring the Participant's care. CMs will facilitate and coordinate access to all medically necessary physical (PH) and BH, pharmacy, and LTSS services to ensure Participants receive care and services outlined in their person-centered care plan in the appropriate amount, duration, and scope to achieve the best health outcomes in an efficient manner, that reduces potential duplication and helps to maintain the Participant in the least restrictive setting. An integrated managed care model that is inclusive of a wide range of services and populations can reduce fragmentation and effectively meet members' needs through integrated, holistic care planning and a mix of individualized services and supports, regardless of diagnosis, to avoid hospital admission and/or institutionalization.

Supporting Service Delivery--Keeping the Core Values.

MCH recommends full population-based coverage plus all medical/ pharmaceutical coverage for Medicaid services for dual-eligible individuals for all three specialty programs: BH, DD and LTSS. A full population-based model allows MCOs to more effectively coordinate acute, primary, and specialized health services with long term services and supports to reduce system fragmentation and simplify Michigan's overall health care system approach. We also recommend, based on our experience, full integration of BH (as opposed to block grant funding or the provision of BH services through a third-party contract) across all populations. This provides MCOs the flexibility required to implement creative, recovery-based and self-determined approaches that recognize the link between behavioral health and overall wellness. MCH also recommends a dental benefit be included in full population-based coverage given the direct link between dental care and health outcomes. Population-based coverage is an essential ingredient to achieving improved health, enhancing patient experience, and reducing or controlling costs. A fully-integrated benefit

inclusive of facility and community-based services will allow MCOs to build on Michigan's progress to date rebalancing funds across settings and funding sources. A comprehensive, integrated approach allows MCOs to dedicate resources to 'follow the person,' facilitate a whole-person and self-determination approach, while measuring system-wide factors that influence outcomes. The streamlining of traditionally fragmented categorical funding sources that a coordinated care approach achieves is particularly beneficial for high-risk populations where multiple co-morbid conditions and multiple treating providers are prevalent, such as with the special populations identified through this model proposal. It also eliminates a "silo approach" to care management and cost savings and, instead, creates an incentive to look at the entirety of each member's needs. Immediate access to data and the ability to closely monitor a member's care is crucial and better facilitated through this approach.

Organizations Involved.

MCH's recommends moving the populations and services outlined above into a full managed care system, where Managed Care Organizations (MCOs) are responsible for contracting service providers, authorizing, coordinating and monitoring all care, and providing payment to providers. However, in our experience the MCO is only one critical organization involved. MCOs would need to work with state agencies, providers (PH, BH dental, pharmacy and LTSS), local community service organizations, centers for independent living, Area Agencies on Aging, advocacy organizations and other stakeholders to ensure coordination.

Accountability, Funding Mechanisms and Engaging with MDHHS.

MCH, based on the experience of our health plan affiliates, reinforces the need for MDHHS to provide MCOs with the highest level of flexibility in their operational design and service delivery to cultivate innovation and encourage cost-effective practices. For instance, MDHHS should delegate to MCOs the authority to select, monitor, and finance any vendors critical to implementation, such as vendors providing electronic visit verification; participant direction counseling and financial management services; and medical and nonmedical transportation. Mandating MCOs' use of external, "third party" vendors often leads to increased administrative complexity, including with claims processing, since external systems and contracting procedures are typically designed for Fee-for-Service. MCOs, when they contract with vendors directly, are able to support vendors (as a part of the contracting and transition process) to develop accurate and timely claims processing practices. MCH recommends that MDHHS allow MCOs to select vendors based on quality, cost, and demonstrated performance so MCOs can ensure the highest quality of service through well-defined roles, quality benchmarks, and financial agreements. We recommend that MDHHS, through the RFP process and MCO contract language, require MCOs' administrative and service design elements to be directly aligned with and in MDHHS's policy recommendations. MCOs' success should be systematically and routinely measured against MDHHS quality benchmarks (inclusive of both medical and non-medical measures), and MCOs should be financially compensated based on their performance. MCOs' success is often dependent on receiving a capitation rate inclusive of institutional, BH and community-based services as well as the medical and non-medical supports typically required by specialty populations. MCH recommends that MDHHS set actuarially sound, transparent capitated rates driven by members' risk levels to incent MCOs to support members in the least restrictive setting most appropriate for their needs. MDHHS can become a national leader by determining rate levels that effectively represent Medicaid enrollees' physical, behavioral, and functional status and then linking these rate levels to members' risk scores identified through a uniform functional assessment tool. MCOs, following this process, should have full authority to provide members with access to a rich benefit that represents the continuum of services and supports that exist, including medical and innovative community services (e.g., peer support and recovery-focused diversionary models). This comprehensive approach will

allow all resources to “follow the person” and allow MCOs to facilitate a holistic approach that ensures integrated care and improved outcomes for the members they serve. Michigan has made inroads with their payment reform efforts and pursuing an integrated approach with Medicaid and Medicare services, our proposed pilot will keep this momentum moving forward with more efficient and effective care coordination, better health outcomes, a reduction in barriers to care, and reduced cost.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
Populations Affected:
MCH proposes to serve individuals receiving services for behavioral health (BH), developmental disability (DD) or long-term services and supports needs (LTSS) through Medicaid FFS into a single managed care pilot program.
Exclusions:
The only excluded population we recommend for this pilot is existing MMP Participants. However, we do recommend integrating all benefits (pharmacy, dental as well as BH, PH and LTSS). Participants often communicate the desire for a simpler system in which they can obtain the full scope of benefits available to them. MCH supports a holistic approach to healthcare and recommends against service carve outs such as transportation services or population carve-outs.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
Services and Supports.
MCH brings the collective experience of our parent company, Centene, which has more than 30 years of managed care experience in 20+ states, plus the experience of our internal behavioral health affiliate, Cenpatico, which has more than 21 years of experience with behavioral health utilization, care and disease management working with adult, adolescent and child/youth members with serious mental illness, severe emotional disturbance, substance use, developmental disorders and co-occurring disorders in all levels of care. In Michigan, we have already developed relationships with the PIHPs and have worked to create integrated approaches to coordination and services for our MI Health Link. Additionally, Centene is currently the largest Medicaid Managed Long Term Services and Supports (MLTSS) MCO in the country, serving more than 210,000 MLTSS Participants in 9 states (expanding to 10 in 2017 with Pennsylvania). Through this experience, we have identified the benefit of having full integration of a robust behavioral health benefit that includes inpatient, outpatient, mobile crisis and crisis stabilization, residential, partial hospitalization, intensive outpatient, in-home, services including psychosocial rehabilitation, peer support and other community based services.
Impact to Services and Supports.
When these services and supports are layered into an acute care physical health benefit, and LTSS services for Participants it enables our Care Managers to more easily coordinate and provide streamlined support. We understand from our experience in other markets that transitioning to a fully integrated system is more successful through training and data sharing.
Training Supports.
We have experience providing support for providers and community support agencies on evidence-based practice for behavioral health such as Screening Brief Intervention Referral and Treatment (SBIRT), Recovery-Oriented Systems of Care, Trauma Informed Cognitive Behavioral Training (TF-CBT), Cultural Awareness and Sensitivity (tailored to the community, and including the understanding "the culture of poverty"), Supported

Employment, Assertive Community Treatment (ACT) and Permanent Supportive Housing. Our BH affiliate has also developed a specialized integrated training for primary care providers as well as facility providers to help them better manage behaviors for LTSS Participants.

Data Sharing to Ensure Inclusion and Communication of Services. Among our nine affiliates with experience coordinating BH models, five affiliates (our health plans in Arizona, Florida, Illinois, Ohio and Texas) currently serve both LTSS and ABD Participants. Our experience serving this unique combination of populations has uncovered a multitude of best practices borne from lessons learned, which include offering service coordination tailored to populations with LTSS needs, that go beyond the bounds of physical and behavioral healthcare services. For example actively sharing data through secure integrated portals and integrated shared care plans with counterpart high performing behavioral health managers is key to successful service coordination and an improved Participant experience. MCH would offer a secure Portal for Participants, authorized caregivers, network and appropriately authorized out-of-network Providers to provide secure access to PCSP/Care Plans. Participants also will be able to access their assessment and other data through the portal.

Integrated Care Team for Optimized Care/Service Coordination. The level of support required by Participants is likely to change over time, care/service coordination is best delivered through a multidisciplinary, Integrated Care Team that incorporates cultural competency as a key factor in engaging LTSS Participants in their physical and BH and providing services that meet their needs. Therefore, in addition to face to face integrated Care Management, and secure integrated portals for data sharing, MCH recommends the integrated pilot program conduct Joint Clinical Rounds with counterpart high performing behavioral health managers to ensure all services for our highest-risk Participants are carefully integrated, recognizing the multiple physical and behavioral co-morbidities that often exist in chronically ill LTSS Participants. MCH will provide dedicated, tailored training to nursing facilities and other providers serving our LTSS Participants to strengthen care/service coordination across physical and BH services, employing flexible resource utilization to ensure that LTSS Participants' needs, goals, and preferences are the primary driver of service coordination interventions, while looking holistically at each unique individual when making decisions about the services they receive. These additional decisions may lead to increased considerations, including the necessity for increased call center staffing needs, more specialized providers, and rebalanced CM caseloads.

Enhancing Crisis, Diversion and Step-Down Services. MCH and our affiliates provide 24/7 crisis intervention and access to emergency services staffed by qualified nurses and behavioral health professionals to offer verbal de-escalation, crisis assessment, triage, referral and rapid crisis response dispatch. Our crisis line staff operate through linked information technology platforms for ease of follow-up and comprehensive care coordination. Key to improving and expanding the full continuum of crisis services includes working collaboratively with system partners to provide education, resources, and the support necessary to change the behavior of system partners, reducing emergency department reliance and expanding safe, community based crisis diversion alternatives, increasing the use of CMTs, and stabilizing people in their homes and communities. Also, we support the continuum of crisis services through our state-of-the-art technology to operate a 24/7/365 Crisis Line, dispatch teams, schedule services, manage crisis resources, and close the loop on every crisis contact. Lastly, we work with providers to expand diversion and step-down services, programs and stabilization facilities in the region.

Our history of implementing new programs has proven our capacities to not only implement large programs quickly but also the ability to adapt to program changes such as additional populations or benefit coverage smoothly and successfully. For example, since 2012 our membership in Louisiana has grown by almost 200,000 members and our affiliate health plan continues to meet and exceed contractual obligations. In addition, our Louisiana health plan has worked closely with the State through the RFI process regarding integrating the behavioral health benefit into the

Medicaid MCO contracts. We have been, and continue to, work closely with Louisiana state agencies, and the other MCOs, to fully integrate BH benefits for the Medicaid population.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

Summary.

MCH strongly believes that the best opportunity for Participants, providers, MCOs and the State for integration is represented through a program which balances choice with the need for certain program criteria that maximizes effectiveness. Through this proposal, we are strongly supporting Participant choice for providers, services and honoring Participant choice for who participates in their person-centered care planning team. We recommend two MCOs in each region where this pilot is implemented and allowing Participants to choose their MCO, but we recommend mandatory election and participation for eligible populations. In order to meet the Participant's individualized needs and honor choice, our initial assessment process will identify the full range of the individual Participant's physical health, BH, dental, pharmacy and LTSS needs. The assessment, along with specific input from the Participant and as appropriate their family/caregiver, informs the development of the person-centered care plan (PCCP), which outlines the needed covered and non-covered services. The PCCP will address how the Participant's physical, cognitive, and behavioral health needs will be managed, and how care will be coordinated taking into account choice in providers and service modalities. PCCPs will further address how LTSS services will be coordinated.

Choice to Participate and Seamless Coordination.

Whether a Participant is served by MCH through our integrated pilot or through another mechanism/program, we will ensure seamless, appropriate care and services across the care continuum, including transitions between settings and coverages. We will fully integrate care for those individuals, and will proactively coordinate with providers and staff from other organizations. Providers (with appropriate authorization) may access PCCPs and other information needed to coordinate care via our Provider Portal. PCCPs will incorporate Medicaid and other services, and will address how physical, cognitive, and BH needs will be managed. PCCPswill also address how LTSS services will be coordinated. MCH will educate Participants and caregivers about the importance of, and our role in, coordinating MCH and Medicare services.

In addition to Participant choice, our use of flexible care management and care coordination models driven by person-centered planning processes and members' level of need ensure members receive the right care at the right time by the right people, ultimately improving access and quality while decreasing avoidable hospital and facility admissions, assisting participants to remain living in the least restrictive setting of their choice.

Self-Direction for Choice.

Centene, MCH's parent company, has also invested in self-direction (SD) as a best practice, which gives the responsibility of managing workers and directing care to the Participant. When implemented successfully, this model improves members' quality of care and satisfaction; improves paid and unpaid caregivers' satisfaction; addresses gaps in care; and decreases unnecessary utilization of high cost services. Centene implements a range of SD models across eight health plans.

In addition, Centene, and our health plan affiliates have demonstrated experience supporting diversion and transition efforts for individuals

with behavioral health conditions, developmental disabilities, and LTSS needs. We have assumed, through these experiences, an important role in assisting members to make informed personal and self-determined choices as well as in supporting providers to build capacity to meet members' needs. We are prepared to work with facility and community partners to build on the success of initiatives already in place.
Our success to date has been driven by a few key program characteristics that should be considered in its design of managed care for specialty populations. First, we recommend mandatory enrollment in managed care for the entire population (regardless if one is living in an institution or the community) as necessary to achieve the critical mass in membership to enable the best partnerships with providers. This recommendation would be in combination with a capitated rate for all medical and non-medical services based on members' risk level and functional status (rather than setting) provides MCOs the ultimate flexibility to serve people based on need and in the setting of their choice. In conjunction with this, we recommend the State develop and implement transition of care/enrollment processes that encourage ongoing care of members, regardless of which MCO/program is serving them. We do not recommend an "opt-in" or "opt-out" approach for this pilot model. Another key component of our affiliates' integrated managed LTSS programs has been development and inclusion of a Nursing Facility Transition Center of Excellence to streamline and optimize outcomes for Participants who wish to return to the community from a nursing facility. In 2016, 65% of all LTSS spend in Michigan was nursing facility spend verses 47% average nationally. A Nursing Facility Transition Center of Excellence supports Participants by managing PH/BH services across settings, and identifying home and community based supports that will enable them to remain in, or return to the least restrictive setting of their choice.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
Enhancing Coordination of Physical Health and Behavioral Health Services.
Our person-centered approaches will integrate services across the care continuum to maximize quality of life, health, and functional outcomes. This includes coordination at the delivery system level through timely information exchange and ensuring the right services at the right time. Coordinating across delivery systems is most effective when payers and key stakeholders work as partners to remove system-level barriers. MCH will implement innovative models to improve coordination across Medicaid covered and non-covered services. For example, we will explore Value-Based Purchasing strategies that incentivize successful community transitions and reduce readmissions. Additionally, we would work with advocacy groups to ensure the right services, supports and provider quantity/mix to serve the population and ensure the right connections for Participants.
Enhancing PH/BH/LTSS Service Coordination.
MCH recommends MDDHS request that CMS provide historical Medicare claims and utilization data to the MCOs to assist with early identification of needs and risk stratification. MCH Care Managers will utilize a secure electronic clinical documentation system (MCH uses TruCare), which will incorporate all screenings, assessments, PCCP and documentation of outreach and contact. This documentation system enhances coordination by providing a holistic view of Participant needs, goals, utilization, and PCCPs, including coordination of services. In addition, our integrated MLTSS pilot recommends the MCO utilize a secure Provider Portal and/or Electronic Health Record, as well as encouraging providers to participate with health information exchanges to maximmize communication of care gaps and service history to

increase coordination between providers on the Participant's community based care team. MCH's secure Centelligence™ Health Record is able to display the PCCP, gaps in care, recommended by evidence-based guidelines, current and historical claims, assessments, and other data; and an ED Flag indicating ED utilization. In addition to requiring LTSS Providers to notify us of admissions (which will improve our ability to participate in discharge planning), we will receive real-time Admission/Discharge/Transfer (ADT) data for all Participants. This information allows timely discharge planning to address post-discharge LTSS and other needs.

Integrated Care Team Coordination Across Delivery Systems.

Our multidisciplinary, Integrated Care Team will account for the different ways Participants receive services, which impacts provider willingness to coordinate, data available to support coordination, and whether there is another entity's case manager to work with. Regardless of the complexity of needs or diversity of services each Participant will have a single point of accountability for coordinating all needed services. We will assign a CM to coordinate across all providers as needed for all LTSS Participants. For all Participants, the CM will coordinate/ensure access to Medicaid and other needed services, with behind-the-scenes support from other members of our internal Integrated Care Team, which includes nurses, BH clinicians, social workers, dental and pharmacy staff, Housing and Employment Specialists, and NF Transition staff. MCH will implement Centene's integrated staff training to ensure staff think and operate in an integrated manner about physical, BH, and LTSS needs and services. Topics will include both benefit structures, as well as when/how to coordinate with other plans and providers. MCH will adopt a proven strategy employed by our affiliate health plans whereby the IC Team includes CMs with practical BH experience. We recommend all integrated pilot CMs receive comprehensive BH training, upon hire and regularly thereafter, which allows them to more effectively perform assessments and authorizations using information such as care gap alerts, claims data, and utilization history. We recognize that this knowledge is critical as it relates to developing comprehensive PCCPs, engaging with BH providers, and using BH quality outcomes to inform improvement opportunities. For Participants with complex BH issues that the Participant's assigned CM will be a licensed BH clinician who will be supported by the other members of the Integrated Care Team. MCH's BH Manager, a BH clinician will provide CMs with continual, in-depth training on BH topics relative to delivering whole-person service coordination. Training events will occur upon hire and regularly thereafter. Specific training topics will include assisting with identifying and coordinating services for Participants with BH needs, such as addressing secondary BH issues or screening for depression after a new physical health diagnosis. MCH's affiliates serving LTSS Participants have expanded their training reach beyond the health plan to a national level including presenting on relevant LTSS and BH topics at national conferences. We also recommend engaging with high performing BH providers to incorporate their best practice trainings to raise the bar for the community.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

Promoting Collaboration.

In addition to the techniques for improving coordination discussed above, MCH recommends strong collaboration among MDDHS, participating pilot MCOs and other interested health plans, high performing BH providers and other key stakeholders on pre-implementation initiatives to develop coordination protocols, such as for assessment, care planning, and hospital discharge planning. We also recommend that MCOs, MDDHS, other health plans, state and local medical societies, pharmacy associations, and other stakeholders collaborate on a pre-implementation initiative to educate providers about coordinating with MCOs. MCH's proposed model includes a coordination liaison to establish and monitor the effectiveness of our coordination with other plans, and identify and address any coordination issues with network

MCO and D-SNP Providers. We recommend establishing ongoing coordination and service delivery improvement meetings with MDDHS and MCOs/aligned D-SNPs (and CMS if possible), a practice which has been successful for our MMPs through their Contract Management Teams. MCH will continuously identify opportunities to improve collaboration through monitoring and analysis of data such as Participant and Provider satisfaction; input from our Provider Advisory Group and Participant Advisory Committee and high volume Providers; issues identified by our coordination liaisons; quality performance metrics such as for wounds and falls; and MDS data. MCH will work with all partners, network Providers and CM staff to address identified opportunities to improve cross-Provider collaboration. MCH proposes development of an annual conference with MDHHS and other MCOs for all Medicaid and Medicare Providers to share best practices or collaboration, coordination and integration. In addition, we recommend regular work groups for collaboration with other MCOs and D-SNPs in geographic areas with sufficient Participant density to continuously develop best practices.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?
MCH's proposed integrated MLTSS pilot/model focuses on creating efficiencies in funding of services and reducing potential duplication of community based case management by bringing all responsibilty for coverage, contracting and coordination for PH/BH/LTSS service needs through an integrated plan. This improves accountability for coordination and quality monitioring. For this reason we also recommend including pharmacy and medication management within our integrated MLTSS pilot.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
Summary.
MCH understands that providers that are supported and engaged will provide better care, and experience less turnover. Our pilot will include training, tools and support mechanisms to increase efficiency (thus expanding reach and availability of workforce), bring enhanced value and engagement to the workforce (reducing turnover) and working with providers and community agencies to help identify innovative ideas for recruitment, training, retention and career ladder development to strengthen the workforce. As noted in a previous section MCH brings, and recommends, training and technical assistance for providers to ensure they have the expertise and engagement to better serve Participants while improving the quality of care. Additionally, MCH would provide actionable data and support to providers in order for them to understand the population they serve at the individual and system level for better coordination (individual) and population health management. We would look to incent providers performance through value-based contracting strategies including, but not limited to pay for performance.
Recruiting and Training.
Our integrated pilot model has a strong focus on community partnership. MCH would look to community organizations, providers, State agencies (MDDHS and others) to identify potential providers and trainings that can support the delivery of high-quality services and supports. In

addition, MCH's Florida affiliate, in coordination with our internal BH affiliate, has recently started training providers on appropriate use, and titration of LTSS services for individuals with SMI. We believe recovery is possible, and should be expected. We offer providers and community-based case managers training to re-focus their service-planning efforts to ensure members have access to the services they need and are eligible for, but that service planning is tailored to only include the elements of LTSS services that meet that member's needs. This approach is more person-centered and helps members to re-engage with the community while increasing access for all members. Additionally, we work with providers to train them on understanding LTSS and children's psychosocial services, how to apply them most effectively and how and when to titrate the frequency of services. This is effective when the service plan includes identification of natural supports and non-therapeutic services in the community that help the member transition.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

Empowering Individuals.

MCH supports Participant voice, choice and empowerment in decision making about service delivery, supports and inclusion of the Participant's chosen circle of support in care planning. Every Participant in our pilot model would have a Care Manager (CM) who would, with the Participant's (and if the Participant wished, their caregiver or circle of support) develop the person-centered care plan which includes identification of goals and supports that empower the Participant to achieve their highest quality of life. Using a self-directed model empowers individuals to make personal choices regarding the services available to them, and as appropriate or desired by the Participant we educate the Participant and support them in implementing self-direction. CMs, as part of the person-centered planning process, will provide members with the opportunity to include their self-directed workers in their Integrated Care Teams, providing the member with interdisciplinary technical assistance to address their self-directed worker issues and ensuring swift Integrated Care Teams communication and action when the member experiences a change in status. The ability for the MCO to have consistent insight into dual eligible members across both their Medicare and Medicaid plans allows for a more holistic approach in developing a person-centered service plan and supporting the member in the management of their health. Participants can make decisions outside the "self-directed" model, for example choosing their own health and well ness goals, choosing providers and services, and choosing individuals that participate on their community based care team.

Would this model affect the administration of complaints, grievances, and appeals?

Administration of Complaints, Grievances and Appeals.

MCH does anticipate some changes to the way that complaints, grievances and appeals are handled. For those physical health acute care complaints, grievances and appeals these would be handled by the MCO, similar to how they operate today. However, BH and LTSS complaints, grievances and appeals would no longer be handled, for example, by the current behavioral health manager (for BH) or the State (for LTSS), but would be handled by the MCO. Similarly, dental and pharmacy would be handled by the MCO. We anticipate that the state fair hearings and/or

additional remedies available to Participants beyond MCO administered complaints, grievances and appeals processes would continue in the manner they are offered today including use of an Ombudsmen.

How would the model support continued access for individuals to current services, supports, and providers?

Continued Access to Current Services.

MCH will facilitate and coordinate Participant access to all necessary covered services including primary, acute, BH, LTSS, and other services. We will combine the on-the-ground expertise of entities such as the Area Agencies on Aging (AAAs), Centers for Independent Living (CILs), and service coordination entities already serving the population, with the national experience and proven practices of our parent company, Centene, in serving similar populations through a variety of managed care models. Given the need to ensure Continuity of Care from implementation through the life of the program, we anticipate an extended monitoring phase for the integrated pilot program to ensure successful transition for Participants. Monitoring key post-implementation performance indicators delivers regular assessments of the overall health of the project. By closely monitoring the overall progress of the implementation, appropriate corrective actions can be taken, as necessary, and consistent "total project" auditing can be employed when the performance deviates or is not adequate. To minimize the need for Participants to change providers, MCH will follow Centene's successful practice of first building a network of traditional physical health, BH, LTSS, dental, pharmacy and other providers that already serve the Participant populations unique needs. Additionally, we propose to implement other continuity processes used successfully by our MLTSS plans including MI Health Link, such as timely notification of MDDHS of transitions, and evaluate continuity processes via our QM/UM programs.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

Governance and Accountability.

One of MCH affiliates' best practices for ensuring Participant and provider feedback into the governance has been to establish a board of directors that includes Participants and Providers. In addion, we promote transparancy and accountability for delivery by establishing Participant and Community Advisory Committees which include members from diverse behavioral health (BH), development disabilities (DD), dental heatlh, pharmacy, long term services and supports (LTSS) and advocacy organizations throughout the state who meet throughout the length of the contract. Through this, we build trust and local accountability, identify potential reinvestment opportunities, and solicit important feedback on regional concerns for these special populations.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

Engaging for Person-Centered Care Planning.
MCH's Care Managers (CMs) will employ person-centered planning strategies for needed screenings; comprehensive needs assessment; person-centered care plan development; and quality monitoring. CMs will serve as the single point of contact for the Participant (to include their family and/or caregivers as appropriate or desired by the Participant) and will build trust through respectful discussions that encourage Participant engagement in all phases, from identifying unmet need to evaluating the success of services. Participants determine, from their perspective, what it means to be well and what is needed to achieve their desired goals. The role of CMs is to fully understand the Participant and his/her needs, through standardized assessments, motivational interviewing, and active listening, so we can provide assistance that is consistent with the Participant's expressed values and culture. CMs will work with Participants and their chosen community based care team, or chosen circle of support during the care planning process to examine the Participant's needs holistically and develop person-centered care plans that authorize their access to services, allow for concrete measurement of progress, and are easily modified as goals are met or conditions change. Other activities to support Participant engagement include but are not limited to: Motivational Interviewing, support for self-direction, incentives for participation in health and wellness/prevention activities, linkage to community supports (non-covered services) and informal supports.
Engaging Participants, Community Members and Others for Programmatic Direction and Delivery.
MCH will engage Participants, providers and the greater community to get input and guidance into service delivery of publicly funded of services and supports to ensure we obtain necessary feedback and guidance to impact the design of our model, programmatic direction and ensure adequacy of our network to offer choice in services and access to appropriate levels of care for the membership. MCH proposes to use Participant Advisory Committees (PAC) and Community Advisory Committees to help facilitate this critical communication. PACs will be open to pilot participants (and their families), care givers, and/or advocates. We will convene pre-implementation, and on-going Participant and Community Advisory Groups to obtain input into program, process and network design, and work through start-up issues. These meetings ensure all requirements are met and guarantee our ability to deliver service excellence.
Results from Previous Experience.
MCH's affiliates have implemented these approaches for locally-driven quality improvement strategies that have enhanced Participants' community access and have supported Participants' engagement and overall quality of life. Our Florida affiliate transitioned 1,059 Participants from facilities in CY2015 (136 in November alone). Our Texas affiliate's 2014 Care Management Survey indicated 98.3% of Participants (across all Medicaid populations served) were pleased with how their health and quality of life improved because they received help from their Care Manager, and 98.5% of those with cultural needs were satisfied with how their needs were met by their Care Manager. Our affiliates also have expanded Participants' access to self-direction; 69.8% of Participants served by our Arizona affiliate chose self-direction in 2015, and since 2013, Florida affiliate self-directed Participants have increased from 4.6% to 16.6%.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?
Financing Mechanisms. The Integrated MLTSS Pilot would need to be budgeted with actuarily sound rates.

What changes would need to be made to provider reimbursement in order to implement the model?
Provider Reimbursement.
MCH proposes that MCO(s) delivering this program would need to be contracted with BH providers and LTSS providers as well as physical health providers in order to fully administer the program. We would recommend and emphasis on Pay-for-Performance (P4P) with incentives tied to faciliatation and achievement on specified quality metrics.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
Incentive Programs.
MCH will use incentive programs that include P4P and gain and risk sharing. MCH will offer P4P for patient centered medical homes (PCMH) and other Providers with a minimum combined panel size and a high panel average risk score, for example, 50% higher than the average risk for all Participants. MCH proposes the pilot develop a uniform methodology for assigning a risk score for each Participant, using similar logic to risk scores produced by the Medicare Hierarchical Condition Categories (HCC) score. The incentive will be based on the Provider's performance on access-oriented quality measures that apply to physical health and behavioral health providers, such as after-hours and weekend appointments, 7/14-day follow-up after hospitalization, and potentially avoidable admissions, readmissions, and ED visits. Gain and Risk Sharing Programs.
Providers with more advanced capabilities will be able to participate in our Gain and Risk Sharing Value-Based Purchasing Programs based on the same set of measurements noted above. All our Gain and Risk Sharing Programs use risk-adjusted cost metrics. We also will adjust targets and performance improvement expectations based on the Provider's baseline risk-adjusted costs and performance to ensure that those caring for these complex Members/Participants are treated equitably.
For PCPs, MCH recommends using the following Participant-based incentive program. Participants with complex medical needs assigned to many individual PCP practices or practice groups across the network may likely be limited. Therefore, we will base the incentive on the individual risk scores for their assigned Participants with complex needs. The incentive program will be financed by using an actuarially sound methodology that accrues a specified percentage of premium to fund an Incentive Pool from which each Provider can earn payments based on their performance on access-oriented quality measures. Payments will be adjusted by the medical complexity of each Participant as defined by risk score. In addition, we would develop similar incentive programs, with mutually agreeable options that recognize the multivariate service professionals that deliver care, services and supports to our Participants.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?
Measurement and Continuous Improvement. MCHbrings the experience of our parent company, Centene, which has more than 30 years of managed care experience and is currently the largest Medicaid Managed Long Term Services and Supports (MLTSS) Managed Care Organization (MCO) in the country, serving more than 210,000 MLTSS Participants in nine states (expanding to 10 in 2017 with Pennsylvania). MCH affiliate plans have extensive experience monitoring Participant outcomes using a variety of quality and performance measures which we would leverage

to further design and implement this pilot.
Measuring Quality and Effectiveness of Services.
In addition to tracking physical health and BH measures for these members, such as the National Committee for Quality Assurance (NCQA's) Medicaid and Medicare HEDIS measures, as data is available, MCH's affiliate MLTSS health plans also have experience reporting and monitoring LTSS performance measures. We are currently implementing comprehensive dashboard reporting to include key performance indicators (KPIs) covering Clinical Quality, Service Coordination, Quality of Life, Participant Satisfaction, Utilization, Operations, and Cost of Care. The Dashboard also includes selected measures that directly impact one's ability to maintain or improve health and the ability to live in the least restrictive setting. Physical Health Measures and Performance. Among our affiliate MLTSS plans, the range of measures that we would track for the pilot could vary based on many factors including, but not limited to, contract requirements, characteristics of populations served, and services included in the pilot based on Participant, State and community/provider feedback.
Measuring Service Delivery and Access to Care.
Our affiliate MLTSS plans monitor an array of performance measures that specifically look at aspects of Utilization, Timeliness of Service Delivery, and Rebalancing of Services. Examples include but are not limited to: Hospitalizations (Non-Psych & Psych), ED Visits (Non-Psych & Psych), All Cause Readmissions within 30 Days of Hospitalization (%), Home Health Aide/Personal Care Assistant Hours (PMPM), Mandated Contacts Conducted Timely (%), New Participant Orientation Visits Conducted Timely (%), Number of members transitioned from institution to community setting, Number of members transitioned from community to institution setting. For populations similar to those that we would include in this pilot, MCH considers measures associated with quality of life, rebalancing of services, and clinical quality to be the most meaningful when looking at an integrated, whole-health approach to physical health, behavioral health and measuring LTSS. We look to achieving better performance through the lens of the Triple Aim: improving the health of our Participants and their experience of care and services while lowering costs. We fundamentally believe that performance on physical health and behavioral health measures also is key to improving quality of life and tenure in preferred settings.
For this Pilot, MCH would work with all providers to ensure access through compliance with established ADA accessibility standards. As needed we would provide training and assistance to providers in meeting ADA requirements. MCH will collaborate with providers to ensure all Participants have access to effective communication for best outcomes in service delivery and auxiliary aids such as assistive technology, interpreters, readers, and materials in large print or in braille. MCH will further promote access to services by conducting annual appointment access audits to ensure provider compliance. In addition, for those providers who are receiving incentives, such as a Care Coordination PMPM, we will assess their level of compliance with care coordination/office accessibility requirements annually, or as indicated.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

Strategies for Success.
Success of MCHs proposed integrated pilot will be driven by a specific program characteristics that should be considered in the design of managed care for specialty populations. First, mandatory enrollment in managed care for the entire population (regardless if one is living in an institution or the community) in combination with a capitated rate for all medical and non-medical services based on members' risk level (rather

than setting) provides MCOs the ultimate flexibility to serve people based on need and in the setting of their choice. In conjunction with this, we recommend the State develop and implement transition of care/enrollment processes that encourage ongoing care of members, regardless of which MCO is serving them. Limiting enrollment windows to the federal requirements (e.g., switching pilot MCOs within the first 90 days without cause, and no more than annually thereafter) allows members to have choice in MCOs while emphasizing continuity in care and minimizing MCO risk for their members who are admitted to a hospital or facility. Finally, the MCOs' authority to design and implement strategies necessary to experience optimal coordination, de-fragmentation, and cost savings. For example, MCOs should design case management models for specialty populations that are fluid and are driven by data specific to the population served, the environment in which they are being served, and MDDHS-defined quality outcomes. Also, MCOs should have the authority to choose, incentivize, and monitor vendors who are critical to state programs and desired outcomes (e.g., vendors for participant direction, Money Follows the Person, and electronic visit verification). MCOs must also have the authority (and willingness) to work with any willing provider and pay providers, at minimum, Medicaid rates to ensure members have access to providers they rely on and that MCOs develop the provider capacity necessary to effectively meet members' needs.

Defining Success.

MDHHS and MCOs should work with stakeholders to develop a range of measures that assess the impact managed care has on specialty populations' access to appropriate care and overall quality of life. Member quality of life and satisfaction measures should assess, at minimum, members' level of choice and control (e.g., their direct influence on assessment, goal setting, and service planning); preferred setting and existing setting; level of community integration; satisfaction with MCO and provider services; and informal caregivers' satisfaction and/or stress. Additionally, MCOs should implement a quality improvement program that carefully examines interventions and processes implemented to achieve the goals of the pilot.

Enhancing and Developing Benchmarks.

We also recommend MDHHS' use of the National Core Indicators in addition to examining other promising national efforts to standardize measures across specialty populations and home and community-based (HCBS) supports. This could include, but not be limited to, improved transitions, decreasing waiting lists and HCBS CAHPS surveys to measure Participant satisfaction. MCH recommends that MDHHS continue to collect the rich data required to inform the growth and improvement of participant direction models (e.g., the number of people who self-direct and their medical, functional, quality of life, satisfaction, and cost status).

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

MCH has developed our recommendation for a managed care program for integration of physical health, behavioral health and LTSS services for Participants eligible for LTSS as a pilot program. In order to best ensure the success of the pilot, and effectiveness of value-based purchasing programs to help achieve quality improvement, the pilot would need to be implemented in a region with a critical mass of eligible membership.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

While MCH has developed our recommendation for a managed care program for integration of physical health, behavioral health and LTSS services for Participants eligible for LTSS as a pilot program, we also believe this could be implemented as a statewide program. If implemented as a statewide program we recommend the State develop and release an RFP with no more than two statewide awardees. Limiting the number of awards enables MCOs to have a mix of Participants with varying risk stratification and critical mass to be able to implement effective, efficient and innovative practices to produce improved quality outcomes.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

In order to implement this integrated pilot, the State would need to amend their existing MI Health Link waiver (1915(b)) to allow for managed LTSS with mandatory enrollment.

(Optional) Are you aware of any other states or communities which have implemented this model?

Other states that have implemented a fully integrated managed LTSS program include: Arizona, California, Illinois, Ohio, Kansas, Texas. MCH health plan affiliates operate models in each of states.

Model #15

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Michigan Integrated Care (MICare) Project

Name of Submitting Organization: Health Alliance Plan (HAP)/HAP Midwest with the full support of the parent organization, Henry Ford Health System (HFHS)

Model Partner Organization(s): Henry Ford Medical Group, which includes Behavioral Health Services. We hope that PIHPs, Community Mental Health Agencies and community non-profit groups, and Medicaid Health Plans operating in target demonstration regions of the state also partner to participate in the MICare Project.

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

Overview of Proposed Model: The current funding structure for behavioral and physical health services in Michigan is confusing to beneficiaries and providers, lacks accountability for many aspects of care, including care management and coordination for patients who have chronic and complex medical and behavioral health needs, and is administratively burdensome, which adds costs to the system and can lead to delays in treatment. Several states have moved to "carve-in" models that integrate the financing, administration and delivery of physical health, behavioral health, long-term services and supports (LTSS) and other social supports needs into a comprehensive managed care model." HAP Midwest, with the full support of Henry Ford Health System and its Behavioral Health Services team, supports this approach and proposes that Michigan develop and implement a comprehensive, multi-payer, managed care "carve-in" model demonstration, called the Michigan Integrated Care (MICare) Project. The MICare Project addresses the structural shortcomings in Michigan's current system, is based on the core values identified by the MDHHS Section 298 Initiative workgroup, and is designed to improve the coordination of behavioral and physical health services for individuals with mental illness, intellectual and developmental disabilities and substance use disorders. The MICare Project is based on three key foundational elements: 1) holistic, person-centered care; 2) integrated behavioral, physical health and long term services and supports (LTSS) care delivered collaboratively by health care and LTSS providers, PIHPS and Community Mental Health agencies; and 3) integrated financing and benefit administration through Integrated Care Organizations (ICOs) (See model diagram in Attachment 1).The MICare Project model design is aligned with those implemented in several states that have moved to "carve-in" behavioral health with physical health care. As of January 2016, 16 states currently provide or are planning to offer behavioral health services through an integrated care model." There is no one-size-fits-all model for behavioral health integration due to the variation in recommended treatment and treatment location for different behavioral health conditions. We believe, however, that the MICare Project model is a good fit for Michigan due to our experience with the MI Health Link demonstration for dual eligible beneficiaries. The MICare Project represents an expansion of that demonstration project by integrating benefit administration for behavioral health specialty supports and services under a demonstration ICO and expanding the beneficiaries and regions served across the state. The MICare Project will include both Medicaid (including the Healthy Michigan Plan) and dual-eligible (Medicare and Medicaid) beneficiaries. Under the MICare Project, all Medicaid and dual-eligible health benefits will be administered by a demonstration Integrated Care Organization (ICO) that contracts with CMS and the Michigan Department of Health and Human Service (MDHHS). In this model, Medicaid and dual-eligible behavioral health benefits can be either administered by the PIHP/Community Mental Health (CMH) system or through a demonstration ICO, which delegates the administration to the PIHP/CMH system through capitated rate payment and risk sharing structures. While we believe the most efficient and effective model would be for the demonstration ICO to administer benefits for the complete array of behavioral, LTSS and physical health care and supports services, we want to maintain an option for beneficiaries who

choose to receive care directly from the PIHP/CMH system. Financial incentives for meeting demonstration project performance measures should be included at both the ICO and provider level.The MICare Project provides beneficiaries with flexibility in choosing a “primary” care coordinator. Once enrolled into the MICare Project, the beneficiary will select a “primary” care coordinator from either the demonstration ICO or, if preferred, a CMH supports coordinator (through delegation from the ICO). The ICO care coordinator has ultimate responsibility to ensure that the beneficiary’s supports and services are provided as contracted and to the beneficiary’s satisfaction. Should the beneficiary have a physical health problem, the ICO coordinator will become the “primary” care coordinator, working with the beneficiary’s chosen supports coordinator, to help the beneficiary identify and receive the needed physical health care. When the physical health crisis/episode ebbs, if the beneficiary desires, the supports coordinator once again would assume the “primary” care coordinator role for the beneficiary. Under the MICare Project, clinical navigators will be embedded within health care provider settings to improve care coordination for the beneficiary both within the health care system and between the health care system and the PIHP/CMH system. The navigator works with the member’s chosen coordinator to assure that the physical health providers are actively engaged in the member’s care plan and with behavioral care providers. We believe the MICare Project will decrease overall program costs while improving the quality of care and outcomes for beneficiaries. The proposed model also offers Michigan an opportunity “to align system incentives, increase accountability for managing a complete range of services and provide more seamless care to beneficiaries, as other states have already started through their carve-in programs.” We believe our proposed model offers the most effective and efficient carve-in approach while maintaining choice and minimizing the impact on existing behavioral and physical health care service organizations.The MICare Project will base financing on current risk-adjusted, capitated rates for Medicaid (including the Healthy Michigan Plan) and Medicare and the MI Health Link dual eligible demonstration; and current MI Health Link rates for Medicaid LTSS adjusted for County and Level of Care (LOC). We recommend that the MICare Project be implemented using a phased approach to full integration of behavioral and physical health over a three-year period: • Pre-Implementation: ICO readiness evaluation and procurement phase • Year One: Beneficiaries with Physical Health and/or LTSS service needs • Year Two: add Beneficiaries with Behavioral Health (mentally ill and /or SUD) service needs • Year Three: add Beneficiaries with Intellectual/Developmental Disability and/or Autism Spectrum Disorder service needsThis phased-in approach would help ensure that all MICare Project contracted entities including ICOs, PIHPs/CMHs, and health care providers are fully prepared to handle the demonstration project requirements around care coordination, financing, provider reimbursement, workforce training, beneficiary and provider communications, quality measurement and electronic record sharing. The ICO readiness evaluation and procurement phase is consistent with the process used for the MI Health Link demonstration projectAs an integrated health system, HFHS and HAP/HAP Midwest are interested in participating in the demonstration project. HFHS is a Michigan-based, not-for-profit integrated health system, including medical (physical) and behavioral care delivery along with a comprehensive health insurance company/managed health care plan (Health Alliance Plan/HAP Midwest). HFHS, in our service areas, is uniquely positioned to provide managed health insurance that is integrated with our physical and behavioral health care delivery system. We offer the full complement of provider capabilities and payer experience across all product lines to ensure a successful demonstration of the proposed model. The people we serve, from the Detroit and Jackson metropolitan areas, are diverse. While experiences differ, diversity is leveraged to directly or indirectly influence the equitable delivery of culturally appropriate care and treatment of our patients, beneficiaries, employees and community partners. To help address the socioeconomic barriers to health care that our most vulnerable beneficiaries face, including many with Medicaid coverage, we are transforming our integrated care model to be more accessible, portable and person-centered. Under the proposed model, HAP Midwest could function as a

demonstration Integrated Care Organization (ICO) and contract with HFHS providers, other health care providers, LTSS, PIHPs, and CMHs to deliver the full range of behavioral, LTSS and physical health care and support services for model beneficiaries. More information on HFHS and HAP/HAP Midwest is provided in Attachment 2.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
The MICare Project will include both Medicaid (including the Healthy Michigan Plan) and dual-eligible (Medicare and Medicaid) beneficiaries. Dual-eligibles often have significant health and social service needs, making them among the highest-need, highest-cost populations. Integrating the financing and delivery systems for these beneficiaries (as has been started with the MI Health Link project) has the potential to improve beneficiary and family experience of care, increase care quality and reduce costs. The MICare Project will include beneficiaries in the following health plans; there will be no exclusions. All beneficiaires currently served through these programs would be included in standard voluntary and/or passive enrollment into the MICare Project: • Medicaid Health Plan Benefits and Services including the Healthy Michigan Plan • Medicaid managed specialty supports and services concurrent 1915 b & c Waiver • Medicare parts A , B & D plan benefits • Long Term Services and Supports through MI Health Link Medicaid 1915 b & c Waiver, personal care, supplemental benefits and nursing facilityThe MICare Project target populations have a complex array of behavioral and physical health needs, and currently are served in fragmented systems of care that offer little to no care coordination. HFHS believes the MICare Project will address the fragmented care through improved care coordination between behavioral health, LTSS and medical care providers and through the administration of benefits by a single entity - the ICO.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
Under the MICare Project, a single entity – demonstration ICOs - will coordinate the financing and benefit administration for eligible beneficiaries in the targeted Medicaid and dual eligible health plans. ICOs will finance and administer all physical health benefits and LTSS benefits and contract with providers to deliver these services. The ICO will administer the behavioral health and substance use benefits funded through the Medicaid managed specialty supports and services concurrent 1915 b and c waiver and offer delegation contracts for care coordination, provider network management and administration of Medicaid managed specialty supports and services to CMH agencies and/or PIHPs that directly provide Supports Coordination. Beneficiaries would be provided options of care coordinator either through the ICO or the delegated PIHP/CMH provider organizations. Overall, the ICO will offer expanded options and choices to beneficiaries with this portable benefits approach to care, resulting in more choice and fewer barriers to care.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?
Under the MICare Project, the state will offer beneficiaries the opportunity to enroll into the demonstration project by selecting a demonstration ICO. Once enrolled, a demonstration ICO care coordinator will reach out to the beneficiary and ask him/her to select his/her “primary” care coordinator. The beneficiary can choose the ICO care coordinator, or if he/she has a preferred, existing relationship with a supports coordinator within the CMH system, the beneficiary can choose to continue to work primarily with the supports coordinator. The

beneficiary's supports coordinator and the ICO care coordinator (if not the same) will partner with the beneficiary to complete the health care assessment and care plan. The beneficiary's care plan will be contained in a single electronic health record, maintained by the ICO, which contains all behavioral and physical care information. The ICO care coordinator has ultimate responsibility to ensure that the beneficiary's supports and services are provided as contracted and to the beneficiary satisfaction. Should the beneficiary have a physical health problem, the ICO coordinator will become the "primary" care coordinator to help the beneficiary identify and receive the needed physical health care. When the physical health crisis/episode ebbs, the supports coordinator, if the beneficiary desires, once again assumes the "primary" care coordinator role for the beneficiary. Other key features of the MICare Project that represent its commitment to the Section 298 core values include: Governance and Transparency: Beneficiaries, their chosen allies, caregivers, and family members will be an integral part of the design and implementation of the demonstration project.Person-Centered Planning: Beneficiaries, their chosen allies, caregivers, and family will drive care decisions. Assessments and care plans will revolve around the beneficiary. Pre-planning assures that beneficiaries decide when they meet, who is at their meeting and which physical and behavioral health services they will have. Care plans are fluid; they change as desired and as needed. Care plans are portable, serving beneficiaries where they receive services and supports without regard to boundaries. Coordination of physical and behavioral health: "Care coordination acts as single points of contact for patients [beneficiaries] and as hubs for the multiple providers treating a patient. They can facilitate the appropriate delivery of behavioral and physical health services to patients by assessing patient needs and goals, creating care plans, helping the patient transition from an institutional setting to the community, following up after appointments, monitoring compliance with doctor's orders, supporting the patient's self-management goals and linking patients to community resources." The MICare Project beneficiary chooses a "primary" care coordinator to coordinate physical and behavioral health care when he/she first enrolls, as described above. In addition, health care providers will offer to embed a clinical navigator to help the beneficiary during physical health episodes, navigate within the health system, and between the health care system and Behavioral Health providers. The clinical navigator serves as a single point of contact for referring physicians, patients, and caregivers to provide resources and assistance with accessing clinical and supportive care services offered by the health care provider and in the community. The clinical navigator also facilitates patient appointments, including those made with labs, diagnostic areas, and specialty physicians.The MICare Project includes the expectation that the beneficiary's physical and behavioral health providers have real-time electronic communication to achieve true integration of care. A single client electronic record for all physical, LTSS and behavioral health services will be maintained for each beneficiary by the demonstration ICO. Electronic record sharing will be facilitated through both the ICO and existing state systems that include the ability to communicate directly with the beneficiary's Primary Care Provider (PCP). Expanded access to physical and behavioral health care services for all beneficiaries served through the demonstration project: • Demonstration ICOs will be required to adhere to the Social Welfare Act (MCL 400.109h) exempting the prior authorization requirement for certain prescription drugs used to treat mental disorders, epilepsy, and seizure disorder • Benefits must be portable; beneficiaries can get their care where and when they need it • Supports and services must be accessible and flow seamlessly from facility to community • Gaps in care must be addressed both at the micro (beneficiary-specific) and macro (community health needs) levels Contracts should include identifying, addressing and resolving beneficiary gaps in care. Beneficiary grievance, appeals, recipient rights and protection against abuse, neglect and exploitation • Beneficiaries must understand their rights and protections. • Providers must understand their appeal rights under Medicaid • Demonstration entities must have the resources and technology to identify, monitor, report and resolve grievance, appeals, recipient right violations and abuse, neglect or exploitation. Protections for mental health and epilepsy drugs: Prior

authorization requirements can be adjusted and/or removed to help ensure that there is no delay in treatment and care. An integrated system where providers have real-time ability to communicate with the payer is key to successful implementation of this changeWorkforce training, quality and retention and peer supports: Contracted entities must have the infrastructure to recruit and retain and a high quality, competent workforces and assure compliance with credentialing and oversight, which Includes the ability to recruit, train, credential and retain peer supports specialistsHealth information sharing: Contracted entities must have the infrastructure and resources to develop real-time exchange of electronic information for all providers supporting the beneficiary. This record must entail integrated physical and behavioral health information. Henry Ford Medical Group (HFMG), an integrated physician network, already has in place a single electronic record (EPIC) for all patients using HFMG providers. Currently HAP and HFMG care coordinators and case managers have access to EPIC for patients with HAP/HAP Midwest health plans and HFMG providers. HAP and HAP Midwest can also send information to the PCP as a PDF attachment. Quality measures and uniformity: •Contracting ICOs must have the infrastructure and resources in place to assure compliance with all state and federal quality requirements for Medicare and Medicaid programs •Contracting ICOs must ensure access to care requirements; beneficiaries must get the care they need when and where they need it. Contracting ICOs must have the infrastructure and resources in place to assure value-based care. Pay for performance and risk-sharing contract incentives and provider network outreach, education, monitoring programs must be in place to incentivize high-quality government program performance.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
Coordination of physical, LTSS and behavioral health care supports and services at the demonstration ICO level: The MICare Project model helps ensure the coordination of physical, LTSS and behavioral health services and supports through contracting with a single entity - the demonstration Integrated Care Organization (ICO) - to administer all physical, LTSS and behavioral benefit, including contract language that requires compliance with the integration goal and core values.Under the current funding system, Medicaid behavioral, LTSS and physical health services are administered and delivered under three separate systems, with little to no coordination of the care. Under the MICare Project, the demonstration ICO will be responsible for administering all benefits, including physcial health, behavioral health and all supports and services. The ICO will delegate, through a contracted arrangement, the administration of the Medicaid specialty service providers and supports coordination to the PIHP/CMH. The beneficiary will be given a choice of keeping his/her current behavioral health providers or choosing from a provider network. Similar to contracts with physical health care providers, the contract arrangement between the ICO and the PIHP/CMH will be a shared-risk capitation arrrangement that will include provider incentives for high performance. This will drive compliance and improvement in the quality and efficiency of service provision. The ICO can leverage its pay-for-performance contracts with physical (primary and specialty physician care and hospitals) and behavioral health providers to work together to assure coordination of supports and services. The one care coordinator and one electronic health record will serve as the foundation for this coordination and communication. A case scenario is provided in Attachment 3 to help demonstate how physical, LTSS and behavioral health care wil be coordinated under the MICare Project. Attachments 4a and 4b illustrate how the current system works for John and Aunt Mille while Attachment 4c provides a look at how an integrated system would work under the MICare Project. Coordination of physical and health care services at the provider level: The MICare Project model includes

many options for the organization and coordination of services at the provider level. At one extreme, beneficiaries may choose to receive services from providers in a variety of organizations, networks, and locations, with the only formal point of connection or care coordination being at the ICO level. At the other extreme, beneficiaries may choose to receive all of the services included in the model from a single provider organization, or at least in an arrangement in which a single provider organization accepts full responsibility for management and care coordination across the range of services, even if it does not itself directly provide all of those services.An organization of the latter type, as a provider entity, would closely resemble an Accountable Care Organization as structured in the context of Medicare. A single entity would accept responsibility for managing the full range of services available to beneficiaries, even if some of those services are provided elsewhere. The entity would accept formal responsibility for cost and quality parameters that would then be linked to financial incentives in a shared-savings model. Providers would share in savings related to lower overall costs as long as quality metrics remained high; in a two-sided version of the shared-savings model they would also share in losses if expenses exceeded a target based on historical data adjusted for severity, case mix, and relevant social factors. There would be a formal care coordination or "health home" function in the "ACO" in this case, and the ICO would generally delegate care management functions to the provider entity in this kind of contractual arrangement.Given the scope of services envisioned for this demonstration, the provider entity might be known as a "Behavioral Health ACO" or maybe an "ACO Plus", to acknowledge that the scope of services and scope of care needs for this particular population is significantly broader than that of the current Medicare ACOs. In this model, a "Behavioral Health ACO" or an "ACO Plus" would have to be comfortable with not only integrating physical and mental health services provided by licensed medical professionals, but also integrating the supports and services functions essential to the overall care plan of beneficiaries with severe and persistent mental health, substance abuse, or cognitive deficit issues. It seems likely, although not strictly required, that the care coordination and overall care oversight functions in this special kind of ACO would be based in a Psychiatry or Behavioral Health Services department, and not in primary care, as is generally the case for the current Medicare ACOs. A “Behavioral Health ACO” is not an entirely new concept. The Commonwealth Care Alliance (CCA) in Massachusetts developed the country’s first “Social ACO”, which focuses on the delivery of integrated care for the physical, behavioral and social needs of dual eligible beneficiaries. In an article in Health Affairs Blog, it’s noted that CCA “emphasizes tight linkages with social service entities as opposed to building replacement services”, which is similar to what we propose under the MICare Project. The authors of the Health Affairs Blog article conclude, “We are optimistic that over time, reforms will increasingly prioritize two essential components: capitated payment models that incorporate social spending, and care delivery models that address unmet social needs alongside medical care needs. Achieving this will require alternative policies and contracting models from state agencies that oversee social supports, as well as close partnerships between delivery systems and social services agencies.” We agree with the author’s conclusion as evidenced by the design of our model proposal. (Note: the Behavioral Health ACO is not to be confused with the Managed Behavioral Healthcare Organization Accreditation provided through NCQA).

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?
Under the MICare Project model, the contract arrangements between 1) the State and the demonstration ICOs, 2) between ICOs, LTSS, behavioral and physical health care providers, and LTSS providers. This contracting arrangement will help ensure that all those providing supports and services are working together on behalf of the beneficiary. The single integrated electronic health record, held by the ICO and the beneficiary’s “primary” care provider, will act as the channel that will result in achieving a higher level of integration then the current system.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?
Overall, availability, accessibility and uniformity of physical and behavioral health services and supports will be achieved as follows: • One contract for all benefit administration through the demonstration ICO • Ideally - one administrative department overseeing the demonstration contract process and performance • Ideally - one comprehensive set of performance measures that meets MDHHS and CMS minimum requirements with a single repository for Medicaid external reporting and a single repository for Medicare external reporting • Eliminating prior authorization requirements for certain prescription drugs used to treat mental disorders, epilepsy, and seizure disorder (MCL 400.109h). The current fragmented system does not allow for coordination of physical, LTSS and behavioral health services, which often results in shortcomings in the availability, accessibility and uniformity of services, medications and supports. Often, multiple physicians are prescribing medications and no single care coordinator is assisting the beneficiary to review and reconcile prescribed medications. The same can be said for the care plan recommendations made by providers, for those with both chronic physical and behavioral health needs. In the current system, providers are not speaking to each other or working together to ensure the beneficiaries are getting what they need, when they need it. In the current system, person-centered planning and self-direction are stymied by the fragmentation of supports and services. "Sharing clinical and other patient information can help care managers and providers from different disciplines communicate and coordinate care. Electronic health records can give authorized individuals immediate access to patient data and support knowledge transfer and informed decision-making among providers." In the MICare Project, we recommend that all physical, LTSS and behavioral health care service information be housed within a single integrated electronic record and the single care coordinator, employed by the ICO, works with the "primary" care coordinator selected by the beneficiary, and is responsible for ensuring that ALL providers have the consent and access to transfer and receive the information needed to communicate and work together. The single primary care coordinator supports not just the beneficiary but the providers to coordinate and implement one integrated care plan.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
The behavioral and physical health workforces are trained and focused on, appropriately, their specific areas of expertise, responsibility and accountability. The MICare Project is designed to bridge the current gap between behavioral and physical health care through tools including improved care coordination across and within behavioral and physical health services and LTSS services, provider education and training on the concepts of behavioral health and interdisciplinary care teams, use of a single electronic record for each beneficiary that provides a complete care picture; and standardized performance measures that align incentives across services and supports. We believe these tools will help address the structural gap between physical and behavioral health care, which often results in delayed care and duplication of services.But tools are not useful unless the workforce has the skills and training to use them properly. We see the need for investments - by the demonstration

ICOs and care providers - in care coordination and case management teams, and provider education and training, to help ensure that linkages are made between physical, LTSS and behavioral health and to support the work being done by behavioral, LTSS and physical health professional providers. Case management teams should include extension positions such as peer supports specialists, community health outreach workers and health navigators, who are all part of the team that helps ensure the beneficiaries are engaged and getting what they need, where they need it and how they want it. In an integrated model, the workforce is cross-trained and cross-functional, while also working at the "top of their skill level", where clinicians perform clinical work and support staff perform support functions. Physical and behavioral health staff work together to identify and address gaps in care and duplication of services. Efficiencies will occur in this model that should be re-invested into workforce development, recruitment, training, and retention activities that strengthen the model. All members of the physical health, LTSS and behavioral health workforce – professional clinicians, care coordinators, case management team, and the administrative and support staff – will need to receive standardized training and communication about the MICare Project to ensure a common understanding of the program goals and requirements. Under the MICare Project, we expect that the workforce will become more engaged and satisfied with their work because they will have the proper tools, training and skills to do their job well - providing the best possible care to beneficiaries. This will hopefully lead to increased job satisfaction, improved beneficiary outcomes, improvements in quality of care, and decreased overall costs (measures of which can be built into the program evaluation).

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

Under MICare Project, the beneficiaries, their chosen allies, caregivers, and family will drive care and service delivery decisions. Assessments and care plans will revolve around the beneficiary. Pre-planning between the primary care coordinator and each beneficiary ensures that the beneficiary makes the decision about when to meet, who is at their meeting, which supports and services are needed, and how those services will be delivered. Care plans will be fluid; they will change as desired by the beneficiary and as needed by the. Care plans are portable, serving beneficiaries where they are without boundaries.

Would this model affect the administration of complaints, grievances, and appeals?

The MICare Project requires complaints, grievances and appeals from beneficiaries and providers to be administered by the demonstration ICO.
• Beneficiaries and/or their chose allies, caregivers and families must understand their rights and protections. Demonstration ICOs must have the resources to ensure that beneficiaries receive coordinated education through active and engaged outreach •Providers must understand their appeal rights under Medicaid. Demonstration ICOs must have the resources needed to assure provider education through active and engaged outreach • ICOs must have the resources and technology to identify, monitor, report and resolve grievances, appeals, recipient right violations and abuse, neglect and exploitation. We recommend that MDHHS contract with a separate entity to manage and monitor these reports and assure timely resolution by demonstration ICOs and their contracted providers.

How would the model support continued access for individuals to current services, supports, and providers?

Demonstration ICOs would contract with PIHPs/CMHs (either through delegation of administration of the network and/or directly) and with LTSS and physical health care providers. For example, Henry Ford Health System provider entities, including the HFMG, clinics and hospitals, are interested in participating in this demonstration. In addition, the MICare Project will: • Implement voluntary and passive enrollment into the program • Assure no interruption in services with continuity of care contract provisions • Offer expanded options and choices with the portable benefits approach to care described earlier. This model design results in more beneficiary choice and fewer barriers to access care.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

Beneficiaries, their chosen allies, caregivers and family members should be an integral part of the design and implementation of the demonstration project. ICOs would be required to establish advisory councils. Advisory council members would include beneficiary primary and secondary stakeholders. Advisory council recommendations would be reviewed by ICO governing boards and incorporated into strategy and planning. Performance measures would be established tied to this requirement to help ensure compliance. In addition, public forums will be held quarterly during Year One of the MICare Project implementation and minimally, annually thereafter, to assure communication and information is shared with the public and gathered from the public. MDHHS and the ICO and advocacy/rights organization websites would include quarterly newsletter updates and be programed to accept public comments, on an ongoing basis, which would be reviewed at the Advisory Council meetings.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

Through the person-centered planning practices mentioned earlier, beneficiaries would determine who is involved in their assessment and care planning activities. Guardians would be engaged as required and as desired by the beneficiary. Individualized and person-centered care plan meeting would occur. Invitations to this meeting would be sent to the beneficiary's desired participants. At this meeting the risks and needs identified through the assessment process would be discussed as desired by the beneficiary, barriers to care are identified and goals established that are person-centered and beneficiary-approved. Documented evidence of beneficiary and/or guardian (if applicable) approval of the care plan must be in the beneficiary record. All those responsible for providing supports and services are in-serviced on the relevant information within the care plan. Documented evidence of these in-services must be in the beneficiary record. As desired and/or as a result of significant change in the beneficiary status or condition, re-assessments and updates to care plans are completed following the same practice. Progress made towards goal achievement is discussed minimally, at each required contact and documented in the care plan and contact note. Minimum contact requirements are established based on the assessed beneficiary risk level. Care plans are fluid; they change as desired and as needed.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?
Capitated funding for the MICare Project would flow from the MDHHS's Medical Services Administration (MSA) Department, which has oversight of Michigan's Medicaid Program, to the demonstration ICOs for beneficiaries enrolling in the demonstration project. MSA will continue to work in partnership with MDHHS's Behavioral Health and Developmental Disabilities Administration (BHDDA), which is responsible for the oversight of state substance use disorders (SUD) appropriations, the Substance Abuse Prevention and Treatment Block grant, Mental Health Block Grant, and Medicaid-funded specialty services and supports. MDHHS will also need to establish a demonstration project risk corridor for the demonstration ICOs.Ideally MDHHS would combine departments currently administering physical health, behavioral health and long term services and supports, into one integrated care department that would administer this project.

What changes would need to be made to provider reimbursement in order to implement the model?
We suggest the following provider reimbursement levels be implemented: For Medicaid: • Physical health and LTSS benefits: Apply the current MI Health Link Level of Care (LOC) rates with county, level of care, and risk adjustment process Add LOC and separate rate for personal care services Add LOC and separate rate for hospice services • Behavioral health benefits: Apply current Medicaid specialty service and support rates Establish level of care codes and rates Apply county, LOC and risk adjustment process General funds continue to flow through PIHP/CMHs ICO would establish managed care contract rates that would be adjusted based on general funding amounts with PIHP/CMHs providers. For Medicare: Apply capitated rates with adjustments for risk scoring. While it is not a common practice to use capitated contracts, we support the use of value-based payment in the proposed MICare Project.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
Yes, we recommend that both payer and provider performance incentives be developed and implemented for the MICare Project. For Payers: we recommend that MDHHS establish a demonstration risk corridor for the demonstration ICOs; we support the inclusion of incentives tied to compliance with quality measures as currently applied in the MI Health Link dual eligible demonstration project. For Providers: we recommend that pay-for-performance risk sharing arrangements be established.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?
One important feature of the MICare Project is the use of one unified set of quality measures at the ICO level, reflecting the full scope of responsibility and scope of services being provided through the ICO. The set of measures would include: (a) measures generally used at the health plan level for ongoing primary care, preventive services, screening, and management of routine chronic conditions (the Healthcare

Effectiveness Data and Information Set (HEDIS) measure set); (b) measures of care specifically for either mild-to-moderate or severe/persistent mental illness (list below from a report from the National Academy of State Health Policy); and a novel set of measures focusing specifically on the issue of care integration and coordination (list below).Individual beneficiaries will naturally only be in the denominator population for a subset of measures at any one time, but the ICOs themselves will be held accountable for the full set of measures that reflect the full scope of physical and behavioral health and support services included in the MICare Project. Whenever possible, the selected measures should focus on outcomes of care, rather than processes or structural elements, to allow the maximum degree of flexibility and innovation at both the ICO and contracted provider level for achieving good outcomes. Since the set of available outcome measures is very limited, though, some process measures are included when there is a sufficiently strong evidence link between process and outcome to justify focus on a particular process step. The measure set does not include structural measures, as the link between structure and outcome is generally so weak as to not justify any provider reporting burden for structural measures. Rather, structural characteristics like accreditation status, appropriate staffing levels, presence of an electronic medical record, etc., can be handled in the context of criteria for provider network inclusion and continued contracting rather than in the context of quality measurement, particularly as most of these criteria are fundamentally yes/no characteristics.Presented below is a list of quality measures to consider for inclusion in the MICare Project: HEDIS Measures focusing on Care of Physical Health Conditions:We recommend including HEDIS measures focused on physical health conditions as part of the quality measures for the MICare Project. The list of HEDIS measures is long and can be looked at more closely during the development of quality measures for the demonstration project. The full set of 2017 HEDIS measures for physical health conditions can be found at http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2017. Examples of HEDIS measures of particular relevance to the MICare Project include:Physician Measures: • Effectiveness of care measures (e.g., antidepressant medication management, follow-up care for children prescribed ADHD medication, follow-up after ER visit for mental illness, and/or for alcohol and other drug dependence, diabetes screening for people with schizophrenia or bipolar disorders who are using antipsychotic medications, diabetes monitoring for people with diabetes and schizophrenia, cardiovascular monitoring for people with cardiovascular disease and schizophrenia, adherence to antipsychotics for medications for people with schizophrenia, metabolic monitoring for children and adolescents on antipsychotics, use of multiple concurrent antipsychotics in children and adolescents) • Access/Availability of Care measures (e.g., adult's access to preventive/ambulatory health services, children's and adolescent's access to primary care practitioners, initiation and engagement of alcohol and other drug dependence treatment, use of first-line psychosocial care for children and adolescents on antipsychotics) • Utilization (e.g., adolescent well-care visits)Another way to categorize these measures is by behavioral health condition (several of these are duplicates of the measures listed above) • Mild-to-Moderate Behavioral Health Conditions Antidepressant medication management (NQF #0105) Initiation of alcohol and other drug dependence treatment (NQF #0004) Follow-up care for children prescribed ADHD medication (NQF #0108) • Severe and Persistent Mental Illness Adherence to antipsychotic medications for individuals with schizophrenia (NQF #1879) Follow-up after hospitalization for mental illness (NQF #0576) •Care Coordination Screening for clinical depression and follow-up plan (NQF #0418) Timely transmission of transition record (discharges from an inpatient facility to home/self-care or any other site of care) (NQF #0648) HBIPS-6 Post discharge continuing care plan created (NQF #0557) HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge (NQF #0558) Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (NQF # 1932) Cardiovascular monitoring for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (NQF #1927) Continuous improvement in quality and cost of

care requires collaborative effort by the demonstration ICO and contracted providers. One key step in that collaboration is identifying a primary locus of responsibility for each measure – is it primarily the responsibility of primary care, or of a LTSS agency, or of behavioral health? In order to create financial incentives for quality and cost improvement at the provider level, the ICO can implement a variety of contractual elements that create financial incentives for continuous improvement. These features can include financial bonuses for exceptional performance or improvement from year to year, or financial withholds that become payable upon evidence of either satisfactory performance or improvement, or adjustments to base payment levels in a future year based on quality performance in the previous year(s). The exact choice of financial incentive mix should be left up to the individual ICOs, and may vary within health care sites across different provider contracts. There is no current evidence that one specific incentive model works better than the others. ICOs will provide regular and frequent feedback reports to contracted providers on their performance on the selected cost and quality measures, including comparative reports that show providers how their performance compares to their peers in the plan network. Valid comparisons require careful risk adjustment, so ICOs will be obliged to incorporate current "best practices" in the area of risk adjustment into all metrics, financial incentive programs, and comparative feedback reports.These steps will provide incentives to providers and information on priorities for improvement, but they will not help providers do the work of actual improvement. There is some room for simply letting providers use their own internal tools of process improvement to change, but ICOs working in this model can also learn from the successful "Value Partnership" program managed by Blue Cross Blue Shield of Michigan (BCBSM) that includes statewide quality improvement collaboratives as a key component. The collaboratives involve regular meetings of providers (e.g., spine surgeons, cardiac surgeons, medical oncologists) to review comparative performance data, discuss possible avenues for improvement, and share their own experiences with local innovations and process changes associated with outstanding performance. The quality collaboratives have been successful over a period of nearly 20 years now, and stand as a model for how plans (on a more limited scope, given their narrower geographic reach and smaller budgets) can serve as catalysts for quality improvement in a helpful, pro-active, and non-punitive way.MDHHS should expect and reward continuous quality improvement at the ICO level, in terms of its contracting with demonstration ICOs. The same mix of quality bonuses, payment withholds, or adjustments to base capitations payments can be used in the context of contracts between MDHHS and ICOs working in this model. ICOs would be held accountable for performance on a set of measures with relative weights for each measure in some overall scoring formula to be determined by MDHHS with input from the ICOs and from other program stakeholders.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

Success of the model would naturally be measured in two or three major domains - quality improvement, cost savings/efficiency, and patient and family member or caregiver reports on the experience of care.Measuring success in the quality improvement domain is relatively straightforward, as long as there are standard metrics in use now and can be continued into the model implementation period and interpreted as reflecting comparable underlying performance in both the "before" and the "after" periods. Even if all of the metrics listed in the item above cannot be used in this way, a specific subset identified as relevant for policy evaluation can be used, with success of the program based on the extent to which most or all of the relevant metrics are moving in a positive direction.Since many of the metrics would be on trajectories of improvement anyway, even without the model in place, the analysis will have to identify one or more relevant comparison populations - individuals like those in the model but not participating in the model. Statisticians and program evaluation experts can work out the specific

methods of forming valid comparison or control groups, but the essence would be a "difference in difference" approach in which the improvement among participants in the model would be compared to similar client groups or similar organizations working under different models.The cost or efficiency analysis would focus on State payments for the comprehensive set of services included in the model, comparing those costs in the model to the same set of costs, for comparable clients or patients, being seen in other payment models. Since the fundamental concept of the proposed model is a "carve-in" of one set of services with other existing set of services, it should be feasible to calculate a total of the entire set of services for the "carve-in" approach and compare it to the current approach, or any other distinct new pilot model approach, with suitable adjustment for case mix or condition severity if those factors are suspected to be different across models being compared. Again, it is likely that costs in general are on a rising trajectory, so the comparison will have to take that trajectory into account. The model could be judged successful in terms of cost or efficiency even if costs rise somewhat compared to prior year(s), as long as that increase is lower than it would have been (or is in other models) for the same or comparable populations served. Analysis of specific components of cost (e.g., primary care, specialty medical care, inpatient psychiatry, LTSS) can be done to understand in more detail the reasons for any overall differences in per-participant program costs. The patient experience can be measured through use of standard experience of care surveys, with any current caveats about individual participants' ability to produce valid survey data being applied to the new model. Surveys like the CAHPS survey that are currently used in the context of Medicaid managed care can be used in the new model as well, for that same set of participants. Individuals with severe or persistent mental illness, or significant cognitive deficit will not be able to participate in these surveys in the same way, but their family members or caregivers can respond on their behalf, as they do now in other parts of the program to be "carved-in" to the Medicaid managed care program. The same analytic points about quality data would apply to the survey data as well. Choice of appropriate comparison or control groups will be crucial, even if there is not a clear temporal trend in the survey measures being used.With this three-pronged approach to evaluation of program success, there should be a clear indication of whether the model is successful in any or all of the three main measurement domains. Qualitative research (e.g., interviews with program managers, health plan staff, clinicians, clients, caregivers) can also be used to supplement the quantitative analysis and provide richer detail on the underlying dynamics of the model as it is implemented.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

We recommend that the MICare Project be implemented as a demonstration pilot within the current MI Health Link demonstration counties, which include Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren and Wayne and all counties in the Upper Peninsula. We further recommend including the Southeast Michigan counties of Lenawee, Livingston, Lenawee, Monroe, Oakland and Washtenaw, where the majority of Medicaid and dual eligible beneficiaries reside. We recommend that the MICare Project be implemented using a phased approach to full integration of behavioral and physical health over a three-year period: • Pre-Implementation: ICO readiness evaluation and procurement phase • Year One: Beneficiaries with Physical Health and/or LTSS service needs • Year Two: add Beneficiaries with Behavioral Health (mentally ill and /or SUD) service needs • Year Three: add Beneficiaries with Intellectual/Developmental Disability and/or Autism Spectrum Disorder service needs. This phased-in approach would help ensure that all MICare Project contracted entities including ICOs, PIHPs/CMHs, and health care providers are fully prepared to handle the demonstration project requirements around care coordination,

financing, provider reimbursement, workforce training, beneficiary and provider communications, quality measurement, electronic record sharing and more. The ICO readiness evaluation and procurement phase is consistent with the process used for the MI Health Link demonstration project. HAP Midwest is one of the ICOs that provide services to MI Health Link enrollees and is well positioned to participate in the MICare Project demonstration pilot.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

Yes, we believe this MICare Project, a comprehensive managed care "carve-in" model, could be implemented statewide although we highly recommend that it be piloted in selected regions of the state, as recommended earlier, prior to statewide implementation. If the pilot is successful, we recommend that, prior to statewide rollout, another ICO readiness review and procurement process be conducted. This would allow the state to assess ICO readiness to meet MICare Project requirements including network adequacy, care coordination capabilities, experience with alternative payment models and more. As noted in the model overview, sixteen states have or are planning to "carve-in" Medicaid behavioral health services through an integrated care management benefit. Different approaches are used across states for the "carve-in"; we believe the MICare Project is closely aligned with the comprehensive managed care carve-in implemented in Kansas and Texas. These two states "carved-in" behavioral health services to managed care plans that provided physical health services and/or LTSS to all or most Medicaid beneficiaries. Managed care plans may subcontract with behavioral health organizations (BHOs) that manage behavioral health needs but continue to bear the risk for managing benefits. The Center for Health Care Strategies, in an April 2016 brief, notes that "Administering integrated systems of managed care for high-need beneficiary populations … is a complex undertaking. These programs requires 1) specialized clinical expertise at the health plan [ICO] level; 2) state capacity for robust oversight and monitoring; 3) innovative strategies for advancing whole-person care to address beneficiaries' complex needs and 4) mechanisms for achieving and maintaining provider and other stakeholders' support. We believe demonstration ICOs have the needed clinical expertise, especially those already involved in managing care for Medicaid and dual eligible beneficiaries. We believe the MICare Project design advances whole-person care for beneficiaries, while offering choice and flexible benefits. MDHHS is interested in developing and implementing a demonstration project and, thus, we assume has or will have the capacity for oversight and monitoring, and obtaining/maintaining provider and other stakeholders' support (working in conjunction with demonstration ICOs, health care and LTSS providers and PIHPs/CMHs).

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

We do not have this information.

(Optional) Are you aware of any other states or communities which have implemented this model?

There are sixteen states that have moved to integrate behavioral and physical health care. http://www.chcs.org/media/BH-Integration-Brief_041316.pdf

Attachment 2: Henry Ford Health System Background

HFHS is a Michigan-based, not-for-profit integrated health system, including medical (physical) and behavioral care delivery along with a comprehensive health insurance company/managed health care plan (Health Alliance Plan). Our vision is transforming lives and communities through health and wellness, one person at a time. Our business strategy is based on core values of each beneficiary first, respect for people, high performance, learning and continuous improvement, and a social conscience.

HFHS corporate offices are based in Detroit, where we have served the community - and partnered with others serving this community - for over 100 years. HFHS offers health care services across the care continuum through a diverse network of facilities in South Central (Jackson) and South East Michigan (Detroit). In the Jackson region, we recently acquired Henry Ford Allegiance Health and the Jackson Health Network (a clinically integrated physician network). In the Detroit metropolitan area, we have eight business units providing integrated health care including Henry Ford Hospital (HFH), Henry Ford Macomb Hospital (HFMH), Henry Ford Wyandotte Hospital (HFWH), Henry Ford West Bloomfield Hospital (HFWBH), Henry Ford Medical Group (HFMG)(a clinically integrated physician network), Henry Ford Behavioral Health Services (BHS), Community Care (CCS) Services, and Health Alliance Plan (HAP)and HAP Midwest, a subsidiary of HAP, which focuses on Medicaid and dual-eligible populations (more detail about HAP and HAP Midwest is provided in the next section).

The people we serve, from the Detroit and Jackson metropolitan areas, are diverse. While experiences differ, diversity is leveraged to directly or indirectly influence the equitable delivery of culturally appropriate care and treatment of our patients, beneficiaries, employees and community partners. To help address the socioeconomic barriers to health care that our most vulnerable beneficiaries face, including many with Medicaid coverage, we are transforming our integrated care model to be more accessible, portable and person-centered.

HFHS, thus, is uniquely positioned in our service areas to provide managed health insurance that is fully integrated with our physical and behavioral health care delivery system.

<u>Health Alliance Plan (HAP)</u>
Currently, HAP and HAP Midwest serve more than 660,000 members through six product lines: group insured commercial, individual, Medicare, Medicaid, self-funded and network leasing. HAP Midwest, a subsidiary of HAP, offers government-funded insurance coverage through Medicaid, the Healthy Michigan Plan (expanded Medicaid) and Medicare Dual Special Needs Programs. In 2015, HAP Midwest was awarded a MI Health Link contract to provide integrated physical, behavioral and long term services and supports benefits and care to dual eligible beneficiaries living in Wayne and Macomb counties. HAP Midwest currently provides Medicaid coverage in St. Clair, Sanilac, Tuscola, Lapeer, Genesee, Shiawassee and Huron counties. HFHS's ability to leverage community-based care coordination through its government-funded health insurance programs and coordinate care with community organizations, offers a one-stop shop approach to assuring that consumers get the care and services they need when they need it.

HFHS and Affirmant Health Partners (Affirmant)

HFHS is a member of Affirmant Health Partners (formerly known as The Federation Care Network), which is made up of seven non-profit health systems that have joined to form the state's largest clinically integrated network. Affimant plans to jointly contract for at-risk and value-added type contracts with payers, employers and other groups on a statewide basis. The seven systems will also share best clinical practices to improve the quality and coordination of beneficiary care, work together to learn new ways to reduce costs and prepare for financially at-risk payment models to prepare for expected health care financing and delivery system changes.

HFHS Behavioral Health Services

Detroit Area

Behavioral Health Services (BHS) is a division of HFHS. BHS provides a full continuum of mental health and substance abuse services through a large integrated delivery system of two hospitals (HF Kingswood Hospital and HF Maplegrove Center), five outpatient clinics, a partial hospitalization program, and more than 500 employees, including fully licensed social workers, psychologists, nurses, and psychiatrists who collectively serve Southeastern Michigan. HFMH (Mt. Clemens facility) and HFWH also have inpatient psychiatric units.

Henry Ford Kingswood Hospital, a 100-bed psychiatric hospital in Ferndale, has been serving the community for more than 40 years by providing comprehensive inpatient psychiatric treatment for children, teens and adults with mental health disorders in a warm, professional environment. Kingswood's board-certified psychiatrists and therapeutic staff are experienced in diagnosing and treating all types of mental health disease, including anxiety disorders, bipolar disorder, depression, post-traumatic stress disorder, psychosis, suicidal thoughts, suicide attempts and psychiatric illness combined with substance use. Treatment is designed to fit the unique needs of each patient and may include individual counseling, DBT, group therapy, family counseling, intensive care management or medication management.

Henry Ford Maplegrove Center is the premier addiction treatment facility for adults and adolescents in metro Detroit, offering both residential and outpatient treatment. Located in a peaceful, wooded area of West Bloomfield, Michigan, Maplegrove provides a safe and stable environment to initiate recovery. Maplegrove treats patients as we would members of our own family and we recognize that each person is different. Our team of addiction-certified physicians, nurses, psychologists, social workers and support staff are at the forefront of addiction therapy.

BHS collaborates with Primary Care to support a team of psychiatric-trained and state-licensed nurse practitioners, social workers, and psychologists, who provide integrated behavioral health care embedded within the 27 primary care clinics across the region. The Division of Neuropsychology employs five neuropsychologists and completes over 1600 evaluations per year. This team is an integral part of various multidisciplinary clinics within the HFHS. These include the sports concussion clinic, autism clinic, and normal pressure hydrocephalus clinics. In

addition, Nurse and Social Work Care Coordinator staff, through assessments, evaluations and care planning, work with consumers across care settings to mitigate psychosocial or environmental barriers to access and offer support to those who require assistance with daily living needs, through referrals to other divisions within the system such as the Program of All-Inclusive Care for the Elderly (PACE) and MI Health Link, Medicaid Waiver or Personal care Programs.

Jackson Area

Henry Ford Allegiance Health (HFAH) offers a full continuum of behavioral health services through outpatient counseling, psychiatric consultation and medication management, and partial or full hospitalization. HFAH maintains an experienced team of mental health professionals with extensive training in a variety of specialties. The team includes psychiatrists, nurse practitioners, physician assistants, licensed social workers, psychologists and mental health therapists. HFAH board-certified psychiatrists are trained in child/adolescent, adult and geriatric treatment.

The Addiction Recovery Center is a substance abuse treatment center helping adults addicted to drugs and/or alcohol. Services range from chronic to acute detoxification to residential and intensive outpatient programs. The program is designed specifically for those also living with the challenges of substance abuse and mental health disorders. The Substance Abuse Services program specializes in outpatient treatment of substance abuse and chemical dependency; it offers a range of individual, group and family therapies to help people experiencing concerns with drugs and/or alcohol. The Access Center offers 24/7 assistance and referral services whether the person calling is in a crisis or experiencing emotional or addictive disorders that disrupt daily life.

Attachment 3: Case Scenario: John and Aunt Mille

John and his Aunt Millie, both adults, live together in Oakland County MI.

John is an adult living in the community who is a Medicaid beneficiary. John is dually diagnosed with bi-polar disorder, has a physical disability and uses a wheelchair. John is obese, incontinent, and has uncontrolled diabetes, high cholesterol, and high blood pressure.

John lives with his aunt Millie. John's aunt is elderly and his only source of support. John relies on his aunt to assist him with his Instrumental Activities of Daily Living (IADL) needs as well as medical supplies, medication administration, transportation and assistance for community needs including medical and behavioral health treatment appointments. Aunt Millie is unable to adequately care for John. As a result, John is non-compliant with his medications and medical and psychiatric appointments and his behavioral and physical health conditions are uncontrolled.

John has had four visits to the ER in the last six months: three for psychiatric issues and one for a medical issue. The ER visits resulted in two inpatient hospital admissions. On John's last admission, his transition to home was delayed because the hospital discharge planner was unable to coordinate a safe discharge home; John's aunt had experienced a fall, which required hospitalization.

Aunt Millie is a dual eligible beneficiary who is a smoker and has high cholesterol and high blood pressure. Aunt Millie has difficulty caring for her own medical needs and her health is suffering with the burden of caring for her nephew. Neither John nor Aunt Mille are employed; they each receive social security as income. They pool their income to pay for their living expenses and have no other natural supports that can help them. These two love each other and want to remain living in the community with each other.

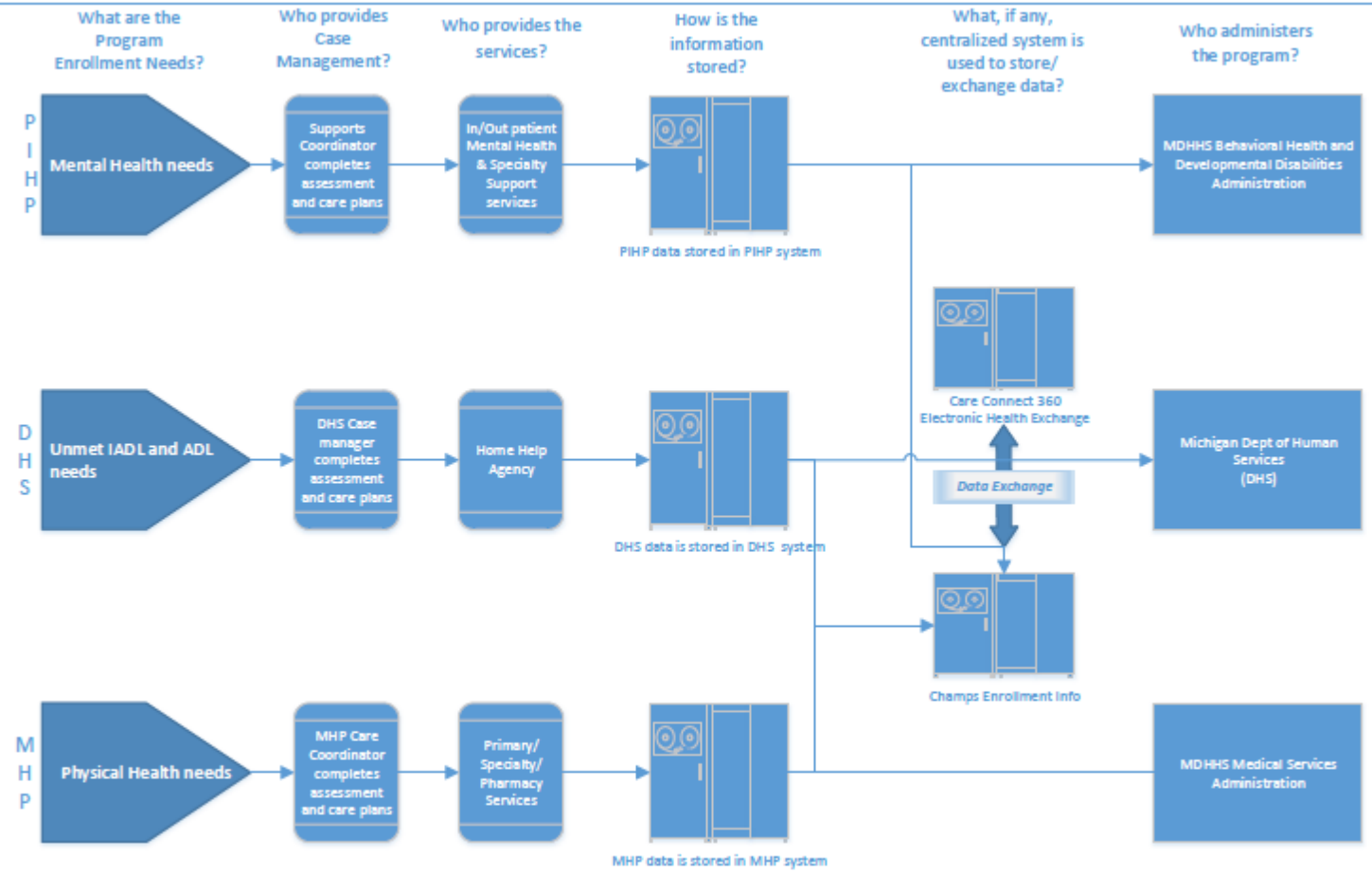
In the current system, John and Aunt Mille are reliant on their behavioral or physical health providers to connect them to the resources they need, which is unlikely to happen. In Oakland County, there is no single organization that can help John with the physical, behavioral and long term service and supports (LTSS) he currently needs. He would need to be referred to the Oakland County PIHP for behavioral health services and to DHS for home help services to assist him with his IADL and Activities of Daily Living (ADL) needs that his aunt is not able to adequately provide. Aunt Millie would need to be referred to the Area Agency on Aging 1B (AAA), which has a waiting list for MI Choice waiver services. The PIHP and the AAA would focus on the socio-economic needs, while the health conditions would be the secondary focus. Both John and Aunt Millie would be considered high risk and would have care coordination staff trying to assist them with their physical health needs, telephonically from their insurance companies.

If these two were able to secure the services described above, there would be multiple case managers who would be working within this household, who would not be communicating with each other or coordinating the care. In addition, beneficiary health information is stored in

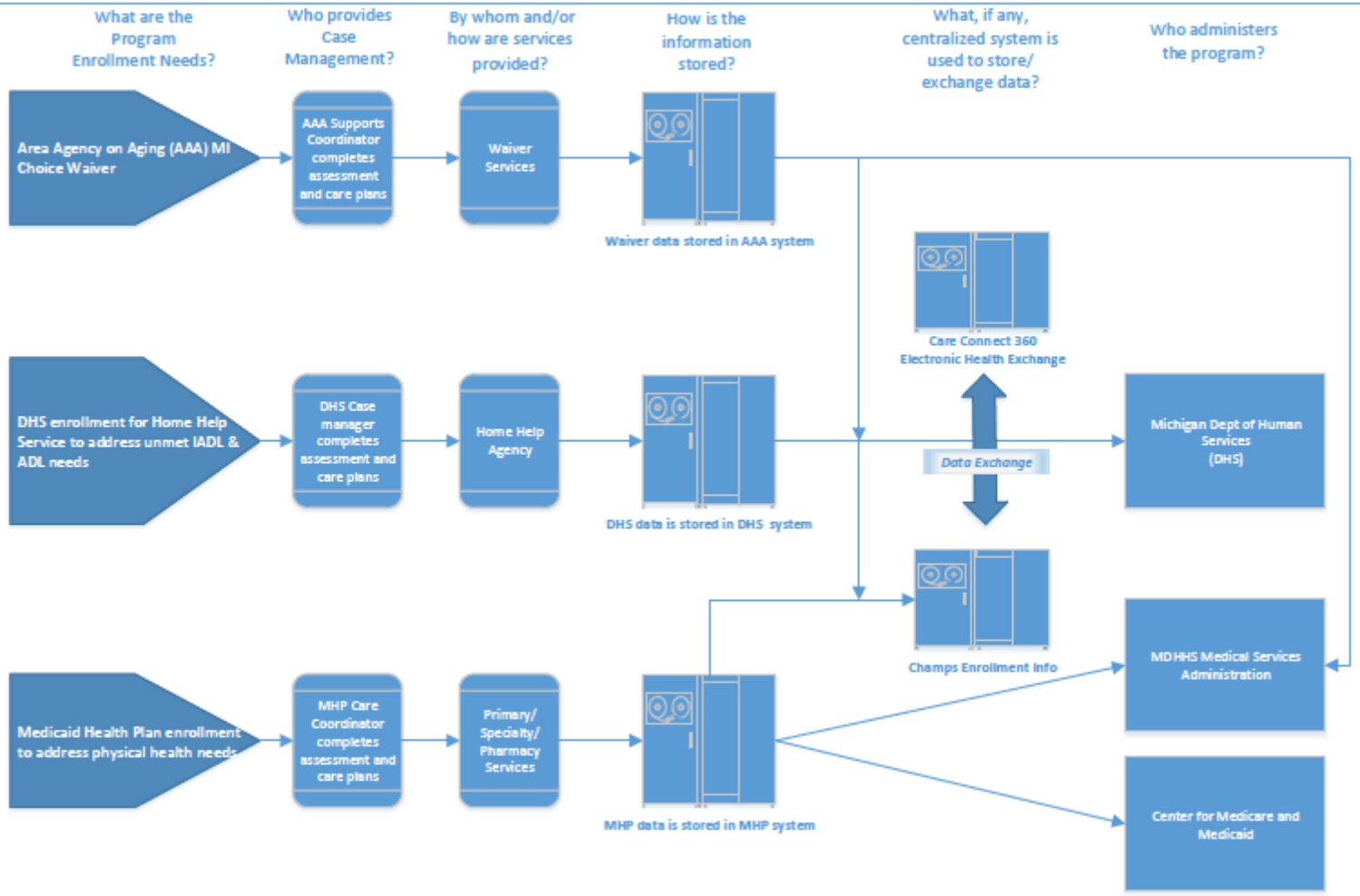
multiple systems that are not connected and do not exchange information. And finally there are multiple MDHHS administrative agencies who are not communicating with each other. In this fragmented system, the beneficiary health outcomes are likely to be poor and both John and Aunt Mille could end up being institutionalized. In addition, the current system is fraught with inefficiencies, duplication of efforts and complexities that result in access issues which further contribute to beneficiary barriers to care and increase cost of care.

Under the MICare Project, both John and Aunt Millie could be supported for all their needs by one organization – the demonstration ICO - which would coordinate the physical, behavioral and LTSS care needed to support this family to remain living in the community and help ensure that each beneficiary's gaps in care are addressed, that preventive care services are provided so that their health outcomes are improved and re-admissions reduced. If MDHHS combined administrative departments who contract, regulate, monitor and pay these service organizations, efficiencies could result in improved quality and cost savings.

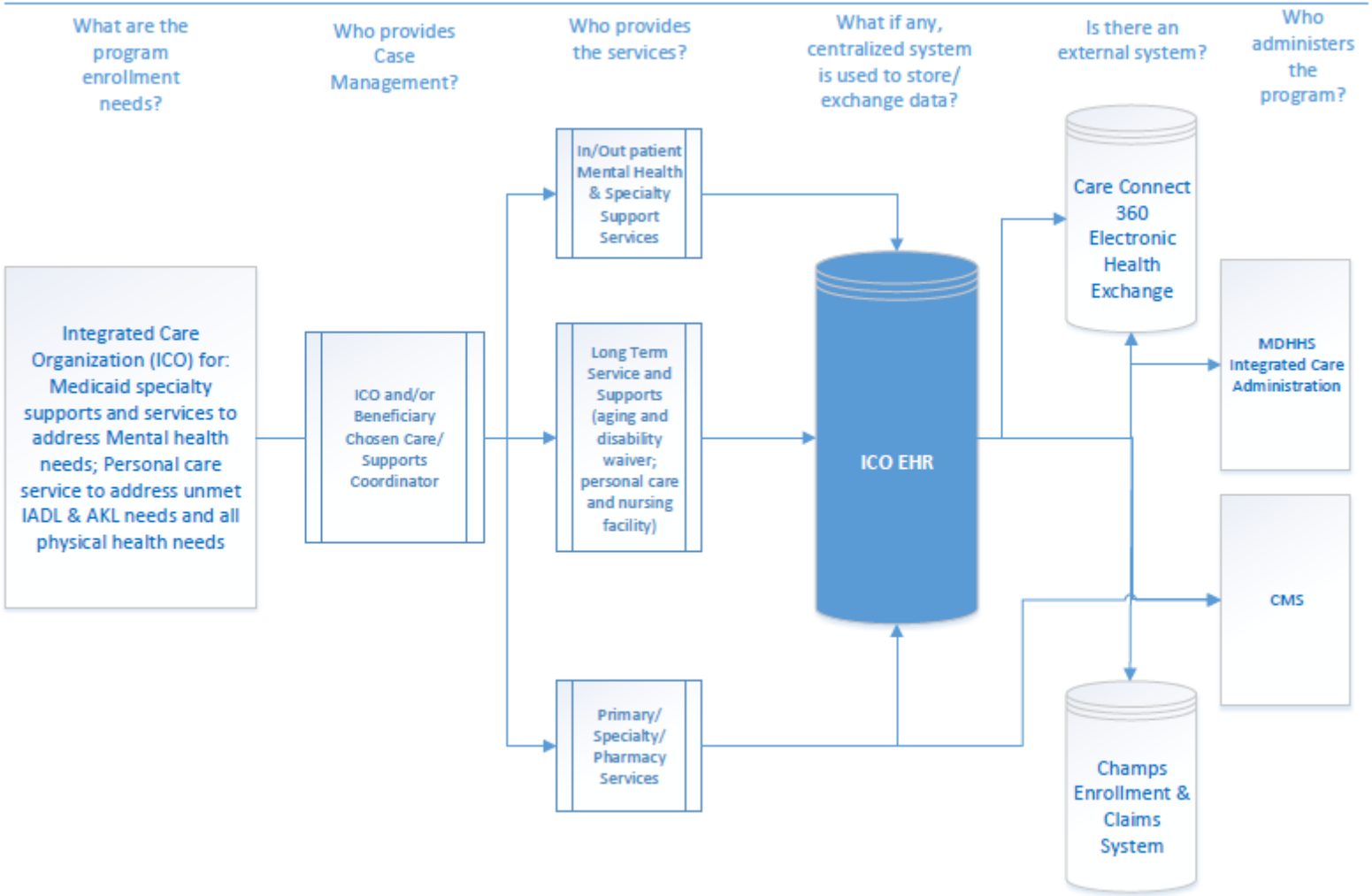
John's Current System



Aunt Millie's Current System



Proposed MICare Project Model: Future Care for John and Aunt Millie



Model #16

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Community Mental Health Organizations acting as integrated care entities

Name of Submitting Organization: Hiawatha Behavioral Health

Model Partner Organization(s): Click here to enter text.

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

Behavioral health organizations (BHOs) have specialized capacity around managing behavioral health services, particularly for individuals with SMI/ IDD Thus an alternative to integrating care through contracting with BHOs to provide both physical and behavioral health services for individuals with SMI/IDD/SED, the population that community mental health organizations have an expertise in. CMHSP's have a great deal of experience dealing with individuals who have SMI/IDD?SED diagnoses and a long history of dealing with specific consumers. Other similar models such as CCM with the Behavioral Health Organizations taking the lead, have proven to be successful in other pilot projects across the country. Pros: Integration of services creates alignment of financial incentives across physical and behavioral health systems. Full integration of administrative data for care management purposes is possible. Beneficiaries have seamless access to benefits and services. This option leverages specialty capacity of the behavioral health system to serve a population that it may know best, and where consumer engagement may be greatest. BHOs have core managed care capacity that can be leveraged across a broader array of benefits, namely information systems, quality management/ utilization management functions, experience in building and managing provider networks, and communicating with beneficiaries- In Michigan this is already true as our Behavioral Health Organizations act in a Managed Care environment with these functions delegated to them by the PIHP.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

The current population served by community mental health organizations in Michigan, CMHSP would continue to serve the population that they are experts in serving, while the HMO's would continue to oversee the physical and behavioral health of their priority population. The CMHSP would manage the physical and behavioral health of the 300,000+ residents they are currently tasked at serving.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

All current Behavioral Health services as required by the Medicaid Array of Service would continue to be provided as well as case managers/care managers working to integrate phsyical health by working to get consumers set up with primary care providers that are understanding of their behavioral health issues and that they have a good rapport with. Case/Care managers will follow up and coordinate appointments with primary care and specialists as needed, all while collecting the important physical health information that can have an impact on their behavioral health conditions.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

Choice has always been at the center of the behavioral health system in Michigan . This program would be no different. Individuals would have choice whether or not they want their phsycial care managed by the CMHSP and a choice of care/case managers. In the past few years we have seen many programs that threaten this choice that has been a mainstay in this system. The MI Health Link project that automatically enrolled people without individuals understanding and the confusing disenrollment process was a threat to choice in the behavioral health system. We do have to remember that people have a choice. CMHSP have always encouraged phsycal health care and encouraged phsycical health services to our consumers, some refuse. Bottom line is they do not want it in some cases, however, CMHSP's are in the best position to get consumers to use these services and work towards preventative care and healthier lifestyles.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

Behavioral Health will coordinate all the phsical and behavioral health services of the individuals they serve either through becoming Federally qualified Health Centers or collaboration with current community providers. The HMO's can contract with the CMHSP to provide this service as well, however, leaving the carve our for behavioral health services with the CMHSP as it currently is.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

Though one organization managing the physical and behavioral health for the carve out population

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

The system of collaboration proposed would leave the mental health code intact. It would not threaten some of the core values of the system that other proposals have. CMHSP are required to play by different rules and have more stringent regulation than the HMO's do. In Mi Health Link Pilot regions access to Medications have already been greatly hindered and the preauthorization hold from PA 248 was not carried over at the start of this program leaving many individuals scrambling for medications. This extra work fell to the safety net, the community mental health organizations, which worked to get prescriptions preauthorized or paid for individuals presctiptions out of General Fund dollars.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
The propsed model would be a slight expansion of community mental health. It would require more people to be involved but not a complete overhaul of the system. Showing an investment in the future of community mental health would allow us to recruit and retain more staff. Stagnant funding in the current system has led to stagnant wages, Increases in minimum wage has led to it being harder to recruit and retain direct care staff. Also, the unknown future is not great for recturiting. SAMHSA note in a 2013 study that the third leading cause of recruitment difficulties in behavioral health is stigma. Integration efforts coordinated by the efforts of those with the expertise have and will continue to significantly impact stigma across all regions. That being said, we always manage to provide the services we are required to. We have all the necessary key personnel to provide the full array of Medicaid covered services. Can the Health Plans say the same? People not seeking services equates to profits for the Health Plan, funding is not treated the same. The Health Plans are responsible for the inadequate provider network that exists for behavioral health services for those individuals not seen by the CMHSP. 67% of individuals with a behavioral health issue do not get treatment in a given year, primary care are not comfortable dealing with individuals that are SMI and the various drug protocals.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?
No changes from current system

Would this model affect the administration of complaints, grievances, and appeals?
No changes to current system

How would the model support continued access for individuals to current services, supports, and providers?
No changes to current system

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?
Through the same current system that exists with local authorities and a board of directors.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?
Through the person centered planning process which would now be expanded through to their phsyical health as well. Implementation of an integrated electronic medical record system is crucial to this process.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?
Working though the details of how the HMO's with contract with Behavioral Health organizations to manage the physical health of the population served by community mental health.

What changes would need to be made to provider reimbursement in order to implement the model?
None- it would still be a managed care format- which has proven to provide savings

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
Incentives are what is missing from the CMHSP system. The only incentive currently is to help all of those that fit our priority population. Where HMO's have incentivized their position into profits, roughly 1.3 billion from 2 011- 2015 (Source Crains Detroit) As a tax payer I find that number to be very distubing. CMHSP excessive funds are reinvested in the system, as they should be. HMO's and Health Insurers need heavier regulations. Our tax dollars are not intended to be profits for large "non profit" companies. Value based incentives as currently designed should expand to fully incorporate realistic and necessary levels of integration based on volume and utilization. (ie. Smaller rural areas may not warrant level five integration per SAMHSA 's "Five Levels of Collaboration".

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?
One organization would be responsible for collecting and reporting data, which would make collecting of information and thus measuring success more accurate. Value based incentives as currently designed should expand to fully incorporate realistic and necessary levels of integration based on volume and utilization. In addition indicators of timeliness and satisfaction will continue to be utilized as measurements of value based outcomes.

Define “success” for the model? How will the model’s success be measured? What types of benchmarks would be appropriate for evaluating the model?

Success would mean creating ease and access to services for the indivudals CMHSP's serve relating to both mental and physical health, while not duplicating service and reducing expense. Meeting the needs of all people served in a holistic and timely manner. Benchmarks of success will continue to include; measures of satisfaction, timeliness and efficiency. In addition, we will include measures to assess integration efforts via; documentation of collaboration and follow up for individuals identified with a medical diagnosis in addition to SMI/IDD/SED diagnoses.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Yes, similar to the way the MHL project was piloted, in a few regions. Although, we should carefully evaluate the results of these pilot programs before going further. Why have we not examined the results the the MI Health Link project. Have people had better coordination of care, has there been financial savings? Or are there just more individuals involved complicating the process with unncessary personal care studies, unnecessary follow up calls, etc.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

Yes, I would propose implementation after careful analysis of pilot projects.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

No- it is the same system just expanded duties

(Optional) Are you aware of any other states or communities which have implemented this model?

Similar models have occurred in states in pilot projects

Resources: http://www.integratedcareresourcecenter.com/pdfs/ICRC_BH_Briefing_document_1006.pdf http://aims.uw.edu/resource-library/collaborative-care-implementation-guide; http://www.integration.samhsa.gov/resource/four-quadrant-model; http://www.integration.samhsa.gov/integrated-care-models/list; https://www.milbank.org/wp-content/uploads/2016/05/Evolving-Models-of-BHI-Exec-Sum.pdf; http://www.crainsdetroit.com/article/20160727/NEWS/160729869/michigan-health-insurers-post-record-profits-in-2015

Model #17

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model:
Person-Centered System of Care

Name of Submitting Organization:
Truscott Rossman

Model Partner Organization(s):
To be determined by interested participants in the pilot demonstration

Section II: Model Description

The Person-Centered- System-of-Care Model (PCSC), ensures that the person served maintains a choice of service provider and service portability regardless of where he or she lives. The PCSC model reduces the number of administrative entities by 90%, by reducing the number of PIHP's from 10 to 1 and allowing the remaining PIHP to contract with provider groups directly. The remaining PIHP would function as a statewide Managed Care Organization (MCO) and would contract with individual service providers or Accountable Risk Entities (ARE) located in a specific geographic area or statewide. The Statewide PIHP (MCO) would also have the ability to delegate Behavioral Health MCO functions to health plans to align the overall healthcare needs of the individual served. The PCSC model aligns with the values and recommendations of the 298 workgroup. Please see the attached presentation of the PCSC model for a more in-depth description.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

This pilot demonstrates the benefits of continuity of care regardless of the assessed severity of the diagnosis. Accordingly, the pilot will affect the following populations:

- Mentally ill regardless of level of care including mild/moderate and severe/persistent
- Intellectually and Developmentally Disabled
- Substance Use Disorders

This model is predicated on continuity of care and meaningful full integration of care and does not exclude any populations.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

All Medicaid-funded behavioral health services and supports as prescribed in the Michigan Medicaid Provider Manual would be incorporated in the implementation of the model including:

- 1915(b) services for mental health - substance abuse
- 1915(b)(3) specialty supports and services
- 1915(C) home and community based services for persons with developmental disabilities
- Autism services

- Healthy Michigan Plan services
- SUD Community grant services
- MIChild services

The Medicaid behavioral health services and supports referenced above would be coordinated and funded through a per member per month capitated payment arrangement administered by the single statewide PIHP via the Comprehensive Health Care Program Contract.

While the aforementioned lists include the scope of all Medicaid-funded behavioral health services and supports and populations for this pilot, the efficacy of this pilot can be demonstrated through and would be flexible to consider the inclusion of any combination of services, supports, and/or populations.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

Individuals will be able to select from a list of Accountable Risk Entities (ARE's) under contract with the MCO. The ARE's will be located in a specific geographical area or statewide. Individuals will utilize the Person-Center-Planning process to determine medically necessary services as described in the Medicaid Provider Manual. Services will be delivered by the providers that are part of the ARE or if Self-Determination is utilized, by providers selected by the individual served who then be paneled by the ARE.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

This model enhances the coordination of physical health and behavioral health services and supports for the individual by bringing the administration of physical and behavioral health together through a single care coordinator. This model enables the ability to manage the full scope of a member's health care needs.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

This model promotes greater collaboration amongst providers, service agencies, and payers at the service delivery level by requiring the sharing of data and information. This model eliminates the bifurcation that impedes coordination in the present system. In this proposed model the care manager connects with the provider, service agency, payer, and the person served.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

This model allows for better availability, accessibility, and uniformity by making the behavioral health benefits portable across the state for all beneficiaries through elimination of the barriers that exist in today's system when crossing county lines. By coordinating the physical and behavioral health care through the PIHP (MCO) the beneficiary has a portable benefit and is no longer restricted or owned by a geographical entity.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

This model strengthens the workforce supporting the delivery of high-quality services and supports by eliminating administrative costs enabling more resources to be directed to the point of service provision. This model allows for funding currently swallowed in administrative layers to go to increased compensation for direct care providers.

This model was developed to align with the overarching findings of the MDHHS 298 Workgroup and support the core values that were adopted as a precursor to this initiative. At a high-level, this model is designed to ensure that integration occurs at the level of the person needing treatment or services, i.e., deliver services when and where they are needed and provide care coordination accordingly.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

This model empowers individuals to make decisions about services delivery through a better understanding of the relationship between behavioral and physical health with the consult of a single care manager backed by physical and behavioral health teams. At the heart of this model is the person-centered plan, self-determination, and choice ensured by a value-based contract with an expert behavioral health partner working closely with the beneficiary and, where appropriate, their legal guardian.

Would this model affect the administration of complaints, grievances, and appeals?

This model affects complaints, grievances, and appeals by eliminating the conflicts that exist in the current system where the CMH acts as both funder, provider, and administrator in many regions. This model moves complaints, grievances, and appeals to either the PIHP level or a newly created organization at the state level. This model brings uniformity and consistency to recipient rights statewide.

How would the model support continued access for individuals to current services, supports, and providers?

This model supports continued access by demanding value-based contracting with behavioral health providers held to metrics that will demonstrate improved behavioral and physical health outcomes for the population served. These improved outcomes will be demonstrated to the department and the Legislature.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

Governance is streamlined in this model through the reimbursement contract between the department and the PIHP (MCO). Transparency is improved and accountability increased by removing the additional administrative layers that do not add value to the

services provided in the present system. The proposed model will utilize value-based contracts with improved outcome metrics reported back to the department and the Legislature. Governance would be publically appointed and include consumers and consumer family members. Suggested governance would include, nine members (three each appointed by Governor, MDHHS Director, Legislature) with at least three of these being consumers or family members.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

The individual served is at the center of the decision-making process via Person-Centered Planning and Self-Determination. The PCSC model empowers individuals served and their families the full authority to select the types of services and providers that meet their needs. Also, individuals and their families will be actively engaged in decision-making via the local needs assessment requirements of the PIHP, participation in satisfaction surveys and membership on ARE Consumer and Family Advisory Boards.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

This model would require a single contract between the State (MDHHS) and the single PIHP (MCO). The PIHP would then have sub-contracts with both Health Plans and ARE's.

What changes would need to be made to provider reimbursement in order to implement the model?

None, Payments would just come from 1 PIHP instead of 10 PIHPs and 46 CMHSPs, this would instantly create common contracts, rates, and value-based metrics.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

This model utilizes value-based payments at the provider level through a fee schedule developed by the PIHP (MCO).

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

The quality of services will be measured through outcome metrics developed in partnership with MDHHS, PIHP, AREs, and Health Plans. This model will demand improved physical and behavioral health outcomes utilizing consistent metrics allowing for comparison within Michigan and against other states. This model recommends the behavioral health outcomes be measured utilizing HEDIS and the National Behavioral Health Quality Framework developed by the Substance Abuse and Mental Health Services Administration. Continuous improvement is ensured through mandated improved outcomes in subsequent contracts with the MCO and provider.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

Success for the model will be demonstrated by better health outcomes as demonstrated by tangible improved outcomes in both HEDIS measures and the National Behavioral Health Quality Framework outcomes. Important benchmarks appropriate for evaluating the model will include assessment of co-morbid health conditions, reduction of re-hospitalizations, meeting goals of the individual served as prescribed in their person-centered plan.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

This model can be piloted. The suggested pilot is to demonstrate improved outcomes in a particular county before expanding regionally and then statewide.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

This model can be implemented statewide and is replicable by combining the existing 10 PIHP's into one entity and allowing the creation of AREs statewide.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

This model would require either a change to the mental health code, waivers, state plan amendment, or the definition of a Prepaid Inpatient Health Plan in the MDHHS appropriation bill.

(Optional) Are you aware of any other states or communities which have implemented this model?

More and more states are carving behavioral health services into existing managed care plans. Recent states that have made this move include Louisiana, Washington, and Nebraska.

Model #18

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Integrated Care Coordination Model

Name of Submitting Organization: Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS)

Model Partner Organization(s): Coordinating Care Integrator (TBD)

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

Section 298 of the Governor's Fiscal Year 2017 Executive Budget Recommendations put forward the following: ...transfer the service funds appropriated in part 1 currently provided to PIHPs through the Medicaid mental health services, Medicaid substance use disorder services, Healthy Michigan – behavioral health and Autism services lines to the Health plan services line by September 30, 2017. To implement this change the department shall:a) Amend the contracts for the Medicaid health plans to include responsibility for covering the full array of specialty services and supports for eligible Medicaid beneficiaries with a serious mental illness, developmental disability, serious emotional disturbance, or substance use disorder upon completion of a plan to integrate these specialty services and supports in to the comprehensive health plan contract.This language recommends the "carve-in" of the behavioral health and intellectual-disability benefit from the Community Mental Health Services Program (CMHSP)/Prepaid Inpatient Health Plans (PIHPs) to the management of Medicaid Health Plans (MHPs). The recommendation adds the following provision:(2) The contract amendment described in (1) shall require Medicaid health plans to contract with the existing CMHSPs for the provision of specialty services and supports.This suggests that the real intent of the Original Section 298 Budget Recommendation was to preserve the public CMHSP system, but replace the CMHSP designated Prepaid Inpatient Health Plans (PIHPs) with Medicaid Health Plans. There are three (3) CMHSPs that MDHHS permitted to maintain dual roles as CMHSPs and PIHPs (Oakland, Macomb, and Detroit-Wayne CMHSPs). For the balance of the state, MDHHS required the remaining 43 CMHSPs to create ten (10) new regional entities to serve as regional PIHPs. It is estimated that the PIHP administrative costs, separate from CMHSPs, are $200 million annually. We support the 70 recommendations put forward in the 298 Facilitation Workgroup Interim Report, which includes the preservation of the public community mental health system and opposes the Original Section 298 Executive Budget recommendation to "carve-in" the Managed Medicaid Behavioral and Intellectual-Developmental Disability Specialty Supports and Services Program under the management of Medicaid Health Plans (MHPs). Notwithstanding our opposition to a "carve-in," we support the direction the state is taking to achieve greater coordination, integration, and alignment of behavioral health and intellectual-developmental disability specialty supports and services with physical health care. To achieve this goal, however, we believe the MDHHS needs to pursue alternative and more viable ways for not only reshaping the public community mental health system, but restructuring the Managed Medicaid Specialty Supports and Services Program. Included in our final comments and recommendations to the Section 298 Facilitation Workgroup, we pointed out a very important component of the Original Section 298 recommendation that was overlooked during the Workgroup's deliberations – a plan that should be reframed and reconsidered as a viable alternative to the recommended "carve-in" and a way to restructure the Managed Medicaid Specialty Supports and Services Program. The component of Section 298 that we are referring to is provided below:(1) The department shall…(c) Contract with an administrative service organization to provide oversight of the Medicaid health plans and the CMHSPs and ensure continuity of care for the served populations. This

organization would be responsible for, at a minimum, conducting analytics on claims from the Medicaid health plans and CMHSPs, reducing duplicative administrative functions at the CMHSP and the service delivery level, and advising state on performance outliers and population health status. The department may issue a request for information to identify potential administrative service organizations. The department is authorized to conduct a competitive direct solicitation to procure services in accordance with state procurement policy.We urge MDHHS to consider contracting with a single statewide "Integrator" to replace the ten (10) Prepaid Inpatient Health Plans (PIHPs). According to Donald Berwick, "the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Preconditions for this include the enrollment of an identified population, a commitment to universality for its members, and the existence of an organization (an "integrator") that accepts responsibility for all three aims for that population. The integrator's role includes at least five components: partnership with individuals and families, redesign of primary care, population health management, financial management, and macro system integration… An "integrator" is an entity that accepts responsibility for all three components of the Triple Aim for a specified population. Importantly, by definition, an integrator cannot exclude members or subgroups of the population for which it is responsible. The simplest such form, such as Kaiser Permanente, has fully integrated financing and either full ownership of or exclusive relationships with delivery structures, and is able to use those structures to good advantage. The statewide "Integrator" can be an entity that serves as a statewide Administrative Service Organization (ASO), as described in the Original Section 298 recommendation, with minor changes as follows: The department shall…(c) Contract with an administrative service organization to provide oversight of the CMHSPs and ensure continuity of care for the served populations. This organization would be responsible for, at a minimum, conducting analytics on claims from the CMHSPs, reducing duplicative administrative functions at the CMHSP and the service delivery level, and advising state on performance outliers and population health status. The department may issue a request for information to identify potential administrative service organizations. The department is authorized to conduct a competitive direct solicitation to procure services in accordance with state procurement policy.We believe a statewide "Integrator" should be selected through an open and competitive procurement process and placed directly under contract with the MDDHS. This statewide "Integrator" would be considered the "right arm" of the Behavioral Health Developmental Disability Administration within the MDHHS, whose primary responsibility would be to enter into relational contracts with each of the existing CMHSPs in the state. This purpose of this statewide "Integrator" is to efficiently carry out statewide integrative health management functions outlined below:• Design, oversee, and enforce contractual requirements with Medicaid Health Plans (MHPs) and Community Mental Health Services Programs (CMHSPs) established for the purposes of integrating, aligning, and coordinating behavioral health and developmental disability specialty supports and services with physical health care;• Conduct analytics on claims and quality performance measures from MHPs and CMHSPs;• Reduce duplicative administrative functions at the CMHSP and service delivery level;• Assume population-based risk;• Analyze and advise MDHHS on performance outliers and population health status; • Assist MHPs and CMHSPs in creating effective locally based integrated health networks and contracts; • Administer prepaid capitation payment systems to CMHSPs; and• Monitor, track, measure performance of CMHSPs and integrative health collaborations and initiatives.The statewide "Integrator" could also be a Health Plan, Insurer, or Prepaid Inpatient Health Plan. It is imperative, however, that the organization selected would possess the necessary management infrastructure and years of experience to manage statewide managed care administrative functions. It would be a grave mistake to waste precious and limited resources, and time in selecting organizations that will have to build these capabilities from the ground up to meet expectations. The statewide "Integrator" should be a publicly created entity or private non-profit organization that has a single

statewide governing board composed of consumers, advocates, providers and other stakeholders, similar to the composition of the Original 298 Workgroup. This would provide statewide oversight of Behavioral health and Intellectual-Developmental Disability specialty supports and services delivered by CMHSPs, and make policy recommendations for the improvement of integrative health collaborations and alignments between Medicaid Health Plans and CMHSPs. This would also permit individual CMHSP Boards to return to their statutory responsibilities, without outside interference, governess over their geographically designated CMHSPs in accordance with Chapter 3 of the Michigan Mental Health Code. This will also eliminate conflict of interest concerns that are currently present between members appointed to PIHP Regional Entity Boards and participating CMHSP Boards. Please refer to Attachment 1 for a diagram of the Proposed Behavioral Health and Intellectual and Developmental Disability Specialty Services System.The proposed Integrated Care Coordination model that we are proposing to the 298 Facilitation Workgroup is designed to test this alternative, which is to establish a single "Integrator" (hereinafter referred to as a Coordinating Care Integrator) that will enter into a relational and collaborative contract with a CMHSP to create a more effective, efficient, and futuristic Managed Behavioral Health and Intellectual-Developmental Disability Specialty Services System. We firmly believe this model, which is proposed to be piloted in Kalamazoo County, can and should be replicated statewide to achieve the goals of greater alignment and integration of physical and behavioral health and intellectual-developmental disability specialty supports and services. Our Integrated Care Coordination Model demonstrates a collaborative system of care model between a Coordinating Care Integrator and a CMHSP designed to improve the coordination of physical health and behavioral health and intellectual-developmental disability specialty supports and services. The overarching goal and purpose of this model is for the Coordinating Care Integrator to work together with Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) to identify shared enrollees with physical and behavioral health needs, jointly develop and implement processes to manage their care, eliminate inefficiencies and improve health outcomes. The result? An individual that receives the right care at the right time regardless of funding source, improved health outcomes, access to care and a system that provides relevant health information to care providers and shared enrollees. The current split healthcare system is difficult for individuals and providers to navigate. These two organizations will collaborate to create a system that allows coordination creating more integrated care for the individual. It is designed to bridge the coordination gaps and de-fragment the healthcare system complexity that exists for individuals and providers while supporting the person-centered planning process which is at the heart of supporting individual choice and control. (1) The Integrated Care Coordination model is a collaborative model between KCMHSAS and the Coordinating Care Integrator is designed to assist individuals and families in navigating the often complicated system of healthcare and to promote care coordination and integration between behavioral health and physical health treatment providers. The model identifies KCMHSAS as the Coordinating Care Integrator's preferred provider for mild/moderate outpatient services to support seamless and integrated care and improve access to specialized behavioral health services for the Coordinating Care Integrator's enrollees. The Coordinating Care Integrator will work with KCMHSAS to identify and stratify high-risk cases including established processes, standards, shared care plans and quality metrics. The Coordinating Care Integrator and KCMHSAS will actively educate and engage both individuals and providers regarding system-level care coordination. The model includes a team of care management staff from both KCMHSAS and Priority Health that assists individuals in making and keeping appointments with their healthcare providers, providing appropriate referrals and understanding their benefits. Individuals also have the opportunity to work with a Peer Support Specialist who can provide outreach, support, encouragement, and basic health coaching. The Peer Support Specialist has the flexibility to meet with individuals in their home as well as attend appointments. The model is intended to support the individual and their current treatment providers, coordinate services (as needed) and enhance services and

supports to ensure individuals are receiving the right care at the right time regardless of funding source. (2) The Coordinating Care Integrator, which is a Medicaid Health Plan, and KCMHSAS, a Community Mental Health Services Program will jointly administer, manage and monitor the model. (2.1) The Coordinating Care Integrator is a not-for-profit, integrated healthcare system and is nationally recognized for improving the health and lives of the people it serves. It continues to lead the industry in engaging members in their health, delivering effective health and disease management programs and working with physicians to improve health care outcomes and performance. (2.2) Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) is a county created Community Mental Health Services Program Authority serving Kalamazoo County that has been delivering services for over thirty (30) years. Their vision states, "We provide a welcoming and diverse community partnership which collaborates and shares effective resources that support individuals and families to be successful through all life phases." KCMHSAS promotes and provides mental health, developmental disability and substance use resources that empower people to succeed. KCMHSAS is guided by the following values: community, competence, diversity, effectiveness, integrity, leadership, recovery & self-determination, respect, responsibility, teamwork and trust. In addition to providing crisis and emergency mental health services 24 hours, seven days a week, KCMHSAS provides the following specialty supports and services: Supports Coordination and Case Management, Individual and Group therapies, Psychiatry, Family Education and Support, Supported Employment, Skill Building Assistance, Enhanced/ Supportive Healthcare Services, Respite Services for Children and Youth, Home-Based and In-School Services for Children and Youth, Wraparound Services for Children and Youth, Recovery Mental Health Court, and Juvenile Justice Mental Health Services. (3) The model proposal was developed to improve collaboration and information sharing between the Coordinating Care Integrator and KCMHSAS to identify shared enrollees, jointly develop and implement processes to manage their care, eliminate inefficiencies, improve health outcomes and implement a care model that extends beyond the traditional organizational silos requiring coordination. It was developed to align with, and strongly support, the core values and recommendations included in the interim 298 report. Specifically, the model was developed with the following goals; (a) Increase access to behavioral health services and physical health services (primary care), (b) decrease health care costs, (c) provide the right care at the right time regardless of funding source (d) increase engagement and self-management skills (e) increase coordination with treatment providers and provide information to the individual to make informed decisions regarding overall healthcare and (f) develop a coordinated care plan that focuses on communication, collaboration and coordination between the provider team on behalf of the individual. The coordinated care plan will include, but is not limited to, the following care management activities; (e.1.) assistance with ways to navigate the health care system and receive health care services, (e.2.) coordination of benefits with the Medicaid Health Plan Care Manager, (e.3.) communication and coordination between KCMHSAS providers, Medicaid Health Plan providers and primary care providers on behalf of the individual, (e.4.) patient education and self-management skills for individuals, (e.5.) recommendations for community resources to enhance health and wellness and (e.6.) other needs or barriers the individual faces that may impact their ability to access or engage in healthcare. The coordinated care plan is not a replacement for the person-centered plan. It is designed to bridge the coordination gaps and de-fragment the healthcare system complexity that exists for consumers and the provider team while supporting the person-centered planning process which is at the heart of supporting individual choice and control. (4) KCMHSAS and the Coordinating Care Integrator have committed to implementing this model and will be seeking grant funding to support implementation. It is anticipated that the initial cost of the model will be supported by grant funding, applicable fee for service billing and investment from both entities. Ongoing financing and payment mechanisms will be based on anticipated shared savings from both the primary care and behavioral health sides. (5) KCMHSAS, a county created Community Mental Health Services

Program Authority serving Kalamazoo County, and the Coordinating Care Integrator, a non-profit integrated healthcare system, will jointly administer, manage and monitor the model. The model is based on real time sharing of claims and clinical data which promotes transparency and accountability of publicly funded physical and behavioral health care provided through the Medicaid health plan and KCMHSAS both of which are competent public bodies.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
The model ensures access to integrated care for all age groups and populations. It is an innovative and cost-effective model that coordinates care, services and community resources in ways that promote the physical and behavioral health of the Coordinating Care Integrator and KCMHSAS joint enrollees. The model identifies KCMHSAS as the Coordinating Care Integrator's preferred provider for mild/moderate outpatient services to support access to the Integrated Care Coordination model and additional Specialty Medicaid Services and Supports when clinically appropriate. This is a system level approach therefore it is not anticipated that any populations would be excluded from the model.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
This model incorporates the full continuum of Medicaid services and supports identified under the specialty Medicaid benefit as well as the mild/moderate outpatient benefit. The model embeds a masters-level care manager and a peer support specialist at KCMHSAS to provide care coordination for shared individuals. The coordinated care plan developed in this model is not a replacement for the Person Centered Plan or any other treatment documents developed and managed between an individual and provider. The Integrated Care Coordination team will not replace targeted case management or other services provided through the KCMHSAS system of care, and it will not provide physical health interventions. The coordinated care plan is a wrap-around plan that focuses on communication, coordination, and collaboration between the provider team on behalf of the individual. This model is intended to support all treatment providers by facilitating care coordination, real-time information sharing and shared treatment planning to aid individuals in meeting their goals and improving their overall health.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?
This model continues to support individual choice in services and providers currently offered through the Coordinating Care Integrator and KCMHSAS. The system level care management elements of this model will be implemented based on a Business Associate Agreement between the two parties allowing communication to coordinate benefits and services for shared consumers. KCMHSAS will identify individuals through this system level care management model who are in need of enhanced care coordination services and will offer them the opportunity to participate. If an individual chooses not to receive the additional supports, access to clinically appropriate services and current person-centered plan will not be disrupted or changed. Although a care manager would be hired specifically for the model, there will be others employed by KCMHSAS that could meet program needs and work with an individual should this be needed or requested by the individual. This model offers an opportunity for enhanced care coordination, physical and behavioral health integration and collaboration among behavioral health and

physical health treatment providers. The model is not intended to replace existing providers and/or services but to support the individual and their current treatment providers to ensure integrated care that treats the whole person.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
A high percentage of Medicaid and dual eligible enrollees have complex behavioral and physical health needs. Individuals may receive care from two different entities that may not effectively communicate or work together to ensure appropriate care. The individual is often placed "in the middle" and responsible for navigating the two systems on his/her own even though his/her health needs are inter-connected. The Coordinating Care Integrator and KCMHSAS have expertise and experience in providing and coordinating integrated healthcare services including strong relationships with primary care providers, co-located primary care services at key sites, wellness and prevention services, and other targeted projects enhancing primary care's capacity to manage behavioral health conditions. The overarching goal and purpose of this model is for the Coordinating Care Integrator to work closely with KCMHSAS to identify shared enrollees with physical and behavioral health needs, jointly develop and implement processes to manage their care, eliminate inefficiencies and improve health outcomes. The model will include, but is not limited to, the following care management activities; (1) assistance with navigating the health care system, (2) coordination of benefits with the Medicaid Health Plan Care Manager, (3) communication and coordination between KCMHSAS providers, Medicaid Health Plan providers and primary care providers on behalf of the individual, (4) patient education and self-management skills for individuals, (5) recommendations for community resources to enhance health and wellness, (6), opportunities to participate in enhanced health services through Priority Health such as the Depression and Disease Management program, the on-line Cognitive Behavioral Therapy tool and other targeted programs that enhance primary care's capability to manage behavioral health conditions, (7) other needs or barriers the individual faces that may impact their ability to access or engage in healthcare, (8) primary care provider education and support to manage behavioral health concerns, (9) and real time claims and clinical data sharing.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?
The Coordinating Care Integrator and KCMHSAS recognize that better health care outcomes will be achieved for Kalamazoo County residents through the development of an improved collaborative system of care between the aforementioned organizations. The improved collaborative system of care is three pronged and includes integrated physical & behavioral health (1) funding, (2) care coordination and (3) service delivery. The Coordinating Care Integrator supports developing a collaborative model to identify high risk mutually served individuals, creating a defined process for coordinated care management and ensuring an integrated care model for service delivery. The model will promote access to specialized behavioral health services for individuals and service coordination between the individuals' primary care providers, specialty providers, KCMHSAS and the Coordinating Care Integrator's system of care. This model is intended to support all treatment providers by facilitating care coordination, real-time information sharing, shared coordinated care planning to aid individuals in meeting their goals, access to additional consumer supports for mild/moderate population. Additional supports for the mild/moderate population include but are not limited to peer support specialist services, access to Children's Health Access Program (CHAP), and timely transfer to additional specialty Medicaid

services including behavioral health services targeted at addressing different co-morbidities (such as the Whole Health Initiative program) when clinical appropriate. The model includes development of a coordinated care plan with the individual and the individual's healthcare team, which is periodically updated based on shared information between KCMHSAS, the healthcare team and the Medicaid Health plan. A care conference may be requested at any point to assist with resolution of issues that are preventing successful progress. Care conferences will include all members of the individual's healthcare team, who agree and are able to attend, to discuss the individual's coordinated care plan.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?
This model will improve the availability, accessibility and uniformity of services and supports by (1) breaking down the barriers associated with the split Medicaid health benefit (including medications), and (2) supporting all treatment providers by facilitating care coordination, real-time information sharing and shared care planning to aid individuals in meeting their goals and improving their overall health. The model proposal was developed to improve collaboration and information sharing between the Coordinating Care Integrator and KCMHSAS to identify shared enrollees, jointly develop and implement processes to manage their care, eliminate inefficiencies, improve health outcomes and implement a care model that extends beyond the traditional organizational silos. The use of predictive modeling including behavioral health diagnosis, co-morbid health conditions and behavioral health and physical health care utilization will allow Priority Health and KCMHSAS to jointly identify shared enrollees appropriate for the care coordination program. Further, system-level analysis may support preventive outreach and access to individuals appropriate for mild to moderate outpatient services including timely access to psychiatric treatment. Individuals will have a team from both KCMHSAS and the Coordinating Care Integrator helping them schedule and keep appointments with their physical health doctors, provide appropriate referrals including psychiatric evaluations as indicated and understand their benefits. Individuals also have the opportunity to work with a Peer Support Specialist who can provide outreach, support, encouragement, and basic health coaching. The Peer Support Specialist has the flexibility to meet with individuals in their home as well as attend appointments. As noted previously, the coordinated care plan is not a replacement for the Person Centered Plan. It is designed to bridge the coordination gaps and de-fragment the healthcare system complexity that exists for consumers and the provider team while supporting the person-centered planning process which is at the heart of supporting individual choice and control. The Integrated Care Coordination team will not replace targeted case management or other services provided through the KCMHSAS system of care, and it will not provide physical health interventions.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
The Coordinating Care Integrator and KCMHSAS will actively educate clinicians, peer support specialists, KCMHSAS staff and providers in key concepts of system level care coordination. Marketing and training materials including a co-branded brochure will be developed for use by the Coordinating Care Integrator and KCMHSAS to introduce identified shared members to the model. Face-to-face meetings with large primary

care offices will be arranged to introduce the model and request support in improving members' access to primary care services. The Coordinating Care Integrator and KCMHSAS will partner to present seminars on "Coordinating Care with a Medicaid Health Plan." These CEU-eligible seminars will be attended by behavioral health case managers and providers in Kalamazoo County.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

This model empowers individuals to make informed decisions about their healthcare by providing information on the benefits of integrated care and available services and supports offered through the health plan and KCMHSAS; thus supporting the person-centered planning process which is at the heart of supporting individual choice and control. The model addresses the unmet needs of the individual through the following care coordination activities: (1) assistance with ways to navigate the health care system and receive health services, (2) coordination of benefits with the Medicaid Health Plan, (3) communication and coordination between KCMHSAS providers, Medicaid Health Plan providers and primary care providers on behalf of the individual, (4) patient education and self-management skills for individuals, (5) recommend community resources to enhance health and wellness and (6) other needs or barriers the individual faces that may impact their ability to access or engage in healthcare. The implemented coordinated care plan supports the Person-Centered Plan and any other treatment documents developed and managed between an individual and provider.

Would this model affect the administration of complaints, grievances, and appeals?

This model would not affect the administration of complaints, grievances, or appeals. Education and information about grievance and appeals would be available.

How would the model support continued access for individuals to current services, supports, and providers?

This model, once implemented, is not intended to replace existing providers and/or services but to support the individual and their current treatment providers. The implemented coordinated care plan is not a replacement for the Person Centered Plan or any other treatment documents developed and managed between an individual and provider. The coordinated care plan is a wrap-around plan that focuses on communication, coordination, and collaboration between the provider team on behalf of the individual. This plan is designed to bridge the coordination gaps and de-fragment the healthcare system complexity that exists for individuals and the provider team. The model identifies KCMHSAS as the Coordinating Care Integrator's preferred provider for mild/moderate outpatient services to support seamless and integrated care and improve access to specialized behavioral health services for the Coordinating Care Integrator's enrollees. The individual and provider would not have to navigate multiple systems of care rather the model would be the hub of care, supports and service coordination.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

There would be no change in governance structure; however, there will be a shared implementation team between KCMHSAS and the Coordinating Care Integrator to jointly administer, manage and monitor the model. The model is based on real time sharing of claims and clinical data which promotes transparency and accountability of publicly funded physical and behavioral health care provided through the Medicaid health plan and KCMHSAS.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

Current mechanisms for engaging individuals, family members and other community members (such as KCMHSAS or the Coordinating Care Integrator Board membership, Customer Advisory Committee, etc.) will continue under this model including foundations of person-centered and family- centered planning and education as well as increased ability to make informed choices for individual care.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

No changes would need to be made to financing mechanisms for payers to implement the model.

What changes would need to be made to provider reimbursement in order to implement the model?

Changes would need to be made to provider reimbursement for mild/moderate services to cover the cost of care management for shared consumers. This could be managed through either a staffing grant, per member/per month, or an enhanced fee schedule from the Medicaid health plan.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

Incentives would not be used under this model.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

The plan for quality of service evaluation of the program is designed with metrics in financial and clinical domains. Quality indicators include; (1) reduced physical health costs through reduction in the utilization of high cost services evidenced via pre and post utilization and cost data, (2)

individuals will have better access to primary care and specialty behavioral health services as evidenced by an increased number of individuals with an identified primary care physician and behavioral health provider, (3) improve the follow-up after hospitalization for mental illness within 30 days measure as evidenced by utilization and claims data, (4) decrease avoidable Emergency Department utilization, (5) decrease number of avoidable behavioral health hospital admissions or readmissions and (6) improve medication adherence. Quality indicators as outlined will be periodically assessed and reviewed by the joint implementation team.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

Success of the model includes maintaining or reducing cost and improving clinical status/ utilization. The evaluation metrics designed to measure the model's success answer the following questions; (1) Is cost maintained or reduced (cost of intensive behavioral health services such as inpatient and crisis residential and cost of emergency department visits and/or admission to inpatient medical facilities) and (2) Is clinical status improving (comparison of intensive behavioral services utilization against utilization of less intensive services designed to maintain stability, comparison of high cost medical services utilization against utilization of outpatient and measurement of readmission to intensive behavioral or physical services)?

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Yes, this model could be piloted and will be piloted. KCMHSAS and the Coordinating Care Integrator have committed to implementing this model and will be seeking grant funding to support implementation. It is anticipated that the initial cost of the model will be supported by grant funding, applicable fee for service billing and investment from both entities. Ongoing financing and payment mechanisms will be based on anticipated shared savings from both the primary care and behavioral health sides. If approved, we are hoping that the MDHHS §1115 Demonstration waiver will provide funding flexibility to sustain this pilot. The Coordinating Care Integrator is committed to improving the health and lives of its members and has long-valued an integrated care management approach to address both the medical and behavioral health needs of its members. Both the Coordinating Care Integrator and KCMHSAS agree that higher quality service with better health outcomes will be achieved for individuals through the development of a collaborative system of care. Together, they have developed, and intend to implement, this proposal for a shared care management and coordination program whereby both entities will collaborate to provide effective health care services to residents of Kalamazoo County.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

Yes, this model can be replicated and implemented statewide. The Coordinating Care Integrator for our proposed pilot implemented a similar model in 2014 with another CMHSP in Michigan, which demonstrates successful efforts of a Medicaid Health Plan and a CMHSP to collaborate

and provide care management and coordination for shared enrollees with complex conditions. This model has proven that better health care outcomes are achieved when services from multiple systems of care are combined. The Coordinating Care Integrator has shown how a partnership with a CMHSP improves access to specialized behavioral health services for the Coordinating Care Integrator's enrollees and service coordination between physical health care providers and the public mental health system of care. The model identifies and stratifies high risk cases and includes established processes, standards, shared care plans and quality metrics all of which can be replicated through similar partnerships statewide. As mentioned earlier, we urge MDHHS to consider contracting with a single statewide "Integrator" to replace the ten (10) Prepaid Inpatient Health Plans (PIHPs). We believe a statewide "Integrator" should be selected through an open and competitive procurement process and placed directly under contract with the MDDHS. This statewide "Integrator" would be considered the "right arm" of the Behavioral Health Developmental Disability Administration within the MDHHS, whose primary responsibility would be to enter into relational contracts with each of the existing CMHSPs in the state. This purpose of this statewide "Integrator" is to efficiently carry out statewide integrative health management functions outlined below:• Design, oversee, and enforce contractual requirements with Medicaid Health Plans (MHPs) and Community Mental Health Services Programs (CMHSPs) established for the purposes of integrating, aligning, and coordinating behavioral health and developmental disability specialty supports and services with physical health care;• Conduct analytics on claims and quality performance measures from MHPs and CMHSPs;• Reduce duplicative administrative functions at the CMHSP and service delivery level;• Assume population-based risk;• Analyze and advise MDHHS on performance outliers and population health status;• Assist MHPs and CMHSPs in creating effective locally based integrated health networks and contracts; • Administer prepaid capitation payment systems to CMHSPs; and• Monitor, track, measure performance of CMHSPs and integrative health collaborations and initiatives.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

We are not aware of any changes that would need to be made to statutes, regulation, policies, or waivers in order to implement the model. The Coordinating Care Integrator developed a similar model in 2014 with another CMHSP in Michigan, which demonstrates successful implementation without any changes made to statutes, regulations, policies or waiver.

(Optional) Are you aware of any other states or communities which have implemented this model?

Another CMHSP in Michigan implemented a Care Coordination pilot between the Coordinating Care Integrator and the CMHSP in April 2014 that demonstrated successful efforts of a Medicaid Health Plan and a CMHSP to collaborate and provide care management and coordination for a targeted group of shared enrollees with complex conditions. This pilot provided proof that better health care outcomes are achieved when services from multiple systems of care are combined including cost-effectiveness and quality of care. This model demonstrates how partnerships between Medicaid Health Plans and CMHSPs improve access to specialized behavioral health services for the Coordinating Care Integrator's enrollees and service coordination between physical health care providers and the public behavioral health system of care. The model identifies and stratifies high risk cases and includes established processes, standards, shared care plans and quality metrics. The model proposed in this document expands the other CMHSP's Care Coordination pilot to include individuals with mild to moderate behavioral health needs.

Model #19

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Serving the needs of the Whole Person

Name of Submitting Organization: Michigan Association of Health Plans

Model Partner Organization(s): Medicaid Heatlh Plans and their contracting providers

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

The proposed model recommended is based on the Michigan Association of Health Plans's Board of Directors adopted policy on Integration that will focus on the integration of services at both the service and payment level. Integration must be: inclusive of the core values developed by consumer Stakeholder process as well as the core principles of person-centered planning; utilizes self-determination, and recovery orientation; and must assure continuity of care for consumers of behavioral services during any transition and avoidance of disruption of services and supports.

Because the anticipated services to be provided under this proposal would be all those currently provided under Medicaid contract with the PIHPs and would use either a new MDHHS Integrated Contract, or amended contracts currently in use that have been approved at the state and federal level, MAHP expects that Medicaid Health Plans will: Have fully contracted and credentialed behavioral health provider networks, implement innovative reimbursement models for value based contracts, assure that care coordination and quality incentives will be focused on supporting consumers living in the homes of choice and fully participating in their communities across their life-span. Financing for this model will be based on actuarial rates developed by the state actuary that anticipate the underlying policy and incentives that will be used in the state's contract with medicaid health plans. Medicaid Health Plans have demonstrated their competency and effectiveness over nearly two decades of contracting with MDHHS and are recognized nationally as among the best managed care companies in the United States. Medicaid Health Plans are licensed HMOs, domiciled in the State of Michigan, are regulated by the DIFS under authority granted in the state Insurance Code and required to have individual Governing Boards in compliance with state statute.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

All Medicaid eligible individuals would be affected by implementaion.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

As mentioned above, the model assumes that all current medicaid benefits, including supports services would be included within the expected benefit package to be provided to eligible beneficiaries.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

There would be choice of medicaid health plans (with the exception of places where CMS has approved a rural exemption to consumer choice) and within each health plan, choice of provider would be a core principle--as it has been over the past two decades. Because of the needs to assure continuity of care and avoid disruption, current care coordinators/managers would be used to the extent practicable and beneficiaries would always have the option of choosing other providers.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

Under this proposal, the overall accountability would be located in one organization. It is expected that overall improvement in coordination and assurance for sevices at the individual service level will be assured through effective contract management with performance measures and incentives that focuses on individual access and coordination of services.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

Because there would be a single contracting organization to serve the needs of the individual, each provider serving that individual will be aware of the continuum of services, providers and related programs intended to meet the needs of beneficiaries as well as a point of accountability. State oversight will be enhanced as the focus will be on performance--and not imposing complicated coordination requriements.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

One of the hallmarks of Medicaid Health Plans is the documentaion of service providers and data reporting on utilization of services. This would be extended to the benefits for behavioral services and providers and reporting to MDHHS on access will be an expected performance measure. Medicaid Health Plans already are experienced in implementing the pharmacy benefit and know which products are on the formulary, and which are exempt from prior authoritization due to state policy.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

Because the model would be inclusive of the entire Medicaid benefit, including behavioral services, the expectation would be that Medicaid Health Plans would contract with current and additional providers to guarantee access to services and exceed contractual network adequacy standards. Experience with other populations, (e.g. Children Special Health Care Services, Physically Disabled, pregnant women, foster care children) have demonstrated the capability of Medicaid health plans to effectively use "non-traditional" providers, take advantage of community health workers, and be receptive to other means of serving the needs of consumers. Procedurally, it would be expected that current arrangements and providers would be grandfathered for a discrete period of time to assure continuity and avoid disruption. It is expected that the model will result in greater access to consumers.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

Simlar to the experience of Medicaid Health Plans with choice of providers as a core value and the implementation of childrens special health care services that relies on individual care planning, the empowerment for individual choice will be a core element as experience has shown that such personal involvement results in better care and lower utilization of high cost services.

Would this model affect the administration of complaints, grievances, and appeals?

Medicaid Heatlh Plans already are experienced in the administration of formal complaint/grievance process under medicaid contracts. Further, enrollees of Medicaid Health Plans may seek adminisrative relief from the State's Insurance Commissioner (Director of Department of Financial and Insurance Services, DIFS) under the provisions of the State's Insurance Code and the Patient Right of Indepent Review Act (PRIRA) Under this process, DIFS will use an accredited independent review organization, IRO, to render decisions regarding benefits and any denial of benefits. The discussion within the Section 298 workgroup regarding an "informal" process to address complaints, etc. would be welcomed by Medicaid Health Plans, as that process would likely reduce the number of formal complaints and arrive at more expediant decisions.

How would the model support continued access for individuals to current services, supports, and providers?

Similar to all other inclusion of populations into Medicaid Managed care, the Contract between the State (MDHHS) and Medicaid Health Plans would likely require a transition period where existing arrangements and providers would be accepted by the Mediciad Health Plan to asssure no disruption and assure continuity of care. Such transition would generally be for a specific period of time or throughout a specific episode of care.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

Transparency is already required for Medicaid Heatlh Plans under both the State Contract and under the Insurance Code. Licensed HMO's are required to submit publically avaliable financial information, are perpetually open to inspection and audit by DIFS and MDHHS.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

Consumers would be involved at the board level--requirements for 1/3 board representation or process to assure consumer input via board established advisory committees would be one point of involvement. At the service level, commitment to person centered planning and care coordination would obviously involve individuals and their family.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

The monthly capitation rates paid to Medicaid Health Plans under this proposal would need to be developed for the integrated model. The use of actuarialy sound modeling that explictly identifies serivces to be included would be part of the financing.

What changes would need to be made to provider reimbursement in order to implement the model?

Medicaid Heatlh Plans would need to have contracted arrangements with providers--part of which is the agreed upon reimbursement between the Medicaid Health Plan and the provider. The use of incentive payments would likely be involved as well .

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

Incentives would be involved at two levels. First between the State and the Medicaid Health Plan to assure performance and accessibility of services--this incentive would likely be part of "capitiation withhold". Second, under contracts between providers and Medicaid Health Plans would be the use of incentive payments--tied to performance, access, and other measures that would be expectded.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

Medicaid Heatlh Plans are currently measured under a number of HEDIS and Encounter Data elements--third party audits, and external reviews. This would continue and be inclusive of services provided for behavioral benefit.

Define “success” for the model? How will the model’s success be measured? What types of benchmarks would be appropriate for evaluating the model?

Success would be measured, first by access. That is, improvements in access to care. Other measures would include utilization of inpatient and ER admissions, consumer satisfaction indicators and proxy measures.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Similar to other states, this propsoal could be "piloted" by region. That is, a phase-in approach could take place in those properity regions of the states that have demonstrated their readiness (by virtue of state readiness review) to implement the integrated benefit. The use of incentives by the State for "early adopters" would be a method to help facilitate such pilots.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

Phase in the proposal over a period of several years by prosperity region.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

The model proposal can be implemented without change on statute or regulation…..the Waivers governing the behavioral and comprehensive benefit may have to be revised or consolidated.

(Optional) Are you aware of any other states or communities which have implemented this model?

It would be useful to view the State of Washington's model as well as New York, Arizona.

Model #20

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
MODEL PROPOSAL TEMPLATE
SECTION 298 INITIATIVE

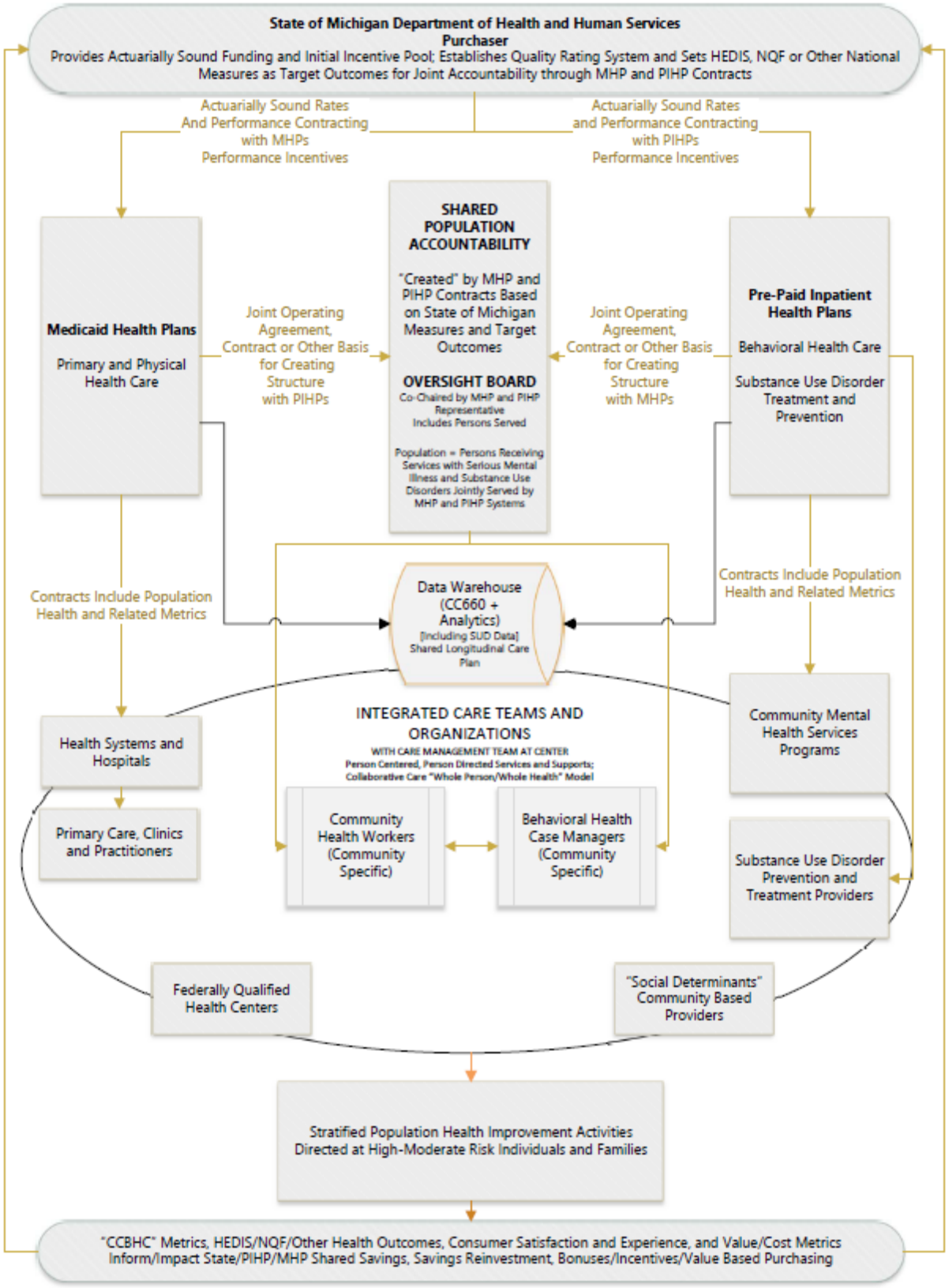
Section I: Model Name and Contact Information

Name of Model: *PAYER-LEVEL ACCOUNTABILITY FOR CARE COORDINATION STRUCTURAL MODEL*

Name of Submitting Organization: *MID-STATE HEALTH NETWORK*

Model Partner Organization(s): *State of Michigan, PIHPs, MHPs, FQHSs, CMHSPs, Substance Use Disorder (SUD) Providers, Health Systems and Hospitals, Primary Care Clinics and Practitioners, Community Based Social/Human Services Organizations*

PAYER-LEVEL ACCOUNTABILITY FOR CARE COORDINATION STRUCTURAL MODEL



Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

The proposed model is depicted on the accompanying graphic. The model calls for the State of Michigan, as Purchaser, to establish a Quality Rating System (as required by the recently finalized managed care "mega-rule") HEDIS, NQF and/or Other National Measures as Target Outcomes and contractually bind Pre-Paid Inpatient Health Plans (PIHPs) and Medicaid Health Plans (MHPs) to these measures as joint performance requirements via master contracts with each entity. This model calls for the State, as purchaser, to establish an initial incentive pool. The model calls for PIHPs and MHPs to forge joint agreements among and between the organizations to create systems and structures for shared population health accountability based on the performance requirements of the State of Michigan master contract. The proposed collaboration could be structured as a Qualified Service Organization for the purposes of sharing substance use disorder data and improving health outcomes for persons with substance use disorders. It is proposed that these contracts create an oversight board comprised of individuals receiving services and co-chaired by a MHP and a PIHP representative (elected/appointed from among the MHPs and PIHPs) and to include a State of Michigan representative, among others. The model proposes the use of Care Connect 360 (CC360) as the data sharing platform, with analytics software used by the various organizations to create a data warehouse that accomplishes risk stratification, establishes mutual access to care plans and informs integrated care team/organization activities at the "person-served" level. Integrated care teams are created by contributions of community health workers (by the MHPs) and Care Managers (PIHPs) that are accountable to each of their organizations but also to the Integrated Care Oversight Board. Integrated care teams engage with persons served on a stratified risk prioritization basis and with the myriad of community based physical healthcare, behavioral healthcare, substance abuse treatment, social services organizations, health systems and hospitals, and other community based organizations as a result of person-centered, family focused and youth guided, self-directed principles and processes. In the proposed model, each payer retains responsibility for paying for services it is contractually obligated to provide; each entity contributes proportional shares of resources to fund integrated care teams (or redeploys existing resources) with sustaining funding deriving from efficiencies/savings generated as a result of the model's implementation.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

The individuals in our State with the highest care coordination/integration needs are individuals living with substance use disorders and individuals living with mental illnesses. This group of people has also been historically under-served in primary care and tend to over-utilize acute care services. The proposed model is intended for individuals living with substance use disorders and mental illnesses (mild through severe) that are mutually served by the PIHPs and MHPs (enrolled and served; not eligibles). The model excludes individuals and families living with intellectual/developmental disorders with no presenting (or co-occurring) mental illness or substance use disorder. Individuals living with Intellectual/Developmental Disabilities would continue to be served through the PIHP system.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

The full array of Medicaid (and/or Healthy Michigan Plan [HMP]) covered supports and services would be available through this model; existing services and supports would not be affected. Implementation would also require the activation of care coordination HCPCS/CPT codes to PIHPs as are currently available to Federally Qualified Health Centers (FQHCs) and MHPs.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

The proposed model does not impact enrollment or choice of providers; the proposed model promotes choice of who and where care is coordinated; the proposed model promotes service access and coordination across community based service providers.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

The proposed model creates (or formalizes/enhances where they exist) community based care coordination teams and expands them to include community based organizations that address other social determinants of health. The proposed model promotes person centered, youth guided and family focused care planning and self-directed supports. Under the proposed model, PIHPs and MHPs can partner to help promote care integration through the development and implementation of common standards for providers, ensuring enabling technologies are in place (e.g., shared care plans, longitudinal care platforms, etc.) and that incentives alight to promote fidelity to the model and better care, experience and value outcomes.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

Mutual accountabilities for health outcomes, care experience and value propagated throughout the healthcare delivery system (inclusive of health and behavioral health) should focus providers on achieving performance objectives. The Care Team concept, implemented with person-centered planning and inclusive of community-based organizations addressing social determinants of health, should enhance and in many cases formalize partnerships in care delivery.

This model would be enhanced through the inclusion of community mental health services programs and substance use disorder treatment programs on Medicaid Health Plan provider network panels at rates that cover the cost of service.

This model protects and builds on the health integration structures and systems, including primary care services and pharmacy, that already in place at and through Michigan's Community Mental Health Services Programs.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

The proposed model is based on data sharing and care coordination focused on individuals with a high risk trajectory. Incentives are naturally aligned to improve outcomes through earlier intervention and prevention. The proposed model utilizes existing provider networks and expands them to include community based organizations as partners in care coordination. It is important to note that funding for community based social/human services organizations would continue through existing/traditional pathways but could be enhanced through future delivery system design changes engineered through the proposed model.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

While not specifically intended to strengthen the workforce, the proposed model should enhance the skill levels of workforce members through training and cross-training that will be necessary to properly implement a care team model. The model recognizes, incorporates and builds upon the strengths and availability of community health workers, peer supports providers and recovery coaches to serve individuals included in this model.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

No change to individual choice/decision-making regarding service delivery is anticipated. The model is centered on a care team concept based on person-centered, youth guided, family driven planning processes.

Would this model affect the administration of complaints, grievances, and appeals?

The model would function in a manner aligned with current complaint, grievance and appeal structures or any that may evolve.

How would the model support continued access for individuals to current services, supports, and providers?

No impact on the services, supports or providers for persons served is anticipated.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

Agreements between the PIHPs and MHPs envisioned as creating Shared Population Accountability would not change the governance model of the PIHPs or the MHPs. These agreements are proposed to create an Oversight Board (or Council) to oversee Statewide consistency and to monitor effectiveness/outcomes/efficiencies of care coordination/integration activities. The Oversight Board (or Council) could be composed of any number of members, but minimally would include representatives of each MHP and each PIHP, individuals representing the MDHHS (Behavioral Health and Developmental Disabilities Administration and the Medical Services Administration), persons served and other key stakeholders. The body is proposed to be co-chaired by a MHP and a PIHP representative. In the alternative, the body could be chaired or co-chaired by MDHHS representatives. It is proposed that the Oversight Board, while not a governance board per se, function in compliance with the Open Meetings Act and other public transparency statutes.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

This model proposes the inclusion of individuals, family members, community members and other stakeholders to participate as members of the Oversight Board (or Council) and to participate in meetings or the body as interested members of the public.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

The proposed model retains responsibility of the MHPs and the PIHPs to finance and pay for services for which they are contractually obligated through their contract(s) with MDHHS. The proposed model allows for pooled funding between the MHPs and the PIHPs to create structures and fund services, supports or activities directed to achieving improved health outcomes, better care experiences and better value. The proposed model is sustainable through savings and other efficiencies gained through the implementation of the model, which should be reinvested in to community networks, services, providers and provider systems focused on addressing social determinants of health.

What changes would need to be made to provider reimbursement in order to implement the model?

Barriers to pooled funds and shared savings in relation to PIHPs must be addressed prior to implementation. Barriers to the creation of incentives for public bodies (for example, Community Mental Health Services Programs) by PIHPs must also be addressed. Earned incentives must be able to be retained as local funds by PIHPs and CMHSPs.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

The model does not require incentives, but they are envisioned as a key strategy in motiving the delivery system to perform in ways that are desirable. Incentives would be aligned around health outcomes improvements, care experience improvements and value enhancement. Adverse selection is not an issue in this model as the proposed model is focused on all members of the service population living with mental illnesses or substance use disorders shared between the MHPs and PIHPs. Value Based Purchasing arrangements – already permitted under current system structures – would be expanded under this model to ensure alignment of outcomes and related service purchasing (payments/incentives) arrangements.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

The proposed pilot will identify a portfolio of measures that will align with national initiatives. The recently finalized "Managed Care Mega rule" also requires State-designed Quality Rating System (QRS). The QRS can easily fit within the structure proposed in this model. These metrics and QRS elements are proposed to be included in the contract by MDHHS with PIHPs and with MHPs. These measures include HEDIS, NQF, CCBHC or other quality and outcomes measures. Adoption of standardized measures will allow for comparison of performance with other plans and providers. Customer satisfaction measures should be standardized (Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys are an example) and should be utilized to measure engagement, support and service provision. Additional measures relevant to the care coordination activities could be developed and implemented by the Oversight Board.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

The primary success of the model will the achievement improvements in metrics established by MDHHS in its contracts with MHPs and PIHPs. The metrics are focused on the "Triple Aim goals of improved health, improved care experience(s), and better value.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Yes; the model could be piloted by one or more PIHPs and one or more MHPs.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

Yes; the model is designed in contemplation of Statewide implementation.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

Data sharing of substance use disorder information would need to be addressed. It is possible that the contracts between the PIHPs and the MHPs could be structured as Qualified Service Organizations under 42CFR2 but this issue requires further analysis and resolution. Care coordination codes available to the FQHCs and MHPs would need to be made available to the PIHPs. Financing to permit public bodies (PIHPs, CMHSPs) to retain earned incentives as local would be required, and barriers to implementation of incentives and shared savings, including reinvestment, would need to be addressed and resolved. Other statutory, regulatory or policy implementation issues would require further research and resolution.

(Optional) Are you aware of any other states or communities which have implemented this model?

This model is based in part on the structure of Hennepin Health and related work in Hennepin County, Minnesota and also on the Oregon Coordinated Care Organization (CCO) model.

Model #21

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: A New PCMH Partner: Behavioral Health

Name of Submitting Organization: Medical Network One

Model Partner Organization(s): Judson Center, Oakland Health Integrated Network, Oakland Family Services, Common Ground

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

Our overall project goal is to improve the health of individuals struggling with poorly controlled chronic health including mental health conditions. Medical Network One is recommending an innovative model which would be designed to bring together behavioral, chemical and physical health care for people with mental and substance use disorders, and serve as a "one-stop-shop" for both adults and children who have trouble getting the services they need. We will do this by developing an innovative, proactive, inter-professional care team that includes patients, families and their caregivers at the center, empowering them to set their own healthcare goals and implement self-management strategies that are culturally and personally relevant, leading to better outcomes. The care team will collaboratively and proactively address the myriad of factors that contribute to poorly controlled chronic conditions ,mental and substance use problems within our resource challenged patient population and support our patients as they develop more effective ways to manage their health. We will use grant funds to add chronic care wellness-coaches, pharmacists along with enhanced behavioral health services to our existing team of physicians, nurses, medical assistants, community health workers and behavioral health providers. Research shows that true inter-professional team care is difficult to achieve and that co-location alone usually fails to achieve desired effects. Thus, in addition to adding team members, we will allocate funding to support an experienced practice coach that is versed in collaborative care, team building, communication, and service delivery redesign. We will also utilize this coach to guide other primary care practices to expand Patient-Centered Medical Home capabilities with enhanced population management strategies, quality improvement processes and improved outcomes. An enhanced, proactive, interdisciplinary, patient-centered care team aligns with the goals for this initiative: increased access to a mental health specialist, improved service delivery by integrating behavioral health specialists in the PCMH and improved quality of care. Helping our patients stay healthier up front will be more cost effective and will free up time and resources to increase access and address the needs of more people. An expanded care team will also give our patients access to wellness services and supports that are currently unavailable to them. A clinic culture that systematically promotes wellness will improve the care that we deliver to our patients and have a positive impact on health outcomes. Additionally, substance use disorder services and mental health services should be integrated, and that programs to build trauma-informed care should be expanded. Michigan, under the direction of the MDHHS should reach out to physician/provider organizations to assist in implementing, spreading and sustaining the PCMH model that embraces whole person orientation.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

The Patient Centered Medical Home Model is all patient and all payer. No one would be excluded from having access to a behavioral health specialists integrated in the PCMH.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
Within the PCMH patients/clients would have access to a multi-disciplinary care team and community health workers with support provided by faciitators of various programs such as Diabetes Prevention, Diabetes Self Management Education, PATH, Matter of Balance within the practice. As need would be identified additional recources and services would be added. The PCMH has very specific criteria regardinbg access, coordination of care, and quality improvement activities to enhance HEDIS scores and other outcome driven metrics.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?
Patients/ clients will be able to opt-out of the services provided oin the PCMH. However, to enhance access and coordinationof care patients/clients will have the opportunity of receiving their care via telehealth tools. A visit in a practice could be replaced with a virtual which reduced barriers to receiving care and adds to the "feeling safe" factor of the patient/client and caregive.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
Medical Network One has a ten year history of integrating behavioral health into primary care practices. We monitor HEDIS scores of all our primary care physician members and practice coaches/community health workers engage in outreach efforts to ensure the patient/client receives not only prevention services but oversity that might be needed for chronic illness care including identified mental health conditions. In a PCMH model the practice team performs an environmental scan and establishes close relationships with not only physical health providers byt also with communty service agencies, behavioral health specialists so that a true team approach becomes not "best practice" but "common practice."

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?
Medical Network One is an early adapter of HIT. We monitor admissions, discharges and transfers via real time PINGS and provide IT solutions to our member physicians. Each practice (including two large behavioral health practices) utilize a patient registry in addition to other IT solutions. These solutions are available without cost to the physician and behavioral health specialist community. Once permissions are obtained fromn patients to share data the community of care givers is far more efficnet and effective when caring for their population.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

The health care provider who is ready and willing to weave real time technology into their daily workflow has better outcomes and is able to maintain a closer eye on their population. The PCMH model relies on team-based care. Medical Network One and their member health care professionals and teams monitor use of the information technology services. The teams that support the PCMH model and Medical Network One activities are coprissed of D-NPs, PA-Cs, PharmDs, RNs, MSWs, LMSWs, PhD Health Psychologists, RDs, CDEs, Health Coaches, Exercise Specialists and Practice Coaches. Patients/clients and facilies/caregivers have direct access to these teams. To ensure uniformity of delivery a playbook was designed for each new team member and practice mopving toward PCMH recognition. Ongoing traing and education of the teams is key to successful care coordination, communication and collaboration.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
Recruiting quality personnel for the work being done at Medical Network one and in the PCMH model is not simple. Resumes are scrutinized and the prospectice team member is not only interviewed by the HR team but also by the clinicql team he/she will work with. The prospectice hire is also interviewed by the practice team where they may be working. Culture, language and health literacy play a part n the hiring process. Medical Network One and the care team members have specific SMART goals that are outlined. Prior to beginning her/his employment, each candidate must complete various trainings based on a "onboarding check list" created the Medical Network one Leadership and Management Teams. Onboarding includes HIPAA, OSHA, CMS Fraud and Abuse, MAPS, EHR access/use, PatientPing, Patient Registryy, HEDIS, STARS, QI, Model for Improvement and software required to perform day to day activities. Each new hire completes a battery of training that focuses on care management/coorindation activites. Some of the topics: Motivational Interviewing, Self Management Training including Brief Action Planning, Evidence based Guidelines (MQIC), Model for Improvement, Group/Shared Visits, Communiocation Strategy, Team Care, Improvisation, and many more topics. These workshops have received international recognition through the IACET review and accreditation process. To enhance learning much focus is placed on role playing and improv. The workshops cascade similar to college course levels: 095 (just starting), 100 level, 200 level, 300 level and 500 level (reinforcement of knlwdge, skills and aptitude). The Care Teams also attend case reviews. The facilitators are behavioral health specialists, geriatricians, family physicians and others as needed.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

Shared-decision making is front and center in the PCMH model. Patients/clients are not "told what to do" but they engage in conversation with the care team members. Shared decision making is enhanced by Motivational Interviewing skills and both the Flinders Model of Conversation and PATH.

Would this model affect the administration of complaints, grievances, and appeals?

Key to the success of any program is a CG-CAHPS survey that provides the care teams with feedback. Additionally Medical Network One has a PhD health psychologist who, if needed, provides coaching to enhance skills of the care teams. The Patient Centered Medical Home model identifies that care is "patient-centered" and that there is access to an individual who can assist in reseqarching and resolving the complaint. The guidelines for this activity are specifically outlined in a PCMH Policy/Procedure Manual.

How would the model support continued access for individuals to current services, supports, and providers?

The PCMH model which embraces whole person care and integrated behavioral health focuses on enhanced access to care (24/7 coverage). That 24/7 access is bolstered by virtual care: telehealth. The patient/client, family/caregiver can now talk/see a member of the care team "virtually" and if there is a need for a clinical decision maker (ability to prescribe medication or provide more intensive care) an on/call specialist is available as well.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

Medical Network One relies on it Clincal Integration Network (CLIN) which includes psychiatry, psychology, and MSW. The CLIN includes specialists who are trained in health care delivery for the pediatric, adolescent, adult and geriatric person. This same CLIN is able to address the needs of the transgender and LGBT community. In additional to the CLIN Medical Network One employs a full time controller and CPA. Routine audits are completed.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

If awarded the grant, Medical Network One would include the following categories to be included in the decisin making: members of community health agencies, patients/clients receiving care from a Medical Network One care team members, health care professionals, Medicaid payer(s), academic institution, and health system representatives. Others would be added as need would be identified.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?
The credentialing process for behavioral health specialists integrated in the primary care practice should be modified. Physician Organization such as Medical Network One would want to identify and recommend specific behavioral health specialists for participation in this initiative. Not every behavioral health specialist would fit into a PCMH model. Medical Network One would be willing to engage in a risk sharing model as well as a traditional fee-for-service payment model.

What changes would need to be made to provider reimbursement in order to implement the model?
Co-payments should be removed for any behavioral health services beinbg rendered in a PCMH.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
Medical Network One would prefer to see a Value Based Reimbursement Model developed between MDHHS and a provider organization. Identifying metrics, agreeing to the metrics and the P4P policy should occur when all partners are at the table. Collaboration, cooperation and transparency should be front and center when it comes to funding.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?
Medical Network One employs four MPH who are trained in quality improvement methods including the Model for Improvement and whose sole responsibility is to identify gaps in care and create opportunities for the care team to do outreach and close those gaps. The care managers understand HEDIS and STARS metrics and share their knowledge with the PCMH practice and the care managers.Su

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?
Here is an example of a beahvioral health initiative Medical Network One will implement next month: Proposal for Quality Improvement Plan…Identification of a quality improvement problem: Depression is a common and debilitating condition that negatively impacts other chronic health conditions; contributes to increased morbidity and mortality; impairs work, school and social functioning; increases health care cost; and reduces overall quality of life. While depression typically starts in adolescence, it is often not detected for several years and the average delay between onset of symptoms and interventions has been shown to be 8 to 10 years. Early identification and treatment of depression in adolescent populations is important to promote healthy developmental trajectories and prevent escalating health problems and social impairment. In 2016, the United States Preventive Services Task Force released a recommendation to screen for major depressive disorder in adolescents aged 12 to 18 with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. Also recognizing the importance of improved depression detection and treatment, NCQA recently released several related HEDIS measures. These

measures encourage systematic use of standardized depression tools to detect and monitor depressive symptoms across the age span and extend to adolescents. Medical Network One proposes a Quality Improvement Plan to systematically enhance depression care for adolescents consistent with these newly released guidelines and recommendations. Methodology for collecting data to determine a baseline and to monitor progress: Data will be collected from claims and the patient registry. Information about how the PO plans to collaborate with behavioral health specialists to address the problem: We will start by utilizing embedded pediatric behavioral health specialists at four pediatric practice units (five locations). These behavioral health specialists will collaborate directly with primary care providers via shared access to medical records and patient registries, routine meetings, team huddles and shared visits. They will also provide care coordination between the practice units and community behavioral health providers.Plan for implementing a quality improvement strategy including: Our quality improvement plan involves systematically using a patient registry to track the use of the PHQ-9(A) to screen and monitor depressive symptoms over time. PHQ-9(A) results will be shared with treating PCPs and behavioral health specialists. Research shows that systematic feedback of this type results in treatment plan adjustments and improved outcomes. Patients with positive screens or with existing depression diagnoses will be monitored at regular intervals with follow-up PHQ-9(A)s. Those who do not receive follow-up PHQ-9(A)s within designated intervals (minimally every four months) will be flagged and contacted for follow-up assessment.We are prepared to pull baseline data and begin implementation of this project immediately. Our registry will be updated with data from claims on a monthly basis and with PHQ-9(A)s as they are administered. Data entry will be the responsibility of our embedded behavioral health specialists but may be delegated to other practice unit or PO staff depending on availability and work flows. Reports to monitor the quality improvement project will be generated on a monthly basis by our data analytic team. Our Director of Behavioral Health Integration will provide project oversight to the practice unit teams with monthly meetings to address implementation barriers and challenges. Our intent is to start with practice units that have or will have an embedded pediatric behavioral health specialist. Our longer term goal is to 1) expand the use of our registry to track depression symptoms across all of our practice units, both pediatric and adult, and to 2), increase the number of our practices who have access to embedded behavioral health specialists.Measurable and actionable goals including a clear set of performance improvement indicators that will measure effectiveness Goal 1: Increase the number of adolescents who are systematically screened for depression. Performance indicator: 1) The number of adolescents (age 12 to 18) who have a PHQ-9(A) score entered into the registry. Goal 2: Increase the number of adolescents with depression who receive follow-up depression care and monitoring. Performance indicator: 1) The number of adolescents who have a depression diagnosis or a positive PHQ-9(A) who have follow-up PHQ-9(A)s entered into the registry. 2) The number of adolescents who have a depression diagnosis or a positive PHQ-9(A) who have documented depression care plans. 3) The number of adolescents who have a depression diagnosis or a positive PHQ-9(A) who have been seen by a behavioral health specialist or by their PCP for a depression care follow-up appointment. 4) The percent of adolescents who have a depression diagnosis or a positive PHQ-9(A) who have improved PHQ-9(A) scores at follow-up.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Yes, integrating behavioral health into a PCMH model can be piloted TODAY. Medical Network One, or for that matter any provider/physician organization would need to hire and train behavioral health specialists eager to work within a PCMH model and willing to think out of the box. A

pre-assessment of physicians/advance practice providers in the PCMH would need to be completed prior to embedding a behavioral health specialist. Culture and willingness to change are key to successful implementation. One also needs to identify a champion who is willing to "make it happen." Many independent provider/physician organizations have been enaged in practice transformation activities. Medical Network One recommends reaching out to those organizations and also tapping professional socities such as the MOA and MPA for guidance. If MDHHS were to ask Medical Network One and their Director of Behavioral Health Integration as to their readiness you woud hear a resouding "bring it on."

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

The SIM CHIR teams and Michigan's Physician/Provider Organization might be a good avenue to discuss future activities. Sprpeading the mopdel is simple. The question is how to ensure the model sustains. Learning Collaboratives are a great way to begin the planning and conversation process. Practice Transformation Institute (PTI) and Independent Health Partners (Battle Creek,MI) have facilitated over 15 year long Learning Collaboratives. Perhaps a discussion with them would provide additional insight.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

The ability to share information electronically is hindered: state law and/or HIPAA. The admission, discharge and transfer information (CCD) does not include any mental health/behavioral health diagnoses. Therefore outreach cannot be completed and patient care is hindered. Coordination of care cannot be completed.

(Optional) Are you aware of any other states or communities which have implemented this model?

Minnesota, Wyoming, Colorado

Model #22

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model:
Person-Centered System of Care

Name of Submitting Organization:
Meridian Health Plan

Model Partner Organization(s):

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

This model proposal expands upon Meridian Health Plan's additional proposal to consolidate the existing Behavioral Health system to one statewide PIHP. This model below provides a proposed long-term integrated structure for Managed Care Enrollees accessing physical and behavioral health services. As proposed, the existing Medicaid Managed Care Organizations operating in their respective prosperity regions would contract with the region's CMHSPs, AREs, and providers to administer the newly integrated physical and behavioral health benefit to their existing populations served. The Medicaid MCOs would assume responsibility to provide the administrative functions correlated with these services and would have the long-awaited ability to coordinate care for the whole-person. Furthermore, in this recommended restructure, there remains a need to implement a statewide entity (proposed as one consolidated PIHP) to provide regulatory and administrative oversight of the behavioral health benefit provided for populations served outside of managed care. This statewide PIHP would not provide direct services but would instead serve as the managed care entity to promote and ensure consistent oversight, compliance, and delivery of services through contracts with all CMHSPs, AREs, and providers throughout the State.

The Person-Centered System of Care is constructed with the understanding that the existing system creates many barriers that prevent consistent and effective care from being delivered to this most vulnerable population. This model aims to center the focus back on the persons served and promotes innovative improvements to the delivery system as a whole.

As it stands today, the system is flawed with obsolete organizational layers that burden and complicate the delivery and access of services. The system is inundated with an archaic and inefficient funding model that directly impacts the services being administered to beneficiaries accessing the system. At a minimum, there is no transparency, consistency, or portability. Money passes through 10 PIHPs and 46 CMHSPs before reaching the Providers and Persons Served. With each organizational layer, duplicative administrative costs are incurred leaving less money to be invested in the services provided to consumers.

This Person-Centered System of Care reduces the number of Prepaid Inpatient Health Plans (PIHPs) from 10 down to 1 to remove inconsistencies with oversight and service delivery across the State. This proposed Person-Centered System of Care includes a model in which the statewide PIHP would have administrative oversight of the CMHSPs, AREs, and Provider/Provider Groups providing care for the for persons served outside of the managed care population. The Medicaid HMOs would contract with the CMHSPs, AREs, and Providers to administer behavioral health services to the Managed Care Populations bringing physical and behavioral health services integrated through the health plans.

Restructuring the existing system into one PIHP has significant advantages that directly improve the care delivery model for the persons served. At a minimum, the following benefits would transpire through this model:

- Generate uniformity with benefits, contracts, training reciprocity, outcome measurement, and utilization management.
- Allows for statewide portability and uniformity of services for the person served.
- Reduces administrative cost in several areas of the existing system, including but not limited to:
  - Integration of administrative functions, removing the current duplication across the existing10 PIHPs
  - Use of a single IT platform
  - Streamlining of the accreditation process in line with CMS rules
- Allows for increased coordination with other agencies responsible for social determinates of care (i.e. DHHS, Housing, MRS).
- Eliminates current PIHP/CMHSP conflict of interest.
- Ensures uniform protection of rights for all persons served.
- Standardizes and centralizes the Medicaid Appeals & Grievances process.

This model also allows and encourages the formation of regional or statewide Accountable Risk Entities (AREs) to increase provider options and overall access to care for the person served. An Accountable Risk Entity would be defined as a group of doctors, hospitals, and other health care providers who partner together to provide high quality, coordinated care to their patients. These AREs would directly contract with the sole PIHP to provide the full continuum of behavioral health services and would allow for the complete separation of PIHP and Provider functions. The AREs would utilize evidence-based and best practices to ensure uniform clinical outcomes and would be incentivized on achieving clearly defined outcomes and care management strategies.

The benefits of adopting this Person-Centered System of Care model reach far beyond just the importance of reducing administrative cost and inconsistency. This model is constructed on a strong foundation of core values and principles that solely focus on improving the health care delivery and outcomes for the persons served.

Person-Centered System of Care—Core Values and Principles

- Person-Centered Care— Ensure that the needs and rights of persons served supersede needs of maintaining any system structure or configuration.
- Consumer/Patient Choice— Provide a full range of service and provider options where a person can move freely about the state and carries the same benefit plan through one PIHP.
- Quality— Utilize evidence-based and best practices to ensure highest quality services for persons served.
- Transparency—Exhibit transparency in all aspects of service delivery and management.
- Efficiency—Eliminate multiple layers of administration or redundancies in services.
- Comprehensive Services— Provide a full continuum of services within an integrated and holistic care context, including all aspects of health and wellness.
- Stewardship—Ensure that resources stay as close as possible to the person served.

Through these core values, we envision this integrated model being supported by State and local public policies to promote a quality driven and efficiently run system for persons served in the community. As proposed, this model is designed to:

- Allow for increased resources to be directed back into care delivery and services through the reduction of administrative layers and cost.
- Allow for portability throughout the State of Michigan without a change in access or benefit
- Increase beneficiary choice of service provider and method by allowing the person served to choose from multiple Accountable Risk Entities (AREs)
- Allow for uniform protections for the person served via the creation of an independent, centralized statewide Recipient Rights office

With the extensive efforts invested into the 298 Workgroup surrounding the concept of Behavioral and Physical Health Integration, this Person-Centered System of Care aligns with several key findings by the collective group, in that this model would:

- Integrate care at the level of the person needing treatment or services, i.e., deliver services when and where they are needed and provide care coordination;
- Standardize administrative functions and reduce the multiple tiers of administration and oversight without diminishing services
- Introduce an independent, state-level entity for all grievances, appeals, and recipient rights complaints of CMHSP and MHP service applicants and recipients

» Develop uniform policies, procedures, and operational definitions for the entire public behavioral health system.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

This model affects the following populations enrolled in Managed Care:

- Mentally ill regardless of level of care including mild/moderate and severe/persistent
- Intellectually and developmentally disabled
- Substance Use Disorders

This model is predicated on continuity of care and meaningful full integration of care and does not exclude any populations.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
All Medicaid funded behavioral health services and supports as prescribed in the Michigan Medicaid Provider Manual would be in scope, including:

- 1915(b) services for mental health - substance abuse
- 1915(b)(3) specialty supports and services
- 1915(C) home and community based services for persons with developmental disabilities
- Autism services
- Healthy Michigan Plan services
- SUD Community grant services
- MIChild services

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

We believe that in order for behavioral and physical health integration to be successful in Michigan, the Health Plans must partner directly with the providers and CMHSPs who are integral in providing behavioral health services in their respective communities. Through this model, we propose that the Health Plan execute newly defined contracts with the CMHSPs, providers, and newly created Accountable Risk Entities to provide the specialty services and supports currently being administered through the existing Behavioral Health service delivery model, and in addition, account for newly reimbursable services (i.e. value-based contracting, delegated credentialing, quality bonus programs to improve service access, utilization, and delivery, etc.). Likewise, the Statewide PIHP would contract with these providers to administer the behavioral health benefit to the non-managed care enrollees.

Through this arrangement, the CMHSPs, AREs and service providers would provide comprehensive access and care management to the respective populations. Individuals would have freedom to choose what services and supports they receive in this model and have available to them a case manager to aid in their understanding of the options available to them. The individual served chooses their service provider(s) and has the ability to choose the entity coordinating their care as well as the freedom to choose their care coordinator. The PIHPs would be consolidated to one statewide entity that provides no direct services in the State.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
This model enhances the coordination of physical health and behavioral health services and supports for the individual by bringing the administration of physical and behavioral health together through a single, sophisticated carrier, with vast capabilities related to access, administration of services, data sharing, and care coordination. Through enhanced partnerships with the CMHSPs and providers, this model promotes enhanced provisions which drastically improves the collaboration between physical and behavioral health care delivery and removes the existing administrative barriers from the behavioral health structure that currently impedes efficiencies.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

This model promotes greater collaboration amongst providers, service agencies, and payers at the service delivery level by eliminating the administrative inefficiencies that currently impedes coordination in the present system making it a much for navigable system.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?
As proposed, this model is designed to; allow for increased resources to be directed back into care delivery and services through the reduction of administrative layers and cost, allow for portability throughout the State of Michigan without a change in access or benefit, increase beneficiary choice of service provider and method by allowing the person served to choose from multiple Accountable Risk Entities (AREs) and allow for uniform protections for the person served via the creation of an independent, centralized statewide Recipient Rights office

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
This model strengthens the workforce supporting the delivery of high-quality services and supports by eliminating administrative costs enabling more resources to be directed to the point of service provision. This model allows for funding currently swallowed in administrative layers to go to increased compensation for direct care providers. This will enable recruitment and retention of higher caliber care providers.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?
This model empowers individuals to make decisions about service delivery through a better understanding of the relationship of behavioral and physical health. Beneficiaries would have access to the services, providers, and specialists deemed appropriate through self-determination and the comprehensive care coordination of their physical and behavioral health needs.

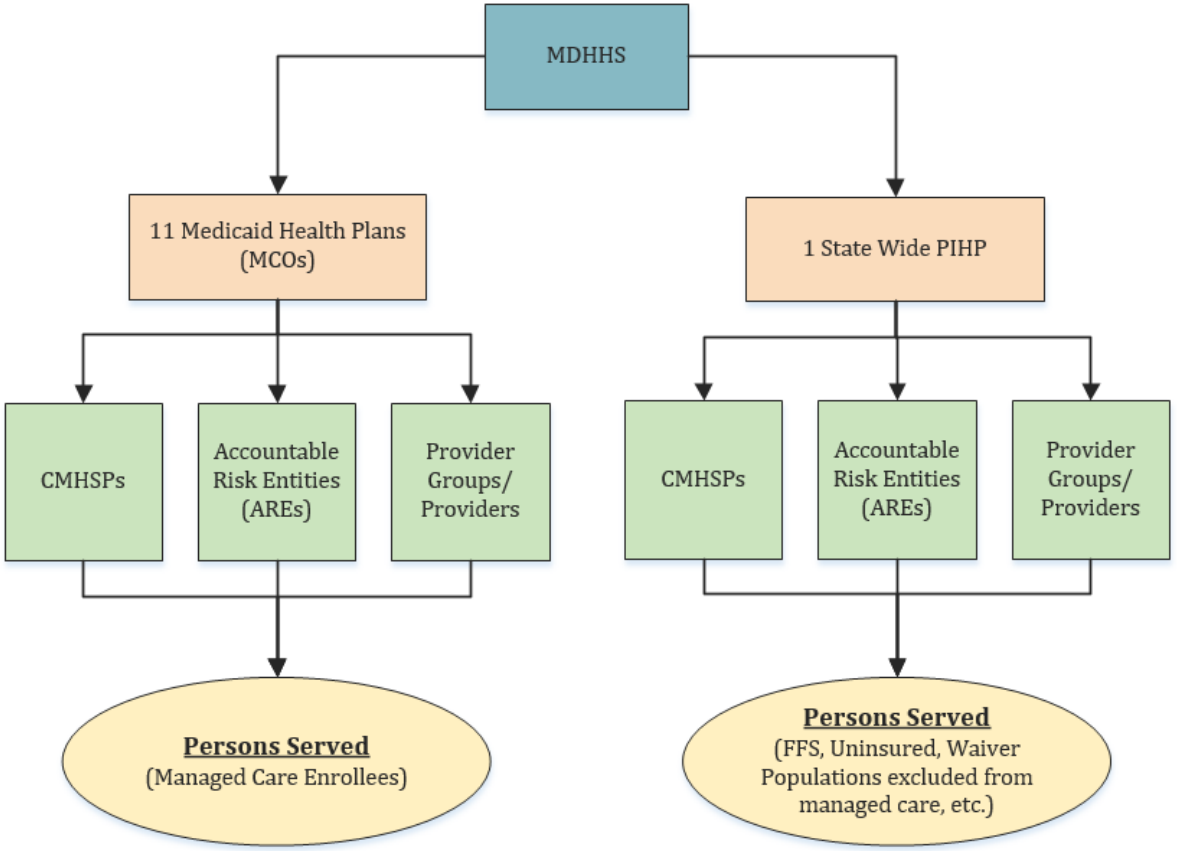
Would this model affect the administration of complaints, grievances, and appeals?

This model proposes the creation of a Centralized Office of Recipient Rights that is maintained at a statewide level that is not funded and located within the CMHSP system.

How would the model support continued access for individuals to current services, supports, and providers?
As outlined above, this model supports (and enhances) continued access by demanding value-based contracting that propose metrics that will demonstrate improved behavioral and physical health outcomes for the population served. These provisions would ensure that continuous collaboration exists between the physical and behavioral health organizations. These improved outcomes will be demonstrated to the department and the Legislature.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?
Transparency is improved and accountability increased by removing the additional administrative layers that do not add value to the services provided in the present system. The proposed model will utilize value-based contracts with improved outcome metrics reported back to the department and the Legislature.



How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

Individuals and family members are engaged by a common care manager for the individual served. This care manager will follow a person-centered plan consulted regularly with the individual served and, where appropriate, with family members and legal guardians.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?
This model would require that the existing flow of funds through the 10 current Prepaid Inpatient Health Plans be directed to the one statewide entity for non-managed care enrollees. Likewise, the flow of funds for Managed Care enrollees would be directed to the Medicaid Health Plans to administer the physical and behavioral health benefits.

What changes would need to be made to provider reimbursement in order to implement the model?
Prior to implementation, this model would require that MDHHS develop a fee schedule for all behavioral health services.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
This model utilizes value-based payments at the provider level and is designed through improved health outcomes and service administration.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?
Prior to implementation, and in order to assess the efficacy of care delivery, a defined set of agreed upon metrics/standards must be developed with MDHHS and outlined in the contracts with the CMHSPs, AREs and providers. This model will demand improved physical and behavioral health outcomes utilizing consistent metrics allowing for comparison within Michigan and against other states. This model recommends the behavioral health outcomes be measured utilizing HEDIS and National Behavioral Health Quality Framework developed by the Substance Abuse and Mental Health Services Administration, as well as other fundamental metrics utilized in other states that have already went through the steps for behavioral health integration. These metrics/standards are drafted to assess the successfulness of critical objectives (the "Triple Aim"):

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability), and;
- Reduce, or at least control, the per capita cost of care.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

Success for the model will be demonstrated by better health outcomes as demonstrated by tangible improved outcomes in both HEDIS measures and the National Behavioral Health Quality Framework outcomes. Important benchmarks appropriate for evaluating the model will include assessment of co-morbid health conditions, reduction of re-hospitalizations, meeting goals of the individual served as prescribed in their person-centered plan. Efficacy of this model can also be assessed by the financial savings, incurred through the cost-efficient restructure, which is to be reinvested back into the system to allow for adequate services to be provided to this population.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?
This model is intended to be a restructure of the existing behavioral health system. This model could be piloted regionally.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?
This model is intended to be implemented statewide.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

(Optional) Are you aware of any other states or communities which have implemented this model?

Model #23

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model:
CMHSP Collaboration

Name of Submitting Organization:
Meridian Health Plan

Model Partner Organization(s):

To be determined by interested participants in the pilot demonstration

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
This model is predicated on continuity of care and meaningful full integration of care and does not exclude any populations, regardless of severity. To ensure the measurement of success is accounted for, it is recommended to include the following populations currently covered under the Medicaid program in this pilot:

- Mental Illness (MI)
- Intellectual and Developmental Disabilities (I/DD) and;
- Substance Use Disorder (SUD)

While these populations are in scope for this model, the efficacy of this pilot can be demonstrated through and would be flexible to consider the inclusion of any combination of services, supports, and/or populations.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
All Medicaid funded behavioral health services and supports as prescribed in the Michigan Medicaid Provider Manual would be incorporated in the implementation of the model including:

- 1915(b) services for mental health - substance abuse
- 1915(b)(3) specialty supports and services
- 1915(C) home and community based services for persons with developmental disabilities
- Autism services
- Healthy Michigan Plan services

- SUD Community grant services
- MIChild services

The Medicaid behavioral health services and supports referenced above would be coordinated and funded through a per member per month capitated payment arrangement administered by Medicaid Managed Care Organizations (MCO) via the Comprehensive Health Care Program Contract.

While the aforementioned lists include the scope of all Medicaid funded behavioral health services and supports for this model, the efficacy of this pilot can be demonstrated through and would be flexible to consider the inclusion of any combination of services and supports.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

We believe that in order for behavioral and physical health integration to be successful in Michigan, the Health Plans administering the physical health services must partner directly with the CMHSPs who are integral in providing behavioral health services in their respective communities. Through this pilot, we propose that the Health Plan execute a newly defined contract with the CMHSPs to provide the specialty services and supports currently being administered through the existing Behavioral Health service delivery model, and in addition, account for newly reimbursable services (i.e. value-based contracting, delegated credentialing, quality bonus programs to improve service access, utilization, and delivery, etc.).

Through this arrangement, the CMHSPs and their credentialed networks, in addition to the Health Plans credentialed network, would provide comprehensive access and care management to the respective populations. Individuals would have freedom to choose what services and supports they receive in this model and have available to them a case manager to aid in their understanding of the options available to them. The individual served chooses their service provider(s) and has the ability to choose the entity coordinating their care as well as the freedom to choose their care coordinator.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

This model enhances the coordination of physical health and behavioral health services and supports for the individual by bringing the administration of physical and behavioral health together through a single, sophisticated carrier, with vast capabilities related to access, administration of services, data sharing, and care coordination. Through enhanced partnerships with the CMHSPs, this model promotes enhanced provisions which drastically improves the collaboration between physical and behavioral health care delivery and removes the existing administrative barriers from the behavioral health structure that currently impedes efficiencies.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

This model promotes greater collaboration amongst providers, service agencies, and payers at the service delivery level by requiring the sharing of data and information. This model eliminates the bifurcation that impedes coordination in the present system making it a much for navigable system for providers, service agencies and payers. In this proposed model the care manager connects with the provider, service agency, payer, and the person served for comprehensive collaboration across all parties.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

This model allows for better availability, accessibility, and uniformity by making the behavioral health benefits portable and accessible to all individuals. The MCO would reimburse all providers through the use of a uniform and actuarially sound fee schedule for all services currently provided under the scope of Behavioral Health. Medicaid Health Plans would reimburse the CMHSPs and the entire owned/contracted network of providers with this defined fee schedule.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

This model strengthens the workforce supporting the delivery of high-quality services and supports by eliminating administrative costs enabling more resources to be directed to the point of service provision. This model allows for funding currently swallowed in administrative layers to go to increased compensation for direct care providers. This will enable recruitment and retention of higher caliber care providers. The use of a uniform and actuarially sound fee schedule allows for and supports the adequate payment of all providers, and eliminates the barriers that exist today.

This model was developed to align with the overarching findings of the MDHHS 298 Workgroup and support the core values that were adopted as a precursor to this initiative. At a high-level, this model is designed to ensure that integration occurs at the level of the person needing treatment or services, i.e., deliver services when and where they are needed and provide care coordination accordingly.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?
This model empowers individuals to make decisions about services delivery through a better understanding of the relationship of behavioral and physical health with the consult of a single care manager backed by physical and behavioral health teams. At the heart of this model is the person-centered plan, self-determination, and choice ensured by a value-based contract with the CMHSPs who have expert knowledge in working closely with the beneficiary and, where appropriate, their legal guardian. Through this model, the individual would not be limited to having their health care decisions for service delivery be contingent upon meeting qualifications for access to PIHPs. They would have access to the services, providers, and specialists deemed appropriate through self-determination and the comprehensive care coordination of their physical and behavioral health needs.

Would this model affect the administration of complaints, grievances, and appeals?
This model affects complaints, grievances, and appeals by eliminating the conflicts that exist in the current system where the CMHSPs act as the funder, provider, and administrator in many regions. This model moves complaints, grievances, and appeals to the state level and adopts the Medicaid Managed Care requirements as it relates to the proper administration, investigation, and oversight of complaints, grievances, and appeals. This model brings uniformity and consistency to recipient rights to align with the Medicaid Health Plan procedures compliant with Michigan legislature and Federal Regulations.

How would the model support continued access for individuals to current services, supports, and providers?
As outlined above, this model supports (and enhances) continued access by demanding value-based contracting with the CMHSPs and behavioral health providers. These agreements would hold the CMHSPs and providers to metrics that will demonstrate improved behavioral and physical health outcomes for the population served. These provisions would ensure that continuous

collaboration exists between the physical and behavioral health organizations. These improved outcomes will be demonstrated to the department and the Legislature.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?
Governance is streamlined in this model through the reimbursement contract between the department and the MCOs. Transparency is improved and accountability increased by removing the additional administrative layers that do not add value to the services provided in the present system. The proposed model will utilize value-based contracts with improved outcome metrics reported back to the department and the Legislature.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?
Individuals and family members are engaged by a common care manager for the individual served. This care manager will follow a person-centered plan consulted regularly with the individual served and, where appropriate, with family members and legal guardians.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?
This model would require that the existing flow of funds through the current Prepaid Inpatient Health Plan be directed to the participating MCOs.

What changes would need to be made to provider reimbursement in order to implement the model?
Prior to implementation, this pilot would require that MDHHS create an actuarially sound fee schedule for all services currently provided under the scope of Behavioral Health. Medicaid Health Plans would reimburse the CMHSPs and the entire owned/contracted network of providers with this defined fee schedule in addition to the value-based services outlined in the agreements.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

This model utilizes value-based payments at the provider level and requires the implementation of a fee schedule developed by MDHHS. Incentives are designed through improved health outcomes and service administration.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

Prior to implementation of the pilot, and in order to assess the efficacy of the initiative, a defined set of agreed upon metrics/standards must be developed with MDHHS. This model will demand improved physical and behavioral health outcomes utilizing consistent metrics allowing for comparison within Michigan and against other states. This model recommends the behavioral health outcomes be measured utilizing HEDIS and National Behavioral Health Quality Framework developed by the Substance Abuse and Mental Health Services Administration, as well as other fundamental metrics utilized in other states that have already went through the steps for behavioral health integration. These metrics/standards are drafted to assess the successfulness of critical objectives (the "Triple Aim"):

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability), and;
- Reduce, or at least control, the per capita cost of care.

- The following metrics/standards are among a few of the many examples that would be recommended for consideration:
  - Percent of enrollees with established integrated person centered care plan
  - Percent of clients completing their course of treatment
  - Percent of patients referred to mental health specialty care who attend initial visit
  - Length of time between primary care referral and behavioral health appointment
  - Level of client satisfaction with accessibility and effectiveness of mental health and physical health services
  - Number and proportion of behavioral health patients with avoidable ED utilization.
  - Number and proportion of behavioral health patients with avoidable hospital admission or re-admission.
  - Follow-up After Hospitalization for Mental Illness within 30 days
  - Medication Adherence

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?
Success for the model will be demonstrated by better health outcomes as demonstrated by tangible improved outcomes in both HEDIS measures and the National Behavioral Health Quality Framework outcomes. Important benchmarks appropriate for evaluating the model will include assessment of co-morbid health conditions, reduction of re-hospitalizations, meeting goals of the individual served as prescribed in their person-centered plan. Efficacy of this pilot can also be assessed by the financial savings, incurred through the cost-efficient restructure, which is to be reinvested back into the system to allow for adequate services to be provided to this population.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?
This model is intended to be piloted. The suggested pilot is to demonstrate improved outcomes in demonstration counties/regions.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?
This model is intended to be implemented statewide and is replicable by utilizing the MCOs contracted across the state. Statewide implementation would occur through contracts between MDHHS and multiple MCOs.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?
This model would require either a change to the mental health code, waivers, state plan amendment, or the definition of a Prepaid Inpatient Health Plan in the MDHHS appropriation bill.

(Optional) Are you aware of any other states or communities which have implemented this model?

Model #24

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model:
PIHP Consolidation

Name of Submitting Organization:
Meridian Health Plan

Model Partner Organization(s):

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

As a byproduct of the Boilerplate 298 workgroup, beneficiaries, community advocates, payers and providers established a set of core values and guiding principles as we shift our focus on enhancing the existing system in the State of Michigan. In line with the core principles, we envision a system that is person-centered, maximizes consumer choice, ensures quality services, exhibits transparency, maximizes efficiency, provides a continuum of health and wellness services, and maximizes resources reaching the persons served. Collectively, this concept is being referred to as the Person-Centered System of Care designed by the MI Care Council and is strongly supported as a proposal that paves the way for effective reform to an antiquated payment model that exists in the behavioral health system today.

The Person-Centered System of Care is constructed with the understanding that the existing system creates many barriers that prevent consistent and effective care from being delivered to this most vulnerable population. This model aims to center the focus back on the persons served and promotes innovative improvements to the delivery system as a whole.

As it stands today, the system is flawed with obsolete organizational layers that burden and complicate the delivery and access of services. The system is inundated with an archaic and inefficient funding model that directly impacts the services being administered to beneficiaries accessing the system. At a minimum, there is no transparency, consistency, or portability. Money passes through 10 PIHPs and 46 CMHSPs before reaching the Providers and Persons Served. With each organizational layer, duplicative administrative costs are incurred leaving less money to be invested in the services provided to consumers.

This Person-Centered System of Care reduces the number of Prepaid Inpatient Health Plans (PIHPs) from 10 down to 1 to remove inconsistencies with oversight and service delivery across the State. This proposed Person-Centered System of Care, with one PIHP, would then allow the Medicaid Behavioral Health System to operate in partnership with the Medicaid Health Plans to provide comprehensive and integrated physical and behavioral health care.

Restructuring the existing system into one PIHP has significant advantages that directly improve the care delivery model for the persons served. At a minimum, the following benefits would transpire through this model:

- Generate uniformity with benefits, contracts, training reciprocity, outcome measurement, and utilization management.
- Allows for statewide portability and uniformity of services for the person served.
- Reduces administrative cost in several areas of the existing system, including but not limited to:
  - Integration of administrative functions, removing the current duplication across the existing10 PIHPs
  - Use of a single IT platform
  - Streamlining of the accreditation process in line with CMS rules
- Allows for increased coordination with other agencies responsible for social determinates of care (i.e. DHHS, Housing, MRS).
- Eliminates current PIHP/CMHSP conflict of interest.
- Ensures uniform protection of rights for all persons served.
- Standardizes and centralizes the Medicaid Appeals & Grievances process.

This model also allows and encourages the formation of regional or statewide Accountable Risk Entities (AREs) to increase provider options and overall access to care for the person served. An Accountable Risk Entity would be defined as a group of doctors, hospitals, and other health care providers who partner together to provide high quality, coordinated care to their patients. These AREs would directly contract with the sole PIHP to provide the full continuum of behavioral health services and would allow for the complete separation of PIHP and Provider functions. The AREs would utilize evidence-based and best practices to ensure uniform clinical outcomes and would be incentivized on achieving clearly defined outcomes and care management strategies.

The benefits of adopting this Person-Centered System of Care model reach far beyond just the importance of reducing administrative cost and inconsistency. This model is constructed on a strong foundation of core values and principles that solely focus on improving the health care delivery and outcomes for the persons served.

Person-Centered System of Care—Core Values and Principles

- Person-Centered Care— Ensure that the needs and rights of persons served supersede needs of maintaining any system structure or configuration.
- Consumer/Patient Choice— Provide a full range of service and provider options where a person can move freely about the state and carries the same benefit plan through one PIHP.
- Quality— Utilize evidence-based and best practices to ensure highest quality services for persons served.

- Transparency—Exhibit transparency in all aspects of service delivery and management.
- Efficiency—Eliminate multiple layers of administration or redundancies in services.
- Comprehensive Services— Provide a full continuum of services within an integrated and holistic care context, including all aspects of health and wellness.
- Stewardship—Ensure that resources stay as close as possible to the person served.

Through these core values, we envision this integrated model being supported by State and local public policies to promote a quality driven and efficiently run system for persons served in the community. As proposed, this model is designed to:

- Allow for increased resources to be directed back into care delivery and services through the reduction of administrative layers and cost.
- Allow for portability throughout the State of Michigan without a change in access or benefit
- Increase beneficiary choice of service provider and method by allowing the person served to choose from multiple Accountable Risk Entities (AREs)
- Allow for uniform protections for the person served via the creation of an independent, centralized statewide Recipient Rights office

With the extensive efforts invested into the 298 Workgroup surrounding the concept of Behavioral and Physical Health Integration, this Person-Centered System of Care aligns with several key findings by the collective group, in that this model would:

- Integrate care at the level of the person needing treatment or services, i.e., deliver services when and where they are needed and provide care coordination;
- Standardize administrative functions and reduce the multiple tiers of administration and oversight without diminishing services
- Introduce an independent, state-level entity for all grievances, appeals, and recipient rights complaints of CMHSP and MHP service applicants and recipients
- Develop uniform policies, procedures, and operational definitions for the entire public behavioral health system.

The intent of this model is to serve as the ideal system of care to address the barriers experienced in the behavioral health system.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

All populations currently receiving services through the behavioral health system would be indirectly affected through implementation of this model.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
All Medicaid funded behavioral health services and supports as prescribed in the Michigan Medicaid Provider Manual would be in scope, including:

- 1915(b) services for mental health - substance abuse
- 1915(b)(3) specialty supports and services
- 1915(C) home and community based services for persons with developmental disabilities
- Autism services
- Healthy Michigan Plan services
- SUD Community grant services
- MIChild services

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

Through this model, we propose that newly defined contracts are executed with the CMHSPs, providers, and newly created Accountable Risk Entities to provide the specialty services and supports currently being administered through the existing Behavioral Health service delivery model, and in addition, account for newly reimbursable services (i.e. value-based contracting, delegated credentialing, quality bonus programs to improve service access, utilization, and delivery, etc.).

Through this arrangement, the CMHSPs, AREs and service providers would provide comprehensive access and care management to the respective populations. Individuals would have freedom to choose what services and supports they receive in this model and have available to them a case manager to aid in their understanding of the options available to them. The individual served chooses their service provider(s) and has the ability to choose the entity coordinating their care as well as the freedom to choose their care coordinator. The PIHPs would be consolidated to one statewide entity that provides no direct services in the State.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
This model enhances the coordination of physical health and behavioral health services and supports for the individual by bringing the administration of physical and behavioral health together through a single, sophisticated carrier, with vast capabilities related to access, administration of services, data sharing, and care coordination. Through enhanced partnerships with the CMHSPs, this model promotes enhanced provisions which drastically improves the collaboration between physical and behavioral health care delivery and removes the existing administrative barriers from the behavioral health structure that currently impedes efficiencies.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?
This model promotes greater collaboration amongst providers, service agencies, and payers at the service delivery level by eliminating the administrative inefficiencies that currently impedes coordination in the present system making it a much for navigable system.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?
As proposed, this model is designed to; allow for increased resources to be directed back into care delivery and services through the reduction of administrative layers and cost, allow for portability throughout the State of Michigan without a change in access or benefit, increase beneficiary choice of service provider and method by allowing the person served to choose from multiple Accountable Risk Entities (AREs) and allow for uniform protections for the person served via the creation of an independent, centralized statewide Recipient Rights office

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
This model strengthens the workforce supporting the delivery of high-quality services and supports by eliminating administrative costs enabling more resources to be directed to the point of service provision. This model allows for funding currently swallowed in

administrative layers to go to increased compensation for direct care providers. This will enable recruitment and retention of higher caliber care providers.

Section IV: Rights, Protections, and Service Continuity

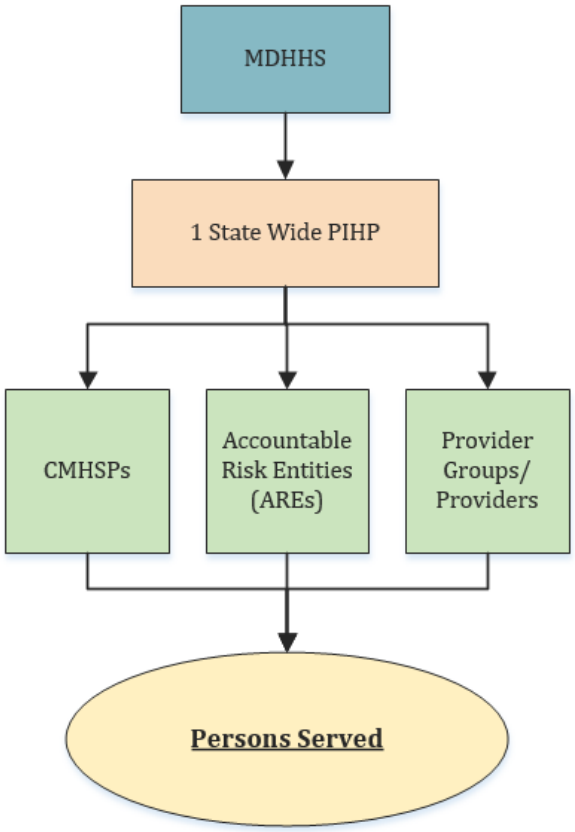
How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?
This model empowers individuals to make decisions about service delivery through a better understanding of the relationship of behavioral and physical health. Beneficiaries would have access to the services, providers, and specialists deemed appropriate through self-determination and the comprehensive care coordination of their physical and behavioral health needs.

Would this model affect the administration of complaints, grievances, and appeals?
This model proposes the creation of a Centralized Office of Recipient Rights that is maintained at a statewide level that is not funded and located within the CMHSP system.

How would the model support continued access for individuals to current services, supports, and providers?
As outlined above, this model supports (and enhances) continued access by demanding value-based contracting that propose metrics that will demonstrate improved behavioral and physical health outcomes for the population served. These provisions would ensure that continuous collaboration exists between the physical and behavioral health organizations. These improved outcomes will be demonstrated to the department and the Legislature.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?
Transparency is improved and accountability increased by removing the additional administrative layers that do not add value to the services provided in the present system. The proposed model will utilize value-based contracts with improved outcome metrics reported back to the department and the Legislature.



How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

Individuals and family members are engaged by a common care manager for the individual served. This care manager will follow a person-centered plan consulted regularly with the individual served and, where appropriate, with family members and legal guardians.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?
This model would require that the existing flow of funds through the 10 current Prepaid Inpatient Health Plans be directed to the one statewide entity.

What changes would need to be made to provider reimbursement in order to implement the model?
Prior to implementation, this model would require that MDHHS develop a fee schedule for all behavioral health services.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
This model utilizes value-based payments at the provider level and is designed through improved health outcomes and service administration.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?
Prior to implementation, and in order to assess the efficacy of care delivery, a defined set of agreed upon metrics/standards must be developed with MDHHS and outlined in the contracts with the CMHSPs, AREs and providers. This model will demand improved physical and behavioral health outcomes utilizing consistent metrics allowing for comparison within Michigan and against other states. This model recommends the behavioral health outcomes be measured utilizing HEDIS and National Behavioral Health Quality Framework developed by the Substance Abuse and Mental Health Services Administration, as well as other fundamental metrics utilized in other states that have already went through the steps for behavioral health integration. These metrics/standards are drafted to assess the successfulness of critical objectives (the "Triple Aim"):

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability), and;
- Reduce, or at least control, the per capita cost of care.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

Success for the model will be demonstrated by better health outcomes as demonstrated by tangible improved outcomes in both HEDIS measures and the National Behavioral Health Quality Framework outcomes. Important benchmarks appropriate for evaluating the model will include assessment of co-morbid health conditions, reduction of re-hospitalizations, meeting goals of the individual served as prescribed in their person-centered plan. Efficacy of this model can also be assessed by the financial savings, incurred through the cost-efficient restructure, which is to be reinvested back into the system to allow for adequate services to be provided to this population.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?
This model is intended to be a restructure of the existing behavioral health system.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?
This model is intended to be implemented statewide.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

(Optional) Are you aware of any other states or communities which have implemented this model?

Model #25

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model:
Continuity of Care

Name of Submitting Organization:
Meridian Health Plan

Model Partner Organization(s):
To be determined by interested participants in the pilot demonstration

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

[Attachment enclosed]

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

This pilot demonstrates the benefits of continuity of care regardless of the assessed severity of the diagnosis. Accordingly, the pilot will affect the following populations:

- Mentally ill regardless of level of care including mild/moderate and severe/persistent
- Intellectually and developmentally disabled
- Substance Use Disorders

This model is predicated on continuity of care and meaningful full integration of care and does not exclude any populations.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

All Medicaid funded behavioral health services and supports as prescribed in the Michigan Medicaid Provider Manual would be incorporated in the implementation of the model including:

- 1915(b) services for mental health - substance abuse
- 1915(b)(3) specialty supports and services
- 1915(C) home and community based services for persons with developmental disabilities

- Autism services
- Healthy Michigan Plan services
- SUD Community grant services
- MIChild services

The Medicaid behavioral health services and supports referenced above would be coordinated and funded through a per member per month capitated payment arrangement administered by Medicaid Managed Care Organizations (MCO) via the Comprehensive Health Care Program Contract.

While the aforementioned lists include the scope of all Medicaid funded behavioral health services and supports and populations for this pilot, the efficacy of this pilot can be demonstrated through and would be flexible to consider the inclusion of any combination of services, supports, and/or populations.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

Individuals have freedom to choose what services and supports they receive in this model and have available to them a case manager to aid in their understanding of the options available to them. The individual served chooses their service provider and has access to services across the state. They will not be limited by geography. The individual has the ability to choose the entity coordinating their care as well as the freedom to choose their care coordinator.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

This model enhances the coordination of physical health and behavioral health services and supports for the individual by bringing the administration of physical and behavioral health together through a single entity and provides unified administration of comprehensive services delineated down to the level of the care coordinator. This model enables the ability to manage the full scope of a member's health care needs.

This model was developed to align with the overarching findings of the MDHHS 298 Workgroup and support the core values that were adopted as a precursor to this initiative. At a high-level, this model is designed to ensure that integration occurs at the level of the person needing treatment or services, i.e., deliver services when and where they are needed and provide care coordination accordingly.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

This model promotes greater collaboration amongst providers, service agencies, and payers at the service delivery level by requiring the sharing of data and information. This model eliminates the bifurcation that impedes coordination in the present system. In this proposed model the care manager connects with the provider, service agency, payer, and the person served.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

This model allows for better availability, accessibility, and uniformity by making the behavioral health benefits portable across the state for all beneficiaries through elimination of the barriers that exist in today's system when crossing county lines. By coordinating the physical and behavioral health care through the MCO the beneficiary has a portable benefit and is no longer restricted or owned by a geographical entity.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

This model strengthens the workforce supporting the delivery of high-quality services and supports by eliminating administrative costs enabling more resources to be directed to the point of service provision. This model allows for funding currently swallowed in

administrative layers to go to increased compensation for direct care providers. This will enable recruitment and retention of higher caliber care providers.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

This model empowers individuals to make decisions about services delivery through a better understanding of the relationship of behavioral and physical health with the consult of a single care manager backed by physical and behavioral health teams. At the heart of this model is the person-centered plan, self-determination, and choice ensured by a value-based contract with an expert behavioral health partner working closely with the beneficiary and, where appropriate, their legal guardian.

Would this model affect the administration of complaints, grievances, and appeals?

This model affects complaints, grievances, and appeals by eliminating the conflicts that exist in the current system where the CMH acts as both funder, provider, and administrator in many regions. This model moves complaints, grievances, and appeals to the state level. This model brings uniformity and consistency to recipient rights statewide.

How would the model support continued access for individuals to current services, supports, and providers?

This model supports continued access by demanding value-based contracting with behavioral health providers held to metrics that will demonstrate improved behavioral and physical health outcomes for the population served. These improved outcomes will be demonstrated to the department and the Legislature.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

Governance is streamlined in this model through the reimbursement contract between the department and the MCOs. Transparency is improved and accountability increased by removing the additional administrative layers that do not add value to the services provided in the present system. The proposed model will utilize value-based contracts with improved outcome metrics reported back to the department and the Legislature.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

Individuals and family members are engaged by a common care manager for the individual served. This care manager will follow a person-centered plan consulted regularly with the individual served and, where appropriate, with family members and legal guardians.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

This model would require that the existing flow of funds through the current Prepaid Inpatient Health Plan be directed to the participating MCOs.

What changes would need to be made to provider reimbursement in order to implement the model?

Providers are reimbursed through a fee schedule with a managed care factor developed by the department.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

This model utilizes value-based payments at the provider level through a fee schedule developed by MDHHS. Incentives are designed through utilization of a managed care factor.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

Quality of services will be measured through improved health outcome metrics developed with MDHHS. This model will demand improved physical and behavioral health outcomes utilizing consistent metrics allowing for comparison within Michigan and against other states. This model recommends the behavioral health outcomes be measured utilizing HEDIS and the National Behavioral Health Quality Framework developed by the Substance Abuse and Mental Health Services Administration. Continuous improvement is ensured through mandated improved outcomes in subsequent contracts with the MCO and provider.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

Success for the model will be demonstrated by better health outcomes as demonstrated by tangible improved outcomes in both HEDIS measures and the National Behavioral Health Quality Framework outcomes. Important benchmarks appropriate for evaluating the model will include assessment of co-morbid health conditions, reduction of re-hospitalizations, meeting goals of the individual served as prescribed in their person-centered plan. Efficacy of this pilot can also be assessed by the financial savings, incurred through the cost-efficient restructure, which is to be reinvested back into the system to allow for adequate services to be provided to this population.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

This model can be piloted. The suggested pilot is to demonstrate improved outcomes in a particular county before expanding regionally and then statewide.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

This model can be implemented statewide and is replicable by utilizing the MCOs contracted across the state. Statewide implementation would occur through contracts between MDHHS and multiple MCOs.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

This model would require either a change to the mental health code, waivers, state plan amendment, or the definition of a Prepaid Inpatient Health Plan in the MDHHS appropriation bill.

(Optional) Are you aware of any other states or communities which have implemented this model?

More and more states are carving behavioral health services into existing managed care plans. Recent states that have made this move include Louisiana, Washington, and Nebraska.

Model #26

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Collaborative Community For Health Innovation

Name of Submitting Organization: HealthWest

Model Partner Organization(s): HealthWest, Mercy Health, Affinia, The Health Project, Hackley Community Care, Muskegon Family Care, Harbor Hospice, CHIR governance, any willing Medicaid Health Plan.

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

The proposed pilot model embraces many of the concepts in the Blue Print for Health Innovation and builds off of the work that one community has done as part of the SIM pilot. We believe that a key consideration in the evaluation of the 298 pilots is that it should align with other state initiatives such as CCBHC and SIM that also support integrated treatment. All of the organizations listed in this model proposal are involved in both SIM and the Pilot proposal. The Accountable System of Care (Affinia), the PCMH and the CHIR components described below are all components of SIM that provide the infrastructure to support clinical integration envisioned by 298. The state will be able to align its policies to maximize investment through SIM. The model will focus on transforming service delivery and payment models by focusing on patient and family –centered health homes; coordination and accountability of the service/medical neighborhood, integration of behavioral health, long term care and primary care, and integration of community resources and safety net services. The model also recognizes that better health and quality of life outcomes requires a comprehensive approach involving safe and healthy communities, workplaces, homes and lifestyles. All of this can only be successful if the individual is in charge of their own plan, inclusive of choice and an opportunity for flexibility of both traditional and non-traditional services and supports. We operationalize several evidenced based clinical models to support integration.

This is accomplished through a partnership with all willing and able providers in the community and building on systems that are already well established. Major partners include HealthWest (Muskegon Community Mental Health), Mercy Health, Affinia Health Network (Accountable System Care), FQHC's Hackley Community Care and Muskegon Family Care) and the Health Project (Pathways HUB).

The financing model will pool funds inclusive of behavioral health carve out, mild to moderate benefit and physical health dollars. The model will be refined through participation of our governance structure members inclusive of individuals with lived experience.

The SIM infrastructure is set to test payment reform and healthcare delivery transformation as envisioned in 298. The original role of the ASC in SIM was originally defined as a risk bearing entity.

The goals of the model are to:

- Provide a full range of behavioral health (Mental Health and Substance Use disorders) as described in the Certified Community Behavioral Health Center Criteria , Inclusive of Services for persons with intellectual and other disabilities,
- Provide easy access to a health home of persons choosing that best meets their needs that will be responsible for coordinating care in an integrated comprehensive manner (Health Home can be CMH (CCBHC), and or PCMH. When appropriate a complex care model (COMPASS ,described below) will be operationalized for those with highest need. Roll of health home is to provide care coordination closest to the individual served (not at the plan level but at the provider of choice.
- Create system opportunities and technology that allows for sharing of coordinated care plan with access to all members identified by the persons served (health provider, behavioral health, social service provider, friends, family etc.).
- Create funding structure that incentivize desired consumer outcomes, and maximizes direct service dollars. A model is described in the SIM Blueprint that would Create a finding structure that aligns with collective impact model used in CHIR that would incentivize outcomes and maximize direct service dollars. Examples include utilizing financial organizations community reinvestment dollars to support social service agencies who demonstrate impact.

(1) **Types of Services and Supports:**
Individuals will have access to full array of services traditionally provided by Behavioral Heath Carve Out and services traditionally provided to mild to moderate benefit through the Medicaid Health Plans. They will have access to all specialty services, emergency/urgent care and primary care. In addition improved access and coordination to all community services such as transportation, housing, domestic violence services, etc.

(2) **Organizations**: Will include those organizations that have come together to work on the SIM pilot. While we have highlighted the larger partners bellow it is intended to be inclusive and no community partner is to be excluded. This model will be a public private collaborative utilizing structure of the existing CMH/PIHP public system and the private ASC (Affinia) though this could be any ASC. We believe this can be replicated in any community.

a. HealthWest, Muskegon Community Mental Health is a CMHSP currently certified as a Certified Community Behavioral Health Center (CCBHC.) We directly provide a full array of services ranging from prevention to crisis residential for persons with Substance Use Disorders and/or mental health needs and /or intellectual disabilities/developmental disabilities. We have numerous partners including contract organizations who provide a wide array of services thus giving choice to our consumers.
b. Mercy Health Provides acute and emergency Care including behavioral health inpatient (managed by Pine Rest). Mercy Health is also part of Trinity Health, a large non-profit health care delivery system operating in 21 states coast to coast.
c. Affinia Health Network, is the Accountable System of Care identified in the SIM project who has experience in alternative funding mechanisms that reward outcomes not service volume. Affinia is a non profit partnership of hospitals, physician practices and federally qualified health centers in West Michigan. The purpose of Affinia is to allow hospital-employed and independent physicians to better work together to provide seamless, coordinated care to consumer populations, while improving quality and reducing waste in the current system. Affinia provides technical support to members that have established themselves as a PCMH (Patient Centered Medical Home).
d. Hackley Community Care- A federally qualified health center that partners with others to increase access to primary care. Particularly for those that have traditionally had difficulty accessing primary care, such as persons with developmental disabilities , serious mental illness, or those that may have been "fired" from their physician due to substance misuse. Examples include health center that is co-run within the walls of HealthWest and Teen Health Centers in Schools.
e. The Collaborative network of service providers will include the existing non-profit providers within the community.
f. The Health Project is the community benefit ministry of Mercy Health as well as the designated Backbone Organization (BBO) for the SIM's Community Health Innovation Region (CHIR). As the community benefit ministry, outreach, enrollment and care coordination support programs are available to assist -consumers and families. They also serve as a convener for 13 active coalitions based on community identified needs in the areas of prevention to substance uses for youth, sexually transmitted infections and health disparities. As the BBO they serve as the fiduciary and convener to oversee the implementation of the Muskegon SIM project.
g. Payers will participate in the pilot by delegating certain managed care functions and transferring accompanying financial resources to the public private partnership, allowing the Community Collaborative to streamline clinical functions and direct an increasing proportion of resources into services. The Lakeshore Regional Entity PIHP has committed to partner with us and all health plans will be invited to participate.

(3) ***298 Values and Recommendations*.** The identified pilot partners developed the plan with an eye to the values and recommendations outlined in the 298 report. We believe that coordination of care happens closest to the person served and that people should have an array of choice that appreciates their individual strengths, needs, cultural needs, preferences, and direct their own plan of service. We reviewed community needs assessments and consumer satisfaction and other feedback to inform our model. We believe that the right care at the right time and right place can reduce medical costs that can be reinvested in the system and improve outcomes and experience of service. Additionally a better integrated system will improve overall access to services and reduce administrative costs.

(4) **Financing.** The basis for the proposed finance model is aligning the financing with the clinical model. If we want to eliminate silo thinking of service provision we must also eliminate silo thinking of financing. The solution is risk bearing provider entities (organizations) that are financed by capitated payments or similar non fee for service models. Under this model the public behavioral health dollars would continue to be managed by the public behavioral health system (this can be a CMH (HealthWest) and its network of providers or a several CMH's forming one provider entity to cover a greater geographic area.) Affinia will contract with the participating Medicaid Health Plan(s) for similar funding and will operate as a risk bearing physical health organization. These risk-bearing provider entities (public /private) would then partner to form a pooled fund for identified population and jointly manage the funds. There are many examples nationwide of similar partnerships. In this model some managed care services would be delegated to the Community Collaborative that are consistent with model such as care coordination, quality management, consumer engagement, referral and access to traditional and nontraditional services. These are services that should be close to the individual served. Other managed care functions would remain with the payer (PIHP /Health Plan). This will result in reduction on administrative services. Pooling the three funding steams Behavioral Health Carve Out, mild to moderate behavioral health benefit and physical health funding eliminates three separate systems. The coordination of these funding streams helps people get to the rights level of service and improve outcomes. For example, it is not uncommon for someone who is receiving outpatient level of care to return to the same outpatient provider after an acute psychiatric stay, sometimes multiple times. It is also true that individuals who is doing quite well and is stable remains at a high level of care (Assertive Community Treatment level) when they no longer need that level of care for such reasons as access to their psychiatric prescription medications. These are system barriers that add to inefficiencies and do not help people get right services at the right time at the right place. Pooled flexible funding structure will better support this goal. We are also seeking to test a model that has the ability to pay for non-traditional services that consumer and research regard as critical to health outcomes. This could include things such as stable housing, use of technology to improve quality of life, and health coaching to sustain health behaviors.

(5) **Public Management Body**. In this model, the public Community Mental Health Services Program (CMHSP) will serve as the primary public behavioral health management body. The PIHP will partner to support this model. Affinia would serve as the private non-profit providers to form a public/private partnership that offers a full and seamless array of integrated care services. However more importantly the management of the pooled resources would be responsive to the CHIR governance structure established through SIM. This is an independent governance that includes those with lived experience in the public system, Health care, community members, legal system, Schools, DHHS, CMH, Public Health, and payors.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
No populations would be excluded from this model. In fact we would propose that the population be expanded to all individuals in our community. Again consistent with the SIM model a well-coordinated, integrated system of care should be available to all regardless of who the payer of services is, therefore it should be available to not just the Medicaid population but Medicare, private insurance, veteran, all; third party payment and indigent populations. Essential parts of care model are that it is available to all members and we do not create additional silos based on who is paying the bill. However we suggest the pilot start with a smaller subset to test the model and demonstrate success. Consistent with the SIM pilot we would prioritize those who are high emergency room utilizers (five or more visits). Our initial evaluation of the data supports that these individuals have a high incidence of co-occurring mental health conditions, substance use disorder or developmental disabilities along with chronic health conditions. While we feel we have developed a good clinical model to support these individuals and better assist them in accessing appropriate care we do recognize we will need to make enhancements to the clinical continuum to meet the needs of those with substance use disorders particularly those with opiate dependency. Focusing on this target population will help us further develop clinical model and test on an identified priority group. It will also give us the best opportunity to include all partners in the community.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

All current services currently delivered by CMHSPS and contracted agencies for persons with serious mental illness, serious emotional disability and developmental disabilities would be included in the pilot model, additionally behavioral health services would be expanded to include all services offered under the mild to moderate benefit. All services offered under the medical benefit through the Medicaid health plan would also be included.

The expectations of service delivery described in the CCBHC certification would also be available. This means serving regardless of ability to pay, 24 hour mobile crisis for all populations, culturally competent services for veterans and indigenous people, and an integrated service delivery approach. Also consistent with both CCBHC criteria and SIM it would include all specialty services and community supports addressing the social determinants of health. Formal coordination agreements with problem solving courts, homeless and domestic violence services, schools, jail diversion and treatment services, probation and courts, FQHC, health care systems, employment services, community coordinating council, shelters, churches, advocacy groups, and others. As mentioned above we are currently working on an expansion of coordination of care efforts of Substance Use Disorder treatment. The SIM clinical team is working on implementation of SBIRT inclusive of all Patient Centered Medical Homes, and expansion of medication assisted treatment beyond HealthWest and one methadone provider. It is our intent to engage multiple physicians' offices and both FQHC's to expand MAT.

Through partnerships with HealthWest and other SUD providers we will work collaboratively to provide necessary behavioral health support to physicians to implement MAT. Our clinical model will include an screening tool that helps to identify the most appropriate health home, note this is only a tool and does not replace consumer choice. We recognize there are individuals currently not linked to services or getting the amount of support needed and this would help guide a PCMH office to make appropriate referrals and access needed behavioral health or other social services. We already have a process in place to make referrals to Community Health Workers but would also assist in accessing those with complex care needs that may benefit from CMHSP or FQHC services both of which have more comprehensive services located in one place assisting in the coordination of care. We also want to identify those that may benefit from Health coaching which has been very successful in our community. Individuals who are connected to a PCMH but may need some help in managing chronic conditions such as diabetes or smoking cessation. We know to be successful we need to engage individuals in their own treatment and that means meeting them where they want to receive their service and where they already have a trusted relationship. This model is meant to allow flexibility that they do not necessarily need to cease services in one environment just to get a different level of care elsewhere.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

As mentioned above we will use community wide assessment tool that helps identify needs inclusive of treatment needs as well as social determinants. However it is client's choice as to who is their care coordinator. Most often this is where the individual will be seen most often and/or who they have a trusting relationship. This is key to our model that care coordination cannot occur at the health plan level where they do not have any relationship. It is important to meet the person where they are at in treatment and use motivational interviewing to engage. It is also important to offer individuals choices, We believe our model is robust and flexible enough that it does so, for example while they may be getting services from an outpatient provider and have a strong relationship with this person, if the outpatient level of care is not meeting their needs they should not have to cease services with this person just to get more intensive services at a CMHSP. In addition if they have a good relationship with their PCMH then there is not a reason to automatically switch the health home to CMHSP, the CMHSP would work with care coordinator at CMHSP to coordinate care. The experience of the consumer participating in this pilot should assist with access to services and choice of provider. The concepts of person centered and self- determination are core to the model.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

Three main components of model needed to improve coordination of physical and behavioral health care.

1. Public Private Partnership of provider entities that utilize Pooled Funding giving us flexibility to meet the needs of all consumers and implement the clinical model described below.
2. A shared information system that is efficient and allows providers to use a total treatment approach without having to dig through volumes data and alerts treatment team when appropriate.
3. A strong clinical model described below: Our Clinical Care model that supports coordination of integrated care embraces three practice models, the CCBHC practice model, establishment of accredited Health homes of consumer choice, and the COMPASS model. Components include:

    - CCBHC includes the standards and principals that support integrated care as established by the federal government. These components include a no wrong door approach and assessment to all who request services. While there are CCBHC's established across the state we have had to expand on this clinical model to support the Michigan public system. For example consumers with DD are also included and we need to expand beyond role of the CMH managing

DCO as established in federal rule and include the entire network of qualified providers in our community. Including the entire network of providers provides for additional choice and helps to meet demand. The expansion of this model provides the right clinical framework and also helps to develop a robust behavioral health provider entity that is well organized and needed to achieve financial integration. Also consistent with this model is the need to develop strong electronic connections that support the delivery of care. It is important to all providers to have access to critical information in an efficient manner.

- Health Homes or Medical Home. In Michigan we currently have a Patient Centered Medical Home (PCMH) and are actively seeking to ensure each consumer has an identified health home. Making sure that individuals are connected to their health home can be a challenge. Helping individuals choose their health or medical home and helping them understand what that means is important. In our model the individual may choose their primary care physician, their psychiatrist, the FQHC or possible even their specialty care provider. We have embedded the use of Community Health Workers in this model, and PCMH practices can easily make referrals and coordinate with the care coordinator at the PCMH. This model works for a large number of our consumers. However the target populations we have identified to focus on in the pilot are the High ED utilizers. The model described below is a specialty Health Home Model.

- COMPASS (Care of Mental, Physical and Substance Use Symptoms) model. While we hope to have many of these elements at all practice locations we will be implementing the COMPASS model initially at three locations, the FQHC's, the CMH, and the Hospital. These are individuals often with co-occurring complex health conditions, mental health and or substance use disorders. COMPASS combines components of several researched based collaborative care models, IMPACT, Team Care and SBIRT. COMPASS intervention will also focus on unneeded emergency department visits, hospitalization, tests and consultation that do not add value in order to reduce overall health care or achieve the triple aim.

- CHIR. The above primarily addresses the clinical needs of individuals but we are aware that it is the social determinants of health that impact health outcomes as much (or more) than behavioral health or medical conditions. Full implementation of the CHIR will help to fully include community organizations and others that are not part of the provider community but key to total health. In addition to engagement of community resources the CHIR will also assist in community dashboards based on established outcomes that help report on the success of the model to the community at large

All of these components work well together and share the need for a strong HIE system with access to a shared care summary. It would be the role of the health home to coordinate the services and develop the cared shared summary including getting any necessary releases. This summary is intended to provide only the key pieces of information needed for providers to coordinate care. It does not for example replace the care plan one receives from the hospital or physician's office and it does not replace the persons centered planning process that is part of the public behavioral health system. The consumer would consent to who is included in this shared summary. We are currently collecting data from consumers and providers on what they think are the important element's to include on the shared care plan summary. We are currently reviewing existing HIE systems in our community that can support this. The health home would facilitate necessary releases so that we can share this information including substance use treatment. While our community is already heavily invested in integrated model as over 90% of physician offices, the FQHC's and HealthWest are all accredited as a Health Home, additional cross training is needed.
We also understand that multiple models are important to meet the needs and provide consumers with choice. Therefore both FQHC's and some physician offices have co-located behavioral health services. HealthWest also has onsite primary care clinic targeting those with the most complex needs. For example we have individuals with developmental disabilities that have such severe reaction to physician office that the provider goes to the consumer. We also have adapted our environment to help for individuals who have no mobility with special equipment, added calming devices (headphones they can choose what to listen to) and adjusted visits to handle individuals with high anxiety. Hackley Community Care offers both primary Care and behavioral health care at school locations. These are models that can be replicated and improve access to those that are having difficulty accessing health care. The model is that every person will have an identified health home, so regardless if they are getting their services all under one roof or at multiple locations the individual will receive coordinated care. Another key component is educating the consumers and their families as to the value of coordinated care.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

- Increase needed information to providers to better coordinate care in an efficient manner. Know who is on team.
- It will decrease duplication of tests and lab work.
- Moving from Fee for service model of payment and pooling funds allows for creative solutions and eliminates barriers currently in place.
- Facilitate turning on of billing codes
- Increases access to specialty services (ie primary care access to psychiatry consultation)
- Provides supports and skills to providers for complex patients , i.e. persons with substance use disorders

- Financial incentives for sites that follow clinical model,
- Offer care coordination to all consumer not just those that are eligible for behavioral health "carve out"
- Allow all providers in network to be creative in meeting needs of consumers.
- Increase opportunity to use non-traditional approaches to meeting needs of consumers.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?
Working collaboratively to increase access by sharing limited resources and developing a common language of service/program descriptions that go beyond the CMH public system will increase access, capacity and uniformity. The clinical model defines what is included in the array of services supporting uniformity. The community collaborative has established a clinical care team that represents providers. We use this group to identify needed training and supports for providers who want to expand their service array. For example we have identified a need to increase the involvement of primary care in delivering and supporting persons with substance use disorders. Currently only Health West and two other physicians provide Medication Assisted Treatment (other than Methadone) so to further develop this we have a sub group training others on model including policies and procedures and identifying what they would need to implement this practice. At times individuals feel they need to remain open to services due to psychiatric prescriptions only though they are stable. Another example, although it needs further refinement we have established a policy where the primary care physician can seek consultation at any time from psychiatrist if they agree to take on medication management and they also can refer back for assessment to the psychiatrist at any time if the person is having difficulty. defining We would support the current medication formulary and advocate that it be available to those in mild to moderate benefit as well.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

We recognize that staff training is essential for both primary care and behavioral health. We have already consulted with Dr. Joe Parks from Missouri about training of care coordination and other staff about necessary changes in attitudes and how to avoid creating barriers for coordination such as unintended consequences for the consumer. CHW, peer support, peer mentors, parent support partners, youth peer support and recovery coaches are already embedded in our model. Currently the training for these staff groups already includes role of integration. All but CHW's are embedded on every team at HealthWest. CHW's are part of

Pathways program and embedded in our clinical model. We see these individuals with lived experience key to the success of the model and are helpful in engaging others to treatment, communicating with health care providers and providing support. It is our goal to add more positions of persons with lived experience to additional providers so they are available as a resource regardless of where they receive services. We have already expanded recovery coaches in contract agencies and added mentors and peer supports to schools. In addition we are working with local community college to develop a certification program for community health workers in alignment with the Michigan Health Worker Alliance. This development continues to help stabilize the community workforce.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

Person-centered planning, self-determination, and choice are core to the values of CCBHC. As part of the SIM pilot this past year we have been able to help the health care community understand why these concepts will improve health outcomes. Pooling dollars to eliminate silos should support a broader array of services to all, and we would embrace persons centered planning for individuals in the mild to moderate category of funding as well as anyone regardless of who the payer is including private insurance, it is the best practice and should not be limited to a subset of people in our community. Expanding behavioral health service array to physician practices and including all providers in the network will increase choice. It will also allow consumers to change providers when it makes sense without fear of losing a needed service.

Would this model affect the administration of complaints, grievances, and appeals?

If a complaint can be resolved immediately by the provider this is best practice and promotes better customer service. However persons must have the ability to file formal complaints, grievances and appeals to oversite body if they choose or their issues cannot be resolved to their satisfaction. Under our current system PIHP and the Health Plan would serve this role.

How would the model support continued access for individuals to current services, supports, and providers?

- This model increases access and does not put any barriers that would reduce access to services. its focus on whole-person recovery;
- consumer support to establish and maintain medical home for primary care

- ability to support and address their social determinants of health;
- enhanced access to evidence-based practice;
- No wrong door, community wide screening that will assist in referrals no matte where the person seeks help.
- An increase in individuals in the workforce who have lived experience and represent the cultures of those in services
- Increase in coordination and availability of MAT
- Education and support to primary care on working with persons with complex needs

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

The public system (CMHSPS) has a board of directors and must adhere to all rules regarding transparency and accountability. Outcomes for the model would be established and reported regularly to the public and persons served. In addition as described above we would also utilize the CHIR governance structure to share outcome data including financing, practice model and consumer outcomes as well as provide feedback. The CHIR board would make recommendation for funding and service needs through an annual community needs assessment. The CHIR board includes persons with lived experience, the health department, the health system,. Payers, CMH, FQHC's, and long term care. In addition to that it includes a broad base of service providers and law enforcement from the community.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

The HealthWest board utilizes standards established in CCBHC to ensure the community is represented including those with lived experience that we serve. In addition we have consumer advisory committee to involve additional consumers. As mentioned above the CHIR board also includes persons with lived experience.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

Both the public system (HealthWest or collaboration of CMHSP) and Affinia become risk bearing provider entities with the ability to reinvest funding into services. To support the piloting of this model, collaborating payers will agree to delegate certain managed care functions and resources, which will be embedded at the provider level for improved flexibility, coordination, efficiency, and impact on outcomes.

What changes would need to be made to provider reimbursement in order to implement the model?
No changes would need to be made to provider reimbursement regarding HealthWest and Affinia. Affinia has much experience with alternative payment structures. We have also had some of our larger contract organizations express interest in participating in a value based purchasing program and would work to implement such models that would create flexibility in meeting needs of individuals.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
Incentive plans will need to be developed/designed with payers and providers. It is our intention to utilize incentives, primarily to reinvest in service delivery and give more flexibility in service design. We also understand that payers must have incentive to participate.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?
Metrics would be set aligned with other innovative programs, primarily CCBHC and PCMH metrics. However consumer experience of care would also need to me measured.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

Benchmarks would include consumer experience of care, provider experience (provider turnover in both behavioral health and health care), Health Outcomes consistent with benchmarks above, Cost neutral, Decrease in Emergency Room Use, improved access to care. Establishing effective governance structure that can implement as described. Creating pooled saving for reinvestment.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?
Yes, as described above with smaller subset of population.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?
Yes, model can be replicated. The elements that must be present to be replicated include a public and private provider entity that can assume risk for an attributed population; be able to develop a well coordinate/administer a clinical model that supports integration; be able to administer pooled funds, and develop and monitor outcomes.
re you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?
None
(Optional) Are you aware of any other states or communities which have implemented this model?
There are several that have implemented risk bearing organization either as pilot or state wide such as New York, Colorado and New Jersey. Many elements described are currently being implemented as part of the Michigan SIM model.

Model #27

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Metro Region 298 Proposal

Name of Submitting Organization: Detroit Wayne Mental Health Authority

Model Partner Organization(s): Oakland County Community Mental Health Authority (Mr. Willie E. Brooks, CEO) & Macomb County Community Mental Health (Mr. John Kinch, CEO) and at least two regional health systems (to be determined).

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

1.) Many individuals, like those with spend-downs, dual eligibility and retro-active eligibility cannot be in Medicaid Health Plans, and yet data indicate that this unmanaged group accounts for 50% of overall Medicaid and PIHP costs. These individuals also tend to have higher needs and are more medically complex than individuals enrolled in Medicaid Health Plans. This model would offer improved care coordination for these medically unmanaged individuals that cannot be enrolled in Medicaid Health Plans. 2.) The PIHP would provide care coordination for individuals not in Medicaid Health Plans. The three metro region PIHPs (in Macomb, Oakland and Wayne counties) would partner with 2-3 regional health systems to streamline linkages to primary care, ensure that the individuals medical issues are being adequately addressed, and reduce emergent medical visits. 3.) For many years the PIHP/CMHSPs have received money for case management, but case management is not care coordination. Case management addresses the important psychosocial needs that impact the individual's overall wellbeing like housing, insurance, and finances. Care coordination involves the management of medical conditions, medication, specialty referrals and follow-up and has traditionally been included in the monies given to the Medicaid Health Plans. The PIHP/CMHSPs have a very low administrative rate (7%) that has not allowed for the implementation of care coordination services. Since these individuals cannot be in Medicaid Health Plans, their medical care is entirely unmanaged and many do not receive necessary medical care resulting in poor outcomes and high rates of preventable medical illness. As referenced in the 298 Affinity Group Report, many individuals would choose to have their care coordinated by or through the PIHP/CMHSP system. The PIHP/CMHSP care coordinators would work with both primary and behavioral health providers to help the individuals develop care plans that are person centered and can be meaningfully integrated into the IPOS and shared with the individual's care team and natural supports. 4.)This model proposes that the State provide monies to the metro region PIHP/CMHSPs to provide care coordination for individuals that receive services through the PIHP system and are not enrolled in a health plan. For individuals that do not have a primary care physician, the PIHP/CMHSP care coordinator would help them identify one that meets their needs. The highest utilizers of Medicaid, are an extremely vulnerable and costly population to serve. The top 5% of super-utilizers cost around $41,000 per year and the top 1% cost over $88,000 per year (Burns, 2014). Medicaid super-utilizers are PIHP/CMHSP consumers:•10/10 have a mental illness • 9/10 have a substance use disorder •3/10 are in a group home•2/10 are homeless• Average in 75+ ED visits per year (Hassleman, 2013). In addition, the model would request enhanced payment for primary care providers that accept individuals served within the PIHP/CMHSP system with Medicaid. Many primary care providers in the metro region do not accept Medicaid due to the low reimbursement rates. Low rates, combined with the significant complexity of many PIHP/CMHSP consumers, necessitates higher rates to offset the time required to provide high quality care to this vulnerable group. The PIHP/CMHSP care coordinators would also assist the primary care providers in managing the care for these individuals. The metro region PIHP/CMHSPs would partner with 2-3 regional health systems to develop and streamline primary and specialty care for these

individuals. These primary care clinics would receive enhanced capitation or higher rates for the seeing PIHP/CMHSP consumers and have access to the PIHP/CMHSP care coordinators to assist with managing the medical care for these medically complex individuals. The additional monies spent on care coordination by the PIHP/CMHSPs and primary care providers will result in significant savings on unnecessary urgent and emergent medical care. Those savings could be reinvested in the public health system. 5.) The PIHP/CMHSP system would be responsible for coordinating the care and developing the partnerships with the regional health systems.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
This model would apply to all populations without exclusions. The initial focus would be on individuals identified as high utilizers of urgent or emergent services with unmanaged medical care (fee for service Medicaid).

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
The premise of this model is that integrated healthcare happens at the provider/individual level. The medical care for a significant percentage of medically complex, vulnerable people, has been largely unmanaged and resulted in significant harm to the individuals without adequate care. The PIHP/CMHSP system is not funded to provide medical care coordination to the people it serves (7% administrative overhead). Dollars to support care coordination would support the use of trained medical professionals in managing medically complex individuals. Care coordinators would streamline access to primary and specialty care and help the individual understand and manage medical recommendations and medications. A 2016 evaluation of the Washtenaw Health Home project found that an assigned nurse care coordinator significantly reduced ER use in 6 months (Zivin, 2016). Reductions in preventable ER use throughout the metro region would result in significant savings that could be reinvested in the system to further improve services. Partnerships with 2-3 health systems would ensure individuals have choice and improved access to the primary and specialty medical providers needed to treat complex medical conditions. The PIHP/CMHSP partnerships with the health systems and the addition of care coordinators would support the practitioners in ensuring the individual understands the medical recommendations. Care coordinators would also assist with follow up appointments and referrals.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?
Choice is foundatinal value to the public behavioral health system. Currently, individuals in fee for service Medicaid do not have anyone coordinating their medical care. For individuals that do not have a primary care doctor, the PIHP/CMHSP care coordinator would help him or her select one. In line with the recommendations of the 298 Affinity group, individuals would have the ability to choose whether or not they wanted assistance in coordinating their physical and behavioral health care or if they preferred to have themselves or a family member coordinate their care.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
Medicaid health plans have been managing the mild to moderate behavioral health benefit (single payer) for 30 years and the systems are not integrated. True integration occurs at the provider, not payer level. Currently, individuals in fee for service Medicaid do not have anyone coordinating their medical care. PIHP/CMHSP care coordinators would coordinate the medical and behavioral health care for this vulnerable population and help individuals navigate the often confusing health care system. Partnerships with health systems would streamline the referral process and ensure that individual integrated care teams (behavioral health and ambulatory care) were on the same page.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?
The addition of care coordinators at the PIHP/CMHSP will improve coordination between the behavioral and ambulatory health providers in the metro region. The care coordinators will support the health system staff in managing complex medical conditions and reducing preventable emergency use. The addition of care coordinators at the PIHP/CMHSP will ensure that the person centered planning process includes the important medical issues that impact the individual's life and recovery activities.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?
This model would ensure that all individuals, including the most vulnerable individuals with serious mental illness, intellectual and/or developmental disabilities and children with serious emotional disturbances, have assistance in managing the extremely complex and overwhelming health care system. Primary care providers have been reluctant to accept individuals with Medicaid due to the low reimbursement rates. Every person has the right to quality medical care and the right to choose his or her medical provider. This model would address access issues prevalent in the metro region (prosperity region 10) for individuals with Medicaid by increasing the number of providers and health systems that accept Medicaid. The recent widespread availability of comprehensive Medicaid data shows that there continue to be disproportionate health disparities for individuals with behavioral health conditions. Research overwhelmingly points to integrated healthcare as the solution and the need for integrated services at the consumer and provider level. Funding the PIHP/CMHSP to manage the care coordination will ensure that individuals are adequately supported in managing their overall health. Care coordinators would ensure that there are appropriate referrals from primary care and that medication changes are understood and communicated between primary and behavioral health care providers.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

There is a shortage of primary care physicians and psychiatrists in many regions throughout the State. Amongst practicing physicians, there is sometimes hesitancy to take on too many individuals with Medicaid because of low reimbursement rates. There is also sometimes a hesitancy to accept patients served in the public behavioral health system due to stigma and/or medical/psychosocial complexity. The addition of PIHP/CMHSP care coordinators that understand both the behavioral health and medical issues impacting the individual, can ensure that the individual is able to access high quality services and care of their choosing. In addition, we support expanded use of peers and community health workers to help support individuals in their recovery and advocacy. We recommend that the State expand certification programs for community health coaches, community health workers or other alternative peer roles.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

PIHP/CMHSP care coordinators would provide education and support to individuals trying to navigate the complex health care system. Partnerships with metro region health care systems would increase the number of available providers, which would increase choice around who provides an individual's health care. The metro region PIHP/CMHSPs recommend the State expand training and choice of advocates as independent facilitators that promote self -determination across systems for physical and behavioral health care services.

Would this model affect the administration of complaints, grievances, and appeals?

The Calley Report recommends “an independent state-level entity for all grievances, appeals, and rights complaint of CMHSPs and MHPs service applicants and recipients.” The legal guidance and standards must come from the state level and will require significant changes to the legal underpinnings of those processes. Following these changes, the MDHHS Office of Recipient Rights should embrace the above outlined responsibilities for the entire hospital system. However, for the non-hospital complaints, the “boots on the ground” should remain with the Due Process and Recipient Rights offices/functions currently housed at the CMHSPs and not affiliated with providers. Their independence can provide the expected objective and timely resolution of complaints while retaining local community input and oversight. Centralize the complaint resolution system. The centralized complaint resolution system should be able to resolve the complaint more timely with the assistance of the clinically responsible provider.

How would the model support continued access for individuals to current services, supports, and providers?

The proposal would not prevent individuals from accessing their current services. The model would expand access to additional primary and specialty health providers in the metro region.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

Unlike private health plans, the public behavioral health system provides whole person care and includes crucial community-based resources that address the multiple determinants of health. As a public governmental entity the PIHPs already operate in an environment of transparency and have to comply with laws that private corporations do not. PIHPs are subject to the Freedom of Information Act, the Open Meetings Act (OMA) and the Incompatibility of Public Offices Act, while private entities are not. PIHPs and CMHSPs are also subject to applicable local, state and federal procurement statutes, rules, regulations and ordinances, designed to make them fiscally responsible and a good steward of public resources. PIHP and CMH Boards are composed of members of the community, with 1/3 of the board members having to be either primary or secondary consumers. The boards in most instances are approved by the respective County Commissions in the region that they operate, meaning that the constituents and tax payers in those regions do get to exercise their voting rights and the ultimate accountability. Also, being subject to the OMA mandates the opportunity for the public to be heard at committee and board meetings. The work the PIHPs and CMHSPs do for the public are, and will continue to be, done in front of the public eye. The PIHP/CMHSP system focuses on the most complex, costly individuals and include vital services not offered by Medicaid Health Plans like peer support services, group skill-building, residential treatment, and vocational assistance. Monies realized by keeping individuals in their preferred community dwellings and out of costly hospitals and institutions is redirected into services.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

The PIHP/CMHSPs already include and actively seek out consumers and advocates to provide ongoing input on the services, vision and future direction of the public behavioral health system. All major changes to the PIHP/CMHSP system are vetted to the recipients of services and the community at large prior to implementation. The visions and values of the 298 workgroup support expanded training and choice of advocates as independent facilitators that promote self -determination across systems for physical and behavioral health care services. In the development of the person centered plan, initiate and integrate goals for consumers to become peer support specialists, community health coaches, community health workers as an integral part of recovery. Standardize patient satisfaction surveys that easily accessible and focus on the consumer experience and incorporate feedback in a meaningful way across the system.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

Integration occurs at the provider level, not the payer level. The PIHP/CMHSPs have a very low administrative rate (7%) that has not allowed for the implementation of care coordination services. Funding the PIHP/CMHSPs to provide care coordination would address the completely unmanaged Medicaid fee for service system. Many primary care providers in the metro region do not accept Medicaid due to the low reimbursement rates. Low rates, combined with the significant complexity of many PIHP/CMHSP consumers, necessitates higher rates to offset the time required to provide high quality care to this vulnerable group. The metro region PIHP/CMHSPs would partner with 2-3 regional health

systems to develop and streamline primary and specialty care for these individuals. These primary care clinics would receive enhanced capitation or Medicaid rates for the seeing PIHP/CMHSP consumers and have access to the PIHP/CMHSP care coordinators to assist with managing the medical care for these medically complex individuals. The additional monies spent on care coordination by the PIHP/CMHSPs and primary care providers will result in significant savings on unnecessary urgent and emergent medical care. Those savings could be reinvested in the public health system. The PIHP system would be responsible for coordinating the care and developing the partnerships with the regional health systems. The majority of the cost savings will be realized in reductions in preventable urgent and emergent service use. There needs to be a mechanism for ensuring that these realized savings are shared with both the PIHP/CMHSP system and the primary health providers.

What changes would need to be made to provider reimbursement in order to implement the model?

There is an urgent need to reform the way primary care services are reimbursed. Very low rates have limited individual choice in practitioners and served to further fragment an already complex and difficult to navigate health system. As an alternative to enhanced FFS for primary care for FFS medicaid reimbursement, we would support the concept that the State needs to move away from the fee for service into a value-based, risk-adjusted global payment model. Behavioral health and ambulatory funds would be pooled to improve care coordination and subsequent savings would be proportionally shared between the behavioral health, primary care and Medicaid systems. Either way, the PIHP/CMHSP system would need funds to provide care coordination to its members with unmanaged Medicaid.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

The PIHP/CMHSPs would receive dollars to provide care coordination services. The metro region PIHP/CMHSPs would partner with the 2-3 regional healthcare systems to streamline the care coordination process for this medically complex subset of consumers. Primary care providers are traditionally very busy and unable to provide additional time and resources to coordinate care with the behavioral health system. Primary medical providers would be incentivized with increased rates or capitation payments to support improvements in coordinating with the PIHP/CMHSP system. PIHP/CMHSP care coordinators would support the primary care doctors in ensuring that individuals understood the medical recommendations and attending the necessary follow up appointments. Improvements in quality and outcomes would result in reductions in unnecessary ER visits and lower the cost to Medicaid. The Medicaid savings should be shared with the primary care doctors/ health systems and the PIHP/CMHSPs. This model would also allow for incentive payments based on specified quality outcomes (i.e. improvements in physical/behavioral health related quality of life, symptom scales or other quality benchmarks.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

There needs to be standard consumer surveys and quality and outcome measures across the system, in addition to utilization and cost data. Utilize evidence-based outcome measures like the WHO-DAS or SF-12 to examine overall health related quality of life. Conduct regular measurements and make survey and outcome data available to the public.

Define “success” for the model? How will the model’s success be measured? What types of benchmarks would be appropriate for evaluating the model?

The results of the metro PIHP/CMHSP model will be evident by improvements in health care access, health outcomes, consumer satisfaction and reductions in preventable ER visits and hospital stays.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Yes. This proposal is submitted as a pilot model that could be expanded.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

Yes, there is a need for improved care coordination in this vulnerable population across the State. The PIHP/CMHSP system would be assigned responsibility for coordinating the care for individuals already being served in the public behavioral health system. It is well known that persons with behavioral health conditions and those with intellectual and/or developmental disabilities often receive suboptimal medical care. These individuals are disproportionately affected by preventable, chronic health conditions like cardiovascular disease and metabolic syndrome. To encourage and attract physicians to take individuals served in the PIHP/CMHSP system, the State could provide enhanced payments to any provider serving PIHP/CMHSP consumers. The payments would be tied to the individual and provide enhanced rates to any provider seeing the person.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

Click here to enter text.

(Optional) Are you aware of any other states or communities which have implemented this model?

A 2016 evaluation of the Washtenaw Health Home project found that an assigned nurse care coordinator significantly reduced ER use in 6 months (Zivin, 2016). Reductions in preventable ER use throughout the metro region would result in significant savings that could be reinvested in the sytem to further improve services.

Model #28

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Community Health Worker Mental Health Initiative

Name of Submitting Organization: Mid-Michigan District Health Department

Model Partner Organization(s): Montcalm Care Network

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

The proposed model is that Community Health Worker (CHW) services for people with mental illness and substance use disorders (SUD) should be reimburseable by health plans including Medicaid, in the same way that physical health services or peer supports delivered by community mental health (CMH) agencies are. The problems the model addresses are excessive utilization of emergency departments (EDs) and unacceptable hospital readmission rates for illnesses that should have been controlled the first time. These problems mean that people affected by them remain ill instead of recovering their health, high utilization also drives up healthcare costs. Many of the people affected in this way have mental illness or SUD. It is well established that a major reason ED utilization and readmission rates remain high in this population is that they often lack the resources to navigate the system. CHWs have been shown to be successful in helping people with mental illness and SUD navigate the system, reducing high ED use and readmissions. In particular, CHWs connect their clients with medical homes, mental health and SUD serviceds. Because of this, Michigan has embedded CHWs in the State Innovation model. Michigan has tried to sustain its CHW programs by encouraging health plans to sign contracts with CHW programs, but this is not working in most cases. Michigan's CHW programs are threatened with collapse meaning the proven benefits of CHWs are likely to be lost. In the model, Community Mental Health agencies would authorize CHW services the same way the currently authorize primary care, mental health treatment and peer supports. CHWs do not duplicate peer supports. CHWs work with clients who are not receiving care. They step away once the client is connected to care.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

At this time we are proposing that routine reimbursement for CHW services (rather than negotiated arrangements) be for people with mental illness or SUD. We are not proposing that this be limited to CMH clients only, but also clients of other mental health and SUD providers.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

Typically (although not always) CHWs are peers of the clients they serve rather than nurses or social workers. They work with the sickest and most expensive people in the community. In many CHW programs, referrals can come from anywhere. CHWs evaluate the barriers to care their clients are facing and arrange for services to remove those barriers, whether it is housing, food, transportation, treatment, etc. The goal is to connect the client to primary and mental health care and ensure they continue to receive needed care. The service the CHW provides is navigation, all the other services both community based and clinical are provided by others in the community.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

The decision to meet or work with a CHW or accept services the CHW can arrange for is always made by the client. Inevitably, there are always some people who the CHW reaches out to who decline to work with them or accept services.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

CHWs work with people who are disconnected from care, don't have a medical home or are non-compliant and whose mental illness or SUD is not being treated. Their illnesses are progressing. In many cases they are in danger of premature mortality but before that happens they may consume a great deal of ED and/or hospital resources.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

A CHW's role is to connect or re-connect a person who has serious unmet physical and mental health care needs to the resources in the community that can help them get care and make best use of it. For example, a health plan may be trying to locate an client who is a high utilizer of the ED to find out what is going on. They may already know the individual does not have a primary care doctor and is not taking medications. The CHW can locate the person and discover what is preventing them from getting care (e.g. lack of housing, domestic violence, SUD) and connect them to services in the community to address the problem.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

Like many people with mental illness or SUD, CHW clients are likely to have chronic conditions including diabetes, high blood pressure, chronic pain, depression and addiction that are not being managed. The CHW navigates the client to providers so that treatment can begin, including access to medications if indicated.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

Most CHWs are peers of their clients and are uniquely able to navigate people with complicated co-morbidities to care. Quality is ensured through certification. In some cases it is the CHWs themselves that are certified. In other cases CHWs work for a certified HUB (more about HUBs

in the section on Quality). But Michigan is in danger of losing a large part of its CHW workforce because of the difficulty of sustaining CHW programs. The model proposed is aimed at sustaining CHW programs for people with mental health problems or SUD.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

People who CHWs serve typically start out unable to make any decision about service delivery because they aren't connected to care. Alternatively they may have made a decision to not receive care because they feel disrespected or are afraid something will be taken from them (perhaps they have an addiction). They may have been discharged from care because of behaviors related to their mental illness or because a doctor felt unable to address their complex needs. The CHW's role is to change that and ensure the barriers to receiving services are removed.

Would this model affect the administration of complaints, grievances, and appeals?

By connecting people with complicated issues in difficult circumstances to care there may be a chance for increased complaints. However I would argue that it is better to have people in care with all the difficulty that could entail rather than isolated with their problems untreated.

How would the model support continued access for individuals to current services, supports, and providers?

When a CHW begins working with someone they may continue to do so during a short transition period to ensure that all barriers to receiving treatment are removed and the client continues to participate in care.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

The proposed model would not change the governance of CMH agencies or Medicaid Health Plans.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

Many people who CHWs work with are socially isolated. Sometimes referrals come from family members, emergency departments or others in the community. In every case, the client ultimately decides whether or not to work with the CHW or accept services.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?
CHW visits would become reimbursable by health plans in the same way as physical health care or the services of a peer. Currently health plans decide whether or not to enter into a contract with a CHW program, which services to pay for and how much they are willing to pay. Many are not contracting or are agreeing to pay for only a very limited set of services which cannot address the complex needs of people with mental health and substance use disorders. Making CHW visits reimburseable would remove the reluctance of health plans to engage with CHW programs as a barrier to people who need those services receiving them, and would also remove that reluctance as a barrier to attaining the savings from reduced ED utilization and readmissions.

What changes would need to be made to provider reimbursement in order to implement the model?
Obviously health plans need to be protected from CHWs setting themselves up in business and sending a stack of bills to the plans. There are two ways to ensure the utilization of CHWs is addressing the legitimate needs of clients. One would be for mental health and SUD providers that want to make CHW services available to their clients to form a relationship with a specific CHW program and authorize the services the same way they do with their providers or peers. Another way would be for CHW programs that want to bill for mental health and SUD services to be recognized by the state in the same way that MIHP programs are. The best way to protect the health plans would need to be worked out as the model is developed.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
For whatever reason, payers are not seriously utilizing CHWs to take advantage of incentives including rewards for reducing ED utilization and avoiding readmissions. Medicaid health plans are required to have or work with CHW programs but are not authorizing CHW visits at levels sufficient to have an impact on outcomes.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?
Most CHW programs have a relationship with a HUB--an organization that manages referrals, contracting, billing and deduplicates services. HUBs use databases to manage referrals, assign CHWs and track outcomes. They use these databases to look at the rate at which clients get connected to care and indicators of efficiency such as the length of time clients are enrolled and the number of services consumed. They are also able to monitor the productivity of CHWs, improving supervision. Many HUBs do client satisfaction surveys. What has not been the norm is connecting the HUB data to hospital and health plan data to look at the impact on outcomes and costs. This has been done occassionally as part of evaluations of CHW programs. Michigan's original grant funded CHW programs were evaluated by CMS in this way and were shown to reduce ED utilization and readmissions. Some other evaluations have been done such as the evaluation of the Muskegon CHW program for high risk pregnancies which also showed excellent outcomes. But hospital and payer data remain difficult to get on a routine basis.

Define “success” for the model? How will the model’s success be measured? What types of benchmarks would be appropriate for evaluating the model?

The model has a clear definition of success. First, clients who are ill get connected to primary care, mental health or SUD services. Second, clients are compliant with treatment. Third their conditions improve and ED utilization and/or the rate of readmission goes down.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

The model is being piloted in Lansing, Saginaw, Muskegon and elsewhere in the State and has been shown to be effective. We are proposing changes to reimbursement in order to ensure these services remain present in Michigan communities.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

Yes, it could expand into more Michigan communities and it is important to provide a better reimbursement mechanism to ensure this happens.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

CHW services would need to be made reimburseable for people with mental illness or SUD in the same way as physical health services or peer supports are. In order to ensure CHW services billed are appropriate to the needs of clients mental health providers would need to designate the CHW programs they will work with and authorize the services. Alternatively, CHW programs could be registered with the State like MIHP programs.

(Optional) Are you aware of any other states or communities which have implemented this model?

CHW programs are operating in most states.

Model #29

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Regional HUB Coordination Project

Name of Submitting Organization: Mid-Michigan District Health Department

Model Partner Organization(s): Montcalm Care Network

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

The proposed model is to establish regional HUBs to coordinate community based health care, mental health and home visiting programs like community health workers (CHW), the Maternal and Infant Health Program and others. Many of the clients of these programs have mental illness or substance use disorders (SUD). These HUBs would be financed through Medicaid full cost reimbursement and this is discussed in the section on financing. The problem the model addresses is the extreme level of duplication among these services coupled with poor quality follow up on referrals. This means that some people are offered similar bundles of services multiple times or are offered inappropriate services, while others who want to be served never are. These inefficiencies cost health plans money while clients often don't obtain the potential health benefits they could get if they were well served. The term HUB comes from CHW programs. A HUB is an organization that manages CHW referrals, contracting, billing and deduplicates services. HUBs use databases to ensure clients are referred to services appropriate for their needs, they assign CHWs and track outcomes. They use these databases to look at the rate at which clients get connected to care and indicators of efficiency such as the length of time clients are enrolled and the number of services consumed. They also monitor health worker productivity which improves supervision. The HUBs integrate health care and mental health by making sure appropriate referrals are made and followed up on.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

The 298 Initiative focuses on the integration of behavioral health and physical health services. To accomplish this the problems of duplication of services and poor follow up on referrals need to be addressed. These problems affect many populations not just people with mental illness or SUD, but also perinatal patients, people in health care transitions, the disabled and the elderly, among others. And of course these populations all experience behavioral health issues. To develop the model it will be necessary to start with a defined, manageable population, gain experience, and expand from there. An obvious place to start would be with the existing CHW HUBs. Before going on let's look at this problem within the context of CHW programs, recalling that CHW programs very often work with people with behavioral health problems. In a given area there may be multiple free-standing CHW programs including some that do not work with a HUB. There can also be CHW programs managed by health plans. Clients of all of these programs can also be receiving services from other agencies such as Community Mental Health (CMH), a community action agency, and others. Many of these organization do not have access to Care Connect 360, or if they do they are not responsible for managing the services for the entire population, only their own enrollees. These organizations may be unaware of services being received by their clients from other sources which leads to duplication of services. When an organization refers a client for services in another agency (for

example one CHW program refers a client to a another CHW program) many will not make a "warm handoff" meaning the client may or may not have the ability to act upon the referral. And the referring agency will not know if the client was ever served. All of this confounds health care and behavioral health providers who are trying to do the right thing by assuring their clients' non-medical needs are being met, who find the system to be simultaneously complicated and unresponsive. When multiple agencies use a single HUB, the HUB can identify the most appropriate referrals for clients and knows all of the services clients are receiving. The HUB can ensure the client has the resources to act upon a referral and can ensure the referring organization knows the outcome.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
In the model all organizations of a given type serving a defined population in a defined area would be required to communicate with a single HUB. For organizations that have an agreement with the State this could be accomplished through that mechanism. Ideally they would all agree to use the HUB for delivery of their services but that is not likely to happen. For example a health plan with a CHW program is not likely to turn over its program to the HUB. However in the model such organizations would be required to inform the HUB of who it is serving and what other referrals have been made. In this way the HUB would be able to deduplicate services and ensure that more referrals are successful.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?
The decision to follow up on a referral or accept services is always made by the client.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
Currently some clients are receiving services from multiple agencies. They can have multiple care plans with inconsistent goals. Other people who badly need services may not receive them if they are unable to follow up on a referral and the referring agency doesn't notice this. By deduplicating services and improving follow up on referrals regional HUBs can ensure physical health and behavioral health services are appropriate and fully integrated. This will increase the efficiency with which care is delivered and the frequency with which needed care is received.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?
The model is specifically aimed at increasing communication among providers and payers by giving them a single HUB through which to communicate.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

The model would improve services by addressing two failures in the current system: the failure of physical health and behavioral health providers to communicate with each other and the failure of some to follow up on referrals.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
Regional HUBs would support the existing workforce by making their work more efficient and effective.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?
It is difficult or impossible for individuals to make decisions about service delivery if they have multiple, overlapping care plans, or if promised services are not delivered. Regional HUBs would address this problem by making services delivery more efficient and responsible.

Would this model affect the administration of complaints, grievances, and appeals?
By ensuring care is integrated, appropriate and timely regional HUBs can reduce undue complexity and the chance for grievances.

How would the model support continued access for individuals to current services, supports, and providers?
By increasing efficiency regional HUBs may increase the number of people who can be served. Additionally the HUBs will identify referrals that were not followed up on and ensure that more people are served.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?
The model would not affect the current governance of community mental health agencies or health plans.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

The model would not affect decision making by individuals, families or the community. Decisions about whether or not to accept offered services would remain with the client.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

HUBs are financed in two ways. Some HUBs are stood up by an agency (a hospital, a community mental health agency) because that organization expects to benefit in some way, for example by having healthier patients or saving money. Other HUBs are connected to existing programs--CHW, home visiting, etc. The HUB bills insurances for the programs' services and the rate includes the overhead cost of sustaining the HUB. Neither of these approaches are doing well in Michigan. HUBs funded through the operating budgets of parent organizations are struggling and HUBs connected to programs that bill insurances are finding payers do not want to pay rates that can support HUBs. In the proposed model regional HUBs would cover their costs of doing business through Medicaid full cost reimbursement. HUBs arrange for services, especially behavioral health services, for the Medicaid population. As such, they should be able to use a prospective payment methodology and be cost-reimbursed for allowable services. To do this, they may need to become designated cooperating organizations of certified community behavioral health clinics.

What changes would need to be made to provider reimbursement in order to implement the model?

The model would make regional HUBs eligible for Medicaid full cost reimbursement.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

We are not proposing to incentivize the use of regional HUBs at the present time although the concept is intriguing.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

Regional HUBs would be engaged in continuous quality improvement. They would have the tools to do this. HUBs manage referrals, contracting, billing and deduplication of services. HUBs use databases to manage referrals, assign CHWs and track outcomes. They use these databases to look at the rate at which clients get connected to care and indicators of efficiency such as the length of time clients are enrolled and the number of services consumed. Regional HUBs should all have access to Care Connect 360 and the ability to match records to look at outcomes and cost and measure return on investment.

Define “success” for the model? How will the model’s success be measured? What types of benchmarks would be appropriate for evaluating the model?

We do not have good baseline data on duplication of services or the number of clients who should be receiving a service but are not. Regional HUBs would need to gather data when they begin operating and use a continuous quality improvement approach to increase the efficiency and effectiveness of services defined in these two ways.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

As was mentioned, Michigan currently has three CHW HUBs. There are other HUBs operating in the state, especially for perinatal services. However none is acting as a regional HUB as in the model proposed here.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

One possibility is that we will find this model will prove most valuable in parts of the state that have many resources and programs. It may be less useful in places with fewer services and providers.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

I am sure changes would be required in order for regional HUBs to be eligble for full-cost reimbursement.

(Optional) Are you aware of any other states or communities which have implemented this model?

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Model #30

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Integrating Primary Care into the Specialty Mental Health System

Name of Submitting Organization: Montcalm Care Network

Model Partner Organization(s): Mid-Michigan District Health Department

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

(ITEM 1: EMBED PRIMARY CARE INTO CMHSP.) This model proposes to embed primary care clinics inside the specialty mental health system, specifically within community mental health services programs (CMHSP). Such a model is desirable as it provides ease of access for individuals with Serious Mental Illness (SMI) in that both services are available at one location and allows for the highest degree of collaboration between primary care and mental health providers through shared space and electronic health records. Routine primary care services would be offered, in addition to the specialty mental health benefit, to include: Well Child exams; Annual preventative physicals; Gynecological care and family planning; Screening for mental health and substance use needs as part of routine care; On-site lab services; Easy referral and coordination with specialty providers; Education on the management of chronic health conditions; and, Resources and support for healthy lifestyle changes. (ITEM 2: MODEL INVOLVES CMHSP, PUBLIC HEALTH DEPARTMENT AND/OR FQHC, AND MEDICAID HEALTH PLANS.) Primary care services could be provided by the CMHSP under contract with a County Public Health Department or Federally Qualified Health Clinic (FQHC) or could be provided directly by either of said health entities. Another option would be for legislative changes to allow for CMHSPs to direct provide basic primary care services -- in the same way primary care practices are currently allowed to provide basic behavioral health services. (ITEM 3: PROMOTES A PERSON CENTERED, WHOLE HEALTH APPROACH TO FULLY INTEGRATED CARE.) This model supports the values and recommendations of the 298 workgroup in that it co-locates and fully integrates care for individuals while leveraging the innovations and strengths of the public CMHSP system in supporting individuals through person centered care that is trauma informed and enables people to live self-determined and inclusive lives in our communities. (ITEM 4: ENHANCED REIMBURSEMENT AND SHARED SAVINGS.) As is recognized nationally, primary care for individuals with SMI and potentially co-occurring substance use disorders, is far more complex than the general population. As such, primary care visits for these individuals requires more physician time to adequately identify and address multiple chronic and serious health conditions. To achieve better health outcomes for these individuals, it requires longer appointment times. Current reimbursement rates for traditional primary care appointments are not sufficient to support the level of care and time needed. We see this barrier in our communities every day with few physician practices willing or financially able to serve individuals with SMI. Therefore enhanced rates of reimbursement for primary care services for individuals served by CMHSPs are essential -- similar to other enhanced rates of reimbursement for dental services that partner with public health departments and FQHC services in Michigan. For these enhanced rates of reimbursement comes a full array of supportive services available within the CMHSP system through whole health approaches that are providing for increased patient engagement, follow through, and self care -- resulting in improved health outcomes and overall cost savings to the Medicaid Health Plans. This whole health approach is enhanced when multi-disciplinary teams of social workers, nurses, and peer supports are able to closely collaborate with the onsite primary care providers to treat the whole person. While increased services and costs are absorbed by CMHSPs, the savings are realized by the

Medicaid Health Plan through a reduction in high cost services and emergency care. Therefore collaboration and shared data metrics are needed to demonstrate a connection between increased costs and realized savings with said savings be shared by the organizations in order to spur future innovation and enhancements within the fully integrated CMHSP system of care. (ITEM 5: MANAGEMENT BY CMHSP IN PARTNERSHIP WITH PUBLIC HEALTH DEPARTMENTS AND FQHCS.) Through contractual partnerships, CMHSPs and Public Health Departments (or FQHCs) could embed primary care services within the CMHSP. Alternately, with legislative changes, CMHSPs alone could manage and provide basic primary care services as direct contractual providers under the Medicaid Health Plans.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
Populations to be served through this model would be all CMHSP populations to include: Adults with serious mental illness, individuals with intellectual/developmental disabilities, children with serious emotional disturbances and individuals with co-occurring substance use disorders. Basic primary care services would also be available to anyone in the community that wishes to receive services at the CMHSP location.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
The model utilizes a whole health approach of supporting individuals to address their physical and mental health needs in an environment that embraces and promotes person centered, self determined and trauma informed services. The full array of specialty mental health services would be available to individuals in addition to basic primary care services. Referrals and supports in seeking advanced, specialty physical health services would be facilitated by the fully integrated CMHSP treatment team.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?
Individuals served by the CMHSP would continue to have the option to receive primary care services from outside providers. These individuals could serve as a comparison group in identifying the cost benefit of integrating services within the CMHSP. For those that choose an outside primary care provider, CMHSP would continue to provide services with a whole health approach and would continue to coordinate care with the outside provider.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
This model is a fully integrated model at the provider level. It is currently implemented in the CMHSP in Montcalm County and has 187 individuals open to services. Having a primary care provider onsite provides for immediate access to care for individuals when it is determined the person has a serious health concern and does not have an identified primary care physician. It also provides for ongoing and frequent consultations with staff in supporting the whole health approach.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?
On the ground, the primary care provider is attending regular meetings with various treatment/program teams at the CMHSP facility. This provider is also a CMHSP employee and therefore communication is seamless. Additionally, the CMHSP built a physical health component into its existing electronic health records so all treatment information is accessible to the full treatment team. Medical Assistants are utilized to support clinic operations such as referrals to specialty care, labs and monitoring of treatment adherence. Outcomes of interventions are collected in the fully integrated electronic health record to facilitate ease of reporting to payer sources that are looking for positive outcomes and value based performance.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?
The whole health approach is defined by the CMHSP to include screening tools, a health stratification system for identifying the individual's level of care, and related interventions through established pathways of care for identified chronic health conditions such as diabetes, COPD, high blood presure, smoking and obesity. This whole health approach provides guidance and structure to allow for future measurement to determine effectiveness of staff and particular interventions in improving health. This model increases physical health capacities for consumers in the community and addresses the needs of individuals who historically have not been seen regularly by a primary care provider due to ongoing issues with inconsistency in attending appointments or not following treatment orders due to issues stemming from their behavioral health needs.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
The strength of this model is that it deliberately and purposefully brings together mental health and physical health providers as part of an integrated, multi-disciplinary team. It enhances the system as it enables providers on each side to learn the nuances and practices of the other through cross-training and close collaboration. By implementing a whole health approach, mental health staff are better able to understand, implement and monitor services that come together to treat the whole person. This model represents a continued building on the strengths of the specialty system particularly in relation to care management principles and skill sets in working on multidisciplinary teams. It requires that value be given to the coordination that occurs in assisting an individual with complex, chronic health conditions. A retooling of the CMHSP system is not necessary for this integrated model of care. Training the workforce involves expanding competencies and comfort levels for staff working to share the responsibility of monitoring whole health indicators and expanding vocabularies further into the terrain of physical health care.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

While there are always opportunities for improvement, as identified in the interim 298 report, person centered planning, self determination and personal choice are long standing practices in the CMHSP system. This model empowers individuals by exposing them to wellness opportunities such as fitness and nutrition classes and educates them on self-management to understand the importance of taking better care of themselves. Integrated Health in this model is the essence of choice. Individuals have an array of options available. This includes choosing team members, types of interventions from the physical to mental health arenas. Motivational Interviewing is a key strategy utilized throughout the treatment system to help person evaluate personal readiness. Individuals are exposed to a variety of wellness opportunities including fitness, nutrition, psychoeducation, self-management strategies, all provided in varying modalities - individual, group, family oriented. Meeting people where they are at and providing choice while maximizing the evidence of what works for the population is the advantage of building an integrated program designed around a specialty population. Person-Centered Planning becomes a fluid process within this model to adjust to the changing needs and goals while being a highly interactive model of care in which consumer feedback and choice about what comes next is continually sought.

Would this model affect the administration of complaints, grievances, and appeals?

No

How would the model support continued access for individuals to current services, supports, and providers?

This model enhances the current CMHSP system of care while promoting increased access to primary care services for these individuals.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

No change. CMHSP Board of Directors is appointed by the County Board of Commissioners to oversee operations. As required by the mental health code, 1/2 of these individuals are primary or secondary consumers.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

Stakeholders participate in decision making by serving on the CMHSP Board of Directors and through various quality committees.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?
The embedded primary care clinic is currently operating part-time due to financial constraints as reimbursement rates are not sufficient to support the level of care needed. Grant funding is supporting operations in hopes that processes can become efficient enough to be sustainable ongoing. However, the amount of time needed for appointments continues to be higher than in a standard practice (20-30 minutes versus 10 minutes). Therefore enhanced reimbursement from the Medicaid Health Plans is needed on a fee-for-service basis.

What changes would need to be made to provider reimbursement in order to implement the model?
Enhanced rates to cover the additional time needed to fully address the health needs of this more chronically ill, complex population.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
Medicaid Health Plans could provide enhanced payments to CMHSPs for achievement of agreed upon health metrics or population health outcomes funded through savings realized by the health plans as a result of CMHSP services. Shared savings should be allowed to be held by the CMHSPs to fund innovation and further development and enhancement of the embedded health services. Retention of savings by CMHSPs would require legislative changes.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?
The CMHSP system has a long history of working to continually improve quality and recognizes the importance of seeking stakeholder input through internal processes and formal measures. The importance of improving overall health of individuals and ability to demonstrate value are strong motivators for the system. Specific ideas for measures are detailed further below. While benchmarks specific to fully integrated services for SMI and SUD populations are limited, there are considerable opportunities within electronic records and health information exchanges to collect and analyze data for process improvement.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?
Success is realized when there is increased access to primary care and preventative services for individuals with SMI which together improved health and reduced costs. Measures of the effectiveness of the model in integrating physical health services into the specialty mental health system could include: Structural measures -- extent to which electronic health records are fully integrated, online medication order entry systems, connectivity and utilization of CareConnect 360 data and Health Information Exchange capabilities. Capacity measures -- ratio of providers to patients, average appointment time, wait time, no show rates. Process measures -- frequency of specific interventions and

preventative services for specific chronic conditions, chronic conditions that are controlled. And lastly, Outcome measures -- reductions in hospitalizations and emergency room utilization, self-reported days of improved health, stability in housing, employment, transportation, and attributable cost savings.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Yes. It is already occurring in Montcalm County. Enhanced reimbursement is the missing piece along with shared metrics and savings with the Medicaid Health Plans. Other CMHSPs could be recruited to establish embedded clinics in partnership with local Health Departments or FQHCs (or as stand alone providers if legislative changes were made allowing the CMHSPs to be primary care providers under the law).

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

Yes, the model allows for a variety of approaches however core elements would need to be assured (i.e., shared electronic health record, shared space, shared staffing, shared metrics). Many CMHSPs already have integrated health efforts underway. Implementation could be accomplished through self-readiness assessments and a phased-in approach.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

The current process for achieving the fully integrated model requires CMHSPs to identify willing partners. There may be communities in which a willing partner does not exist. In such a case, legislation would be needed to enable CMHSPs to be providers of physical health services which they are not currently allowed to do under the laws that created them. There would also need to be legislative changes to allow for CMHSPs to retrain shared savings in the same or similar way the Medicaid Health Plans are allowed to do.

(Optional) Are you aware of any other states or communities which have implemented this model?

This fully integrated model closely aligns with the models piloted under the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) grant program. Research on the PBHCI grant program is available at
http://www.rand.org/content/dam/rand/pubs/research_reports/RR500/RR546/RAND_RR546.pdf

Model #31

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Integrated Care Networks for Individuals with Intellectual Disabilities

Name of Submitting Organization: MORC, Inc.

Model Partner Organization(s): interested Medicaid managed care plans

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

This model overview proposes a pilot project to assess the effectiveness of an integrated service delivery network focused on individuals with intellectual disabilities. It would provide an opportunity to assess a variety of integrated care strategies in a specific region among a single population before broadly applying the approach state-wide to all populations served within the public mental health system. The model consists of a private behavioral health entity, such as MORC, Inc. serving as a care integrater. The care integrater would serve as a central care coordinator to develop a person-centered services for individuals with intellectual disabilities that is inclusive of both behavioral health supports and physical health care services. The care integrater would partner with a managed care plan, such as United Healthcare, to coordinate physical health care services. The partnership would make available all current Medicaid funded behavioral health services for individuals with intellectual disabilities as well as the full complement of physical health care services such as routine primary care, prevention and early detection services, specialty care, hospitalization, etc. The care integrater and managed care partner would maintain networks of contracted direct service providers large and diverse enough to both provide the full service array and to offer a wide degree of choice for individuals served. The financial structure of the model consists of the care integrater contracting directly with MDHHS or a delegated administrator to coordinate integrated services within a person centered plan for individuals with intellectual disabilities. The care integrater would be reimbursed via a capitated per member per month payment structure. The care integrater will contract with a network of direct care providers who will be reimbursed via negotiated rates based on type of service provided. The care integrater will reimburse its managed care partner via negotiated fee for service rates for physical health care services. MDHHS or a delegated public entity would serve as the contract manager, establish policy and quality indicators, provide auditing and oversight, and establish an independent body to oversee recipient rights and resolve grievances, complaints and appeals arising from the integrated care network. The proposed model aligns with many of the values and recommedations of the 298 report including person-centered planning, self-determination, and perosnal choice as core values, streamlined access to care, integration that occurs at the individual service delivery level, the ability of the benefit to follow the consumer, the establishment of an independent, state-wide entity for rights and grievance issues, the elimination of multiple administrative layers to improve efficiency, and increased uniformity in service array, policies, procedures, quality standards and data collection.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

The pilot project would focus on individuals with intellectual disabilities. The model views individuals with intellectual disability as distinctly different from individuals with mental illness or substance use disorders. Whereas the focus of services among the mentally ill and those with

substance use disorders is on recovery, the focus of services to those with intellectual disabilities is on long-term supports that are ongoing and typically life long. The health care and support needs of individuals with intellectual disabilites also tend to be more complex, with a more acute need for strong coordination between the physical health and behavioral health services. Additionally, services and supports for individuals with intellectual disabilities represent the highest percentage of Medicaid funds in the public mental health system. Therefore, a pilot project targeting this population will serve as an prudent test study for the effectiveness of integrated care approaches in impacting both quality of care and cost effectiveness of service delivery. It is anticipated that if the model proves successful for those with intellectual disabilities who tend to have the highest support needs, it could be easily replicable to include all populations served by the public mental health system including those with mental illness and substance use disorders.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
The pilot project would ensure delivery of all current Medicaid funded behavioral health services for individuals with intellectual disabilities including the home and community based waiver, autism benefit waiver, Healthy Michigan and MIChild programs while also folding in the management of physical health issues (i.e. primary care, prevention, early detection, medication management, specialty services, hospitalization, etc.) under a single care coordination structure.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?
Depending on the number of integrated care networks established within a region, individuals with intellectual disabilities would choose which integrated network to directly access for their services and supports. This would eliminate all individuals accessing the system through a regional central access point. Once an individual has been intaked, they would have input in selecting a care manager, employed by the care integrater, to assist them with the person centered planning process. All medically necessary Medicaid funded services and supports authorized in an indivdual's person centered plan for both physical health and behavioral supports would then be provided in the person's local community by contracted direct care providers chosen by the individual.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
The proposed model would enhance coordination of physical and behavioral health services in several ways. First, individuals with intellectual disabilities would have a single care coordinator to develop a person-centered plan that addresses both behavioral support needs and physical health needs. The model also proposes the development of a heatlh information exchange so that health information can be shared among all direct care providers to ensure consistency and coordination of service delivery while reducing duplication and redundancy. The model creates the opportunity for regular feedback to be provided from all aspects of services to the central care coordinator so that challenges, changing

needs or alarming trends can be identified and addressed eariler and more efficiently. As needed, case conferencing among various clinicians and direct care staff within the integrated network could be facilitated to help address health care and support needs in a more coordinated way.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?
The proposed model promotes greater collaboration because physical health care services and behavioral support services for those with intellectual disabilities will be coordinated within a single person-centered plan. The use of a health information exchange will make opportunties for collaboration more transparent while enhancing communication and service coordination between primary care physicians and behavioral supports providers. The central partnership between the care integrater and the managed care organization will also allow for a merging of the their provider networks which will provide new opportunities for collaboration, referral relationships, and shared support options.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?
The proposed model would improve accessbility by allowing individuals with intellectual disabilities who meet eligibility requirements to directly access the integrated care network. Direct access to the care integrater versus the current central intake and referral process prominent in most regions, will allow individuals to access services faster and more efficiently. The partnership of the care integrater and the managed care plan will increase availability of providers for all service types, both physical health and behavioral supports. By streamlining the intake process and reducing administrative layers in care coordination, more resources will be available for services to the individuals. Uniformity of service delivery will be greatly enhanced through the development of standardized assessments, contracts, training, credentialing, utilization management, quality standards, data collection and outcome standards.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
The proposed model would not significantly impact the recruitment and retainment of core health care personnel such as clinicians and direct care staff. However, implementing uniform training and credentialing requirements would strengthen the quality and consistency of service delivery throughout the integrated network. Additionally, the proposed model also strongly supports an increase in direct care wages as recommended by the 298 interim report. The extremely high turnover rate that currently exists among direct care workers contributes to instability within the public mental health system as well as disupts continuity of care among individuals receiving services. An increase in wages for this particular employee class would be a vital element in recruiting and retaining quality direct care staff. The project also provides an opportunity for key ancillary personnel such as peer mentors and parent support partners who are common to the public mental health system

to expand their availability and be utilized more broadly in supporting individuals with physical health challenges. As information sharing is a key element of an integrated service delivery network, new job opporunities could develop in the areas of information technology, health informatics, health information management and data analysis.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

The proposed model supports the foundational values of person-centered planning, self-determination and choice that currently exist in the public mental health system. It will reaffirm those values while also carrying them over to the delivery of physical health services. By having the behavioral health entity, who is more familiar with these concepts than the managed care plans, serve as the point of entry and central coordinator of care, the person-centered focus of care plans will be preserved, even as physical health care services are folded into the overall plan of care. The merging of the large existing provider networks currently maintained by the integrater agency and the managed care plan ensures a high level of choice in providers for both physical health and behavioral support services.

Would this model affect the administration of complaints, grievances, and appeals?

Consistent with 298 interim report recommendations, the model proposes a single, independent, state-wide entity to monitor and address Medicaid recipient rights issues. This will improve the uniformity in the rights process by eliminating local rights offices that often have differing processes for reporting and investigating rights complaints and sometimes different interpretations of rights violations. This independent state-wide body would also serve as the final arbiter of grievances, complaints and appeals within the system. In the 298 affinity groups, there was some support for having the opportunity to resolve greivances at the local level first. This could be accomplished by establishing an independent ombudsman to hear grievances at the local level. This local greivance body could be newly established or an existing advocacy agency such as the local Arc could be contracted to provide this function. If the issue cannot be resolved at the local level, it would then go to the state-wide grievance body for final resolution. This model would allow for a local resolution first, but to overall, streamline the grievance process for more prompt, consistent and efficient resolution.

How would the model support continued access for individuals to current services, supports, and providers?

The proposed model supports the idea of the benefit following the individual. Therefore, in the proposed model, there would be a grandfathering process developed that would allow an individual with an intellectual disability who is currently receiving services and has an existing person-centered plan to gain direct access to the integrated care network with previously authorized supports maintained to the highest degree possible. This would eliminate the current practice of individuals having to re-establish eligibility, recreate a new person-centered plan, and have their services and supports reauthorized when they move from one PIHP to another. Once in the integrated network, an assessment of physical health needs would be provided and the person-centered plan modified to incorporate the coordination of physical health services in conjunction with the their behavioral health supports. While consistency of direct care providers could not be guaranteed as the providers

would have to be contracted with either the integrater agency or the managed care plan partner, it is anticipated that the majority of direct care providers within a geographic area will either have an existing contract with the integrater agency or will be able to obtain one under the new model, making it more likely that an individual will be able to maintain their providers. If for some reason an individual's current providers are not available within the integrated care network, then they would still be offered an abundance of choice to select new providers from within the provider network. Maximizing choice through recruitment of a sufficient number of providers for all areas of service will be prioritized in the model. Also, through Self-Determination, individuals can choose their own providers who can then by empaneled by the care integrater.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

In the proposed model, the integrater agency that will serve as thecontractee and the central coordinator of services, is a private, non-profit behavioral health entity. Having a non-profit corporation serve as the central coordinator of care ensures that the focus of service delivery is on providing high quality care to individuals served and not on generating profit. The governance of the care coordinator would follow that of a traditional non-profit board with a specfied number of board seats reserved for representation by individuals or family members served or other key stakeholders. In addition, Board meetings would be subject to the open meetings act, ensuring public access to meetings and broader transparency of information, financial statements and other quality data. Non-profit corporations are further required by law to disclose their financial statements including salary information of directors, officers and key employess to the IRS via a 990 form and also make this information available to the public, further enhancing transparency and acccountability.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

The proposed model would provide a variety of opportunities for individuals, family members and the community to be engaged in decision making. First of all, the model maintains the core values of person-centered planning and self-determination as the foundation of care coordination in the integrated setting. Individuals receiving services and their chosen representatives will serve as the key voice in designing a plan of care emcompassing both physical and behavioral health services based on their needs, wants and personal preferences. The integrated design of the care network will offer a large network of direct service providers to promote a great degree of choice for those served and their families. Further, the proposed governance structure would require opportunities for individuals served, family members and key community stakeholders to sit on the Board of Directors and have a direct role in setting strategy and in decision making. As part of its continuous quality improvement structure, the integrater agency would also design and maintain a variety of mechanisms to solicit feedback from individuals and families served including customer satisfaction surveys, town hall meetings, advisory committees, family advocacy groups, a public website and social media forums.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

The pilot project proposes that the private behavioral health entity, such as MORC, Inc., receive a direct contract from the MDHHS or its delegated administrator to coordinate integrated health service delivery for individuals with intellectual disabilities within a specific geographic cachement area. The care inegrater would be financed based on a per member per month capitated rate in the contract. The behavioral health entity will be partnered with one or more Medicaid managed care plans for physical health care services. Medicaid covered behavioral health services will be provided through the integrater's network of contracted direct care providers via already established reimbursement mechanisms. MORC, Inc., for example, already has an established network of over 300 direct care service providers to deliver behavioral health supports over a tri-county service area. The Medicaid health plans would be reimbursed on a negotiated fee for service basis for physical health services provided through their established networks.

What changes would need to be made to provider reimbursement in order to implement the model?

The model would require a direct contract from MDHHS or its delegated administrator (PIHP) to the care integrater. A fee for service reimbursement schedule would then have to be developed between the integrater agency receiving the contract and the managed care organization coordinating the primary health care services. Direct care providers contracted with either the integrater agency or the managed care plan would continue to be reimbursed through established contracts and reimbursement formulas on both on the physical and behavioral health sides. New providers could be added to the network on an ongoing basis by submitting to established application and credentialing protocols.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

The model proposes the ability to retain any earnings achieved through the contract as an incentive. Under the current structure, contracted service providers must give back any savings achieved, therefore providing no incentive for meeting quality and service delivery goals in the most efficient way possible. The abiity to retain savings achieved creates the opportunity for the funds to be directed back into the integrated network to provide more services to more individuals and to strengthen quality. Additionally, a menu of value, outcome and efficiency based incentives could be designed by the integrater agency in conjunction with its managed care plan partner. These incentives could be added into existing and new contracts as applicable to incentize quality and cost efficiency throughout the service delivery network.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

There are existing, well established quality and performance and improvement indicators directed by MDDHS for service delivery within the public mental health system. The proposed model would continue to collect and report data on those indicators while also seeking ways to integrate the Healthcare Effectiveness Data and Information Set (HEDIS) used by over 90% of managed care plans to track performance over a wide range of health indicators. Data sharing on both of these sets of performance indicators through a health information exchange would allow for identification of key areas of improvement as well as opportunities for improved coordination of care. The integrated care network would also submit to regular audits by MDHHS, its delegated administrators, and appropriate accreditation bodies as applicable as part of a continuous quality improvement process. Customer satisfaction surveys as well as the implementation of consumer advisory commitees and other feedback mechanisms at the care integrater level will also be used to provide ongoing input for continuous quality improvement.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

The proposed model seeks to improve the quality of life and health outcomes for individuals with intellectual disabilities through more streamlined service delivery and greater coodination of physical health care with behavioral support services. More broadly, if successful, the model would clearly demonstrate that the integrated care approach was able to positively impact key quality and cost effectiveness indicators among individuals with intellectual disabilities including: improvements on HEDIS and behavioral healht metrics, a reduction in critical incidents, a reduction in hospitalizations, a reduction in emergency room visits, less duplication of services, a reduction in medication errors, and overall lower costs due to improved coordination of care.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Yes. A suggested approach would be to partner an established behavioral health entity such as MORC, Inc. with a managed care plan, such as United Healthcare, to test it's impact on access to care, health outcomes, and cost effectiveness of services provided to individuals with intellectual disabilities. It would also be useful to pilot the project in two different regions, one in an urban area and one in a more rural area, utilizing local providers.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

Piloting the project in both an urban and rural area would help identify if there are geographic factors that impact the effectiveness of the model that would have to be accounted for before replicating it on a larger, statewide scale.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

Click here to enter text.

(Optional) Are you aware of any other states or communities which have implemented this model?
We are not aware of other states implementing the proposed model.

Model #32

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model:
Total Health Collaborative

Name of Submitting Organization:
Kent County Community Mental Health Authority d/b/a Network180

Model Partner Organization(s):
Affinia Health Network in affiliation with Mercy Health, Pine Rest Christian Mental Health Services

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms, and (5) how a competent, public body would be engaged in managing the model.

A person's physical and behavioral health needs are inextricably intertwined, necessitating effective and readily accessible whole-person health care. Individuals served in the public behavioral health system have especially high rates of co-occurring physical health conditions. Existing Michigan Medicaid physical and behavioral health provider systems are not integrated, leading to reduced care quality, worsened consumer experience, and increased costs.

This pilot assembles willing and able partners into an innovative *person-centered, financially and clinically accountable, integrated provider partnership* that will re-integrate services supporting person-centered, whole-person care. In this not for-profit public/private partnership, Mercy Health's Affinia Health Network ("Affinia"), Pine Rest Christian Mental Health Services ("Pine Rest"), and Network180 (together, the "Total Health Collaborative"), will pool and directly manage physical and behavioral

health funding at the provider level to support seamless services integration for consumers. Clinical providers will collaborate across organizations to provide comprehensive and fully integrated care. This innovative clinical and financing model, developed in collaboration with behavioral health consumers, will solve fragmentation problems, centering care on the people we serve – consumers, their families and communities.

Specifically, the Total Health Collaborative seeks to demonstrate that a *person-centered*, *accountable integrated provider partnership* will:

• Provide the full range of behavioral health services and supports to all pilot consumers including meeting mild, moderate, and severe levels of need;
• Provide a comprehensive array of fully integrated substance use disorder treatment options to all pilot consumers;
• Remove barriers to physical and behavioral health integration for consumers and providers;
• Institute seamless access to care at physical and behavioral health care sites;
• Move clinical managed care functions from the health plan to the provider level, improving efficiency and efficacy, thereby increasing the percent of resources dedicated to direct service;
• Advance effective systems and support for providers in multiple organizations to deliver seamless integrated physical and behavioral health care; and
• Support and incentivize nimble, continuous innovation by directing more resources, responsibility and accountability to the provider level.

(1) *Supports and Services*. Individuals participating in the pilot will have access to a full array of integrated physical and behavioral health services. Physical health services will include primary care, specialty care, acute inpatient care and emergency medicine. Individuals will have access to a complete continuum of behavioral health and intellectual and developmental disability ("I/DD") services and supports with the capacity to meet mild, moderate and severe needs.
(2) *Organizations*. Network180, Pine Rest Christian Mental Health Services and Affinia Health Network are partnering to create the person-centered, accountable integrated Total Health Collaborative. The Total Health Collaborative will operate as a non-profit public/private partnership, providing consumers with a fully integrated care experience and comprehensive physical and behavioral health services.
a. Network180 is the public Community Mental Health Services Program ("CMHSP") for Kent County and provides services directly and through contracted providers to adults and children who experience mental health conditions, substance use disorders, and developmental disabilities.

b. Affinia Health Network operates in affiliation with Mercy Health, a non-profit partnership of hospitals, doctors, and other health care providers throughout West Michigan. Mercy Health is also part of Trinity Health, a large non-profit health care delivery system operating in 21 states coast to coast. The purpose of Affinia is to allow hospital-employed and independent physicians to better work together to provide seamless, coordinated care to patient populations, while improving quality and reducing waste in the current system.
c. Pine Rest Christian Mental Health Services is a large free standing non-profit behavioral health provider, offering a full continuum of services including inpatient and partial hospitalization, residential and outpatient services, addiction treatment and recovery, extensive child and adolescent programs, senior care services, as well as specialized assessment and treatment clinics.
d. The Total Health Collaborative's network of service providers will include the existing non-profit providers within the Network 180 system, Affinia Health Network and Pine Rest Christian Mental Health Services.

Payers will participate in the pilot by delegating certain managed care functions and transferring accompanying resources to the Total Health Collaborative, allowing the Collaborative to streamline clinical functions and direct an increasing proportion of resources into services. The Lakeshore Regional Entity Prepaid Inpatient Health Plan ("PIHP") and one Medicaid health plan ("MHP") have committed to partner with the Total Health Collaborative. (See PIHP Recommendation Letter, page 21). The Total Health Collaborative is open to additional payer participants.

(3) *298 Values and Recommendations*. The Total Health Collaborative's partner organizations fully support the values and recommendations of the Section 298 Interim Report. As illustrated in this proposal, the Total Health Collaborative model is designed to provide a seamless experience of care for consumers and to maximize the percent of resources that reach direct services. In this pilot, increased responsibility and flexible funding are transferred to providers. Jointly accountable providers are then charged with collaborating across organizations to improve consumer experience, health care quality, and outcomes.

(4) *Financing*. The foundation of the proposed business model for the Total Health Collaborative are accountable provider organizations that are financed by capitated payments and similar value-based payment constructs. Under this model, Network180 will be funded with public behavioral health dollars and become a public risk bearing behavioral health services organization. Affinia will contract with the participating MHP(s) for funding and will operate as a non-profit accountable physical health organization. These financially accountable provider entities will then partner with one another and Pine Rest to form the Total Health Collaborative. The Total Health Collaborative partners will pool and jointly manage funds to assure alignment of optimal care with financial incentives. See Diagram 1, page 16.

Certain managed care services would be delegated to the Total Health Collaborative, for example, care management, referral management, quality management and client engagement. Other functions such as Medicaid eligibility and state reporting may be retained by the participating payers. All participating payer and provider entities are prepared to partner in a way that eliminates administrative duplication, removes unnecessary service delivery inefficiencies, and integrates care delivery. The financing model would integrate resources from the traditionally separate behavioral health and physical health risk pools and hold the Total Health Collaborative accountable for managing within these economic parameters while delivering on the defined quality and care experience outcome expectations.

This pooled, flexible funding structure will also support payment mechanisms that remove burden from providers and encourage high value activities not well supported by fee for service structures. This will allow providers to partner with consumers and provide the right care, in the right amount, at the right time for optimal resource allocation and health outcomes.

The Total Health Collaborative also seeks to test a model where flexible funding could be managed to address needs in non-traditional but critical domains that impact health, such as housing and nutrition. This will result in enhanced service and community capacity building around social determinants of health.

(5) *Competent Public Management Body.* In this model, Network180, the CMHSP for Kent County, will serve as the primary public behavioral health management body. The Lakeshore Regional Entity PIHP will partner with Network180 to support this model. The Total Health Collaborative would then pair Network180, the public behavioral health services manager, with two non-profit providers to form a public/private partnership that offers a full and seamless array of integrated services.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

One MHP has committed to partner with the Total Health Collaborative on this pilot model; others may choose to participate. The pilot population will include all individuals enrolled by the participating MHP(s) who also receive their primary care through Affinia Health Network, including adults and children with mental illness, substance use disorders and developmental disabilities. The model's integrated approach will allow the Total Health Collaborative to identify unique needs of individuals, reach out to individuals whose services and supports are not well coordinated, and optimize care for all participants. Following a successful initial implementation, the model is designed to be easily expanded in West Michigan to include members of additional interested MHPs, as well as replicated by payers and providers in other Michigan communities.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

The Total Health Collaborative is designed to offer comprehensive and integrated services for all levels of physical health, mental health, substance use disorder, and developmental disability need. Behavioral health services available to all populations will include all services and supports currently covered by the Medicaid, General Fund, Block Grant, and Public Act 2 funded system. The attached Service Structures Diagram (Diagram 2, page 17) provides a high level overview of the services offered.

The Total Health Collaborative's partners understand the profound impact of substance use disorders (SUD) on individuals, families, health systems, and communities. The Total Health Collaborative will offer a full spectrum of specialty treatment and recovery options, which will be fully integrated into care for individuals experiencing SUD. Through the Total Health Collaborative, consumers will have access to a co-occurring capable crisis stabilization unit for urgent SUD crises, sub-acute detoxification, intensive stabilization, short and long term residential treatment, temporary recovery housing for individuals graduating from treatment, medication assisted treatment, community and home-based therapy and peer-based recovery coaching, intensive outpatient and individual and group outpatient therapy, and peer recovery groups such as Recovery Allies.

In addition to existing behavioral health services, new behavioral health service innovations will be available to increase access and improve consumer experience of care including: a) increased tele-access to behavioral health screening and care, b) an enhanced array of behavioral health crisis services for all pilot populations, serving as an alternative to emergency departments and jails for individuals in crisis, and c) a streamlined joint assessment process for Home Help and Community Living Supports services for individuals with I/DD.

As a supplement to direct treatment, the Total Health Collaborative will share an Integration Consultation Team and Care Management staff to support providers and consumers in coordinating care. The Care Management team will include clinical staff as well as peer supports and recovery coaches who will provide consumer outreach, engagement and self-management support.

The Total Health Collaborative's full integration of these supports and services will have a profound impact on consumer experience of care. The attached Consumer Experience Map (Diagram 3, pages 18-19) illustrates care scenarios of a fictional individual, Roberto, who has a variety of common physical and behavioral health care needs. The Map and accompanying episode of care description compare his care experience and health status under existing structures with improved results under the Total Health Collaborative model.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

Individuals who are enrolled in the participating MHP(s) and receiving primary care through Affinia will be individually invited to participate in the pilot. The Total Health Collaborative will provide potential participants with comprehensive information about providers, services, service locations, and integration strategies available through the pilot. All consumers will have the right and opportunity to choose to receive services outside the pilot. Although integration will occur across multiple organizations within the Total Health Collaborative, each consumer will have the opportunity to select his or her health home, which could be a primary care or behavioral health setting.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

The model would enhance the coordination of physical health and behavioral health by removing barriers that stem from separate funding and service delivery systems. Currently, consumers frequently experience coordination challenges between providers who are funded by MHPs on the one hand, and those who are funded through the public behavioral health system on the other hand. Similarly, individuals with varying levels of behavioral health need run into difficulties navigating between the mild/moderate MHP benefit and more intensive publically funded behavioral health care. Though efforts have been made to integrate substance use disorder expertise into mental health organizations, individuals experiencing substance use disorders frequently find themselves in their own service delivery silo, disconnected from both physical and mental health providers while struggling with intense needs. This pilot removes these problems by pooling funding from both systems at the provider level. Public behavioral health funding is preserved and not merged into a private health plan, but the division between funding sources is not experienced by providers or consumers receiving services. Instead, consumers work with multiple providers of their choice who are able to coordinate all services and supports, who can collaborate easily, and who also share responsibility for quality and outcomes.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

The model will promote greater collaboration among providers and agencies by establishing a shared Integration Consultation Team, which will provide cross-organizational support to clinicians in the areas of clinical decision making, managing risk and complex cases, and troubleshooting social and economic challenges that fall outside traditional healthcare.

In addition, building on a successful three-year Network180-MHP collaborative care management model, the Total Health Collaborative will establish dedicated shared care management infrastructure, including shared Care Management staff and the establishment of norms and simple tools to support cross-organizational communication and collaboration. Essential tools include a shared client registry and high level care strategy plans. The Total Health Collaborative will support participating clinicians by providing dedicated time for cross-provider communication and collaboration.

See the Patient-Centered Integration Diagram (Diagram 4, page 20) for a graphical representation of clinical integration structures.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

The Total Health Collaborative improves the availability of services by offering the full spectrum of physical and behavioral health services to all participants. It will improve access by allowing consumers to seamlessly access behavioral health, including through tele-medicine, at both physical and behavioral health provider sites within the Total Health Collaborative.

Because of Network180's history as a former Substance Abuse Coordinating Agency and longtime investment in delivering co-occurring capable treatment, the Total Health Collaborative is uniquely prepared to offer seamless access to SUD treatment. The Total Health Collaborative will also significantly enhance access by offering a transformative approach to behavioral health crisis services, including a dedicated behavioral health crisis stabilization alternative to emergency department care, mobile community-based crisis intervention teams for adults and children, and crisis residential options. Immediate crisis intervention and linkage to appropriate treatment will increase access and improve resource allocation by providing the right treatment at the right time to individuals with urgent needs. The Total Health Collaborative supports the recommendations of section 4 of the 298 Interim Report regarding uniformity of services and supports, including medications, and will work to implement them in collaboration with MDHHS, payers, and other health provider organizations.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and

other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

Streamlining clinical care management functions by embedding them at the provider level will allow an increased proportion of funding to be allocated to direct services, including supporting the workforce that delivers care. In addition, flexible capitated funding will allow the Total Health Collaborative to explore service and payment models that are more rewarding for health care providers than traditional fee for service structures. For example, in the Total Health Collaborative, providers will increasingly work in multidisciplinary teams and be offered more time to consult, collaborate, and learn from one another. Similarly, when providers can focus their attention on consumers and care outcomes instead of volume or billable units, they are more satisfied and organizations experience less staff turnover.

The Total Health Collaborative supports the recommendations of the 298 Interim Report, the Partnership for Fair Caregiver Wages, and the Section 1009 report, which call for increases in the Medicaid rates paid to direct care staff serving in the I/DD system. The Total Health Collaborative supports the recommendation that payment should reflect the real cost of the increases in the minimum wage and the real costs of attracting and retaining direct care workers who are core to the quality of life of those served by the public behavioral health system.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

The primary goal of the Total Health Collaborative is to make care more person-centered by removing systemic barriers to integration, offering a full spectrum of whole-person care, and empowering consumers to work with their providers to get the care they need when they need it.

The Total Health Collaborative is dedicated to the values of person-centered planning, self-determination and choice. These values are at the core of our service delivery culture. The person centered planning process is central to the provision of services. The Total Health Collaborative would broaden choices presented through the person-centered planning process to include considerations around physical and behavioral health. It would provide the contextual structure to enhance the integration of physical health and mental health services. Central to the Total Health Collaborative model is the empowerment of individuals to have choice and control about their services. At Network180, this is accomplished through the person-centered planning process as well as self-

directed services. Network180 has experienced significant growth in self-directed services. The number of individuals who choose self-directed services has grown from 219 individuals in 2009 to 608 individuals in 2016, and it is anticipated that self-directed services would be significantly enhanced through the Total Health Collaborative.

Would this model affect the administration of complaints, grievances, and appeals?

The Total Health Collaborative will provide a responsive local process to allow for a first attempt to resolve consumer complaints. The Total Health Collaborative supports and will work to implement the 298 Interim Report's recommended redesign of the complaint, grievance and appeals process, and will be adaptive and responsive to changes in the grievance and appeal system as adopted by the State in response to the 298 policy workgroup.

How would the model support continued access for individuals to current services, supports, and providers?

The pilot model supports continuity of care through the belief that every consumer should be connected to a permanent health home, whether the home is located in a primary care or behavioral health setting. Instead of discharging or transitioning consumers who experience varying levels of illness and recovery, primary care and behavioral health homes are designed to flex based on the changing needs of a consumer. This allows a consumer to maintain continuity with his or her care team regardless of the intensity of need at any given time.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

The Total Health Collaborative partners will implement a shared governance model to oversee pooled funds and integrated care service delivery. It is anticipated that for pilot purposes, shared governance responsibilities will be established and defined through contract. Public behavioral health services and funds that are integrated into the Total Health Collaborative are the responsibility of the Network180 Board of Directors. All meetings, data and information related to the model are public and are subject to the Open Meetings Act.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

Network180 provides multiple structures to seek out and incorporate consumer feedback on publically-funded services and supports, all of which would be incorporated into the Total Health Collaborative. The Network180 Board of Directors is comprised of individuals from diverse backgrounds, including family members of individuals who receive services through the public behavioral health system as well as direct consumers, Kent County Commissioners and community members. In addition, Network180 maintains standing consumer advisory groups for individuals receiving behavioral health and I/DD supports and services. Network180 also hosts an annual public hearing and various ad hoc opportunities for consumer engagement and participation, such as a series of "Coffee with the Executive Director" sessions this past year. As the Total Health Collaborative is formalized and implemented, the partners will seek out and provide additional opportunities for consumer and family involvement in service design and delivery.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

In this model both Affinia and Network180 become accountable provider entities with the ability to reinvest funding into services. To support the piloting of this model, collaborating payers will agree to delegate certain managed care functions and resources, which will be embedded at the provider level for improved flexibility, coordination, efficiency, and impact on outcomes.

What changes would need to be made to provider reimbursement in order to implement the model?

No changes would be necessary in order to implement the model. Affinia and Network180 each have considerable experience operating as financially accountable entities, which will be leveraged in creating the integrated Total Health Collaborative. To support optimal health outcomes, quality, and experience of care, however, the Total Health Collaborative intends to design and implement payment models for participating providers that reward high quality care and optimal consumer experience. Network180 has successfully implemented this type of payment with contracted providers and will expand on these payment models for the pilot.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

The Total Health Collaborative plans to participate in value-based and alternative payment mechanisms. Though specific payment models have not been designed, the Total Health Collaborative would seek to reward and support collaboration, communication, teamwork, positive health outcomes, excellent consumer experience of care, optimal allocation of resources, and provider staff satisfaction.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

The quality of service delivery will be measured under the domains of consumer experience of care, health outcomes, resource allocation, and provider staff satisfaction. Specific measures and metrics have not yet been defined. Currently used tools include Medicaid health care quality measures, and Group Practice Reporting Option (GPRO) and Physician Quality

Reporting System (PQRS) measures. Network180 uses a range of clinical assessments and tools as well as the Michigan Mission-Based Performance Indicator System (MMBPIS), which tracks process measures such as the timeliness of inpatient screening, timeliness of initial face-to-face assessment for non-emergency services, timeliness of starting non-emergent services, follow up care within seven days of inpatient hospitalization, and psychiatric hospital readmissions within 30 days of discharge. Affinia and Network180 have experience in tracking total cost of health care. Anticipated sources for additional pilot quality measures include Certified Community Behavioral Health Clinic standards and new metrics that are aligned with and/or developed for Section 298 pilot projects.

Define “success” for the model? How will the model’s success be measured? What types of benchmarks would be appropriate for evaluating the model?

This model will be successful if…
- individuals can access services when they need them;
- physical and behavioral health services are coordinated in a seamless way for consumers and providers;
- consumer experience of care improves;
- care quality increases;
- individuals served experience increases in wellness and recovery;
- more resources are directed toward direct services; and
- providers are more satisfied in their jobs.

Specific measures and benchmarks have not yet been defined.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Yes. Network180, Mercy Health's Affinia Health Network and Pine Rest have committed to implementing this pilot. In addition, one MHP has committed to the pilot. Participation in the pilot would be open to any MHP interested in exploring the financial and clinical model. Both the Network180 Board of Directors and the Lakeshore Regional PIHP Board of Directors have pledged support of pilot development.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

Yes. The concept of a public risk-bearing behavioral health services organization could be implemented between any CMHSP and PIHP or other payer where managed care functions and resources were redistributed, and flexible funding allowed for savings to be retained and reinvested by the CMHSP.

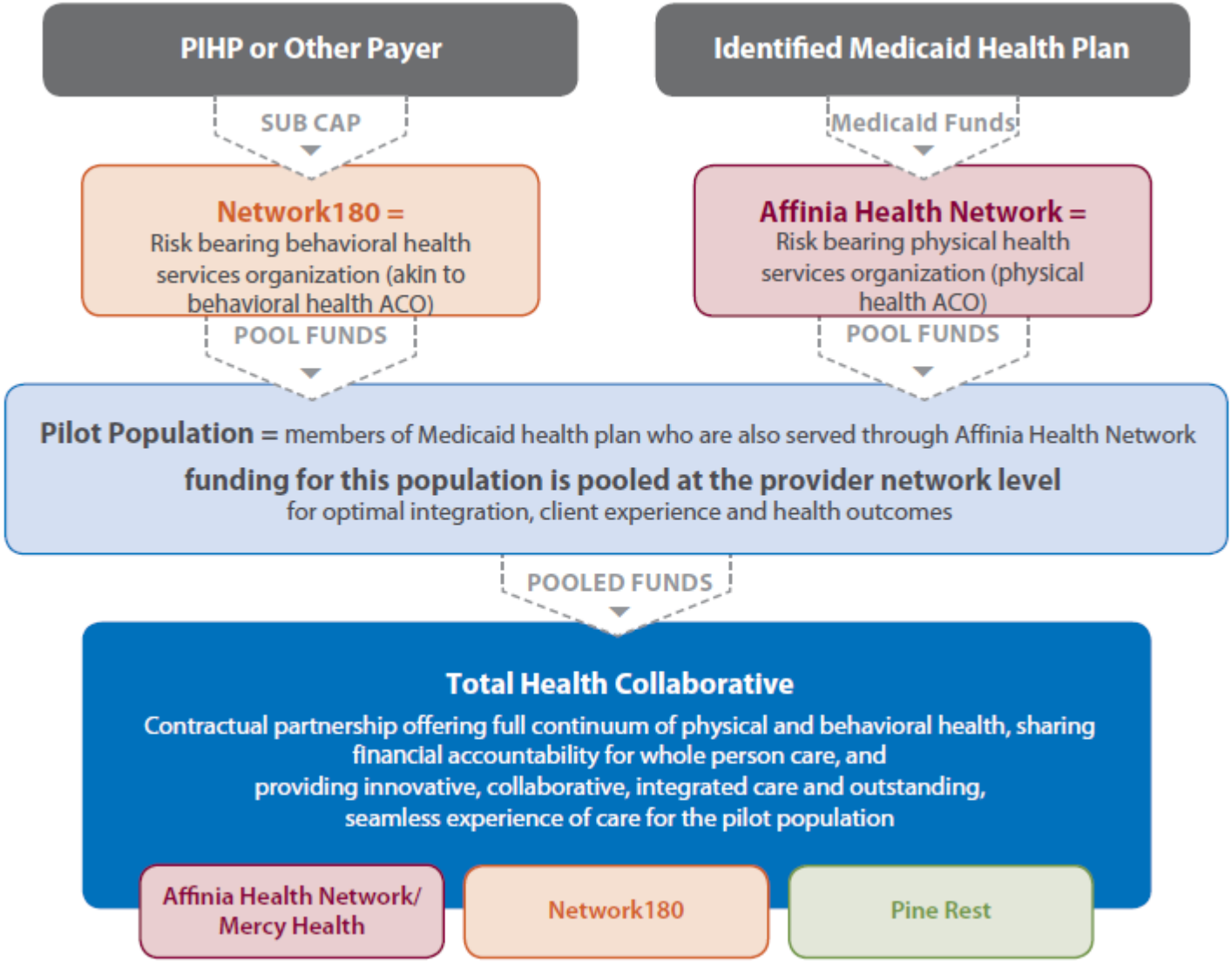
To realize the full benefit of this model, risk-bearing and accountable CMHSPs would enter into partnerships with accountable physical health providers so that funding could be pooled and services fully coordinated at the provider level. Partnerships would reflect the uniqueness of local communities and be based on the providers located there. Trinity Health is committed to replicating this non-profit provider-led integration model in communities throughout Michigan where it provides service.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

Our analysis indicates there would be no needed changes in statute, regulations, policies or waivers in order to implement this model. The only required changes would be contractual. Contract changes between the MHP(s) and Affinia, as well as the PIHP and Network180, would be required to achieve the necessary redistribution of managed care functions and resources. In addition, Network180, Pine Rest, and Affinia would use contracts to define financial and clinical matters for purposes of operating the Total Health Collaborative.

(Optional) Are you aware of any other states or communities which have implemented this model?

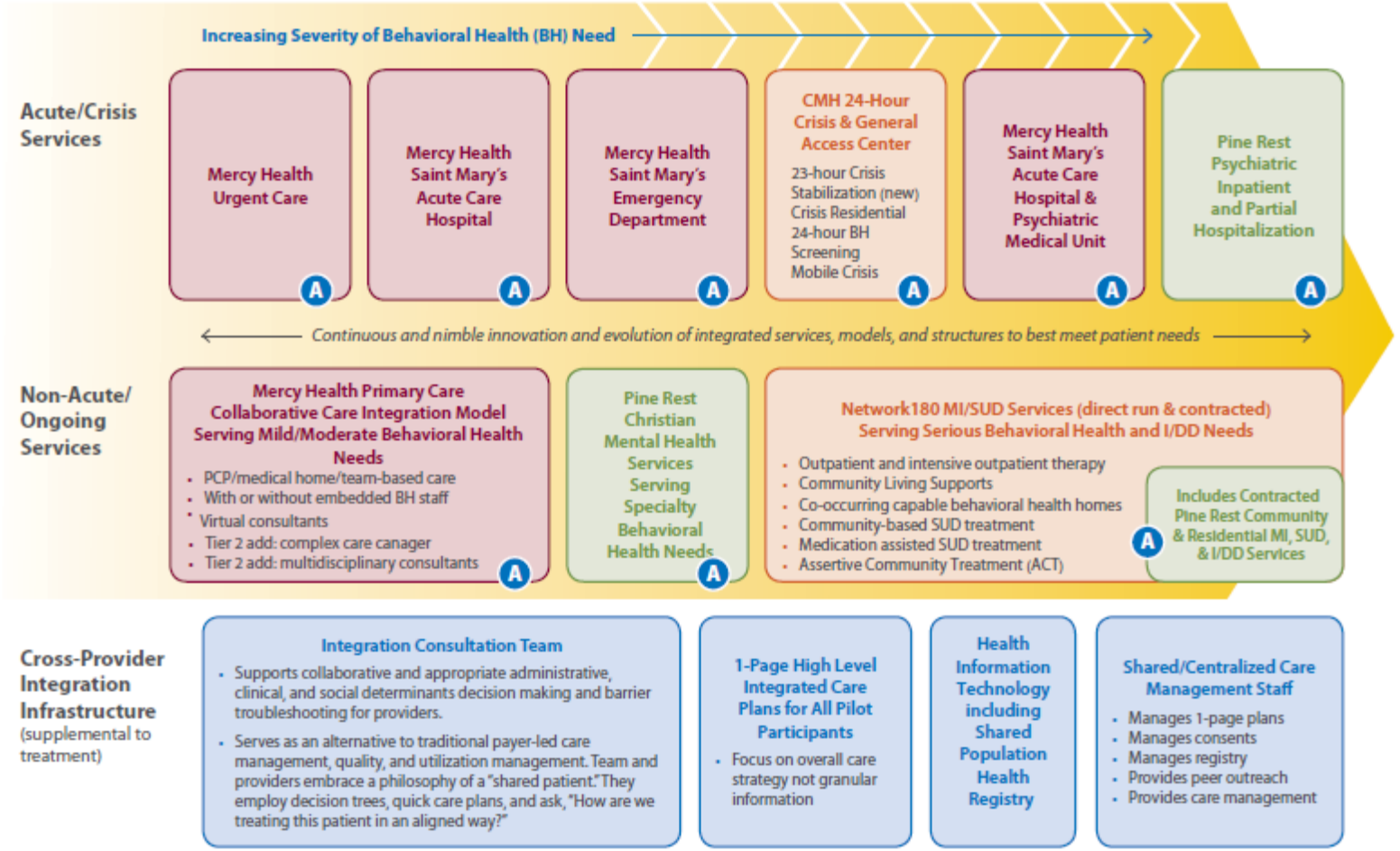
Several states have implemented programs built around accountable Medicaid provider organizations. States operating with some version of risk-bearing Medicaid providers include Colorado, Illinois, Minnesota, New Jersey and New York.


PIHP or Other Payer
Identified Medicaid Health Plan
SUB CAP
Medicaid Funds
Network180 =
Risk bearing behavioral health services organization (akin to behavioral health ACO)
Affinia Health Network =
Risk bearing physical health services organization (physical health ACO)
POOL FUNDS
POOL FUNDS
Pilot Population = members of Medicaid health plan who are also served through Affinia Health Network
funding for this population is pooled at the provider network level
for optimal integration, client experience and health outcomes
POOLED FUNDS
Total Health Collaborative
Contractual partnership offering full continuum of physical and behavioral health, sharing financial accountability for whole person care, and providing innovative, collaborative, integrated care and outstanding, seamless experience of care for the pilot population
Affinia Health Network/ Mercy Health
Network180
Pine Rest

TOTAL HEALTH COLLABORATIVE:

Clinical Structures for Comprehensive Integrated Behavioral & Physical Health Care

Diagram 2



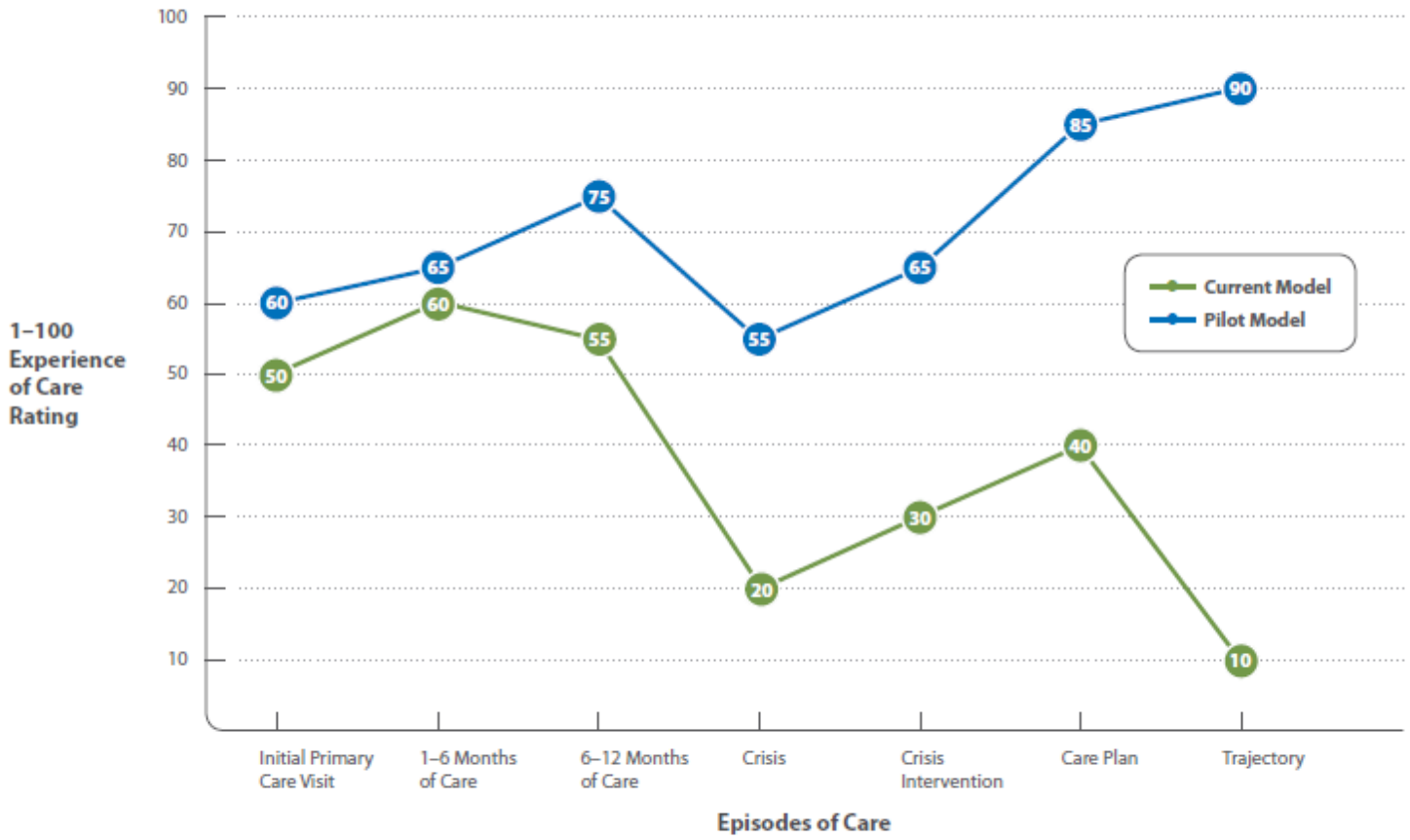
Michigan Department of Health and Human Services

Page 17

Diagram 3

ROBERTO'S CONSUMER EXPERIENCE MAP

(episode description on next page)



Roberto is a fictional individual with significant past trauma, history of alcohol use disorder and family history of diabetes. Roberto has a large supportive family. He has struggled with homelessness over the past few years and has been convicted twice of drunk driving. Roberto is currently living with a family member and has a job that he likes. (Image used here is a stock photo, not an actual consumer.)

Diagram 3

Initial Primary Care Visit	1–6 Months of Care	6–12 Months of Care	Crisis	Crisis Intervention	Care Plan	Trajectory
Existing Model *and* Roberto's 1–100 Experience Rating ()						
Roberto is seen by his primary care provider (PCP) for excessive thirst, increased urination, weight loss and fatigue. His HbA1c is elevated and score on the PHQ-9 leads his PCP to identify possible major depressive disorder (MDD). (50)	Roberto is offered to be connected with a Community Health Worker at the PCP's office, but declines. PCP recommends treatment for his diabetes and prescribes a single anti-depressant effective for MDD, and things improve a bit. (60)	Roberto experiences paranoia and does not share this information with anyone. (55)	Roberto attends a family wedding with an open bar. He ends up drinking and getting into a fight with his uncle, who calls the police. Roberto is arrested for assault. He is released on bond. Roberto becomes suicidal. Roberto's girlfriend petitions for Roberto to be involuntarily committed to inpatient psychiatric services. He is transported to the emergency department (ED) for evaluation. The ED supports the petition. The Community Mental Health center (CMH) authorizes inpatient psychiatric services. Though authorized for inpatient hospitalization, there is no available bed. He grows increasingly agitated in the ED, eventually becoming aggressive, and damages property. After a week of psychiatric boarding in the ED, a psychiatric bed opens up. During this time, Roberto loses his job for not reporting to work. (20)	Roberto is transported to Pine Rest where he receives an assessment and inpatient crisis stabilization treatment. Upon discharge, his psychiatric needs are assessed to be severe enough to need CMH case management services. CMH authorizes Roberto for case management services. (30)	With some stress, Roberto adjusts to a new service location and new rhythm of regularly seeing a case manager and psychiatrist. The CMH case manager helps to manage Roberto's mental health and co-occurring substance use disorder, but coordination with Roberto's primary care doctor around physical health issues is poor. The case manager encourages Roberto to apply for disability benefits so that he has some income. (40)	Roberto qualifies for disability benefits and does not return to the workforce. Roberto is placed on a second generation antipsychotic which causes significant weight gain. Eventually, his diabetes worsens. Poor coordination of care and escalation of diabetes results in a foot amputation several years down the road. (10)
Total Health Collaborative Model *and* Roberto's 1–100 Experience Rating ()						
Roberto is seen by his primary care provider (PCP) for excessive thirst, increased urination, weight loss and fatigue. His HbA1c is elevated and score on the PHQ-9 leads his PCP to identify possible major depressive disorder (MDD). While identifying MDD, the PCP **collaborates with an integrated behavioral health specialist** and also identifies possible Posttraumatic Stress Disorder (PTSD). (60)	Roberto's PCP **connects him with a Total Health Collaborative Care Management Peer ("Peer") as a standard course of care** based on diabetes and clinical impression of MDD with possible PTSD. PCP prescribes a **single antidepressant effective for MDD and PTSD**, and things improve a bit. Over the next several months, **Roberto stays in touch with his Peer.** (65)	Roberto experiences feelings of paranoia and shares this with his Peer. The Peer shares this with the PCP. **The PCP is able to reach out to a psychiatrist for consultation** about treating Roberto's mental health since the paranoia element adds complexity. With psychiatric consultation, the PCP changes Roberto's medications, avoiding medicines that will worsen his diabetes. Roberto again feels better. (75)	Roberto attends a family wedding with an open bar. He ends up drinking and getting into a fight with his uncle, who calls the police. Roberto is arrested for assault. He is released on bond. Roberto becomes suicidal. **Roberto reaches out to his Peer.** The Peer is aware that the community has a 24-hour behavioral health Crisis Stabilization Unit and recommends that Roberto go there. (55)	**Roberto goes to the 24-hour Crisis Stabilization Unit.** He receives a comprehensive behavioral health assessment. He receives **immediate access to psychiatry** and is stable enough to return home with a **temporary crisis intervention team** in place for follow up care from the Crisis Center. **Crisis Center staff coordinate closely with Roberto's PCP.** The Crisis Center psychiatrist may see Roberto directly for 30 to 90 days, working closely with Roberto's PCP. (65)	Roberto's **PCP feels comfortable taking over Roberto's psychiatric medication regimen** in this case, with the opportunity to consult with the psychiatrist as needed. The Crisis Center and PCP staff also coordinate with Roberto to offer him a **therapist through his PCP office.** (85)	Roberto continues to receive therapy and psychiatric medications through his Primary Care health home. His **diabetes management is a top priority** and blood sugar control is felt to be adequate. The therapist provides **evidence-based therapy** and works to strengthen Roberto's natural and community supports. (90)

PATIENT-CENTERED INTEGRATION AMONG MULTIPLE PROVIDERS: Teams and Coordination Characteristics

Model #33

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: SIM Involved Model

Name of Submitting Organization: Northern Michigan Regional Entity

Model Partner Organization(s): AuSable Valley CMH, CentraWellness Network, North Country CMH, Northeast Michigan CMH, Northern Lakes CMH and the Northern Michigan CHIR

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

This proposed model is intended to build on the current SIM and behavioral health home projects in this region. Primary partner organizations would be the Northern Michigan Regional Entity, the five CMHSPs in Region 2, the Northern Michigan CHIR (inclusive of the public health departments involved in that organization), and any Accountable Systems of Care developed within the SIM project. This model addresses the current specialty services and supports, mental health services to the mild to moderate population, SUD services, care coordination and primary physical health care. Initially, payment models and payer would not change. As the SIM project progresses, alternative payment methodologies will be developed. Similarly, current governance structures would not need to change initially. As model is developed, governance may or may not be merged between the PIHPs, CMHSPs, and SIM. However, consistent with the 298 Values, governance must remain public.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

The population served would focus on those currently served by the public behavioral health system, i.e., those with a serious mental illness, intellectual/developmental disability, serious emotional disorder, or substance use disorder. I it would also include those with a mild to moderate mental illness. Particular emphasis would be on those with co-morbid chronic physical health conditions.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

Services and supports would include: those currently provided under the specialty services and supports benefits of the carve out, mental health for mild to moderate need, primary care via either behavioral health homes or patient centered medical homes and care coordination.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

Specialty supports and services, as well as SUD services, will not change. Individuals will have a choice to participate in the Behavioral Health Home or the Patient Centered Medical Home. Care coordination will occur for all who choose to participate in either a BHH or PCMH, as well as for those identified through risk stratification.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

Through the use of behavioral health homes and patient centered medical homes, care coordination will be greatly enhanced for those who choose to enroll. For those who choose not to enroll, the expansion of current care coordination efforts between MHPs and PIHPs, inclusive of CMHSPs, will increase and enhance care coordination. The growth and use of accountable systems of care, via the SIM project, will also enhance care coordination.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

At the center of this model is the Northern Michigan CHIR. This provides a vehicle for coordination and cooperation between the existing MHPs, PIHPs and many of the providers. The collaboration is further enhanced by the use of health homes and medical homes. Lastly, the current and future accountable systems of care will ultimately bring the various provider, payers, and other service agencies together in cooperative structures.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

The most significant way in which this model increases availability, accessibility and uniformity of services is through the increased care coordination. Access difficulties often relate to system navigation, which care coordination will address. Additionally, the increased use of behavioral health homes and patient centered medical homes will improve the availability of well-coordinated care for those individuals served.

As concerns medications, the improved access to physicians via the behavioral health homes and medical homes will improve each person's access to appropriate medication. This model anticipates that the state will continue to fund medications in the current manner.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

This model does not presently address workforce development needs.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

Health Home and Medical Home models are built upon care coordination involving the individual served. Person centered planning will be the basis of all services. It is understood that the quality of person centered planning practices varies across the state and within the region. Rigorous training in person centered planning will be provided. New indicators and measures will be developed to more accurately assess the quality of the person centered planning process. Similarly, training in self-determination and independent facilitation will be developed and provided. These three elements: quality person centered planning, appropriate self-determination arrangements, and the availability of qualified independent facilitators; are seen as critical to providing appropriate, conflict free and effective services.

Would this model affect the administration of complaints, grievances, and appeals?

The new Medicaid Managed Care rules provide for changes in the grievance and appeals processes. This model will adhere to the federal requirements currently and in the future. These rules also provide for required beneficiary supports systems for persons receiving LTSS. These rules may well be the basis for creation of a more independent process. This model will support any such effort.

How would the model support continued access for individuals to current services, supports, and providers?

This model uses current providers for behavioral health and intends to use common physical health providers. Individuals will have a choice of their provider and have the option of choosing to enroll in a health home or medical home.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

Initially, governance would remain as it is. The PIHP would continue as it is, the CHIR would continue as it is. As the model evolves, and various funding models emerge, a common governance structure may become appropriate. Any future governance structure would require the following elements: public governance, stakeholder, community and consumer involvement, and compliance with the Michigan Open Meetings Act.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

Currently, the PIHP has consumer membership on its governing body as well as a consumer council and a recovery council that is inclusive of consumers and CMHSP staff. Any future governance structure will require continued representation on the governing body.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

This model will initial not require changes to the financing mechanisms. As the SIM project evolves and various payment models are developed and tested, changes in financing mechanism will likely be needed. Specifically, methods of reporting care coordination efforts, incentivizing outcomes, and sharing savings will be needed.

What changes would need to be made to provider reimbursement in order to implement the model?

The model will require the expansion of the health home pilot currently in place in Grand Traverse and Manistee Counties.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

As noted, payment models, including potential incentives, will be developed via the SIM project.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

Quality measures will be developed focusing on the following: access timeliness and consistency, reduction in ED utilization, increased coordination of care, and improved transitions from one level of care to another. Addition focus will be given to assessing the quality of person centered planning. The quality metrics will be measured and monitored via the CHIR.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

The success of this model will be measured in terms of improved access to both physical and behavioral health care, and more care coordination. Key benchmarks will address the access timeliness, numbers of people enrolled in health homes or medical homes, reductions in numbers of persons leaving services AMA, and reduced use of ED and inpatient services.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

This model can be piloted and that is recommended. The Northern Michigan CHIR includes 25 counties, however initial efforts are occurring in Prosperity Zone 2, which is only a portion of the PIHP region. It is likely that such a model would be piloted in the counties in Prosperity Zone 2 and then expand to the rest of the region.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

One strength of this model is that it builds on other current initiatives, specifically the SIM project and patient centered medical homes. This makes it quite possible to implement statewide as these other initiatives grow.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

(Optional) Are you aware of any other states or communities which have implemented this model?

Model #34

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Pre-Paid Inpatient Health Plan Enhanced Recommendations

Name of Submitting Organization: NorthCare Network

Model Partner Organization(s):

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

PIHP Proposed Model stabilizes the public behavioral health system by committing to the current PIHP structure. This model is based off of the PIHP Recommendations Stakeholder 298 Input Process submitted in 2016. This model would enhance current system to a more accountable, effective, and efficient public behavioral health system. Critical to this process is the need for clarification and empowerment relative to PIHP roles and responsibilities as distinct from CMH (providers) roles and responsibilities. The Lakeshore Regional Entity Plan of Correction provides a model for this.

1) Type of Services & Supports --person-centered planning, care coordination, conflict free case management along with improving currently offered services and supports.

2) Types of Organizations - MDHHS, MHPs and PIHPs. Both PIHPs and MHPs have mutual and shared obligations in care coordination for Medicaid beneficiaries.

3) Conflict Free Management; Uniformity of access and benefits across the state; publicly governed and managed behavioral health system; person centered planning for behavioral health and physical health.

4) Develop and use of value based purchasing by MDHHS, MHPs and PIHPs and their provider networks. This will rely on a number of key factors including federal and/or state relief from constricted permitted uses of Medicaid Savings; significant expertise in allowable and non-allowable arrangements from CMS and other experts; common definitions of value and related outcomes; state-wide, consistent processes and data in assessing beneficiary needs, functional assessments, and individual health status, quality of life and social functioning.

5) The person centered planning process shall promote consumer voice, choice, and control. Self Determination builds upon a commitment to improve the state wide person-centered planning process. PIHP's will formulate specific plans with

stakeholders to expand the number of people in control of and directing their specialty mental health services and supports to reduce isolation, reduce segregation, promote participation in community life and realize full citizenship rights.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
Persons living with SMI, SED, SUD, I/DD, Co- Occurring, and persons with mild to moderate mental health conditions.
No current populations being served would be excluded from this model.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
All services and supports currently included in PIHP contract as well as mild to moderate mental health conditions currently managed by MHPs who are not included in the MI Health Link pilots. HCBS rules will be implemented and PIHPs will provide adequate oversight and assure compliance in residential and employment settings. Work in cooperation with the BHDDA and MSA to establish criteria to be included in residential and employment contracts. Person-Centered Planning -creating an IPOS for each individual/family served by the PIHP and MHP. Utilization of voluntary Independent Facilitation is a key step in moving the system to one that is more conflict free. The participation of and the voice of the person served in person centered planning must be refined as statewide policy evolves.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?
Initial access to behavioral health services for all populations served by the PIHP/CMHSP and MHP system as well as uniform access to services during the initial or periodic person centered planning process that lead to the creation of an individual/family plan of service. Uniform access does not mean everyone must receive exactly the same type, amount, scope and duration of service, but rather that individuals/families with similar needs have access to similar types, amounts, scope, and duration of services driven by individualized person-centered plans which provides for consumer choice of providers. Self-determination models would also be available and information about self-determination will be broadly published and available to enrollees.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
Uniform access to behavioral and primary medical care is essential. Standards for uniform and timely access to care/services for individuals and families within and across PIHP and MHP regions throughout Michigan will be established. Each individual/family

served by the PIHP and MHP systems is entitled to an IPOS that is developed with integrity to the principles of person centered planning as required by State law. Expanding MI Health Link pilots or similar initiatives would promote improved communication and coordination. Although the most important coordination still needs to occur at the provider level.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?
PIHPs support Care Coordination as a key element of achieving the Triple Aim. Multiple funders and providers have roles in fulfilling these tasks. As of FY 2016, both PIHPs and MHPs have mutual and shared obligations in care coordination for Medicaid beneficiaries. In addition, the four MI Health Link regions have even deeper care management contractual obligations, processes and progress.

Identify and remove barriers to shared savings alignment agreements amongst and between PIHPs and MHPs and their networks; Expand statewide efforts in healthcare system health information exchange and healthcare data analytics; Invest in evaluation of desired outcomes, as determined by DHHS in consultation with PIHPs and MHPs. PIHPs and MHPs would share performance standards.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?
Management of a single Behavioral Health Provider Network by the specialty services PIHP in their region allows access to an integrated continuation of care and reduces the potential for consumer and cost shifting. Management by a single specialty trained entity affords for uniformity of contracts, performance expectations and provider accountability.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
Collaborate with provider networks, MDHHS, community colleges, trade schools, and universities to assure retention and recruitment of a high quality workforce in the following areas: Direct Care Workers; Peer Support Specialists; Recovery Coaches; Psychiatry; Social Work; Psychology; Medical Providers and extenders (RNs, PA-Cs, NPs).

The PIHP structure must support consumer involvement in the design, delivery and evaluation of services. The number of Peer Supports Specialists and Recovery Coaches available to the system will be increased by 25% within two years. In order to meet this goal training opportunities and availability need to be expanded. PIHPs will assist with training by developing a training curriculum in coordination with the MDHHS and providing standardized training regionally.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?
Consumer involvement in the design, delivery and evaluation of services is essential and meaningful representation and participation of consumers on PIHP boards and committees is critical.

Would this model affect the administration of complaints, grievances, and appeals?
The PIHPs will support the implementation of a centralized, statewide system for grievance and appeals, for all behavioral and physical healthcare Medicaid services. The PIHPs will support a centralized Recipient Rights structure for SUD service recipients. The current system, which varies from plan to plan, may involve three or more levels of review. Consistent with the Medicaid Managed Care Rules issued in May 2016, this should be replaced with a system that is clear and consistent. The PIHPs and MHPs will work with the MDHHS to develop a single, statewide system to provide the "plan level" appeal process. The PIHPs shall participate in the development of a centralized, state level recipient rights process for SUD Services recipients.

How would the model support continued access for individuals to current services, supports, and providers?
Sustaining the functional elements of current system ensures continued access to services and providers and reduces the potential for transfer trauma.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

The PIHPs will implement, in a timely manner, the MDHHS Network Management Reciprocity & Efficiency policy. The PIHPs will commit to the following: Establishing training reciprocity system for required residential and CLS staff training; Expanding training reciprocity to additional staff training elements; Establishing a common "site review" provider monitoring system that allows PIHPs and CMHSP to share provider monitoring results; Implementing common provider application, credentialing and contracting processes within each PIHP region.

The system requires the active involvement of all aspects of the public. From Governance to the nuances of full community inclusion, the Medicaid specialty services and supports to approach maximum effectiveness and benefit must have constant interaction with the public. Public Education, Participation, Involvement and feedback must be characteristic of individual service delivery, network providers, CMHs and Regional entities. focus of each region assuring primary and secondary stakeholder participation at all levels (service and organizational). Membership of PIHP Governance Boards should not be limited to CMH board members; broader representation is warranted with less potential for conflicts of interest in the operations of the PIHIP.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

Self Determination extends individual choice to the person's control over qualified providers, service delivery, budget development and implementation community based system of care at all levels. PIHPs will seek to create a network of public information and education using existing community organizations help communities deal with emerging substance abuse challenges.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?
None although specific performance measures and incentives related to Medicaid Loss Ratios would be key.

What changes would need to be made to provider reimbursement in order to implement the model?
Increased focus on outcomes, disease management models, i.e. value purchasing

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
Refinement of current performance measures with increased financial incentives for access penetration, reduced recidivism and measures outcome.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

Invest in evaluation of desired outcomes, as determined by DHHS in consultation with PIHPs and MHPs. Consider external, objective evaluation through a Michigan University. PIHPs will develop a standardized process for ongoing monitoring of access to care. Consumer satisfaction with person-centered planning will be evaluated using an agreed upon survey tool. Additional indicators shall be developed through the performance improvement process.

BHDDA, MSA, and Plans (PIHPs, MHPs) must rapidly establish and produce a system wide performance metric collection, analysis and public reporting system. Such efforts are happily supported in Waivers and via enhanced financing from CMS.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?
Consumer access, consumer experience of care, reduced duplicative administrative functions and associated costs. The establishment of common measures between all the parties referenced above (BHDDA, MSA, PIHPs, MHPs).

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?
This model strengthens the current PIHP structure and would not need to be a "pilot".

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?
The current PIHP structure is statewide and replicable in different communities. This model would enhance and strengthen the current structure statewide.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?
No

(Optional) Are you aware of any other states or communities which have implemented this model?
No, Michigan has historically led the way.

Model #35

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Integrated Care Coordination Model

Name of Submitting Organization: Priority Health Choice, Inc.

Model Partner Organization(s): Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS)

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

The Integrated Care Coordination Model demonstrates a collaborative system of care model between a Health Plan and a CMHSP designed to improve the coordination of physical health and behavioral health services and supports. The overarching goal and purpose of this model is for Priority Health Choice, Inc. Choice, Inc. to work together with Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) to identify shared enrollees with physical and behavioral health needs, jointly develop and implement processes to manage their care, eliminate inefficiencies and improve health outcomes. The result? An individual that receives the right care at the right time regardless of funding source, improved health outcomes, access to care and a system that provides relevant health information to care providers and shared enrollees. The current split healthcare system is difficult for individuals and providers to navigate. These two organizations will collaborate to create a system that allows coordination creating more integrated care for the individual. It is designed to bridge the coordination gaps and de-fragment the healthcare system complexity that exists for individuals and providers while supporting the person-centered planning process which is at the heart of supporting individual choice and control. (1) The Integrated Care Coordination model is a collaborative model between KCMHSAS and Priority Health Choice, Inc. designed to assist individuals and families in navigating the often complicated system of healthcare and to promote care coordination and integration between behavioral health and physical health treatment providers. The model identifies KCMHSAS as Priority Health Choice, Inc.'s preferred provider for mild/moderate outpatient services to support seamless and integrated care and improve access to specialized behavioral health services for Priority Health Choice, Inc. enrollees. Priority Health Choice, Inc. will work with KCMHSAS to identify and stratify high-risk cases including established processes, standards, shared care plans and quality metrics. Priority Health Choice, Inc. and KCMHSAS will actively educate and engage both individuals and providers regarding system-level care coordination. The model includes a team of care management staff from both KCMHSAS and Priority Health Choice, Inc. that assists individuals in making and keeping appointments with their healthcare providers, providing appropriate referrals and understanding their benefits. Individuals also have the opportunity to work with a Peer Support Specialist who can provide outreach, support, encouragement, and basic health coaching. The Peer Support Specialist has the flexibility to meet with individuals in their home as well as attend appointments. The model is intended to support the individual and their current treatment providers, coordinate services (as needed) and enhance services and supports to ensure individuals are receiving the right care at the right time regardless of funding source. (2) Priority Health Choice, Inc., a Medicaid Health Plan, and KCMHSAS, a Community Mental Health Service Program will jointly administer, manage and monitor the model. (2.1) Spectrum Health - Priority Health Choice, Inc. is a not-for-profit, integrated healthcare system with revenue of $4+ billion annually, formed through the merger of Butterworth Hospital and Blodgett Memorial Medical Center in 1997, which also includes Priority Health Choice, Inc., a 650,000 member health plan and several other subsidiaries. Priority Health Choice, Inc. is an award-winning, Michigan-based nonprofit health plan nationally recognized for improving the health and lives of

the people it serves. It continues to lead the industry in engaging members in their health, delivering effective health and disease management programs and working with physicians to improve health care outcomes and performance. Priority Health Choice, Inc. is one of only 20 health plans nationwide offering wellness programs accredited by the National Committee for Quality Assurance, an organization which also rated it among the best health plans in the nation. The State of Michigan named Priority Health Choice, Inc. HMO the benchmark plan for all individual and group HMO plans to model. Priority Health Choice, Inc. offers a broad portfolio of health benefit options for employer groups and individuals, including Medicare and Medicaid plans. Its network includes more than 900,000 health care providers nationwide. (2.2) Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) is a county created Community Mental Health Services Program Authority serving Kalamazoo County that has been delivering services for over thirty (30) years. Their vision states, "We provide a welcoming and diverse community partnership which collaborates and shares effective resources that support individuals and families to be successful through all life phases." KCMHSAS promotes and provides mental health, developmental disability and substance use resources that empower people to succeed. KCMHSAS is guided by the following values: community, competence, diversity, effectiveness, integrity, leadership, recovery & self-determination, respect, responsibility, teamwork and trust. In addition to providing crisis and emergency mental health services 24 hours, seven days a week, KCCMH provides the following specialty supports and services: Supports Coordination and Case Management, Individual and Group therapies, Psychiatry, Family Education and Support, Supported Employment, Skill Building Assistance, Enhanced/ Supportive Healthcare Services, Respite Services for Children and Youth, Home-Based and In-School Services for Children and Youth, Wraparound Services for Children and Youth, Recovery Mental Health Court, and Juvenile Justice Mental Health Services. (3) The model proposal was developed to improve collaboration and information sharing between Priority Health Choice, Inc. and KCMHSAS to identify shared enrollees, jointly develop and implement processes to manage their care, eliminate inefficiencies, improve health outcomes and implement a care model that extends beyond the traditional organizational silos requiring coordination. It was developed to align with, and strongly support, the core values and recommendations included in the interim 298 report. Specifically, the model was developed with the following goals; (a) Increase access to behavioral health services and physical health services (primary care), (b) decrease health care costs, (c) provide the right care at the right time regardless of funding source (d) increase engagement and self-management skills (e) increase coordination with treatment providers and provide information to the individual to make informed decisions regarding overall healthcare and (f) develop a coordinated care plan that focuses on communication, collaboration and coordination between the provider team on behalf of the individual. The coordinated care plan will include, but is not limited to, the following care management activities; (e.1.) assistance with ways to navigate the health care system and receive health care services, (e.2.) coordination of benefits with the Medicaid Health Plan Care Manager, (e.3.) communication and coordination between KCMHSAS providers, Medicaid Health Plan providers and primary care providers on behalf of the individual, (e.4.) patient education and self-management skills for individuals, (e.5.) recommendations for community resources to enhance health and wellness and (e.6.) other needs or barriers the individual faces that may impact their ability to access or engage in healthcare. The coordinated care plan is not a replacement for the person-centered plan. It is designed to bridge the coordination gaps and de-fragment the healthcare system complexity that exists for consumers and the provider team while supporting the person-centered planning process which is at the heart of supporting individual choice and control. (4) KCMHSAS and Priority Health Choice, Inc. have committed to implementing this model and will be seeking grant funding to support implementation. It is anticipated that the initial cost of the model will be supported by grant funding, applicable fee for service billing and investment from both entities. Ongoing financing and payment mechanisms will be based on anticipated shared savings from

both the primary care and behavioral health sides. (5) KCMHSAS, a county created Community Mental Health Services Program Authority serving Kalamazoo County, and Priority Health Choice, Inc., a not-for-profit integrated healthcare system, will jointly administer, manage and monitor the model. The model is based on real time sharing of claims and clinical data which promotes transparency and accountability of publicly funded physical and behavioral health care provided through the Medicaid health plan and KCMHSAS both of which are competent public bodies.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
The model ensures access to integrated care for all age groups and populations. It is an innovative and cost-effective model that coordinates care, services and community resources in ways that promote the physical and behavioral health of Priority Health Choice, Inc. and KCMHSAS joint enrollees. The model identifies KCMHSAS as Priority Health Choice, Inc.'s preferred provider for mild/moderate outpatient services to support access to the Integrated Care Coordination model and additional Specialty Medicaid Services and Supports when clinically appropriate. This is a system level approach therefore it is not anticipated that any populations would be excluded from the model.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
This model incorporates the full continuum of Medicaid services and supports identified under the specialty Medicaid benefit as well as the mild/moderate outpatient benefit. The model embeds a masters-level care manager and a peer support specialist at KCMHSAS to provide care coordination for shared individuals. The coordinated care plan developed in this model is not a replacement for the Person Centered Plan or any other treatment documents developed and managed between an individual and provider. The Integrated Care Coordination team will not replace targeted case management or other services provided through the KCMHSAS system of care, and it will not provide physical health interventions. The coordinated care plan is a wrap-around plan that focuses on communication, coordination, and collaboration between the provider team on behalf of the individual. This model is intended to support all treatment providers by facilitating care coordination, real-time information sharing and shared treatment planning to aid individuals in meeting their goals and improving their overall health.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?
This model continues to support individual choice in services and providers currently offered through Priority Health Choice, Inc. and KCMHSAS. The system level care management elements of this model will be implemented based on a Business Associate Agreement between the two parties allowing communication to coordinate benefits and services for shared consumers. KCMHSAS will identify individuals through this system level care management model who are in need of enhanced care coordination services and will offer them the opportunity to participate. If an individual chooses not to receive the additional supports, access to clinically appropriate services and current person-centered plan will not be disrupted or changed. Although a care manager would be hired specifically for the model, there will be others employed by KCMHSAS that could meet program needs and work with an individual should this be needed or requested by the individual. This model offers an opportunity for enhanced care coordination, physical and behavioral health integration and collaboration among behavioral health and

physical health treatment providers. The model is not intended to replace existing providers and/or services but to support the individual and their current treatment providers to ensure integrated care that treats the whole person.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
A high percentage of Medicaid and dual eligible enrollees have complex behavioral and physical health needs. Individuals may receive care from two different entities that may not effectively communicate or work together to ensure appropriate care. The individual is often placed "in the middle" and responsible for navigating the two systems on his/her own even though his/her health needs are inter-connected. Priority Health Choice, Inc. and KCMHSAS have expertise and experience in providing and coordinating integrated healthcare services including strong relationships with primary care providers, co-located primary care services at key sites, wellness and prevention services, and other targeted projects enhancing primary care's capacity to manage behavioral health conditions. The overarching goal and purpose of this model is for Priority Health Choice, Inc. to work together with KCMHSAS to identify shared enrollees with physical and behavioral health needs, jointly develop and implement processes to manage their care, eliminate inefficiencies and improve health outcomes. The model will include, but is not limited to, the following care management activities; (1) assistance with navigating the health care system, (2) coordination of benefits with the Medicaid Health Plan Care Manager, (3) communication and coordination between KCMHSAS providers, Medicaid Health Plan providers and primary care providers on behalf of the individual, (4) patient education and self-management skills for individuals, (5) recommendations for community resources to enhance health and wellness, (6), opportunities to participate in enhanced health services through Priority Health Choice, Inc. such as the Depression & Disease Management program, the on-line Cognitive Behavioral Therapy tool and other targeted programs that enhance primary care's capability to manage behavioral health conditions, (7) other needs or barriers the individual faces that may impact their ability to access or engage in healthcare, (8) primary care provider education and support to manage behavioral health concerns, (9) and real time claims and clinical data sharing.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?
Priority Health Choice, Inc. and KCMHSAS recognize that better health care outcomes will be achieved for Kalamazoo County residents through the development of an improved collaborative system of care between the aforementioned organizations. The improved collaborative system of care is three pronged and includes integrated physical & behavioral health (1) funding, (2) care coordination and (3) service delivery. Priority Health Choice, Inc. supports developing a collaborative model to identify high risk mutually served individuals, creating a defined process for coordinated care management and ensuring an integrated care model for service delivery. The model will promote access to specialized behavioral health services for individuals and service coordination between the individuals' primary care providers, specialty providers, KCMHSAS and Priority Health Choice, Inc.'s system of care. This model is intended to support all treatment providers by facilitating care coordination, real-time information sharing, shared coordinated care planning to aid individuals in meeting their goals, access to additional consumer supports for mild/moderate population. Additional supports for the mild/moderate population include but are not limited to peer support specialist services, access to Children's Health Access Program (CHAP), and timely transfer to additional specialty Medicaid services

including behavioral health services targeted at addressing different co-morbidities (such as the Whole Health Initiative program) when clinical appropriate. The model includes development of a coordinated care plan with the individual and the individual's healthcare team, which is periodically updated based on shared information between KCMHSAS, the healthcare team and the Medicaid Health plan. A care conference may be requested at any point to assist with resolution of issues that are preventing successful progress. Care conferences will include all members of the individual's healthcare team, who agree and are able to attend, to discuss the individual's coordinated care plan.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?
This model will improve the availability, accessibility and uniformity of services and supports by (1) breaking down the barriers associated with the split Medicaid health benefit (including medications), and (2) supporting all treatment providers by facilitating care coordination, real-time information sharing and shared care planning to aid individuals in meeting their goals and improving their overall health. The model proposal was developed to improve collaboration and information sharing between Priority Health Choice, Inc. and KCMHSAS to identify shared enrollees, jointly develop and implement processes to manage their care, eliminate inefficiencies, improve health outcomes and implement a care model that extends beyond the traditional organizational silos. The use of predictive modeling including behavioral health diagnosis, co-morbid health conditions and behavioral health and physical health care utilization will allow Priority Health Choice, Inc. and KCMHSAS to jointly identify shared enrollees appropriate for the care coordination program. Further, system-level analysis may support preventive outreach and access to individuals appropriate for mild to moderate outpatient services including timely access to psychiatric treatment. Individuals will have a team from both KCMHSAS and Priority Health Choice, Inc. helping them schedule and keep appointments with their physical health doctors, provide appropriate referrals including psychiatric evaluations as indicated and understand their benefits. Individuals also have the opportunity to work with a Peer Support Specialist who can provide outreach, support, encouragement, and basic health coaching. The Peer Support Specialist has the flexibility to meet with individuals in their home as well as attend appointments. As noted previously, the coordinated care plan is not a replacement for the Person Centered Plan. It is designed to bridge the coordination gaps and de-fragment the healthcare system complexity that exists for consumers and the provider team while supporting the person-centered planning process which is at the heart of supporting individual choice and control. The Integrated Care Coordination team will not replace targeted case management or other services provided through the KCMHSAS system of care, and it will not provide physical health interventions.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
Priority Health Choice, Inc. and KCMHSAS will actively educate clinicians, peer support specialists, KCMHSAS staff and providers in key concepts of system level care coordination. Marketing and training materials including a co-branded brochure will be developed for use by Priority Health Choice, Inc. and KCMHSAS to introduce identified shared members to the model. Face-to-face meetings with large primary care offices will be

arranged to introduce the model and request support in improving members' access to primary care services. Priority Health Choice, Inc. and KCMHSAS will partner to present seminars on "Coordinating Care with a Medicaid Health Plan." These CEU- eligible seminars will be attended by behavioral health case managers and providers in Kalamazoo County.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

This model empowers individuals to make informed decisions about their healthcare by providing information on the benefits of integrated care and available services and supports offered through the health plan and KCMHSAS; thus supporting the person-centered planning process which is at the heart of supporting individual choice and control. The model addresses the unmet needs of the individual through the following care coordination activities: (1) assistance with ways to navigate the health care system and receive health services, (2) coordination of benefits with the Medicaid Health Plan, (3) communication and coordination between KCMHSAS providers, Medicaid Health Plan providers and primary care providers on behalf of the individual, (4) patient education and self-management skills for individuals, (5) recommend community resources to enhance health and wellness and (6) other needs or barriers the individual faces that may impact their ability to access or engage in healthcare. The implemented coordinated care plan supports the Person-Centered Plan and any other treatment documents developed and managed between an individual and provider.

Would this model affect the administration of complaints, grievances, and appeals?

This model would not affect the administration of complaints, grievances, or appeals. Education and information about grievance and appeals would be available.

How would the model support continued access for individuals to current services, supports, and providers?

This model, once implemented, is not intended to replace existing providers and/or services but to support the individual and their current treatment providers. The implemented coordinated care plan is not a replacement for the Person Centered Plan or any other treatment documents developed and managed between an individual and provider. The coordinated care plan is a wrap-around plan that focuses on communication, coordination, and collaboration between the provider team on behalf of the individual. This plan is designed to bridge the coordination gaps and de-fragment the healthcare system complexity that exists for individuals and the provider team. The model identifies KCMHSAS as Priority Health Choice, Inc.'s preferred provider for mild/moderate outpatient services to support seamless and integrated care and improve access to specialized behavioral health services for Priority Health Choice, Inc. enrollees. The individual and provider would not have to navigate multiple systems of care rather the model would be the hub of care, supports and service coordination.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

There would be no change in governance structure; however, there will be a shared implementation team between KCMHSAS and Priority Health Choice, Inc. to jointly administer, manage and monitor the model. The model is based on real time sharing of claims and clinical data which promotes transparency and accountability of publicly funded physical and behavioral health care provided through the Medicaid health plan and KCMHSAS.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

Current mechanisms for engaging individuals, family members and other community members (such as KCMHSAS or Priority Health Choice, Inc. Board membership, Customer Advisory Committee, etc.) will continue under this model including foundations of person-centered and family-centered planning and education as well as increased ability to make informed choices for individual care.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

No changes would need to be made to financing mechanisms for payers to implement the model.

What changes would need to be made to provider reimbursement in order to implement the model?

Changes would need to be made to provider reimbursement for mild/moderate services to cover the cost of care management for shared consumers. This could be managed through either a staffing grant, per member/per month, or an enhanced fee schedule from the Medicaid health plan.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

Incentives would not be used under this model

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

The plan for quality of service evaluation of the program is designed with metrics in financial and clinical domains. Quality indicators include; (1) reduced physical health costs through reduction in the utilization of high cost services evidenced via pre and post utilization and cost data, (2)

individuals will have better access to primary care and specialty behavioral health services as evidenced by an increased number of individuals with an identified primary care physician and behavioral health provider, (3) improve the follow-up after hospitalization for mental illness within 30 days measure as evidenced by utilization and claims data, (4) decrease avoidable Emergency Department utilization, (5) decrease number of avoidable behavioral health hospital admissions or readmissions and (6) improve medication adherence. Quality indicators as outlined will be periodically assessed and reviewed by the joint implementation team.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?

Success of the model includes maintaining or reducing cost and improving clinical status/ utilization. The evaluation metrics designed to measure the model's success answer the following questions; (1) Is cost maintained or reduced (cost of intensive behavioral health services such as inpatient and crisis residential and cost of emergency department visits and/or admission to inpatient medical facilities) and (2) Is clinical status improving (comparison of intensive behavioral services utilization against utilization of less intensive services designed to maintain stability, comparison of high cost medical services utilization against utilization of outpatient and measurement of readmission to intensive behavioral or physical services)?

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Yes, this model could be piloted and will be piloted. KCMHSAS and Priority Health Choice, Inc. have committed to implementing this model and will be seeking grant funding to support implementation. It is anticipated that the initial cost of the model will be supported by grant funding, applicable fee for service billing and investment from both entities. Ongoing financing and payment mechanisms will be based on anticipated shared savings from both the primary care and behavioral health sides. Priority Health Choice, Inc. is committed to improving the health and lives of its members and has long-valued an integrated care management approach to address both the medical and behavioral health needs of its' members. Both Priority Health Choice, Inc. and KCMHSAS agree that higher quality service with better health outcomes will be achieved for individuals through the development of a collaborative system of care. Together, they have developed, and intend to implement, this proposal for a shared care management and coordination program whereby both entities will collaborate to provide effective health care services to residents of Kalamazoo County.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

Yes, this model could be implemented statewide. Priority Health Choice, Inc. implemented a similar model in 2014 with Network180, Kent County CMHSP, which demonstrates successful efforts of a Medicaid Health Plan and a CMHSP to collaborate and provide care management and coordination for shared enrollees with complex conditions. This model has proven that better health care outcomes are achieved when services

from multiple systems of care are combined. Priority Health Choice, Inc. has shown how a partnership with a CMHSP improves access to specialized behavioral health services for Priority Health Choice, Inc. enrollees and service coordination between physical health care providers and the public mental health system of care. The model identifies and stratifies high risk cases and includes established processes, standards, shared care plans and quality metrics all of which can be replicated through similar partnerships statewide.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

We are not aware of any changes that would need to be made to statutes, regulation, policies, or waivers in order to implement the model. Priority Health Choice, Inc. developed a similar model in 2014 with Network180, Kent County CMHSP, which demonstrates successful implementation without any changes made to statutes, regulations, policies or waiver.

(Optional) Are you aware of any other states or communities which have implemented this model?

The Network180 Care Coordination pilot between Priority Health Choice, Inc. and Network180 (Kent County CMHSP) implemented in April 2014 demonstrates successful efforts of a Medicaid Health Plan and a CMHSP to collaborate and provide care management and coordination for a targeted group of shared enrollees with complex conditions. This pilot has proven that better health care outcomes are achieved when services from multiple systems of care are combined including cost-effectiveness and quality of care. This model demonstrates how partnerships between Medicaid Health Plans and CMHSPs improve access to specialized behavioral health services for Priority Health Choice, Inc. enrollees and service coordination between physical health care providers and the public behavioral health system of care. The model identifies and stratifies high risk cases and includes established processes, standards, shared care plans and quality metrics. The model proposed in this document expands the Network180 Care Coordination pilot to include individuals with mild to moderate behavioral health needs.

Model #36

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: The Office of Integrated Health Care (OIHC)

Name of Submitting Organization: Starfish Family Services

Model Partner Organization(s): we have many partners including Beaumont Health, University of Michigan, and Detroit Wayne Mental Health Authority for our Integrated Health Care initiatives

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

1) Starfish Family Services has been involved in Integrated Health Care for many years and we are considered leaders in our community and beyond. We utilize the Beahvioral Health Consultant (BHC) model in which a trained Social Worker, Psychologist or Counselor is embedded in the primary care team for Pediatrics, Adult and the OB/GYN population. The BHC is an integral part of the medical team and partners with the Physician and other staff members to provide whole body health and wellness to all patients of the clinic. The BHC meets with patients before, during or after the physcian visit to address any non-medical needs the patient might have including mental health, psychological needs related to physical health issues, and other basic needs services. The BHC supports the use of screenings by physicians (by introducing them when they are not currently being used and/or helps to distribute/score etc.), provides functional assessments (for children the PECFAS/CAFAS), psycho-education for all identified issues (physical, mental health etc.), referrals, resources and consultation with the physician to create the action plan for the patient. In our model, the BHC also helps to educate the clinic staff on current mental health issues by providing mini trainings, attends all staff meetings and participates in all functions of the clinic. In addition to the BHC model, in our service provision, our BHC's also take on an additional function in which they help the clinic/practice to transform from non-integrated to fully integrated. We address this very important but mostly overlooked aspect of integration because many have learned that just placing a mental health into a medical practice without a plan, or manual or expectations rarely results in a successful endeavor. In addition, the consequences of failed integration activities can have negative consequences for the buy-in for any future initiatives. Our two pronged BHC model utilizes our developed and printed Integrated Health Care Implementation Model Manual to guide the BHC in helping the practice to be prepared for and to participate fully in the transition from non-integrated to fully integrated. The model we are currently working on is to take this current initiative to the next level by attempting to transform Integrated Health Care from the payor and State level. Our vision is to create an Office of Integrated Health Care that will be partnered with payors who are piloting and/or moving toward utlizing value based payment structures. We will partner with them (State Medicaid, Qualified Health Plans and 3rd party insurances) to offer all of their contracted clinics/practices the opportunity to become fully integrated using our BHC staff (or their own) and our Implementation Manual. The Office of Integrated Health Care will then complete a full assessment of the functions, workflow, services and management of the clinic to provide them with a designation as "Integrated'. The payor will be notified of the designation and will then begin to pay those clinics a higher rate for their pateint care because they have a proven and audited Integrated Health Care system. The monitoring will work similarly to a COA accredidation Patient Centered Medical Home designation as the clinics will be audited yearly or every two years to ensure their practices continue to meet the standards idendified to continue to receive the higher rates for being integrated. 2) the organizations that would be involved in this system would be the State of Michigan, Medicaid, Qualified Health Plan, 3rd Party Insurance companies, hospital systems for all their clinics, private medical practices and other mental health

providers across the state who might be parterning with physical health care providers to engege in Integrated Health Care activities. 3) we belive that Integrated Health Care is the approach that meets all core needs as a foundation of the model itself. Patients currently do not have the "right" to have a behavioral health proffessional on their primary care team but they do have the right to determine that they do not want integrated health care only when the clinic is integrated. Access to care for all is an integral part of the movement towared Integrated Health Care and to erase the stigma through partnership, normalization and creating a new norm in which mental health issues are addressed as a normal part of routine health care visits. The ability to spread Interated Health Care around out State quickly, efficiently and with accountability allows for inclusion, equity of offered services and choice for all health care consumers. 4) The financing structure proposed for the SFS OIHC and outlined in the attached diagram includes two phases. Phase I (Payer Pilot) utilizes funding for a) direct, fixed contract fees paid to SFS to integrate select providers; this may include additional costs for a Bheavior Health Consultant (BHC), and b) enhanced reimbursement rates paid to providers who achieve “SFS Integrated Provider” designation. Phase II (Shared Cost-Savings) utilizes a funding mechanism in which a percentage of payer cost-savings generated through integrated healthcare services is shared with providers and SFS to enable sustained Integrated designation and integration services. While individual providers may be aware of the benefits of integrated care, they often lack the resources, knowledge, scale, and incentives to proactively invest in these services. This financing structure leverages the significant value that integrated healthcare can provide to payers. SFS’s OIHC model creates a value-add for all stakeholders (payer, provider, and SFS) through improved health outcomes, cost savings, patient satisfaction, and efficiencies. This financing structure can foster transformation of the healthcare delivery system and accelerate a shift from fee-for-service to valued-based payments.. 5) Management of this model could be done on various levels within a partnership with Starfish Family Services. It could be monitored by the State with some other general mandates added to the accredidation process to ensure consistency. The initial accredidation and subsequent re-accredidation format would be used throughout the State to create transperancy, consistency and fidelity to the model of Integrated Health Care. It could also be managed through a partnerhsip at the payor level such as with the health insurance plans and Starfish Family Services as well.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
We believe that providing the staff, tools and technical support to Pediatric, Adult and OB/GYN clinics/practices will affect all populations and will not exclude any populations. We currently focus on primary care, pediatric and OB/GYN services but we also work in specialty health care (Oncology) and are able to replicate that model as well if needed.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
Physicians would be able to provide Integrated Health Care at their clinics and learn first hand how it is done by professionals who are trained and have expreience in not only providing BHC services to patients but also experience and training in the implementation of the model. The mental health system (both Qualified Health Plan providers as well as Community Mental Health) are innundated with patients who may not need full service mental health services. Many patients can be served in the physical health environment thus freeing up resources for patients who need the full service care which will also save the payors money. The BHC is trained to detect the level of care needed for a patient and will refer the right patient to the right service, thus saving the system money but also saving the patient the hassle of going place to place for services they may not even qualify for which is currently a problem in our system. We also have a partnership with MC3 to engage psychiatric

services for certain populations which can help keep patients served in the physical health environment and free up resources of psychiatrists for the systems where they are most needed. We believe that all mild to moderate mental heatlh and physical health services can be provided within the Primary Care system with the appropriate supports provided to the Primary Care system (Integrated Health Care). As in physical health care, there are primary care and specialists. The same should be said for the mental health system. The health plans can serve the mild to moderate patients while the Community Mental Health system can serve as the specialty care.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

There are many options based on geographic location of the practices and available reasources. A physical health practice may be in a more rural area which only has one behavioral health provider and they may choose to partner to provide integrated heatlh care. Depending on the team configuration they choose, they may contract with the mental health provider to embed a BHC and a Care Manager onto the team full time, or part time depending on need. Other larger practices may choose to hire their own BHC directly to provide the services. Individuals will always be informed of the fact that the clinic where they receive care is identified as Integrated when they enter the facility and when they fill out paperwork so they can always choose to say that they do not want to speak to anyone but a physician.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

One of the foundations of the Integrated Health Care model is enhanced coordination of physical and behavioral health. We have found that just connecting a physician and a speciality behavioral health clinic does not work and maintains a "business as usual" environment, fueling the silos that prevent good patient care. Co-location as the next step is a better option, however the physicians and mental health staff continue to operate in a silo environment and patient care is not transformed. Enacting a truly transformational model, culture and workflow afforded by an Integrated practice is the answer for not only enhanced coordination, but true partnership in health care provision for all patients.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

By having an expectation of inegration as the model that is agreed to be the best available, all providers, service agencies, payors and providers will be on the same page for how health care can be transformed in the State of Michigan. By setting standards for Integrated Health Care and providing the tools and technical assistance needed to achieve the goal, all health care can work together to provide consistent services that patients will come to expect from health care in their communities.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

By developing consistent standards for Integrated Health Care, the Office of Integrated Health Care will allow for the consistentcy needed in the creation of what will be a new model for most providers in the State. We believe that by embedding a BHC in physical health clinics, we will make mental health interventions more accessible, available and uniform for all patients. The knowledge of the mental health system is one of the best skills that the BHC can bring to the health clinic to help patients be referred to the correct level of care, to understand better the access and services of the mental health system and to engage in providing mental health expertise to those patients who can be served in the primary care environment. By making correct referrals for mental heatlh services from the physical health enviroment, we believe the right service will be provided within the right system appropriate to the patient need, thus helping to "unclog" the mental heatlh system of patients who might not need full traditional mental health services and could instead get their needs met in the comfort of their trusted physical health care environment, thus also saving the mental health system on waste of resourses and thus save money overall.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
We currently have a partnership with the University of Michigan School of Social Work and the Office of Continuing Education who is very much involved in workforce development for Integrated Health Care systems. Their Masters degree program offers an scholar program for students who are specifically trained in the Integrated Health Care model and they do their internships with us in our Integrated clinic sites. This could be expanded to include more interns for training as BHC's. UofM also offers a Web Based Certificate program in Integrated Primary Care and Behavioral Health for professionals who are currently in the workforce and want to learn about how to provide service in an Integrated system. UofM also runs a grant called Detroit Scholars where they partner with the Wayne County Menatal Health Authority to provide specialized training and internships in the community as well. There is also a model for implementation of BHC and Integrated Health Care in Knoxville Tennessee called Cherokee Health Systems where they provide a 2 day in person training for front line staff all the way up to executives to learn about Integrated Health Care and how to implement in their communities. This model could be replicated here in Michigan as part of the Office of Integrated Health Care and in tandem with the direct staffing and technical assistance offered by our program.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?
We believe that Integrated Health Care provides the most person centered approach to health care for patients. The ability for a patient to receive a team based approach to their health where behavioral health, health behaviors and physical health care needs are provided by a coordinated team will not only positiviely impact the patients experience of health care but also impact their health outcomes. The choice to

not have to leave the physical health silo to enter into the mental health silo can be life changing for some patients. The knowledge that their mental health is in fact, just as important as their physical health and that their clinic staff understand that and provide service with a "whole body health and wellness" approach where behavioral health is detection, intervention and engagement with speciality mental heatlh providers can be a routine part of health care will also help to de-stigmatize mental health. Of course any patient would have the right to decline the services of the BHC that is embedded on their team at any time.

Would this model affect the administration of complaints, grievances, and appeals?

In our experience, the Integrated Health Care model works best in partnership with the Community Mental Health system. Although co-location with a CMH agency can be helpful in many communities, we have found that by focusing on the mild behavioral health needs and providing brief interventions and action plans in tandum with the physician's action plans works best for both the clinic and the patient. For that reason, in our model, the BHC is not providing CMH level services within the primary care setting. They use their mental health expretise to detect needs, assess for level of care and make three distinct decisions: the patient is in need of CMH services and will connect the patient to that level of care; the patient is in need of mental heatlh services but the needs are mild to moderate and will connect the patient to that level of care via their health plan; or the patient is in need of interventions that are able to be provided using a short, solution focused 15-20 minute visit with the BHC (usually up to 5 follow up visits in the primary care office). Due to the fact that in our model, the BHC is not providing an CMH services in the primary care office, all CMH provisions for service delivery will not be impacted by this model. The same way we would not want our Primary Care Physician to perform our heart surgery, we belive the Community Mental Health system is a specialist system, similar to physical health specialist.

How would the model support continued access for individuals to current services, supports, and providers?

In the model currently utilized by Starfish Family Services, any patient who is already receiving mental health services who comes into an Integrated primary care clinic will see no change in their mental health services, however, they will have access to the BHC for coordination of their current mental health care and their physical health care as the BHC can provide the much needed connection between the mental health provider and the patients physician.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

We believe using the Integrated Health Care Implementation manual and the certification process creates transparency, consistency and accountability where there currently is none.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?
Not yet developed

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?
To implement Phase I (Payer Pilot) of the SFS OIHC model, payers will require funds to finance the flat fee contracts with SFS and enhanced reimbursement rates for providers. Depending on payer type (i.e. State Medicaid, Qualified Health Plans, or 3rd party insurance payers), these funds may be made available through: a) investment from payers, b) state granted funds c) philanthropic funds, or d) a pooled fund from in-network providers wishing to be integrated.

What changes would need to be made to provider reimbursement in order to implement the model?
Full implementation of the SFS OIHC model would require several changes to provider reimbursement. As seen in the attached OIHC Financing Mechanism diagram, Phase I (Payer Pilot) utilizes: incentivized reimbursement rates for providers who achieve "SFS Integrated Provider" accreditation. Numerous payers in Michigan offer incentive programs for providers who attain Patient Centered Medical Home (PCMH) accreditation. Incentives may be similar to those included in current PCMH programs. As seen in the attached OIHC Financing Mechanism diagram, Phase II (Shared Cost Savings) utilizes: shared cost-savings in which providers receive a percentage of payer cost-savings calculated by health indicator metrics and contingent on "SFS Integrated Provider" designation.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
In the SFS OIHC model, enhanced reimbursement rate incentives are utilized by payers to promote integrated healthcare at the service provider level. In Phase I, enhanced reimbursement rates are available for providers that achieve and maintain "SFS Integrated Provider" designation. These incentives are designed to reward true integration of physical, mental, and behavioral health services while offsetting initial costs of integration to providers. Incentives may also be available on a per-member per-month (PMPM) basis or for select integrated services (e.g. initiation/continuation of treatment for Alcohol and Other Drug (AOD) dependence, antidepressant adherence) provided by Behavior Health Consultants. In Phase II, provider incentives transition to a shared cost-savings structure. These incentives are designed to promote value-based care and are tied to specific health indicators (e.g. BMI, reduction in psychiatric Emergency Room visits, etc.) that can be prevented or mitigated through integrated healthcare.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?
Our Integration implementation manual has a number of activities to be accomplished and will be tracked in order to meet the quality standard of "integrated". We would then inform the payor that the clinic is integrated. We would audit the practice on an annual or bi-annual basis against these same standards to ensure that the practice is keeping the integrated model at a high quality level in order to continue to receive the higher reimbursement rates identified by the payor. We would place "certified integrated" information at the practice and also provide the same logo for the practice to use in marketing activities.

Define “success” for the model? How will the model’s success be measured? What types of benchmarks would be appropriate for evaluating the model?
Comparing outcome measurements between a non-integrated practice with those of an intergrated practice would be one measurement of success. Annual cost savings for all patients. The number of designated Integrated Health Care sites continued over time. Satisfaction and reports of transformation in how physicians are able to provide their care is an integral part of success. We have numerous pages of feedback from physicians discussing the transformation not only in their level of care but also the satisfaction of their patients. A comparison of health expenditures and outcomes for the State compared to other states over time.

Section VIII: Pilots and Other Considerations

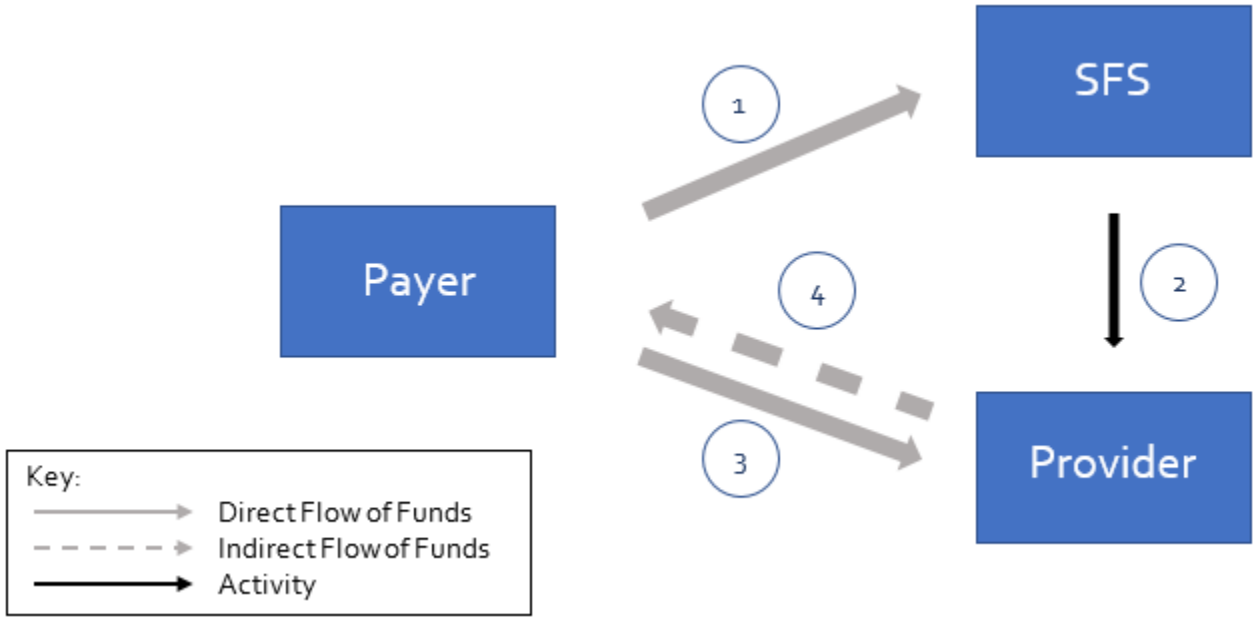
Could the model be piloted? If so, how would you propose a pilot?
Yes. We could start with one payor system such as a Medicaid Quaified Health Plan, integrate 1/2 of their pediatric practices, collect data, outcomes and patient satisfaction and compare to the other 1/2 of the system Pediatric practices to determine success, just as one idea. A full comparison between two separate health plans, one integrated, one not integrated, to compare longer term savings, patient satisfaction and outcomes.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?
Yes, this model could be a standard for replication and evidence of Integrated Health Care and Value Based Payments

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?
Click here to enter text.

(Optional) Are you aware of any other states or communities which have implemented this model?
None that we are aware of.

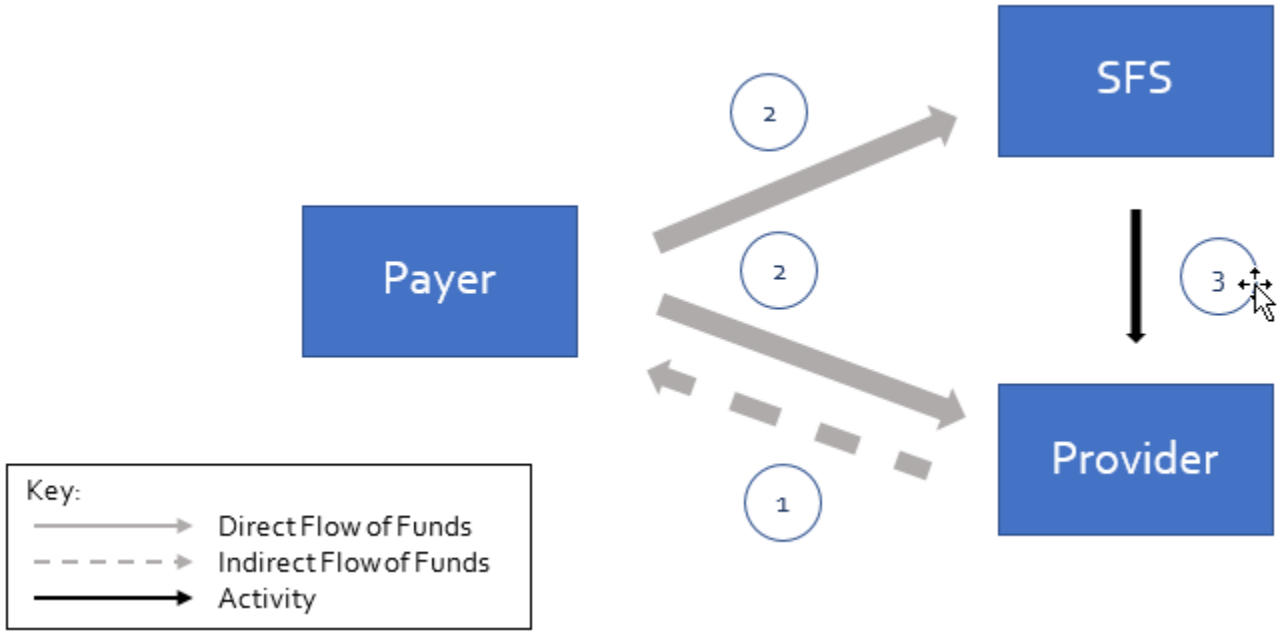
Phase I: **Payer Pilot** Integrate select providers to prove financial implications of OIHC Implementation Model Manual.



1) Payer provides flat fee contract to Starfish Family Services to integrate select providers using the OIHC Implementation Manual.
2) SFS Lead Integrator or Behavior Health Consultant delivers integration services to selected providers, accredits providers as "SFS Integrated Provider."
3) Providers with "SFS Integrated Provider" accreditation receive enhanced reimbursement rates from payer.
4) Payer realizes cost-savings from improved health outcomes.

Provider and/or Payer tracks indicators associated with cost-savings and generated through integrated healthcare.

Phase II: **Shared Cost-Savings** Transition to shared cost-savings for financial sustainability.



1) Cost-savings continue to be generated through integrated healthcare services. Thresh-hold indicator metrics are met.
2) Payer shares a percentage of cost-savings (as calculated by health indicator metrics) with SFS and provider. Flat fee contracts and enhanced reimbursement rates are terminated.
3) SFS continues to provide yearly re-accreditation and integration services for providers.

Provider and/or Payer tracks indicators associated with cost-savings and generated through integrated healthcare.

Payer may continue to contract with SFS to integrate other providers in its network.

Model #37

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Full Service Vertically Integrated Public Model (reflective of Advocacy Priorities No. 1 and Calley Workgroup Design Elements, No. 1)

Name of Submitting Organization: Southwest Michigan Behavioral Health

Model Partner Organization(s): CMS, DHHS, PIHPs, CMHSPs, behavioral health providers, hospitals & health systems, Primary Care Practices including but not limited to FQHCs, and Advocacy Leaders.

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

This Model details the already recommended creation of a publicly-sponsored (PIHPs/CMHSPs), publicly-governed, special needs Medicaid and Healthy Michigan Plan inclusive of all physical health and all behavioral health supports and services designed primarily for persons with Severe Mental Illness, Intellectual and Developmental Disabilities, Autism Spectrum Disorders, Severe Emotional Disturbance, and Substance Use Disorders. The Genesis of the Model is from Lt. Governor Calley Workgroup Design Elements (August 29, 2016) "Carve in physical health services to CMHSPs for persons with behavioral health and physical health care needs," and Advocacy Priorities for Sec. 298 (September 2016) "Carve in physical health services to the CMHSPs/PIHPs for persons with behavioral health and physical health care needs. This means the behavioral health needs of individuals aren't managed by MHPs, insurers, or private (non-public) entities. It also means that behavioral health services (mental illness, emotional disorder, developmental disability, intellectual disability and substance use disorder) must remain a public responsibility and in the public sector." The Plan would be crafted to specific geographies, and be based upon Voluntary Enrollment and reasonable Opt Out protections. The Plan woud be capitated with actuarially sound rates for all services, and presumably operate under cost settlement (with MDHHS), performance-based incentives (proceeds as Local funds), and risk corridor parameters. The Plan would exist as an optional (to eligible beneficiaries) alternative to current MHP and PIHP structures. The Plan would be designed and operated consistent with all Calley Work Group Design Elements and Core Values as well as applicable 298 Facilitation Workgroup Policy Recommendations. 1. Services and supports: All services and supports currently (or by future modification) as available in both the PIHP and MHP packages, or a modified by CMS or DHHS. 2. Types of organizations: The Plan would be sponsored by two or more PIHPs and their CMHSPs, potentially through the Michigan Consortium for Healthcare Excellence, a Michigan non-profit corporation whose Membership is the ten (10) Regional Entities. The Plan could be state-wide or encompass multiple PIHP or Prosperity Region geographies. The Plan would be funded through Medicaid and Healthy Michigan Plan actuarially sound capitations, plus performance bonus incentive payments (to become Local funds upon earning). The Plan would build and/or buy its administrative capacities and competencies, dependent upon cost-benefit analyses. The Plan would assure an accessible, quality Provider Network for all services, with CMHSPs having right of first refusal for applicable supports and services. Enrollment into the Plan would presumably be voluntary, and enrollees would have multiple selecyion options for care coordination responsibility and authority , including but not limited to a. self, b. guardian, c. designated other, d. CMHSP case manager, e. Plan staff member, or f. Primary Care Physician/Practitioner. 3. Service Delivery fully within 298 core values and recommendations: 4. Financing: The Plan would be funded through Medicaid and Healthy Michigan Plan actuarially sound capitations, plus performance bonus incentive payments. Value-Based Insurance Design concepts (see www.vbidcenter.org) would be incorporated throught the design, development and delivery phases. Like-minded, Triple Aim focused capital, operational and strategic partners would be welcomed. Capable, committed Provider Groups would be invited to share resources, risk, capital

and Governance. 5. Competent, public body: As a division or off-shoot of the Michigan non-profit Michigan Consortium for Healthcare Excellence (which has all ten PIHPs as Members), Medicaid benefits management and consumer-centrism with competence and a public nature would be assured. This would be further strengthened by a. Bylaws consistent with industry standard Accreditations, certifications and licensures, b. a minimum of one-third (1/3) Enrollees on the Plan Board (Governing Body), and c. self-imposition of compliance with Michigan Open Meetings Act and Michigan Freedom of Information Act.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
Plan would be primarily designed and developed for persons with mild to moderate mental illness, severe mental illness, intellectual and developmental disabilities, Autism Spectrum Disorders, Substance Use Disorders, and Severe Emotional Disturbance. Plan design would also be developed and marketed for persons with other disabling conditions with material psycho-social impacts. No enrollees would be excluded by virtue of age, condition, or psych-social functioning.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
All services and supports currently (or by future modification) available in both the PIHP and MHP Medicaid and Healthy Michigan Plan packages would be provided, unless modified by MDHHS or CMS. The approach can best be described as a full service (physical health, behavioral health, pharmacy) Plan. It would be ideal if additional psych-social-financial entitlements and benefits could be built into the Plan design and administration. In alignment with the River of Opportunity, the Plan could assume funding, administration and Risk (in full or in part) for supports and services such as MDHHS entitlements, School Vouchers, and similar publicly-sponsored activity. Supports and services would be unchanged, and would be augmented with additional services directed towards citizen-beneficiary ease, Provider and Community comfort/involvement, reduced overall administration, and improved results/outcomes. Utilization Management (a federaly mandated construct which addresses both over- and under-utilization) would be carefully designed separately from the person-centered planning process, with safeguards to assure conflict-free case management and to avoid artifical limits on amount, type, scope and duration of services. Particular attention will be given to adverse childhood events and social determinants of health, related resource needs, partners and shared service locations at the point of care.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?
First and frequent availability/choice of legitimate Self-Determination, Trauma-Informed, community inclusion and Person-Centered Planning concepts and techniques would apply to all supports and services. Additionally, home and community based regulations, ADA, Omtead requirments and related federal and state protections would be strictly adhered to. Enrollment into the Plan would presumably be voluntary, and enrollees would have options for care coordination responsibility and authority, including but not limited to a. self, b. guardian, c. designated other, d. CMHSP case manager, e. Plan staff member, or f. Primary Care Physician/Practitioner.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
The Model will enahance the coordination of physical health and behavioral health services and supports for individuals in multiple ways: 1. Permitting an enrollee to select their primary care provider as their medical home and Care Manager, 2.Establish a single payer for care coordination, and 3. Create a more tightly woven system for healthcare information exchange, healthcare data analytics, and active management of gaps in care. In addition, design philosophy will lean towards crafting best practices from throughout healthcare and community mental health and social servces in aligned accountable, organized systems of care.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?
The Model will promote greater collaboration amongst providers, service agencies, and payers at the service delivery level in multiple ways: 1., Each of these sytem stakeholders can have fully aligned contract terms and conditions, performance goals related to enrollee health status and functional level, 2. Physical health (medical-surgical) hospitals, health systems and primary care practices can be established as founding Plan members, partners, governors and managers, and 3. Enrollee representation on the governing body and various management committees can assure and strengthen the Consumer Voice. Concerted efforts will be made to create and support multi-disciplinary professional and para-professional care-givers, role distinctions, and communications channels. Particular attention will be given to adverse childhood events and social determinants of health, related resource needs, partners and shared service locations at the point of care. Information-sharing, analytics, communications and Member transportation are key elements of design.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?
The Model will improve the availability, accessibility, and uniformity of services (including medications) and supports in multiple ways: 1. As a single Special Needs Plan it will establish and develop consumer- and population-centric availability, accessibility, and intra-Plan uniformity of services, 2. Provider performance metrics, contract terms and conditions, measurment and public reporting will hasten system design and development directed towards assured availability, accessibility and uniformity, and 3. Enrollee and advocate engagement and active authoratative involvement in governance and management will assure a constant positive change management culture, environment, reosurces and accountabilities. The Model can adhere to Section 4 of the Interim Section 298 Report, dependent upon federal and state statutes then current. Beyond this, quality and costs and consumer preferences need not be mutually exclusive be they related solely to pharmacy benefits or more generally. Through tight networks of commited and bonded stakeholders/governors/managers, healthcare information exchange (which strictly honors related statutes and regulations and consumer desires) enrolle, prescriber, and provider views and behaviors can evolve to improve quality and consider costs. Please note the evolution of the Health Information Networks, Care Connect 360, and complementary healthcare daya analytics are foundatinal to all Pilots and Demonstrations, and ought to contine with all due haste. Similarly, enhancements to Michigan Automated Prescription System (content, format, process) are critical, as well.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
The Model would strengthen the workforce by establishing a workforce development model across the Plan, its Providers, and a robust Peer and Parent Provider network. The Model would improve efforts to recruit and retain key staff categories described by creating a workforce development and career ladder structure.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?
The Model will empower individuals to make decisions about service delivery by assuring initial and ongoing access to an internal and contracted network of facilitators/advocates skilled in the concepts and techniques described above. In addition, as a new enterprise, the culture thoughout the organization and system can be developed, trained, supported and monitored to these cultural neceissities. Advocates and subject matter experts in these areas would be solicited to develop, monitor and oversee enrollee feedback mechanisms and metrics.

Would this model affect the administration of complaints, grievances, and appeals?
In this Model the administration of complaints, grievances and appeals would be favorably impacted by establishing a sinbgle point of contact for all enrollee complints, grievances and appeals. In additin, the Model can support these funbctional areas receiving the highest level (CEO) supervision and accountability, and frequent reporting to the governing body inclusive of enrollees and advocates. Systemically, the Plan can contract with an objective outside agency for system monitoring and handling of later stage complaints and grievances.

How would the model support continued access for individuals to current services, supports, and providers?
This Model will support continued access for individuals for current services, supports and providers by establishing a deep and broad provider network inclusive of qualified providers enrollees "bring with them."

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

Governance would be established via a Michigan nonprofit corporation with public quasi-governmental and non-profit partners, enrollees, and Advocates on the governing body (Board). This approach will promote transparency and accountability for the delivery of publicly-funded services and supports by removing the primary profit motive, assuring a governing body representative of beneficiaries, their advocates and care-givers - professional and loved ones alike - alongside subject matter expert community representatives, Governing professional Plan Managers. In addition, while not required under the law for a non-profit corporation, the Plan governing body could subject itself and the Plan to the terms and conditions of the Michigan Open Meetings Act and the Michigan Freedom of Information Act. This will permit active engagement of the community, all enrollees, and Providers alike as performance metrics are established and reported.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

Individuals, family members and other community members can be engaged in decision-making in the delivery of publicly-funded services and supports by establishing a governing body inclusive of a significant proportion of persons from these categories, by establishing meaningful Consumer and Community and Provider Advisory Committees (fairly remunerated for their expertise and time), and incorporation of enrollees and advocates inside the Plan management structure.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

Needed changes to financing mechanisms for payers include greater clarity on CMS-and DHHS-permissible value-based insirance design, value-based provider contracting, performance incentives and sanctions, safe harbors, and performance bonus earnings as Local funds. This is not insurmountable as much has been written and established on these topics, and experts exist.

What changes would need to be made to provider reimbursement in order to implement the model?

Needed changes to provider reimbursement include similar to above, plus additonal considerations for increasing use of case rates, health and functional status improvement payments, Provider risk0sharing and the like. This is not insurmountable as much has been written and established on these topics, and experts exist.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

Incentives at the payer and service level provider would be explored and supported after thorough design consideration. Provider incentives would be carefully crafted to promote community inclusion, choice, health and functional status improvements, and enrollee satisfaction over service diminishments. Much has been written about this and related topics and experts exist. Incentives and sanctions would be subject to

enrollee and advocate representative review. Incentives would be designed and monitored to ensure against adverse selection, avoid under-utilization of services, avoid reduction in choice by persons served, and other unwanted negative consequences.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

Quality of service delivery can be measured and continuously improved by prospectively establish and implementing a cross-functional, structured Plan with individual and mutal commitments and accountabilities. Much exists under federal and state Medicaid requirements as well as Accreditation Standards. Healthe services administration textbooks have been written on this topic. One can look also to the Michigan Duals (Medicare-Medicaid) MI Health Link Demonstration for data and evidence of early success in care coordination, healthcare information exchange, healthcare data analytics and improved individual and population health.

Define “success” for the model? How will the model’s success be measured? What types of benchmarks would be appropriate for evaluating the model?

Success would be achieved when Enrolleess are satisfied (remain in the Plan); their health status shows demonstrable statistically signifciant gains in managing chronic conditions, minimizing acute conditions and avoidance of low value services such as hospital readmissions and ambulatory sensitive condition hospital admissions or services, social functioning is improved congrupuis with enrollee wishes (work, school, social activity, emotional state, etc). Metrics and mechanisms are available to expertly and objectively measure these and other success measures. Benchmarks for Plans and Providers are widely available from federal programs, Accreditation bodies, Advocacy Groups, Academia and more. Explicit design elements will include incorporation of Social Deteminants of Health concepts and focus, as well as adequate "braided" resources of a financial and non-financial nature. Key to evaluation and performance management will be the identification of consistently used instruments for individual and population needs assessment, individual functional status, level of care guidance, admission/discharge/transfer criteria, intensity of service/severity of illness guidance, outcomes measurement and the like. Wherever possible and appropriate, instruments should be standardized, normed, validated and with inter-rater reliability maximized. This Model - indeed all Pilot Models - must have suffficient internal and external/objective monitoring, measurement of outcomes and results and complete, accurate, timely public reporting. BHDDA, MSA and Plans (PIHPs, MHPs) must rapidly establish and produce a system wide performance metric collection, analysis and public reporting system. Such efforts are happily supported in Waivers and via enhanced financing from CMS. Michigan has deep and broad relevant evaluation, analysis and planning experience at the University of Michigan School of Public Health, Health Management Program, and elsewhere.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

The Model can easily be piloted state-wide or in multiple Regions. Consideration must be given to minimum enrollees, enrollee-provider density, and optimum/minimum/maximum Plan geography parameters. Start in 2-5 PIHP Regions combined, ideally geographically contiguous so as to avoid repetitive design work and redundant Governance and management structures. Upon Pilot performance review success, geography and enrollees can be expanded. A single Plan is suggested, rather than this type Plan in several or all Regions. This view is of course subject to discussion and debate.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

Yes, the Model can be implemnted state-wide. See above.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

This is currently under active review.

(Optional) Are you aware of any other states or communities which have implemented this model?

This is currently under active review.

Model #38

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Total Health Care – Total Integration

Name of Submitting Organization: Total Health Care

Model Partner Organization(s):
Michigan Department of Health and Human Services (MDHHS)
Detroit Wayne Mental Health Authority (DWMHA)
Behavioral Health Professionals, Inc. (BHPI)
Health Management Associates
Provider organizations (not an all-inclusive list) – behavioral health providers (all CareLink contracted Behavioral Health Providers); primary care providers (all THC contracted primary care providers); hospitals and health systems (e.g., Detroit Medical Center, Ascension Health, Beaumont); community and human services organizations (not limited to, employment/financial services; education assistance; housing/utilities; transportation; food); universities (Wayne State University).

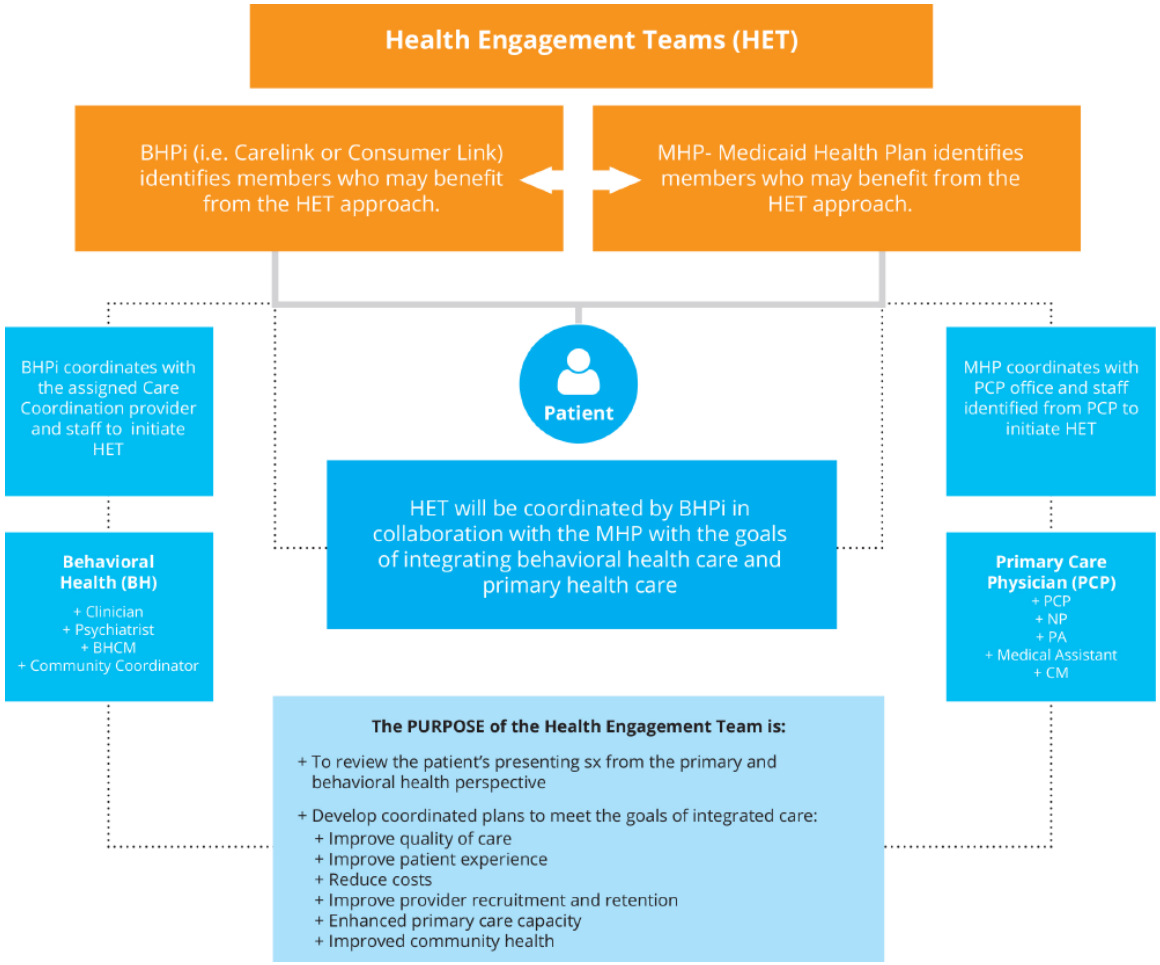
Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

Under the Total Integration project all Medicaid mental health and substance use disorder (SUD) services - collectively behavioral health services - and physical health services would be integrated within a single managed care entity. Under this model Total Health Care (THC), a Medicaid health plan (MHP), will be accountable for providing comprehensive behavioral health treatment and supports as well as traditional medical services. The model seeks to ensure timely access to a full continuum of quality behavioral health and primary care services, improve consumer outcomes and satisfaction, and ensure more efficient use of financial resources.

In analyzing our data, THC was able to determine that the structure of the current service delivery and payment system creates inadequate access to care, poor member outcomes, and unnecessarily higher costs. As it stands, MHPs have no contractual or payment relationship for the entire array of services provided by the specialty behavioral health system. In addition, specialty behavioral health service providers currently have no real incentive to ensure that consumers' care improves. THC and its collaborating partner, Behavioral Health Professionals, Inc. (BHPI), a managed care provider network (MCPN), would implement an integrated care delivery system that ensures the coordination of enrollees' care through use of provider-based Health Engagement Teams (HETs) who are supported in their efforts by staff from THC and BHPI. HETs work effectively to enhance the coordination of care between behavioral and physical health systems and services. This service delivery model (*see* Figure 1 below) focuses on providing individualized, person-centered, and recovery-oriented care management and coordination to ensure that consumer preferences, needs, and values guide clinical decisions that will be made within the HET.

Figure 1 - Health Engagement Team Model Illustrated



The Total Integration model is rooted in the core principles of Medicaid "health home" services, whereby HETs serve as the central point for coordinating, collaborating and ensuring communications among all relevant parties engaged in the delivery of a consumer's care. In addition to a provider organization's clinical staff and case managers, HETs will be comprised of peer navigators

and community health workers (CHWs) who are based on-site at provider organizations. As appropriate, HETs are dispatched throughout communities to carry out core HET functions (e.g., comprehensive care management, care coordination, comprehensive transitional care, health promotion, individual and family support, and referrals to community and social supports).

(1) Services and supports offered in the Total Integration model include comprehensive physical and behavioral health services, including services that address the broad spectrum of enrollee's health needs. Services provided through HETs address social determinants of health and are intended to disrupt patterns of avoidable hospital inpatient and emergency department (ED) utilization, improve consumer involvement, self-management, and recovery supports; and increase access and retention in services to improve overall behavioral health functioning and recovery as well as stabilization and improvement of chronic physical health conditions.

(2) THC will serve as the lead entity for implementation of the Total Integration model. Additional organizations essential for the success of the model include, but are not limited to: the Michigan Department of Health and Human Services (MDHHS), Detroit Wayne Mental Health Authority (DWMHA), Behavioral Health Professionals, Inc. (BHPI), Health Management Associates and provider organizations (e.g., behavioral health providers (all CareLink contracted Behavioral Health Providers); primary care providers (all THC contracted primary care providers); hospitals and health systems (e.g., Detroit Medical Center, Ascension Health, Beaumont). Other key partners include community and human services organizations (not limited to, employment/financial services; education assistance; housing/utilities; transportation; food) and Wayne State University. Under the model, the availability and sharing of information across health system partners is paramount. The model intends to maximize the use of existing information (e.g., Care Connect 360; admission, discharge and transfer (ADT) data; health plan analytics; and provider care management systems), to create actionable resources for use by HETs.

(3) The Total Integration model will support service delivery consistent with core values and recommendations in the interim 298 report by encouraging evidence-based delivery models at the service provision level, increasing opportunities for co-location and other models of bi-directional care and ensuring the consumer's active participation in service delivery options. The model will enable the establishment of value-based payment methodologies to ensure that services and treatments are in line with intended outcomes. In addition to promoting and supporting co-located services and other arrangements for integrated care, behavioral health and primary care providers will receive initial and ongoing training and supports to improve effective collaborations across systems, particularly to ensure that consumers at high or moderate risk of worsening health outcomes or are high intensity service users are prospectively identified to ensure they receive appropriate care planning, coordination, and follow-up by HETs.

(4) In order to ensure that enrollees have access to a full continuum of care to address changing needs (i.e., mild/moderate through severe or acute conditions) and achieve service outcomes, the financing model requires the payment integration of all Medicaid physical, and behavioral health services within Total Health Care. This financing approach enables the design and implementation of value-based payment methodologies, including shared savings approaches, in which behavioral health and primary care providers are able to participate and be incentivized for providing quality care and achieving results.

(5) Under this model, MDHHS, DWMHA, BHPI, THC and Advisory Board (defined under Section V. Governance) representatives of public agencies will work in partnership to identify priority populations or establish quality improvement programs for target enrollees. Also, under the model DWMHA will maintain its current administrative funding levels necessary to conduct monitoring and oversight activities on behalf of MDHHS.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
The population will be all Wayne County residents who are Total Health Care enrollees. Since the model is intended to address the full range of behavioral health needs, the population will include adults with serious mental illness, children with serious emotional disturbance, adults and children with any mental illness condition (i.e., mild-to-moderate), and children and adults with substance use disorders. All 36,701 of Total Health Care's Wayne County enrollee population would be eligible to receive comprehensive physical and behavioral health services under the model. Currently, the population receiving behavioral health services (n = 7304) includes 3,492 adults with SMI (47.8%), 1,292 children with SED (17.7%), 387 individuals with IDD (5.3%) and 2,133 (29.2%) enrollees with a mild/moderate mental illness. The Total Integration model can also address the needs of individuals who have an IDD-only diagnosis at the state's request.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
The Total Integration model encourages primary care and behavioral health providers to deliver services in a manner that promotes coordination and collaboration, supported with tools and resources from THC. The model also supports consumer self-management and promotes the role of the consumer as an active participant in his or her ongoing care. A key element of the model is implementation of a proprietary electronic care management system, which provides capability of reading and writing into other electronic health records (EHRs) across the system and further supports EHR integration, content creation, and personalization. The care management system also contains a comprehensive patient education system, which give clinicians and providers access to a comprehensive library of links to the world's most effective patient education materials. Those materials are sharable with patients via text message or email, and support providers' tracking of patients' interactions with delivered materials.

This proprietary electronic care management system will allow all providers within the HET a way to connect with each individual consumer ensuring that they not only understand what is going on in terms of their care and treatment but it will also provide a consistent message across the HET for each individual consumer who is engaged in care and treatment and also improve health literacy. This will provide a way for the HET to measure, along with our existing systems, quality of care and outcome data as we will be able to monitor various measures of adherence including appointment reminders; prescription use and refills; monitoring of use of educational materials that can be sent to not only the individual consumer but also their support system as well. This system will allow for a more integrated approach to care and treatment. Furthermore, providers will be able to not only provide education around ED use and necessity, but will be able to create clear, consistent messages around when to seek out the ED as well as options available to each consumer other than the ED. Another high-cost variable within the system of care is re-admission to the hospital after being recently discharged. The population of focus frequently is re-admitted for a variety of reasons. Through the use of proprietary electronic care management system, our Admission, Discharge, and Transfer (ADTs) report, and the State's 360 Connect the HET members will be able to identify early on potential reasons for re-admission and therefore will be better equipped to work with the individual consumer and their support system to put additional supports in place as well as education to work with the individual consumer to reduce re-admissions. These may include ensuring the individual consumer understands the post-hospital discharge plans including medication changes, appointments for follow-ups and check-ins by the HET to ensure that the consumer is doing okay once they leave the hospital. Furthermore, the HET will work with the other providers to ensure that the consumer is reminded of their follow-up appointments, will work with the providers to ensure medical transportation is arranged (where applicable), will ensure that the consumer has all the education from the provider regarding possible side effects and what to do if they experience a negative side effect.

Implementation of the integrated care model requires all enrollees to receive an annual health risk assessment (HRA) by a member of the HET so that consumers can be stratified according to an acuity group: high, moderate, or low. The acuity group assignment enables HET members to carry out appropriate care coordination and management interventions and ultimately develop a care plan. Factors that drive placement into an acuity group include, but are not limited to: multiple hospital emergency department (ED) visits, frequent inpatient hospitalizations (including psychiatric hospitalizations), 30-day hospital readmissions for any medical condition, chronic medical condition (e.g., diabetes, congestive heart failure, hypertension, COPD), lack of engagement with a PCP or behavioral health services despite ongoing behavioral health needs, and low rates of medication adherence. For these and similar at-risk consumers, the HET is deployed to work closely with the consumer and across provider organizations and clinicians to holistically review the enrollee's presenting conditions (i.e., from the primary and behavioral health perspective) and coordinate the development of a coordinated care plan.

The role of the HET is to also make use of data analytics and other information to facilitate ongoing training with providers and clinicians to effectively address elements contained in the care plan and achieve improved health and service utilization outcomes. The role of THC and BHPI is ensuring the success of the model and HET interventions, monitoring and oversight, providing training on evidence-based services and guidelines, and ensuring the use of tools and processes to document, track and report performance outcomes metrics. For consumers who do not currently possess risk factors described above, THC and BHPI would regularly assess health risk through ongoing monitoring and use of data analytics as well as by annual administration of the HRA by the DWMHA or behavioral health services provider.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?

For consumers, the model is indistinguishable from the current service structure in that how consumers currently access care or exercise choice of primary care or mental health services provider will not change. And yes, consumers will also have the ability to determine who serves as their care coordinator/manager, which could be a clinician (nurse care manager, peer, CHW, etc.) from the primary care or behavioral health provider. Under the model the HET must engage providers and clinicians across delivery system to ensure effective coordination, care plan development and other related activities.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

While we believe and are proposing this as a statewide model of healthcare integration, THC, BHPI, DWMHA, Wayne State University, and our currently contracted behavioral and physical health providers are positioned to move forward with this demonstration project in Wayne County. Under the Total Integration project, a key component of the model is not just the financial integration of care and services within THC, but ensuring that THC has tools, processes, and relationships in place to enable the coordination of physical and behavioral health care. The role of the HET, reliance on availability and interchange of data and analytics and providing pathways for providers to be effective in delivery of care are essential for the model's success. In addition, the model will have a proprietary electronic care management system that includes a patient education system available that will be available to providers for use with consumers. This system provides HETs' the ability to improve interpersonal and informational continuity, deliver comprehensive services in a seamless manner, and promote treatment of the consumers as a whole rather than addressing individual physical and behavioral health conditions in isolation.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

The model will encourage and support collaboration among physical and behavioral health providers, service agencies and payers by: implementation of standardized processes and clinical pathways that all HETs must adhere to in the delivery of services, through the establishment of a uniform service array that is available to all enrollees within the county, by ensuring uniformity in the use of health risk assessments, and screening tools (i.e., PHQ-9; Physical Health Screening, PCL-C) ; and development of standard benchmarks and metrics to assess outcomes. These processes are intended to facilitate communications and coordination across systems and also promote economic effiencies.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

In analyzing our data, we were able to determine that the structure of the current service delivery and payment system creates inadequate access to care, poor member outcomes, and unnecessarily higher costs. As it stands, MHPs have no contractual or payment relationship for the entire array of services provided by specialty behavioral health system. In addition, specialty behavioral health service providers currently have no real incentive to ensure that consumers' care improves.

The model improves availability, accessibility, and uniformity of services (including medications) and supports by integration of services and funding within a single managed care entity, the MHP. An immediate benefit of integration of services and financing within Total Health Care is the ability of the MHP to monitor prescription drugs and apply lock-in controls for enrollees with suspected drug misuse patterns. Through the model, such information is easily shared among the HET who will follow up with consumers to provide requisite SUD intervention activities.

In addition, this structure ensures that enrollees with any behavioral health condition (mild, moderate, severe) are able to access needed care through a broad network of service providers. The model is intended to ensure the availability of services consistent with consumers' changing health needs as well as ensure access to a continuum of services from a broad array of providers and clinicians. In addition, providers will be incentivized to affect consumer health outcomes by being eligible to participate in shared savings approaches when outcomes are achieved. An individual consumer can access care and treatment at any point within the continuum of HET care model. The services and treatments which will be available to individuals who enter the HET model while

individualized based on the presenting needs of each consumer; as a whole the model remains the same in terms of services and treatments available.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

In addition to encouraging quality consumer care and treatment as well as consumer satisfaction, an important overlay will be the environment in which the providers function. A separate and often overlooked cost is the human and financial costs of high-turnover and low retention rates. Our approach will include on-going training and education, the encouragement of HET where each team member feels valued and plays an important role in the consumer's success, the use of CHWs who have played a critical role in the peer supports and workers who function not only as outreach staff but in addition work with our consumers during the early stages of engagement and warm-hand off to other providers. Our approach would be to seek out and train peer supports that would then be trained and transition over to the role of CHWs. An underlying approach for all HET members and providers will be to ensure that extensive orientation is provided including basics such as software usage and intake and assessments. In order to have better staffing outcomes, time will be taken to provide support, training, care transition and proactive planning and management over time to ensure that best outcomes. The HET will have in place a face-to-face interaction between team members as much as possible to build strong relationships, trusts and facilitate consumer communications. Our model will create a system for internal best practice sharing and peer support. Lastly, HET will solicit input from the HET members for feedback not only in regard to the model but also in addition to the role that they each play.[1]

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

The proposed service delivery model focuses on providing individualized, person-centered, and recovery-oriented care management and coordination to ensure that consumer preferences, needs, and values guide the clinical decisions that will be made within the

[1] McCarthy, D. *QuadMed: Transforming Employer-Sponsored Health Care Through Workplace Primary Care and Wellness Programs*. Commonwealth Fund pub. 1424, Vol. 51.

HET. Under this model the consumer identifies a member of the HET who will assist him or her in navigating options available to the consumer under the enhanced services and supports structure.

Would this model affect the administration of complaints, grievances, and appeals?
This model would not change the current procedures for complaints, grievances, and appeals. Using the existing structures for incident reporting may in fact may be an effective measure to compare and determine a correlation between the number, types and outcomes of problems/issues and concerns compared to the existing, separate service models.

How would the model support continued access for individuals to current services, supports, and providers?
For consumers, the model is indistinguishable from the current service structure in that how consumers currently access care or exercise choice of primary care or mental health services provider will not change. Consumers will also have the ability to determine who serves as their care/coordinator/manager, which could be a clinician (i.e., nurse care manager, peer, CHW, etc.) from the primary care or behavioral health provider. Under the model the HET must include providers and clinicians across the delivery system to ensure effective coordination, care plan development and other related activities.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?
Governance within the Total Integration project will be structured in a manner consistent with priorities and principles in the 298 interim report. An Advisory Board will be comprised of consumers, family supports and other caregivers, community providers, and representatives from MDHHS, DWMHA, THC, BHPI, and public agencies who will work in partnership to identify priority populations or establish quality improvement programs for target enrollees. The PIHP will maintain current administrative funding levels necessary to conduct monitoring and oversight activities on behalf of MDHHS. Furthermore, the structure of this model would ensure that all services and treatments comply with the Michigan's Freedom of Information Act and the Michigan Open Meeting Act. DWMHA, THC, and BHPI will ensure that both transparency and accountability for all services and treatments provided through the inclusion of providers, community members, consumers and family and supports for consumers will be actively involved in the Advisory Board. In addition, the board the Total Integration project will hold public forums in which consumers, their family and supports as well as community members can provide open feedback.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

To ensure that individuals, family members and other community members are actively engaged in the decision-making process in regard to the delivery of public funded services and supports, public forums will be convened. In addition, DWMHA, THC and BHPI will provide reports on the progress of the services and treatments. Reports on outcomes, successes, and challenges associated with the ongoing provision of services and treatments will also be made available. Community members and other stakeholders will be encouraged to provide feedback both verbally during public forums as well as will be encouraged to ask questions of the DWMHA, THC and BHPI and if requested they will be provided with information and education on how to file a complaint, grievance or appeal if they determine that course of action is needed.

Person-centered planning process, representation on existing Boards/Advisory Councils.

Person-centered planning is at the core of the model. In fact, an important component about the Total Integration project is the individualized person-centered plan. From the first point of contact through the entire HET process, the consumer is at the center of care. The model also includes use of peer navigators who understand the unique needs and circumstances of consumers. Peer navigators are able to assist consumers in overcoming barriers by working with the consumer to identify potential solutions. In addition, having consumers be an active part of the Advisory Board, MDHHA, DWMHA, THC and BHPI and all providers will ensure that the structure of our care systems are structured to meet the needs, goals and outcome of the consumers who we serve each day.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

In order to implement the model, and create the structure to accomplish integrated goals, the direct services portion (non administration dollars) of the current specialty behavioral health treatment service allocation would be paid by MDHHS to the MHP. This model is premised on the belief that integrating behavioral health treatment dollars with the current MHP funding will yield greater effiencies and result in reductions in costly, duplicative, and avoidable service use. Those resultant savings will be reinvested in enhancement of the model (i.e., ensuring the availability and use of evidence-based practices, providing staffing and analytic supports for the health engagement teams, and developing provider and patient education services and supports) and also used to make incentive payments to providers.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?
As previously mentioned, the HET model would continuously analyze measures and outcomes through the use of comprehensive data analytics. This will be achieved through many sources of data tracking and monitoring tools including our proprietary electronic care management system, statewide patient health information and detailed record of interactions and medical history, Admission, Discharge and Transfer (ADTs) information, collaborative EMR overview, 360 data and weekly HET meetings in which outcomes will be monitored and modified based on the data provided. We understand that specific measures will be determined by MDHHS; however, key areas to assess relate to: rates of consumer engagement with HETs, retention rates (i.e., total time a consumer remains in treatment), medication adherence, improvements in clinical health outcomes, and consumers' overall experience of care.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?
As stated above, success for the model will be based on the achievement of outcome measures to assess improvements in quality of care, processes of care and consumers' experience of care. MDHHS, DWMHA, THC, and BHPI will be required to work together on the establishment of outcomes measures and appropriate benchmarks, including those that assess changes in service expenditures through more efficient resource usage (please see example outcome measures above).

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?
Yes. The model that we propose would be a model between THC, and BHPI. THC would serve as the MHP and BHPI would serve as the MCPN with DWMHA providing the governance, recipient rights, grievances, appeals and quality assurance with one payer source in which all funding would flow through THC and BHPI would have in place its existing contracts with all Wayne county behavioral health providers through Carelink.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

Yes. As we move down this path, our model has built into practice structure and health care and treatment strategies[2] to shift our focus from the questions about whether the model will work to a more global question about replication, statewide scalability, and sustainability of the model. From our standpoint, in moving forward and areas that will be enhanced will include:

- Identifying additional complex interventions as the population(s) change and grow;
- Maintaining fidelity to the model (while at the same time using data analytics to ensure that the best outcomes are being achieved for the consumers)
- Being mindful of consumer enrollment and active involvement in their own care and treatment
- Reviewing and adapting sustainable financial continuum
- Identifying barriers and modifying rules, regulations and policy to ensure that consumers are receiving the best care and treatment possible

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

We do not believe any changes in regulations or policies would be necessary to implement this model in Wayne County. However, we are prepared to further develop details about this model and further explore the nuances related to implementation of the model with MDHHS and other key stakeholders.

(Optional) Are you aware of any other states or communities which have implemented this model?

Yes, a number states have begun integrating physical and behavioral health services within a single managed care entity (Arizona, Florida, Iowa, New York, Washington) and several other states are on-track to move in this direction (Ohio by January 2018).

[2]Miller CJ, Grogan-Kaylor A, Perron BE, Kilbourne AM, Woltmann E, Bauer MS. Collaborative chronic care models for mental health conditions: cumulative metaanalysis and metaregression to guide future research and implementation. Med Care. 2013;51(10):922-930

Model #39

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: UnitedHealthcare Community Plan - Integrated Care Management for Physical and Behavioral Health Services

Name of Submitting Organization: UnitedHealthcare Community Plan

Model Partner Organization(s): Click here to enter text.

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

Our proposed model would provide fully integrated care management for all UnitedHealthcare Community Plan members with a behavioral health diagnosis, including individuals with mental illness and/or substance use disorder, in a selected region under a single accountable entity. All services would be coordinated by UnitedHealthcare Community Plan, leveraging our extensive expertise serving the physical health needs of Medicaid members in Michigan and our national experience providing the full scope of benefits, including specialized behavioral health services, through our management of integrated physical and behavioral health programs in 22 other states, covering over 5 million members. We believe we would be able have implementation of this model well underway within 90 days. Within our integrated model, members would receive a single, comprehensive assessment that includes all physical and behavioral health needs as well as identifies needs for social supports. The results of this comprehensive assessment are captured in one plan of care, and all services will be coordinated by a unified care coordination team that is focused on the needs of the whole person, including physical, behavioral and social supports. The individual will have a single point of contact within the team to coordinate their overall care. The comprehensive assessment would also be used to support a blended risk stratification process through which we would identify beneficiaries with the highest need across behavioral and physical health domains for immediate intervention. Including behavioral health utilization information in the risk stratification process allows us to also identify members who are not yet in the highest percentile of total cost, but will likely be soon if they are not engaged. Our proposed pilot has the potential to improve the overall system by supporting physical and behavioral health integration at all levels of the program, including benefit design, service delivery, and administrative structure for physical and behavioral health services. Leveraging the infrastructure and assets of UnitedHealthcare Community Plan, supported by a person-centered care model and integrated, nimble technology, our model can lead to true service integration and drive administrative and cost savings benefits. To advance a person-centered, holistic approach to care, we will integrate the delivery of services for members with co-morbid behavioral and physical health conditions leveraging creative contracting strategies to incentivize provider engagement and drive integration at the point of delivery. Our model would place high priority on addressing opioid abuse. We will work with the Community Mental Health Agencies (CMHs) in our selected region to smooth out differences in the availability of treatment services for individuals suffering from opioid addiction to ensure consistency and access as well as implement strategies to stem the growing opioid crisis in Michigan. From an enterprise perspective, UnitedHealthcare has called upon a task force of internal experts and senior leaders to develop creative strategies to resolve the national opioid abuse crisis. We will tap into the resources and leverage the models developed by the task force in our proposed model. Today, UnitedHealthcare Community Plan is contracted with several Community Mental Health Agencies (CMHs) in

the Lower Peninsula to manage the 20 mild to moderate behavioral health visits covered by the Medicaid Health Plans today. UnitedHealthcare has a full behavioral health network in Michigan under contract to serve our commercial members. To integrate the moderate to severe behavioral health services into our Medicaid network, we will leverage the breadth and depth of our enterprise to attempt to contract with the local Community Mental Health Agencies (CMHs) across the selected region to serve the full scope of needs for UnitedHealthcare Community Plan members. We are committed to tapping into the extensive capabilities of our organization to provide an integrated program to our Michigan members. Our model will also leverage the unique assets of UnitedHealthcare Community Plan, namely the myCommunity Connect Centers located in Detroit (Region 10). The myCommunity Connect Centers serve as a conduit for members to local services that address social determinants of health. Connections to social services are critical to create true "communities of health". Our proposed model would integrate the myCommunity Connect Centers directly into the resources provided to our integrated physical/behavioral health members residing in Region 10, driving greater value from these public programs. Lastly, our model will leverage a single care management platform, Community Care, to support a comprehensive care plan that encompasses all beneficiary needs and allows members of the care team, including all behavioral and physical health providers, to access and update the plan. Our platform enables data sharing to support the integrated beneficiary assessment and blended risk stratification. Our integrated technology will enable physical and behavioral health providers to efficiently and effectively collaborate and will provide a holistic view of the individual to anyone touching the beneficiary across the entire provider system, allowing the system to best serve the beneficiary where they are. (1) Types of Services and Supports to be Provided: Identification and risk stratification of both medical and behavioral health disorders; Biopsychosocial Health Risk Assessments to early identify members' medical, behavioral, and social/environmental conditions; Care and Disease Management staff and services that address members' needs in a comprehensive manner; Utilization Management, Care Management, Disease Management, and Discharge Management that functions as a "No Wrong Door" approach to identifying and addressing members' biopsychosocial needs. (2) Types of Organizations Involved: UnitedHealthcare Community Plan, local Community Mental Health Agencies (CMHs) (3) How the model supports the core values of the 298 report: This model truly integrates the physical and behavioral health delivery systems by aligning the goals and processes practices by payers and providers serving members accessing the two systems today. In doing so, the system has greater capacity to serve those with the greatest need while driving greater value in the system by investing in resources that provide the highest quality care and most positive outcomes for beneficiaries. (4) How the model would be financed: The model would be financed through a combination of state and federal Medicaid funding and local county dollars that are used today to fund behavioral health for this population. These dollars would be redirected from the local Prepaid Inpatient Health Plan (PIHP) serving these members to UnitedHealthcare Community Plan via a capitation payment. UnitedHealthcare Community Plan would use those dollars to coordinate integrated care and pay the CMH's and other providers providing care directly. (5) How a competent public body would be engaged: A competent government body would serve an oversight function, ensuring all aspects of the contract/pilot are properly fulfilled by UnitedHealthcare Community Plan as the single accountable entity. As a part of this oversight, the government body would evaluate the success of this proposed model by measuring our performance against a set of mutually-agreed upon quality measures.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
This model would include all UnitedHealthcare Community Plan members in the selected region with mental illness, mild to severe, as well as those with substance use disorders (SUD) and individuals with co-occurring mental health and SUD conditions. Individuals with intellectual and/or developmental disabilities (ID/DD) would be initially excluded from this model, but integrated into the program upon completion of a full network build for ID/DD service providers in the selected region.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
The services and supports that would be incorporated into the model include: Identification and risk stratification of both medical and behavioral health disorders; Biopsychosocial Health Risk Assessments to early identify members' medical, behavioral, and social/environmental conditions; Care and Disease Management staff and services that address members' needs in a comprehensive manner; Utilization Management, Care Management, Disease Management, and Discharge Management that functions as a "No Wrong Door" approach to identifying and addressing members' biopsychosocial needs. Our model will enable services that support primary care providers in identifying behavioral health needs, especially substance use, and help those individuals access care. We will leverage the evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?
Individuals who are enrolled with UnitedHealthcare Community Plan would continue to receive their services from their regular providers (physical health providers and CMHs). Individuals accessing behavioral health services will be provided a single care coordinator to manage across both their physical and behavioral health services, similar to the care coordinator they work with today on just their physical health needs. Individuals would be provided the choice of their care coordinator, including the option to coordinate their own services, leveraging the resources provided by UnitedHealthcare Community Plan as their integrated plan.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
Our model would enhance care coordination of physical and behavioral health services by using a single, person-centered clinical approach that spans the continuum of services. Under this model, UnitedHealthcare Community Plan does not replace or replicate the providers' role; rather we would work to complement providers by "filling in the gaps" for the beneficiary traversing the care system, ensuring they are engaged in the delivery system in the right way. At the start of an integrated program, beneficiaries receive a single, comprehensive assessment that includes all key health dimensions. The results of this comprehensive assessment are captured in one plan of care, which is used to manage and coordinate the beneficiary's care across the health care continuum. The comprehensive assessment is used to identify all services and providers that touch the individual's physical and behavioral health, as well as socioeconomic factors influencing health, such as access to adequate housing and

food. The comprehensive assessment would also be used to support a blended risk stratification process through which we would identify beneficiaries with the highest need across behavioral and physical health domains for immediate intervention. Including behavioral health utilization information in the risk stratification process would allow us to also identify beneficiaries who are not yet in the highest percentile of total cost, but will likely be soon if they are not engaged. This integrated model would allow us to identify and engage the most impactable beneficiaries. For example, substance use disorders can often correlate with high emergency department (ED) utilization. In an integrated model in which the UnitedHealthcare Community Plan as the Medicaid Health Plan (MHP) has access to real-time information regarding behavioral health diagnoses and hospitalizations, we can engage the beneficiary earlier with high touch interventions to help drive behavior change and avoid future trips to the ED. Additionally in this model we would deploy a unified care coordination team that is focused on the needs of the whole person, including physical, behavioral, and social supports. The beneficiary will have a single point of contact within the team to coordinate their overall care. This approach helps alleviate confusion that is often experienced by a beneficiary who, today, often has multiple care managers in both the MHP and PIHP systems and streamlines communications between the beneficiary and the care team. This single point of contact also increases transparency for the beneficiary, ensures coordination across the health care continuum and reduces duplication of services. This single point of contact, referred to as a care team leader, will build trust and understanding with the beneficiary, conduct their holistic assessment, and break down barriers to care. They will ensure the beneficiary is connected to their physical and behavioral health care providers, and if they have gaps in care, will work with the beneficiary to resolve them. The beneficiary's care team leader will also ensure the beneficiary has access to high-value community resources and refer them to those resources if needed. The MHP should coordinate with the Community Health Innovation Regions (CHIRs) created under the State Innovation Model Grant in the appropriate regions to ensure the beneficiary receives full access to local resources. A holistic clinical approach and a comprehensive provider engagement can only be achieved if there is an underlying technology infrastructure that supports comprehensive data exchange and clinical integration. In our integrated model, we will deploy our flexible technology platform, Community Care, across all members of the care team and all behavioral health and physical health providers to support seamless and timely data exchange. Such an approach will enable providers to have full line-of-sight into the medical record of a member to understand their needs as well as seamlessly contract and interact with the member's behavioral health provider and care coordinator on-the-spot, imbedding a holistic, person-centered approach within care delivery. This approach creates integration at the point-of-service, which will improve the member's experience, ease navigation of the system, and drive efficiencies for all providers on the care team.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?
As an integrated MHP, UnitedHealthcare Community Plan would leverage value-based, pay-for-performance contracts to reward and drive integration at the provider level. We can incentivize physical and behavioral health providers to work together to manage the beneficiary's care and align providers behind the goal of addressing the total cost of care, instead of just a piece of it. This includes facilitating the sharing of integrated health records among physical and behavioral health providers. Additionally, physicians often do not have access to reliable referrals

for patients with behavioral health needs. Our model would enable a system that facilitates, encourages, and rewards provider coordination across behavioral and physical health needs can break down these barriers.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?
Today, because the PIHPs contract directly with the CMHs to deliver services, beneficiaries and providers are often unsure how to access behavioral health benefits due to the fragmented system which relies on differentiating the type and severity of their behavioral health needs. The current system does not allow for a single point of access, which would greatly reduce the confusion and burden often experienced by beneficiaries and their providers. In our proposed model, the beneficiary would have a single point of contact within their care team to holistically coordinate their care and services. This could include the individual themselves to conduct self- coordination with guidance through integrated member materials supporting self-management. This approach helps alleviate confusion often experienced by a beneficiary who, today, has to navigate multiple care managers in both the MHP and PIHP systems and streamlines communications between the beneficiary and the care team. The infrastructure and reach of the MHPs will ease differences across geographies by leveraging an integrated approach to care coordination and planning. This is particularly important considering the critical role many counties play in the delivery and purchase of behavioral health services that often leads to differences in processes, services, available benefits and providers across the state. Our models provides the infrastructure to smooth out differences across the delivery system so that it is consistent, integrated and streamlined to ensure access to care and continuity of services. We acknowledge that implementing exemptions on prior authorizations for certain medications is a priority for MDHHS. We understand these requirements and support these efforts to ensure access.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

Our model would strengthen the workforce to support the delivery of high quality, integrated care across the delivery system. To do so, within our model, UnitedHealthcare Community Plan would:
•Develop strong working relationships with the CMHs and identify opportunities for joint quality initiatives, collaborative projects to expand services and provide training or outreach;
•Provide a dedicated team of behavioral health provider representatives to contract and provide oversight, training and technical support to the CMHs;
•Create a provider advisory board that could assist with identification of system gaps to provide feedback to UnitedHealthcare Community Plan and the state;

•Enable telehealth capabilities, including telepsych, to create access to behavioral health services for individuals living in rural areas with provider shortages;
•Develop a Recovery Team of certified peer support specialists expand peer support services and resources; and •Create opportunities for consumer, family, and stakeholder participation by hosting regular public meetings to create an ongoing dialogue on ways in which our services can be improved.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?
Enabling individuals to make informed choices and become fully engaged in determining what services and supports they require to achieve the quality of life he/she desires is foundational to a modern behavioral health model of care. To be done effectively with proper supports and oversight provided by the delivery system, person-centered planning requires integrated infrastructure, with single line-of-sight into all aspects of the individuals' interactions with the health care system Person-centered planning is the basis for our approach to managing the care of those with a mental illness, and/or a substance use disorder. As part of the person-centered planning process, each individual would be able to determine the following elements of the process:
(1) Who facilitates their navigation through the health care system, decided through an informed choice of coordinators;
(2) When, where, and how often meetings with care coordinator will occur; and
(3) How assistance will be provided to support the person's navigation through the health care system.

Would this model affect the administration of complaints, grievances, and appeals?
The model would leverage the process UnitedHealthcare Community Plan has in-place today to address complaints, grievances, and appeals and would extend the scope of this process to address issues that arise among participating CMHs.
How would the model support continued access for individuals to current services, supports, and providers?
Our model will create alignment across physical and behavioral health providers under the single managed care umbrella, and therefore will ensure consistent access to current services and providers. Our model would create a single point of access into the health care system for the beneficiary, which would greatly reduce the confusion and administrative burden often experienced by beneficiaries and their providers. This type of continual access to services and providers that is not achievable today. In today's system, physicians often do not have access to reliable referrals for patients with behavioral health needs. A system that facilitates, encourages, and rewards provider coordination across behavioral and physical health needs, which would be created in our model, can break down these barriers.

Section V: Governance
How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

In aligning physical and behavioral health services under a single accountable entity, funding for those services will also be consolidated under the administration of the single entity. In doing so, as the single entity, UnitedHealthcare Community Plan would have the ability to accurately track the spending of all public dollars across all programs, therefore providing MDHHS line-of-sight into the total cost of care for each beneficiary across the full health care continuum. In enabling this capability, we would be creating a more transparent and accountable Medicaid program. Additionally, this type of integration will provide full line-of-sight into the utilization patterns of individuals accessing both the behavioral and physical health systems. These insights will inform the model of care for each individual and allow us to target clinical programs and interventions to specific populations.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

As an MHP, we will continue to ensure we have at least one-third of the representation on our governing board is comprised of our members and their families. We will work with MDHHS to host public forums to allow consumers, family members and advocates to provide direct feedback to us on best practices and ways to improve the delivery of integrated behavioral and physical health services.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

To implement this model, Medicaid dollars and county funding for behavioral health that is provided to the PIHPs today should be redirected to UnitedHealthcare Community Plan as the single accountable entity as part of an actuarially-sound capitation payment that is intended to cover both physical and behavioral health services. We recommend that MDHHS consider implementing ceilings to provider payment levels, allowing leeway for the MHPs to implement value-based contracting strategies.

What changes would need to be made to provider reimbursement in order to implement the model?

Leveraging the dollars discussed in the previous question, UnitedHealthcare Community Plan will contract directly with the CMHs and other providers, as appropriate, under a negotiated rate.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?

Our model will leverage incentives intended to drive service integration and remove siloes at the provider level. We will offer both physical and health providers financial incentives for demonstrating that they work together to deliver holistic care to the beneficiary and achieving mutually agreed-upon quality measures.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

Our model will leverage defined quality outcome measures for specific behavioral health. We will use HEDIS measures appropriate for behavioral health services that we have experience measuring our performance in integrated programs in other states and use our performance on these measures to inform and continually improve the service delivery provided under our model.

These measures would include:

•Follow Up After Hospitalization
•Antidepressant Medication Management
•Follow up Care for Children Prescribed ADHD Medication
•Initiation and Engagement of Alcohol and other Drug Dependence Treatment
•Adult Schizophrenia Measures
•Child & Adolescent Schizophrenia Measures

Define “success” for the model? How will the model’s success be measured? What types of benchmarks would be appropriate for evaluating the model?

For our proposed model, "success" is defined as providing truly integrated physical and behavioral health care for Medicaid beneficiaries accessing both systems today. To evaluate the success of our model, specific benchmarks could include:

•Emergency Department utilization
•Medical inpatient utilization
•Behavioral inpatient utilization
•PCP follow up after hospitalization
•Behavioral health provider follow up after hospitalization
•Consumer satisfaction & Family member satisfaction
•Behavioral health and Physical health provider satisfaction
•Incremental Savings to Total Cost of Care

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Yes, this model can be piloted in a selected region or set of regions. We propose that this model be launched in Region 10 to leverage the assets of the myCommunity Connect Centers in Detroit. . As noted above, with several CMHs in the Lower Peninsula today, we would be able have implementation of this model well underway within 90 days. In adopting this model in the Detroit area, Michigan will begin to smooth out differences in access to services and help alleviate gaps in care that are created by the fragmented system in-place today.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

Yes, this model can be implemented statewide. UnitedHealthcare and the other MHPs can develop statewide strategies to contract directly with the CMHs across Michigan to develop integrated networks and coordinate integrated care.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

(Optional) Are you aware of any other states or communities which have implemented this model?
UnitedHealthcare has implemented this integrated, whole-person model in 22 state programs, including Kansas, Tennessee, and Washington, covering over 5 million members. We are happy to share information on outcomes and successes on these programs if the evaluation committee would find that information to be valuable.

Model #40

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Complete Health

Name of Submitting Organization: Upper Peninsula Health Plan

Model Partner Organization(s): Upper Peninsula Health Plan (UPHP) and the Upper Peninsula Health Group Physician Hospital Organization (UPHP PHO) that holds network agreements with all Upper Peninsula Community Mental Health (CMH) agencies, hospitals, primary care providers, specialty providers, behavioral health providers (mastered degree social workers, professional counselors, psychologists, psychiatrists), nursing facilities, local health departments, pharmacies, and ancillary providers (durable medical equipment, home health agencies, vision providers, hearing providers, podiatrists, etc.)

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

The Upper Peninsula Health Plan proposes an integrated care model that covers all Medicaid covered services and benefits including inpatient and outpatient acute care, all behavioral health services (including but not limited to therapy, peer support, community living supports, vocational programs, autism services, co-occurring disorder treatment), substance use disorder (SUD) treatment, durable medical equipment, and prescription drugs under one contract with a single entity; the Medicaid Health Plans (MHPs). The MHP would be required to contract with a robust network of providers to cover all services and must include a contract with all Community Mental Health (CMH) agencies in the service area. The goal of this integration proposal is to offer high quality, seamless and cost effective care through coordinated, person-centered services that meet all the needs of Medicaid enrollees. The partnership between the MHP and CMHs will ensure that care will not be disrupted and provide a seamless transition for people who currently receive services through the CMH system. This will also provide individuals with expanded access to behavioral health providers that are already directly contracted with the MHPs. Individuals will continue to have access to high quality community-based services and supports for people who have intellectual or developmental disabilities, those who have serious mental illness, those who have a substance use disorder and those who have a combination of these conditions. This will ensure enrollees will continue to be effectively served and that the services and supports currently received are maintained. The primary goals of this integrated physical and behavioral health delivery system will be to: provide seamless access to all services for beneficiaries, person-centered care coordination across the full spectrum of services integrating care for the whole person, streamlined administrative processes for beneficiaries and providers, expanded access to community based supports and services, and improved quality of services and member satisfaction. The State would contract directly with the MHP for all services and the MHP would be responsible for providing funding and oversight to the CMHs. In order to ensure consistency of funding and member services, we recommend reimbursement from the MHP to the CMH agencies remain the same as the current practice of payment between the PIHP and the Community Mental Health Agencies. UPHP proposes this model be piloted in Upper Peninsula as the region has a single MHP that is already contracted with all CMHs in the service area. During the pilot, we would analyze encounter data to enable us to move towards funding based upon member risk score, including a shift to value based payment arrangements and incentive payments. Consumer input and engagement is critical to the success of this pilot. An Advisory Council would be established under this model. The Advisory Council will provide input and feedback to the MHP's governing board on issues of plan management, delivery of services, enrollee care and member experience. The Advisory Council will be comprised of community advocates, CMH staff, enrollees, family members, and caregivers that represent the population served through the CMH system. A member of the Advisory Council will also serve on the MHP's management committee and serve as a direct liaison between the Advisory Council and the MHP's management committee.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

This model would include all full Medicaid recipients that are currently mandatorily or voluntarily enrolled in a Medicaid Health Plan. It would require the addition of some currently excluded Medicaid subpopulations to mandatory Health Plan enrollment.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
The model would incorporate the full array of behavioral health and substance use disorder services and supports currently available through Medicaid including all State Plan Services (1915(b) Services), Waiver Services (1915(b)(3) and 1915(c) Services), Autism Services, Healthy Michigan Plan mental health/substance use disorder services, and Substance Use Disorder (SUD) Community Grant Services. MHPs would contract directly with the CMHs allowing for them to continue to administer these services as they currently do. MHPs also have a network of behavioral health providers which will allow for expanded access to providers and services outside the CMH system.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?
Member choice is the core of this model. The approach is person-centered and each member would choose whether to receive services and supports. Each enrollee would have the ability to choose their care coordinator and UPHP anticipates this would often be based on their primary service needs. For example, a person requiring mostly supports through the CMH would work directly with that entity to choose his or her care coordinator. A person requiring primarily medical care services would work with the MHP to select a care coordinator. Regardless of the entity acting as the care coordinator that person would be responsible for coordinating both the physical and behavioral health services for the member. The member's care coordinator will be responsible for supporting an on-going person-centered planning process; facilitating access to care and services; facilitating communication among the member's physical and behavioral health providers and authorized supports; coordinating and making referrals to community resources; advocating with or on behalf of the member; and supporting transitions in care as the member moves between care settings. Metrics will be established and MHPs would be evaluated to ensure that all members have access to the services they need and desire.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
The goal of this integrated care model is to position the enrollee to control their care through collaboration with a single care coordinator to develop care and support plans, resolve issues and facilitate receipt of physical and behavioral benefits. Ease of navigating a single system can empower the member and improve participation in self-management activities. Communication between physical and behavioral health providers would improve due to their ability to access an individual's information from one source as well as receive assistance from a single point of contact. Improved communication leads to effective coordination and increased member and provider engagement. The care and

supports coordination for members in this model will operate on a continuum from basic to extensive coordination depending on the needs and preferences of the participant. A person may move back and forth along this continuum as their needs increase or decrease, in response to acute events or gradual changes in physical or behavioral health. Basic care coordination will include assessment, person-centered planning, monitoring, education, referrals and assistance during transitions between care settings. Care coordination will increase to include expansion of the care team, assistance with accessing additional services, frequent contacts, more care team meetings, extensive planning and crisis interventions as the members needs indicate. The CMHs will continue to provide supports and services for members with intellectual and developmental disabilities. The member's care coordinator will be required to collaborate with the primary care medical home and will assure communication between all members of the enrollee's care team to assure integration of physical and behavioral health care. All MHP and CMH supports and services will be delivered in the least restrictive setting, using person-centered planning and self-determination.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?
By unifying all services under one payer you are allowing for a single point of contact for providers, service agencies and members. Providers (across all domains) and the member's care coordinator will have access to a web-based care management solution. This system can manage consents and ensure providers have access to appropriate materials and plans of care when consent has been granted. This solution allows secure access to member information by authorized internal and external users to ensure that all relevant parties have access to the member's most current information. This shared access allows the care coordinator and approved providers to have common access to member care plans, shared member notes, medications, view any letters sent to members or providers regarding care and uploaded medical records. Communication can be sent back and forth between the various approved users utilizing workflow communication tools such as alerts, notifications and follow up events.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?
Medicaid Health Plans are already held to strict provider availability and accessibility standards through their contracts with the State and accreditation standards and have a network of behavioral health providers to treat the mild to moderate population. By adding the CMH providers to this network and combining all benefits under one entity it will allow for more providers and expanded access to all Medicaid beneficiaries. Medicaid Health Plans contract with pharmacy benefit managers (PBMs) to adjudicate medications. The combination of all drugs under one payer will allow for optimization for safety, adherence and utilization edits for all claims. This will decrease the likelihood of adverse events. Access to all claims across all drug classes will facilitate complete drug utilization review, including key quality metrics such as high risk medication (especially in the elderly) and adherence. Outreach to providers would be comprehensive as all prescription claims data would be included in a timely manner. UPHP supports the provision of access to certain prescription drugs, including anticonvulsants, antidepressants, antipsychotics, non-controlled substance anti-anxiety drugs and drugs used to treat mental disorders, epilepsy and seizure disorders. Post payment analysis of these drugs would allow evaluation of appropriateness of therapy and formulary management. UPHP would work with contracted physical and mental health providers in this evaluation. The outcome of this pilot could be evaluated by the State.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

Integrating services through one entity will result in a reduction of administrative costs allowing for more funds to be available for compensation, training, and expanded employment opportunities. Savings can be used to increase compensation rates to a livable wage for these workers resulting in a larger workforce, better employee retention, reduced stress on workforce members and increased availability to beneficiaries. This model could also provide funding to assist with continuing education or continuing licensure costs incurred by clinicians and key personnel. The model envisions an application process whereby the provider could seek to obtain reimbursement for such costs, at least in part, from the MHP. Alternatively, the MHP could also (or in addition) review whether it is able to arrange for continuing education to occur locally to the provider, which would also help with cost reduction. Retention can also be improved by providing additional professional recognition. Additional professional recognition will be achieved through this model due to the incorporation of CMH representatives on the MHP's management committee and on the MHP's Advisory Council. Outside of the Council and management committee, the MHP would also solicit program feedback throughout the year from clinicians, direct care staff and other key personnel, with the MHP then implementing change when feasible based on the feedback received. The MHP would also initiate a public awareness and appreciation campaign highlighting the importance of direct support occupations and would assist area agencies with recruitment of direct care staff.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

As mentioned above member choice is the core of this model. All coordination activity would be provided using a person-centered approach with the opportunity for an enrollee to choose arrangements that support self-determination. Members will select their care coordinator, determine the services and supports they want, and the individuals who will provide the services. Under this model all of these activities would occur with one care coordinator who would have access to all of the enrollee's physical and behavioral health information resulting in a single complete enrollee driven care and supports plan. As part of this process and during interactions with the member, the care coordinator will foster self-management skills supporting empowerment of the individual and continued resilience. The focus of the model remains on the MHP and CMH delivering supports and services in the least restrictive setting, using person-centered planning and self-determination. Clinical coordinators and other key personnel will receive annual training in topics such as self-determination and person-centered planning to assure current knowledge.

Would this model affect the administration of complaints, grievances, and appeals?
Yes. By combining all benefits under one entity for the enrollee you are creating a single source of complaint, grievances and appeals administration. Providers and members would have a single point of contact for all complaints, grievances and appeals regardless of the service type. All members would have the ability to file complaints, grievances directly with the MHP, request a Fair Hearing through the Michigan Administrative Hearing System, and request an External Review through the Department of Insurance and Financial Services (DIFS). Consolidating these services will result in a system with uniform standards that is user-friendly for members while assuring that all State and Federal requirements are incorporated.

How would the model support continued access for individuals to current services, supports, and providers?

The MHPs would contract directly with the CMHs ensuring seamless continuity of care. There would be no transition or gap in care and the individuals would have continued access to their current services, supports and providers. Additionally health plans already contract directly with behavioral health providers outside the CMH system. By combining all benefits through one entity individuals will have increased access to providers.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?
An Advisory Council would be established under this model. The Council will provide input and feedback to the MHP's governing board on issues of plan management, delivery of services, enrollee care and member experience. The Advisory Council will be comprised of community advocates, CMH staff, enrollees, family members and caregivers that represent the population served through the CMH system. The Council will meet at least quarterly or as often as needed. A member of the Council will also serve on the MHP's management committee serving as a direct liaison between the Advisory Council and the MHP's management committee.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?
The local Community Mental Health boards would continue to function under this model. Representatives from the CMHs would also serve on the MHP's management committee in addition to consumer board members. Medicaid Health Plans are currently required to have 1/3 membership of the managing board be consumer members or establish an Advisory Council that reports to the board. UPHP currently has consumer board members and proposes to continue this structure in addition to establishing an Advisory Council. Under this model a portion of the consumer board members must be individuals (or guardians) engaged in community mental health services. Additionally, (as noted above) a member of the Advisory Council will also serve on the MHP's management committee.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?
The State would pay the Medicaid Health Plans for the management and delivery of all mental health, substance use disorder, and intellectual/developmental disabilities services. Under this pilot, we propose the State maintain the same per member per month capitated payment mechanism currently used to fund the PIHP system, and implement a risk corridor for the initial period of the pilot. This would result in health plans taking on financial risk for the full array of physical and behavioral health services while providing some financial protection during the initial phases of the pilot. We believe this approach will result in the least amount of disruption to the system and allow for a robust analysis of service delivery and appropriate financing.

What changes would need to be made to provider reimbursement in order to implement the model?
In order to ensure consistency of funding and member services, we recommend reimbursement from the Plans to the Community Mental Health Agencies remain the same as the current practice of payment between the PIHP and the Community Mental Health Agencies for the initial period. During this time, we would analyze encounter data to enable us to move towards funding based upon member risk score, including a shift to value based payment arrangements and incentive payments.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
Yes, incentives would be used under this model. UPHP currently has a value based payment incentive program that is designed around specific quality measures. This program would be expanded to include additional measures where behavioral health intervention can positively impact the quality of care in critical situations where there is an identified overlap of services. Some examples are diabetes monitoring for people with diabetes and severe mental illness, follow-up after emergency department visit for alcohol and other drug dependence, and antidepressant medication management.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?
This pilot will include a robust program of performance monitoring and quality measurement. The program will identify and define domains of quality measurement, which will include but not be limited to: Access to care, Effectiveness of care, Evaluation of member experience, Coordination of care and services/supports, and Care transitions.

Define “success” for the model? How will the model’s success be measured? What types of benchmarks would be appropriate for evaluating the model?

Success would be the achievement of a health system that provides high quality, seamless and cost effective care through coordinated, person-centered services in the least restrictive setting that members and providers find satisfying. There are several ways to evaluate the program to determine success. Examples of desired outcomes include: Consistently high performance on enrollee satisfaction surveys, Scores exceeding benchmarks on specific quality and wellness metrics; Integration of a person-centered services and supports model across care settings; Development of integrated information technology with a specific focus on electronic medical records and the sharing of data between physical and behavioral health providers; Effective disease management programs; Diminished use of acute care and other institutional services, and Increased workforce availability (clinicians, direct care staff, recovery coaches, peer support specialists, community health workers, etc.).

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

Yes, this model could easily be piloted. The Upper Peninsula service area currently has 1 MHP operating which makes it the ideal place to pilot this model. UPHP proposes this model be piloted in Region 1 for at least a 3 year period as the region has a single health plan that is already contracted with all CMHs in the service area.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?
There is potential for this model to be implemented Statewide however we do recongize there could be challenges. The Upper Peninsula is unique with 1 MHP operating in the service area. We believe by piloting in the Upper Peninsula the State can gather data and experience that will give them the knowledge needed to implement a Statewide model.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?
Click here to enter text.

(Optional) Are you aware of any other states or communities which have implemented this model?
Click here to enter text.

Model #41

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Coordinated Integrated Care

Name of Submitting Organization: Washtenaw County Community Mental Health

Model Partner Organization(s): Click here to enter text.

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

(2)Washtenaw County Community Mental Health (WCCMH) has collaborated with Washtenaw and Livingston Counties' physical health providers, hospitals, safety net providers, community service providers, Center for Healthcare Research and Transformation (CHRT) and public health department through Community Health Innovation Region (CHIR). The CHIR goals are to establish regional health priorities and foster collaboration to improve health of the populations. An initial result of this work was for Washtenaw/Livingston CHIR to apply and receive approval to participte in the State Innovation Model (SIM) in 2016. The goals of the SIM are to build infrastructure, interventions, provider capacities and metrics to address coordinated integrated care (physical and behavioral health needs coupled with social supports) to impact high Emergency Department (ED) utilizers. The overarching goals of the SIM are to improve population health outcomes and lower costs. Part of the process was to advance the spread of Patient Center Medical Home (PCMH) for a subset of consumers to direct their complex care coordination needs. This is expected to improve overall health and lower costs. Community Mental Health provides intensive complex care coordination but cannot be a PCMH limiting funding options for this service under the SIM. In 2014, WCCMH conducted an independent Health Home pilot through the Michigan Department of Health and Human Services (MDHHS) funded by the Affordable Care Act to test an intervention similar to that created by the SIM population by implementing a Health Home. Through this pilot the CMH coordinated patients' health related services, taking the whole person into account. WCCMH introduced the Health Home program, using enhanced health service coordination, monitoring, and physical health support using health information technology and data. Through this program WCCMH assigned nurse coordinators to individuals needing additional support. The University of Michigan conducted an independent evaluation of this Health Home pilot and concluded that participants in the Health Home program with a nurse were sicker than participants in the Health Home program without a nurse. The Health Home program reduced the intensity of acute care service utilization over time relative to before the program. Thus, the program succeeded in both of its goals of appropriate nurse assignment, and decreasing costly physical health service use. (SEE ATTACHMENT A). Furthermore, the WCCMH proposed 298 initiative model builds off the success of the CHIR, SIM and Health Home pilots to introduce and sustain complex comprehensive case management. (1) Establishment of an ACCREDITED CMH Behavioral Health Home (SEE ATTACHMENT B) that can provide the following services, in addition, to existing capabilities: COMPREHENSIVE CASE MANAGEMENT, which consists of at least annual health reviews, condition specific assessments, individualized plan of service and a continuous review of behavioral and physical health needs/goals through an integrated progress review. COMPREHENSIVE CARE COORDINATION, which consists of peers or nurses attending primary care physician visits to assist with transportation to appointments (if necessary), treatment planning, adhering to medications and educating about diagnoses and treatment options for individuals. Comprehensive Care Coordination also consists of CMH staff working with

primary care physicians and health systems to coordinate specialty care and community services for social supports. Additionally, CMH staff attend complex care management team meetings to further assist care coordination between all entities involved in an individual's care. HEALTH PROMOTION, which consists of providing education on self-monitoring and management skills for the promotion of healthy lifestyles and overall wellness while connecting individuals with dietitians, health groups, and other wellness activities within the community. COMPREHENSIVE TRANSITIONAL CARE, which consists of exchanging information and direct participation to facilitate planning and decision making when moves between care settings occur. INDIVIDUAL AND FAMILY SUPPORT, which consists of providing individuals to outreach and engagement activities to build and maintain relationships with consumers and families. (3)An accredited Behavioral Health Home provides MHP and CMH consumers with a choice for integrated complex comprehensive care coordination with input from MHP and PIHPs. (5)We recommend that the CHIR would act as the competent public body to provide oversight and convene the work interested parties (Health Plans, PIHPs, CMHs and Community Service providers) to identify high risk individuals using modified criteria that was established by MDHHS Health Home pilot referenced in table 1 of ATTACHMENT A. The CHIR can ensure interested parties engage consumers in selection of Health Home (medical or behavioral) that provides choice of a similar replicable service to achieves stated outcomes. The CHIR is a reasonable public body since their primary goal is to support improvement in its region's population's health. (4) The payment model will consist of PIHPs/CMHs receiving an enhanced PMPM for its members who meet the eligibility criteria based upon the payment in the in the original Health Home pilot study. For Health Plan consumers who choose to use the CMH as their Health Home, the Health Plan would provide enhanced payments for care coordination activities to CMHs using identified CPT codes. Enhanced payment should be reflective of the amounts received in original Health Home study conducted by MDHHS. When CMHs are involved in holistic care coordination activities that drive down toal cost of care, they should be included in the shared savings financial model.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?
This model would primarily benefit the SMI population, but could be utilized for SED and IDD populations.

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?
All currently contracted PIHP/CMHSP services with the addition of comprehensive case management, care coordination, health promotion, comprehensive transitional care and individual and family supports would be incorporated.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?
Individuals will be given the option to opt in/out through the person centered planning process. The opt-in process associated with the MDHHS Health Home Pilot proved to be a resource intensive process. Therefore we would reccomene an opt-out approach.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?
As described in ATTACHMENT A, this intensive care coordination model has proven to be effective in reducing both physical and behavioral health ED visits. The reduction in visits is mainly due to the intensive, but cost effective services provided by CMH. The individual has a single health care professional for their health care needs who is the conduent between all the health care entities involved in one's care.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?
As described in the previous sections, the comprehensive case management includes an array of care coordination activities. The individual benefits from having a single health care professional translate often complex information to them. The health system and providers benefit by having the care manager communicate the holistic view (physical, behavioral and social needs). The payers benefit from reduced costs of care as identified in ATTACHMENT A.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?
Health Plans and CMHs collaborating within the CHIR governance could review capabilities and capacities in the region to ensure adequate staffing by selected provider/services within expected metrics. CHIR governance could provide direction on problem solving service and/or staffing issues that are beyond an individual CHIR member and present a regional or community issue.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?
This model will reduce resources from high costs services, such as emergency room and hospitalization visits. It should assist in deploying the right number of staff in the right locations with the right consumers. The cost savings from reduction in physician health utilization (ED Visits) should also generate the necessary resources that will be need to fund care coordination resources mentioned in previous sections.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?
Rights protections would remain the same.

Would this model affect the administration of complaints, grievances, and appeals?

The current model would remain the same.

How would the model support continued access for individuals to current services, supports, and providers?

The model would remain the same.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?
Per our statement in section I, CHIR's role is to establish a region's health priorities and convene the interested parties (MHPs, PIHPs, CMH, Health Providers, Hospitals, Community Service Providers) to act in the best interest of the consumer. They have the ability to promote the value of Health Home, consumer choice, and ensure that all involved parties are building the necessary infrastructure and staff capabilities. ATTACHMENT C is a diagram of the governance model.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?
An individual would make their election, if in the eligible population, through the person centered planning process. This process and election should be delivered uniformly across the MHP and PIHP/CMH.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?

Contractual arrangements between Health Plans and PIHP/CMHSP would need to be made to allow for the enhanced payment. The payment would be made through selected CPT codes and shared savings from physical health cost reduction. The physical health cost reduction would need to occur to fund expanded CMH care coordination capacities. CMH, currently, does not manage physical health costs so does not have the ability to redirect those savings on its own within the current financing system. Shared savings could be tied to quality, experience and cost metrics. MDHHS would also need to identify eligilble CMH participants and supply an enhanced care coordination payment to PMPM based upon the fee provided in the original Health Home study.

What changes would need to be made to provider reimbursement in order to implement the model?

Current care coordination G-Codes could be adapted to a fee schedule relevant to the complex comprehensive care management for moderate to complex cases.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
Shared costs savings at payer and CMH level would be used to drive improvement in quality, experience and cost from a decline in the use of physical health services. Metrics and activity levels could determine share of cost savings attributable to PIHP/CMH care coordination efforts.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

ATTACHMENT D outlines the recommended outcome and process measures taken from a list of federal and state measures that are predominantly already in use. The measures encompass quality, experience and health outcomes.

Define "success" for the model? How will the model's success be measured? What types of benchmarks would be appropriate for evaluating the model?
The success of this model can be measured by achieving targets for the population for established measures. The patient experience can be measured through satisfaction surveys and selected quality measures in ATTACHMENT D.

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

CHIR and SIM are pilots that are already underway and currently funded. The MDHHS Health Home model has already been piloted and proven to be successful through the independent evaluation. Funding for this model was discontinued in 2017. Again, we believe the funding can be corrected through cost savings from a reduction in utilization of physical health services. If the State wishes to pilot the proposed payment structure with WCCMH, we would be willing participants.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?
Yes, this model could be implemented statewide. The Health Home Model was piloted by 5 Michigan counties including Washtenaw. Funding was discontinued prior to all Health Home being able to fully enroll enough members to demonstrate their success. Some used this experience to apply for Substance Abuse Mental Health Services Administration (SAMHSA) Primary Behavioral Health Care Integration (PBHCI) grants to further build toward behavioral Health Home clinical capacity. The keys to success identified by the Washtenaw County Health Home program that would benefit the state it it chooses to implement a statewide model: 1) EHR infrastructure to ensure necessary information exchange 2) Aggressive campaign to enroll (opt-in) consumers into the Health Home program or eliminate opt-in requirement to ensure optimal participation, 3) Behavorial Health Home accreditation to assure capacity to deliver results and measure success.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?
Accrediation as a Behavioral Health Home could be accomplished by having the CMHs reviewed by The Joint Commission.

(Optional) Are you aware of any other states or communities which have implemented this model?
Yes, many have participated nationwide through SAMHSA PBHCI grants which has allowed the development of a framework and infrastructure to support such an intervention.

Community Governance Model

CatalyticFOCUS
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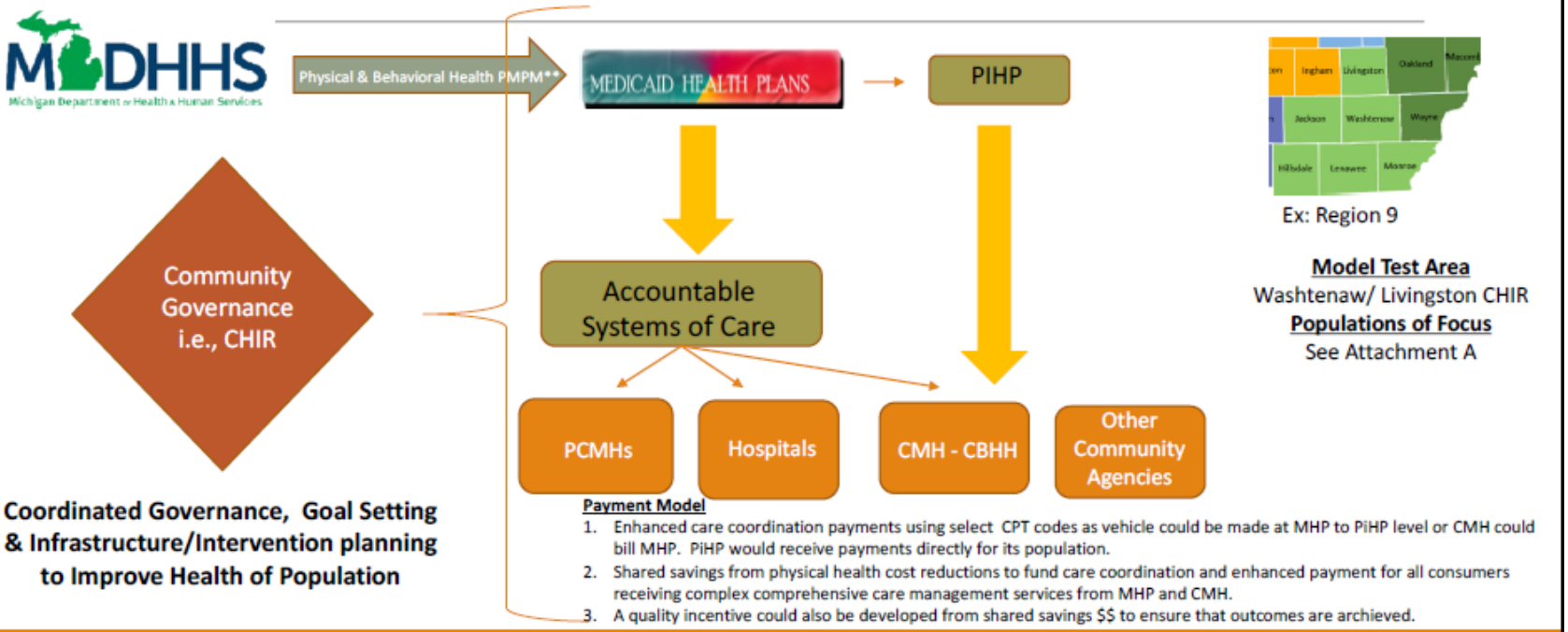
Select MHP consumers (eligibility in table 1 of attachment A) could elect a PCMH or CBHH to provide their integrated complex comprehensive care coordination.



**Excludes DD and Inpatient Psych

Outcome Measures

- Follow-up after ED for MH
- Follow-up after ED for AOD
- Follow-up after hospitalization for MI ages 21+
- All-cause readmission rate
- Housing status
- Diabetes screening for people with schizophrenia or bipolar on antipsychiatric medications
- Adherence to antipsychotic medication for individuals with schizophrenia
- Antidepressant medication management
- Initiation and engagement of AOD dependence treatment
- Family/patient experience of care surveys

Process Measures

- Number/% of new clients with initial evaluation within 14 business day/mean number of days until initial evaluation of new clients
- Adult BMI screening and follow-up
- Weight assessment and counseling for nutrition and physical activity
- Tobacco use: screening and cessation intervention
- Unhealthy alcohol use: screening and brief counseling
- Adult and Child MDD: suicide risk assessment
- Screening for clinical depression and follow-up plan
- Depression remission at 12 months

Model #42

MODEL PROPOSAL TEMPLATE

Section I: Model Name and Contact Information

Name of Model: Michigan Complete Health Integrated Pilot for TBI

Name of Submitting Organization: Fidelis SecureCare of Michigan, Inc.

Model Partner Organization(s): Managed Care Organization

Section II: Model Description

Please provide an overview of the proposed model below. Include in your description: (1) what types of services and supports (expressed categorically, rather than an exhaustive list) would be offered in the proposed model, (2) which types of organizations would be involved in providing, coordinating, and paying for those services (3) how the model would support service delivery in keeping with the core values and recommendations included in the interim 298 report, (4) how the model would be financed including both payer and service provider level financing/payment mechanisms , and (5) how a competent, public body would be engaged in managing the model.

Overview: Services and Supports.

Fidelis SecureCare of Michigan, Inc. (Fidelis) is proud to share with you our proposal for an integrated model that incorporates all services and supports for people with Traumatic Brain Injury (TBI). Individuals with Traumatic or Acquired Brain Injuries (TBI) are excluded from managed care, as their Medicaid benefits are covered by the state's Medicaid program through fee for service (FFS). Through our Michigan Complete Health (MCH) product, we propose a pilot to transition those eligible TBI populations receiving services for behavioral health (BH), or LTSS through Medicaid FFS into a single managed care pilot program that could also be expanded to include people with Intellectual and Developmental Disabilities (IDD) - in our "Michigan Complete Health Integrated Pilot for Managed Long-Term Services and Supports" pilot submission we also included the IDD population to give the Section 298 committee options for this population. We believe that Michigan will achieve the best outcomes by fully integrating the physical health, behavioral health, LTSS benefits. Through our pilot we will utilize an Integrated Care Team approach that provides Participants with a single point of contact and accountability for coordinating all needed services to ensure seamless, continuous, and appropriate care and services across the care continuum. MCH will hire and train specialized TBI Care Managers (CM) who will be that single point of contact and will facilitate the care planning process, coordinating among the Participant, caregiver/supports, all providers and others planning and monitoring the Participant's care. MCH will seek to hire CMs who are Certified Brain Injury Specialist (CBIS) trained through the Academy of Certified Brain Injury Specialists or a comparable training in TBI such as that provided by the Veterans Administration. MCH's Care Manager (CM) will be that single point of contact and will facilitate the care planning process, coordinating among the Participant, caregiver/supports, all providers and others planning and monitoring the Participant's care. CMs will facilitate and coordinate access to all medically necessary physical (PH) and BH, pharmacy, and LTSS services to ensure Participants receive care and services outlined in their person-centered care plan in the appropriate amount, duration, and scope to achieve the best health outcomes in an efficient manner, that reduces potential duplication and helps to maintain the Participant in the least restrictive setting. An integrated managed care model that is inclusive of a wide range of services and populations can reduce fragmentation and effectively meet members' needs through integrated, holistic care planning and a mix of individualized services and supports, regardless of diagnosis, to avoid hospital admission and/or institutionalization.

Supporting Service Delivery--Keeping the Core Values.

MCH recommends full population-based coverage plus all medical/ pharmaceutical coverage for Medicaid services for dual-eligible individuals for all three specialty programs: BH, TBI and LTSS. A full population-based model allows MCOs to more effectively coordinate acute, primary, and specialized health services with long term services and supports to reduce system fragmentation and simplify Michigan's overall health care

system approach. We also recommend, based on our experience, full integration of BH (as opposed to block grant funding or the provision of BH services through a third-party contract) across all populations. This provides MCOs the flexibility required to implement creative, recovery-based and self-determined approaches that recognize the link between behavioral health and overall wellness. MCH also recommends a dental benefit be included in full population-based coverage given the direct link between dental care and health outcomes. Population-based coverage is an essential ingredient to achieving improved health, enhancing patient experience, and reducing or controlling costs. A fully-integrated benefit inclusive of facility and community-based services will allow MCOs to build on Michigan's progress to date rebalancing funds across settings and funding sources. A comprehensive, integrated approach allows MCOs to dedicate resources to 'follow the person,' facilitate a whole-person and self-determination approach, while measuring system-wide factors that influence outcomes. The streamlining of traditionally fragmented categorical funding sources that a coordinated care approach achieves is particularly beneficial for high-risk populations where multiple co-morbid conditions and multiple treating providers are prevalent, such as with the special populations identified through this model proposal. It also eliminates a "silo approach" to care management and cost savings and, instead, creates an incentive to look at the entirety of each member's needs. Immediate access to data and the ability to closely monitor a member's care is crucial and better facilitated through this approach.

Organizations Involved.

MCH's recommends moving the populations and services outlined above into a full managed care system, where Managed Care Organizations (MCOs) are responsible for contracting service providers, authorizing, coordinating and monitoring all care, and providing payment to providers. However, in our experience the MCO is only one critical organization involved. MCOs would need to work with state agencies, providers (PH, BH dental, pharmacy and LTSS), local community service organizations, centers for independent living, Area Agencies on Aging, advocacy organizations and other stakeholders to ensure coordination. For this pilot, examples of stakeholder groups MCH will closely coordinate with include PIHPs, the Brain Injury Association of Michigan, the Michigan Disability Rights Coalition, Defense and Veterans Brain Injury Center, Michigan Veterans County Counselors and Veterans Services Organizations, the Michigan State Housing Authority, School Districts, Housing/Homeless providers and other community agencies. (If this pilot were expanded to include people with IDD, MCH would also involve IDD stakeholders and related organizations).

Accountability, Funding Mechanisms and Engaging with MDHHS.

MCH, based on the experience of our health plan affiliates, reinforces the need for MDHHS to provide MCOs with the highest level of flexibility in their operational design and service delivery to cultivate innovation and encourage cost-effective practices. For instance, MDHHS should delegate to MCOs the authority to select, monitor, and finance any vendors critical to implementation, such as vendors providing electronic visit verification; participant direction counseling and financial management services; and medical and nonmedical transportation. Mandating MCOs' use of external, "third party" vendors often leads to increased administrative complexity, including with claims processing, since external systems and contracting procedures are typically designed for Fee-for-Service. MCOs, when they contract with vendors directly, are able to support vendors (as a part of the contracting and transition process) to develop accurate and timely claims processing practices. MCH recommends that MDHHS allow MCOs to select vendors based on quality, cost, and demonstrated performance so MCOs can ensure the highest quality of service through well-defined roles, quality benchmarks, and financial agreements. We recommend that MDHHS, through the RFP process and MCO contract language, require MCOs' administrative and service design elements to be directly aligned with and in MDHHS's

policy recommendations. MCOs' success should be systematically and routinely measured against MDHHS quality benchmarks (inclusive of both medical and non-medical measures), and MCOs should be financially compensated based on their performance. MCOs' success is often dependent on receiving a capitation rate inclusive of institutional, BH and community-based services as well as the medical and non-medical supports typically required by specialty populations. MCH recommends that MDHHS set actuarially sound, transparent capitated rates driven by members' risk levels to incent MCOs to support members in the least restrictive setting most appropriate for their needs. MDHHS can become a national leader by determining rate levels that effectively represent Medicaid enrollees' physical, behavioral, and functional status and then linking these rate levels to members' risk scores identified through a uniform functional assessment tool. MCOs, following this process, should have full authority to provide members with access to a rich benefit that represents the continuum of services and supports that exist, including medical and innovative community services (e.g., peer support and recovery-focused diversionary models). This comprehensive approach will allow all resources to "follow the person" and allow MCOs to facilitate a holistic approach that ensures integrated care and improved outcomes for the members they serve. Michigan has made inroads with their payment reform efforts and pursuing an integrated approach with Medicaid and Medicare services, our proposed pilot will keep this momentum moving forward with more efficient and effective care coordination, better health outcomes, a reduction in barriers to care, and reduced cost.

Which populations would be affected by the implementation of the model? Would any populations be excluded from the model?

Populations Affected:

MCH proposes to serve individuals receiving services for TBI through Medicaid FFS into a single managed care pilot program

Exclusions:

MCH recommends limiting this pilot to people with TBI, expandable to include people with IDD

Which services and supports would be incorporated in implementation of the model? How would services and supports be affected?

Services and Supports.

MCH brings the collective experience of our parent company, Centene, which has more than 30 years of managed care experience in 20+ states, plus the experience of LifeShare, our internal affiliate with more than 20 years of experience supporting neuro-diverse populations including people with TBI and IDD and our internal behavioral health affiliate, Cenpatico, which has more than 21 years of experience with behavioral health utilization, care and disease management working with adult, adolescent and child/youth members with serious mental illness, severe emotional disturbance, substance use, developmental disorders and co-occurring disorders in all levels of care. Recognizing that with people who are neuro-diverse, communication can come in a variety of ways, MCH will build on our affiliates' experience to implement effective screening, assessment, and service-planning processes that address TBI Participants' communication needs, build on their personal assets and informal supports, and creatively respond to personal obstacles to allow Participants to live high quality, community integrated lives.

In Michigan, we have already developed relationships with the PIHPs and have worked to create integrated approaches to coordination and services for our MI Health Link. Additionally, Centene is currently the largest Medicaid Managed Long Term Services and Supports (MLTSS) MCO in the country, serving more than 210,000 MLTSS Participants in 9 states (expanding to 10 in 2017 with Pennsylvania). Through this experience, we have identified the benefit of having full integration of a robust behavioral health benefit that includes inpatient, outpatient, mobile crisis

and crisis stabilization, residential, partial hospitalization, intensive outpatient, in-home, services including psychosocial rehabilitation, peer support and other community based services.

Impact to Services and Supports.

When these services and supports are layered into an acute care physical health benefit, and LTSS services for Participants it enables our Care Managers to more easily coordinate and provide streamlined support. We understand from our experience in other markets that transitioning to a fully integrated system is more successful through training and data sharing.

Training Supports.

For neuro-diverse populations, our affiliate LifeShare has created more than 40 different trainings used internally with health plan staff as well as delivered externaly to providers and stakeholders. These trainings are designed to increase competency, person-centered and Quality of Life focused supports, and increase overall quality and systemic capacity. Some of the trainings include: Client Centered Supports, Employment Capacity Building, IEP Advocacy Training, Trauma Informed Care and Neuro Psych Evaluations, and Preventing Crisis. We also have experience providing support for providers and community support agencies on evidence-based practice for behavioral health such as Screening Brief Intervention Referral and Treatment (SBIRT), Recovery-Oriented Systems of Care, Trauma Informed Cognitive Behavioral Training (TF-CBT), Cultural Awareness and Sensitivity (tailored to the community, and including the understanding "the culture of poverty"), Supported Employment, Assertive Community Treatment (ACT) and Permanent Supportive Housing. Our BH affiliate has also developed a specialized integrated training for primary care providers as well as facility providers to help them better manage behaviors for LTSS Participants.

Data Sharing to Ensure Inclusion and Communication of Services. Among our nine affiliates with experience coordinating BH models, five affiliates (our health plans in Arizona, Florida, Illinois, Ohio and Texas) currently serve both LTSS and ABD Participants. Our experience serving this unique combination of populations has uncovered a multitude of best practices borne from lessons learned, which include offering service coordination tailored to populations with LTSS needs, that go beyond the bounds of physical and behavioral healthcare services. For example actively sharing data through secure integrated portals and integrated shared care plans with counterpart high performing behavioral health managers is key to successful service coordination and an improved Participant experience. MCH would offer a secure Portal for Participants, authorized caregivers, network and appropriately authorized out-of-network Providers to provide secure access to PCSP/Care Plans. Participants also will be able to access their assessment and other data through the portal.

Integrated Care Team for Optimized Care/Service Coordination. The level of support required by Participants is likely to change over time, care/service coordination is best delivered through a multidisciplinary, Integrated Care Team that incorporates cultural competency as a key factor in engaging LTSS Participants in their physical and BH and providing services that meet their needs. Therefore, in addition to face to face integrated Care Management, and secure integrated portals for data sharing, MCH recommends the integrated pilot program conduct Joint Clinical Rounds with counterpart high performing behavioral health managers to ensure all services for our highest-risk Participants are carefully integrated, recognizing the multiple physical and behavioral co-morbidities that often exist in people with TBI. MCH will provide dedicated, tailored training to nursing facilities and other providers serving our TBI Participants to strengthen care/service coordination across physical and BH services, employing flexible resource utilization to ensure that TBI Participants' needs, goals, and preferences are the primary driver of service coordination interventions, while looking holistically at each unique individual when making decisions about the services they receive. These additional decisions may lead to increased considerations, including the necessity for increased call center staffing needs, more

specialized providers, and rebalanced CM caseloads.
Enhancing Crisis, Diversion and Step-Down Services. MCH and our affiliates provide 24/7 crisis intervention and access to emergency services staffed by qualified nurses and behavioral health professionals to offer verbal de-escalation, crisis assessment, triage, referral and rapid crisis response dispatch. Our crisis line staff operate through linked information technology platforms for ease of follow-up and comprehensive care coordination. Key to improving and expanding the full continuum of crisis services includes working collaboratively with system partners to provide education, resources, and the support necessary to change the behavior of system partners, reducing emergency department reliance and expanding safe, community based crisis diversion alternatives, increasing the use of CMTs, and stabilizing people in their homes and communities. Also, we support the continuum of crisis services through our state-of-the-art technology to operate a 24/7/365 Crisis Line, dispatch teams, schedule services, manage crisis resources, and close the loop on every crisis contact. Lastly, we work with providers to expand diversion and step-down services, programs and stabilization facilities in the region.
Our history of implementing new programs has proven our capacities to not only implement large programs quickly but also the ability to adapt to program changes such as additional populations or benefit coverage smoothly and successfully. For example, since 2012 our membership in Louisiana has grown by almost 200,000 members and our affiliate health plan continues to meet and exceed contractual obligations. In addition, our Louisiana health plan has worked closely with the State through the RFI process regarding integrating the behavioral health benefit into the Medicaid MCO contracts. We have been, and continue to, work closely with Louisiana state agencies, and the other MCOs, to fully integrate BH benefits for the Medicaid population.

How will individuals choose whether to receive services and supports under this model, in addition to by whom and where services are provided? Would individuals have the ability to choose the entity which coordinates their care and their care coordinator/manager?
Summary.
MCH strongly believes that the best opportunity for Participants, providers, MCOs and the State for integration is represented through a program which balances choice with the need for certain program criteria that maximizes effectiveness. Through this proposal, we are strongly supporting Participant choice for providers, services and honoring Participant choice for who participates in their person-centered care planning team. We recommend two MCOs in each region where this pilot is implemented and allowing Participants to choose their MCO, but we recommend mandatory election and participation for eligible populations. In order to meet the Participant's individualized needs and honor choice, our initial assessment process will identify the full range of the individual Participant's physical health, BH, dental, pharmacy and LTSS needs. The assessment, along with specific input from the Participant and as appropriate their family/caregiver/guardian, informs the development of the person-centered care plan (PCCP), which outlines the needed covered and non-covered services. The PCCP will address how the Participant's physical, cognitive, and behavioral health needs will be managed, and how care will be coordinated taking into account choice in providers and service modalities. PCCPs will further address how LTSS services will be coordinated.
Choice to Participate and Seamless Coordination.
Whether a Participant is served by MCH through our integrated pilot or through another mechanism/program, we will ensure seamless, appropriate care and services across the care continuum, including transitions between settings and coverages. We will fully integrate care for

those individuals, and will proactively coordinate with providers and staff from other organizations. Providers (with appropriate authorization) may access PCCPs and other information needed to coordinate care via our Provider Portal. PCCPs will incorporate Medicaid and other services, and will address how physical, cognitive, and BH needs will be managed. PCCPs will also address how LTSS services will be coordinated. MCH will educate Participants and caregivers about the importance of, and our role in, coordinating MCH and Medicare services.
In addition to Participant choice, our use of flexible care management and care coordination models driven by person-centered planning processes and members' level of need ensure members receive the right care at the right time by the right people, ultimately improving access and quality while decreasing avoidable hospital and facility admissions, assisting participants to remain living in the least restrictive setting of their choice.
Self-Direction for Choice.
Centene, MCH's parent company, has also invested in self-direction (SD) as a best practice, which gives the responsibility of managing workers and directing care to the Participant. When implemented successfully, this model improves members' quality of care and satisfaction; improves paid and unpaid caregivers' satisfaction; addresses gaps in care; and decreases unnecessary utilization of high cost services. Centene implements a range of SD models across eight health plans.
In addition, Centene, and our health plan affiliates have demonstrated experience supporting diversion and transition efforts for individuals with behavioral health conditions, TBI, developmental disabilities, and LTSS needs. We have assumed, through these experiences, an important role in assisting members to make informed personal and self-determined choices as well as in supporting providers to build capacity to meet members' needs. We are prepared to work with facility and community partners to build on the success of initiatives already in place.
Our success to date has been driven by a few key program characteristics that should be considered in its design of managed care for specialty populations. First, we recommend mandatory enrollment in managed care for the entire population (regardless if one is living in an institution or the community) as necessary to achieve the critical mass in membership to enable the best partnerships with providers. This recommendation would be in combination with a capitated rate for all medical and non-medical services based on members' risk level and functional status (rather than setting) provides MCOs the ultimate flexibility to serve people based on need and in the setting of their choice. In conjunction with this, we recommend the State develop and implement transition of care/enrollment processes that encourage ongoing care of members, regardless of which MCO/program is serving them. We do not recommend an "opt-in" or "opt-out" approach for this pilot model. Another key component of our affiliates' integrated managed LTSS programs has been development and inclusion of a Nursing Facility Transition Center of Excellence to streamline and optimize outcomes for Participants who wish to return to the community from a nursing facility. In 2016, 65% of all LTSS spend in Michigan was nursing facility spend verses 47% average nationally. A Nursing Facility Transition Center of Excellence supports Participants by managing PH/BH services across settings, and identifying home and community based supports that will enable them to remain in, or return to the least restrictive setting of their choice.

Section III: Coordination of Physical Health and Behavioral Health Services and Supports

How would the model enhance the coordination of physical health and behavioral health services and supports for individuals?

Enhancing Coordination of Physical Health and Behavioral Health Services.
Our person-centered approaches will integrate services across the care continuum to maximize quality of life, health, and functional outcomes. This includes coordination at the delivery system level through timely information exchange and ensuring the right services at the right time. Coordinating across delivery systems is most effective when payers and key stakeholders work as partners to remove system-level barriers. MCH will implement innovative models to improve coordination across Medicaid covered and non-covered services. For example, we will explore Value-Based Purchasing strategies that incentivize successful community transitions and reduce readmissions. Additionally, we would work with advocacy groups to ensure the right services, supports and provider quantity/mix to serve the population and ensure the right connections for Participants.
Enhancing PH/BH/LTSS Service Coordination.
MCH recommends MDDHS request that CMS provide historical Medicare claims and utilization data to the MCOs to assist with early identification of needs and risk stratification. MCH Care Managers will utilize a secure electronic clinical documentation system (MCH uses TruCare), which will incorporate all screenings, assessments, PCCP and documentation of outreach and contact. This documentation system enhances coordination by providing a holistic view of Participant needs, goals, utilization, and PCCPs, including coordination of services. In addition, our integrated TBI pilot recommends the MCO utilize a secure Provider Portal and/or Electronic Health Record, as well as encouraging providers to participate with health information exchanges to maximmize communication of care gaps and service history to increase coordination between providers on the Participant's community based care team. MCH's secure Centelligence™ Health Record is able to display the PCCP, gaps in care, recommended by evidence-based guidelines, current and historical claims, assessments, and other data; and an ED Flag indicating ED utilization. In addition to requiring TBI Providers to notify us of admissions (which will improve our ability to participate in discharge planning), we will receive real-time Admission/Discharge/Transfer (ADT) data for all Participants. This information allows timely discharge planning to address post-discharge LTSS and other needs.
Integrated Care Team Coordination Across Delivery Systems.
Our specialized, Integrated Care Team will account for the different ways TBI Participants receive services, which impacts provider willingness to coordinate, data available to support coordination, and whether there is another entity’s case manager to work with. Regardless of the complexity of needs or diversity of services each Participant will have a single point of accountability for coordinating all needed services. We will assign a CM to coordinate across all providers as needed for all TBI Participants. For all Participants, the CM will coordinate/ensure access to Medicaid and other needed services, with behind-the-scenes support from other members of our internal Integrated Care Team, which includes nurses, BH clinicians, social workers, dental and pharmacy staff, Housing and Employment Specialists, and NF Transition staff. MCH will implement Centene’s integrated staff training to ensure staff think and operate in an integrated manner about physical, BH, and LTSS needs and services. Topics will include both benefit structures, as well as when/how to coordinate with other plans and providers. MCH will adopt a proven strategy employed by our affiliate health plans whereby the IC Team includes CMs with practical TBI and BH experience. We recommend all integrated pilot CMs receive comprehensive TBI and BH training, upon hire and regularly thereafter, which allows them to more effectively perform assessments and authorizations using information such as care gap alerts, claims data, and utilization history. We recognize that this knowledge is critical as it relates to developing comprehensive PCCPs, engaging with TBI and BH providers, and using BH quality outcomes to inform improvement opportunities. For Participants with complex BH issues that the Participant's assigned CM will be a licensed BH clinician

who will be supported by the other members of the Integrated Care Team. MCH's BH Manager, a BH clinician will provide CMs with continual, in-depth training on BH topics relative to delivering whole-person service coordination. Training events will occur upon hire and regularly thereafter. Specific training topics will include assisting with identifying and coordinating services for Participants with BH needs, such as addressing secondary BH issues or screening for depression after a new physical health diagnosis. Additionally, our affiliate LifeShare will work with Michigan TBI stakeholder groups, leveraging their local knowledge and expertise to train our health plan staff and Providers on best practices for early identification; the impact of cognitive and behavioral impairments on functioning; the high incidence of co-existing mental health and substance abuse conditions among people with TBI; and the importance of specialized and lifetime supports.

How would the model promote greater collaboration amongst providers, service agencies, and payers at the service delivery level?

Promoting Collaboration.

In addition to the techniques for improving coordination discussed above, MCH recommends strong collaboration among MDDHS, participating pilot MCOs and other interested health plans, high performing BH providers and other key stakeholders on pre-implementation initiatives to develop coordination protocols, such as for assessment, care planning, and hospital discharge planning. We also recommend that MCOs, MDDHS, other health plans, state and local medical societies, pharmacy associations, and other stakeholders collaborate on a pre-implementation initiative to educate providers about coordinating with MCOs. MCH's proposed model includes a coordination liaison to establish and monitor the effectiveness of our coordination with other plans, and identify and address any coordination issues with network MCO and D-SNP Providers. We recommend establishing ongoing coordination and service delivery improvement meetings with MDDHS and MCOs/aligned D-SNPs (and CMS if possible), a practice which has been successful for our MMPs through their Contract Management Teams. MCH will continuously identify opportunities to improve collaboration through monitoring and analysis of data such as Participant and Provider satisfaction; input from our Provider Advisory Group and Participant Advisory Committee and high volume Providers; issues identified by our coordination liaisons; quality performance metrics such as for wounds and falls; and MDS data. MCH will work with all partners, network Providers and CM staff to address identified opportunities to improve cross-Provider collaboration. . We also recommend a Pathways Liaison, a dedicated professional who works with TBI providers and other stakeholders to help build systemic capacity and awareness of the pilot as well as available trainings and local and national best practices and evidence-based approaches that are available to these various groups via MCH. This Pathways Liaison would also be tasked with closely collaborating with groups such as the Brain Injury Association of Michigan, the Michigan Disability Rights Coalition, Defense and Veterans Brain Injury Center, Michigan Veterans County Counselors and Veterans Services Organizations, the Michigan State Housing Authority, School Districts, Housing/Homeless providers and other community agencies. In addition, we recommend regular work groups for collaboration with other MCOs and D-SNPs in geographic areas with sufficient Participant density to continuously develop best practices.

How would the model improve the availability, accessibility, and uniformity of services (including medications[1]) and supports?

MCH's proposed integrated TBI pilot/model focuses on creating efficiencies in funding of services and reducing potential duplication of community based case management by bringing all responsibilty for coverage, contracting and coordination for PH/BH/LTSS service needs through an integrated plan. This improves accountability for coordination and quality monitioring. For this reason we also recommend including

pharmacy and medication management within our integrated TBI pilot. This is particularly important as our experience shows when an MCO has the ability to truly integrate a "whole person" approach, particularly with neuro-diverse populations, focusing on Quality of Life and Activities of Daily Living combined with Physical Health and Behavioral Health, can reveal the ability to apply more innovative and least restrictive approaches to supports that result in improved outcomes.

[1] Please consider section 4 of the interim Section 298 report for background information regarding the current medication access and financing (carve out) approach.

How would the model strengthen the workforce in order to support the delivery of high-quality services and supports? How would the model affect current efforts to recruit, train, and retain clinicians, direct care staff, and other key personnel (e.g. certified peer support specialists, recovery coaches, community health workers, peer mentors, youth peer support, parent support partners etc.)?

Summary.

MCH understands that providers that are supported and engaged will provide better care, and experience less turnover. Our pilot will include training, tools and support mechanisms to increase efficiency (thus expanding reach and availability of workforce), bring enhanced value and engagement to the workforce (reducing turnover) and working with providers and community agencies to help identify innovative ideas for recruitment, training, retention and career ladder development to strengthen the workforce. As noted in a previous section MCH brings, and recommends, training and technical assistance for providers to ensure they have the expertise and engagement to better serve Participants while improving the quality of care. Additionally, MCH would provide actionable data and support to providers in order for them to have greater insight into the population they serve at the individual and system level for better coordination (individual) and population health management. We would look to incent providers performance through value-based contracting strategies including, but not limited to pay for performance. .

Recruiting and Training.

Our integrated pilot model has a strong focus on community partnership. . As we noted above, MCH would coordinate with local stakeholders and experts including those from the Brain Injury Association of Michigan, the Michigan Disability Rights Coalition, Defense and Veterans Brain Injury Center, Michigan Veterans County Counselors and Veterans Services Organizations, the Michigan State Housing Authority, School Districts, Housing/Homeless providers and other community agencies. MCH would also look to other community organizations, providers, State agencies (MDDHS and others) to identify potential providers and trainings that can support the delivery of high-quality services and supports.

Section IV: Rights, Protections, and Service Continuity

How would the model empower individuals to make decisions about service delivery? How would the model promote the use of person-centered planning, self-determination, and choice as core values of service delivery?

Empowering Individuals.

MCH supports Participant voice, choice and empowerment in decision making about service delivery, supports and inclusion of the Participant's chosen circle of support in care planning. Every Participant in our pilot model would have a Care Manager (CM) who would, with the

Participant's (and if the Participant wished, their caregiver/guardian or circle of support) develop the person-centered care plan which includes identification of goals and supports that empower the Participant to achieve their highest quality of life. MCH's affiliate LifeShare has a founding mission of “Real Life for Real People,” and brings national experience in the areas of integrated care coordination and community transition from hospitals, nursing homes, intermediate care facilities, and psychiatric residential facilities. LifeShare has also developed a Quality of Life assessment process, to help focus on the whole-life needs of Participants and incorporates local self-direction trainings and tools for both internal and external stakeholders. Using a self-directed model empowers individuals to make personal choices regarding the services available to them, and as appropriate or desired by the Participant we educate the Participant and support them in implementing self-direction. CMs, as part of the person-centered planning process, will provide members with the opportunity to include their self-directed workers in their Integrated Care Teams, providing the member with interdisciplinary technical assistance to address their self-directed worker issues and ensuring swift Integrated Care Teams communication and action when the member experiences a change in status. The ability for the MCO to have consistent insight into dual eligible members across both their Medicare and Medicaid plans allows for a more holistic approach in developing a person-centered service plan and supporting the member in the management of their health. Participants can make decisions outside the "self-directed" model, for example choosing their own health and well ness goals, choosing providers and services, and choosing individuals that participate on their community based care team.

Would this model affect the administration of complaints, grievances, and appeals?

Administration of Complaints, Grievances and Appeals.

MCH does anticipate some changes to the way that complaints, grievances and appeals are handled. For those physical health acute care complaints, grievances and appeals these would be handled by the MCO, similar to how they operate today. However, BH and LTSS complaints, grievances and appeals would no longer be handled, for example, by the current TBI or behavioral health manager (for BH) or the State (for LTSS), but would be handled by the MCO. Similarly, dental and pharmacy would be handled by the MCO. We anticipate that the state fair hearings and/or additional remedies available to Participants beyond MCO administered complaints, grievances and appeals processes would continue in the manner they are offered today including use of an Ombudsmen.

How would the model support continued access for individuals to current services, supports, and providers?

Continued Access to Current Services.

MCH will facilitate and coordinate Participant access to all necessary covered services including primary, acute, TBI, BH, LTSS, and other services. We will combine the on-the-ground expertise of entities such as Community Mental Health Services (CMH), Prepaid Inpatient Health Plans (PIHP), the Brain Injury Association of Michigan, the Michigan Disability Rights Coalition, Defense and Veterans Brain Injury Center, Michigan Veterans County Counselors and Veterans Services Organizations, the Michigan State Housing Authority, School Districts, Housing/Homeless providers, Area Agencies on Aging (AAAs), Centers for Independent Living (CILs), and service coordination entities already serving the population, with the national experience and proven practices of our parent company, Centene, in serving similar populations through a variety of managed care models. Given the need to ensure Continuity of Care from implementation through the life of the program, we anticipate an extended monitoring phase for the integrated pilot program to ensure successful transition for Participants. Monitoring key post-

implementation performance indicators delivers regular assessments of the overall health of the project. By closely monitoring the overall progress of the implementation, appropriate corrective actions can be taken, as necessary, and consistent “total project” auditing can be employed when the performance deviates or is not adequate. To minimize the need for Participants to change providers, MCH will follow Centene’s successful practice of first building a network of traditional TBI, physical health, BH, LTSS, dental, pharmacy and other providers that already serve the TBI Participant populations unique needs. Additionally, we propose to implement other continuity processes used successfully by our MLTSS plans including MI Health Link, such as timely notification of MDDHS of transitions, and evaluate continuity processes via our QM/UM programs.

Section V: Governance

How would governance function within the model? How would the model promote transparency and accountability for the delivery of publicly-funded services and supports?

Governance and Accountability.

One of MCH affiliates' best practices for ensuring Participant and provider feedback into the governance has been to establish a board of directors that includes Participants and Providers. In addion, we promote transparancy and accountability for delivery by establishing Participant and Community Advisory Committees which include members from diverse TBI and related advocacy organizations throughout the state who meet throughout the length of the contract. Through this, we build trust and local accountability, identify potential reinvestment opportunities, and solicit important feedback on regional concerns for these special populations.

How would individuals, family members, and other community members be engaged in decision-making on the delivery of publicly-funded services and supports?

Engaging for Person-Centered Care Planning.

MCH's Care Managers (CMs) will employ person-centered planning strategies for needed screenings; comprehensive needs assessment; person-centered care plan development; and quality monitoring. CMs will serve as the single point of contact for the Participant (to include their family and/or caregivers as appropriate or desired by the Participant) and will build trust through respectful discussions that encourage Participant engagement in all phases, from identifying unmet need to evaluating the success of services. Through our affiliate LifeShare's Quality of Life assessments, Participants are empowered to determine, from their perspective, what it means to be well and what is needed to achieve their desired goals. Participants determine, from their perspective, what it means to be well and what is needed to achieve their desired goals. The role of CMs is to fully understand the Participant and his/her needs, through standardized assessments, motivational interviewing, and active listening, so we can provide assistance that is consistent with the Participant’s expressed values and culture. CMs will work with Participants and their chosen community based care team, or chosen circle of support during the care planning process to examine the Participant’s needs holistically and develop person-centered care plans that authorize their access to services, allow for concrete measurement of progress, and are easily modified as goals are met or conditions change. Other activities to support Participant engagement include but are not limited to: Motivational Interviewing, support for self-direction, incentives for participation in health and wellness/prevention activities, linkage to

community supports (non-covered services) and informal supports.
Engaging Participants, Community Members and Others for Programmatic Direction and Delivery.
MCH will engage Participants, providers and the greater community to get input and guidance into service delivery of publicly funded of services and supports to ensure we obtain necessary feedback and guidance to impact the design of our model, programmatic direction and ensure adequacy of our network to offer choice in services and access to appropriate levels of care for the membership. MCH proposes to use Participant Advisory Committees (PAC) and Community Advisory Committees to help facilitate this critical communication. PACs will be open to pilot participants (and their families), care givers, and/or advocates. We will convene pre-implementation, and on-going Participant and Community Advisory Groups to obtain input into program, process and network design, and work through start-up issues. These meetings ensure all requirements are met and guarantee our ability to deliver service excellence.
Results from Previous Experience.
MCH's affiliates have implemented these approaches for locally-driven quality improvement strategies that have enhanced Participants' community access and have supported Participants' engagement and overall quality of life. Our Florida affiliate transitioned 1,059 Participants from facilities in CY2015 (136 in November alone). Our Texas affiliate's 2014 Care Management Survey indicated 98.3% of Participants (across all Medicaid populations served) were pleased with how their health and quality of life improved because they received help from their Care Manager, and 98.5% of those with cultural needs were satisfied with how their needs were met by their Care Manager. Our affiliates also have expanded Participants' access to self-direction; 69.8% of Participants served by our Arizona affiliate chose self-direction in 2015, and since 2013, Florida affiliate self-directed Participants have increased from 4.6% to 16.6%.

Section VI: Financing and Reimbursement

What changes would need to be made to financing mechanisms for payers in order to implement the model?
Financing Mechanisms. The Integrated TBI Pilot would need to be budgeted with actuarily sound rates.

What changes would need to be made to provider reimbursement in order to implement the model?
Provider Reimbursement.
MCH proposes that MCO(s) delivering this program would need to be contracted with TBI and BH providers and LTSS providers as well as physical health providers in order to fully administer the program. We would recommend and emphasis on Pay-for-Performance (P4P) with incentives tied to faciliatation and achievement on specified quality metrics.

Would incentives (at a payer and/or service provider level) be used under the model? If so, how would the incentives be designed?
Incentive Programs.
MCH will use incentive programs that include P4P and gain and risk sharing. MCH will offer P4P for patient centered medical homes (PCMH) and other Providers with a minimum combined panel size and a high panel average risk score, for example, 50% higher than the average risk for all

Participants. MCH proposes the pilot develop a uniform methodology for assigning a risk score for each Participant, using similar logic to risk scores produced by the Medicare Hierarchical Condition Categories (HCC) score. The incentive will be based on the Provider's performance on access-oriented quality measures that apply to physical health and behavioral health providers, such as after-hours and weekend appointments, 7/14-day follow-up after hospitalization, and potentially avoidable admissions, readmissions, and ED visits. Gain and Risk Sharing Programs. Providers with more advanced capabilities will be able to participate in our Gain and Risk Sharing Value-Based Purchasing Programs based on the same set of measurements noted above. All our Gain and Risk Sharing Programs use risk-adjusted cost metrics. We also will adjust targets and performance improvement expectations based on the Provider's baseline risk-adjusted costs and performance to ensure that those caring for these complex Members/Participants are treated equitably.

For PCPs, MCH recommends using the following Participant-based incentive program. Participants with complex medical needs assigned to many individual PCP practices or practice groups across the network may likely be limited. Therefore, we will base the incentive on the individual risk scores for their assigned Participants with complex needs. The incentive program will be financed by using an actuarially sound methodology that accrues a specified percentage of premium to fund an Incentive Pool from which each Provider can earn payments based on their performance on access-oriented quality measures. Payments will be adjusted by the medical complexity of each Participant as defined by risk score. In addition, we would develop similar incentive programs, with mutually agreeable options that recognize the multivariate service professionals that deliver care, services and supports to our Participants.

Section VII: Quality Measurement

How would the quality of service delivery be measured and continuously improved under the model?

Measurement and Continuous Improvement. MCHbrings the experience of our parent company, Centene, which has more than 30 years of managed care experience and is currently the largest Medicaid Managed Long Term Services and Supports (MLTSS) Managed Care Organization (MCO) in the country, serving more than 210,000 MLTSS Participants in nine states (expanding to 10 in 2017 with Pennsylvania). MCH affiliate plans have extensive experience monitoring Participant outcomes using a variety of quality and performance measures which we would leverage to further design and implement this pilot.

Measuring Quality and Effectiveness of Services.

In addition to tracking physical health and BH measures for these members, such as the National Committee for Quality Assurance (NCQA's) Medicaid and Medicare HEDIS measures, as data is available, MCH's affiliate MLTSS health plans also have experience reporting and monitoring LTSS performance measures. We are currently implementing comprehensive dashboard reporting to include key performance indicators (KPIs) covering Clinical Quality, Service Coordination, Quality of Life, Participant Satisfaction, Utilization, Operations, and Cost of Care. The Dashboard also includes selected measures that directly impact one's ability to maintain or improve health and the ability to live in the least restrictive setting. Physical Health Measures and Performance. Among our affiliate MLTSS plans, the range of measures that we would track for the pilot could vary based on many factors including, but not limited to, contract requirements, characteristics of populations served, and services included in the pilot based on Participant, State and community/provider feedback.

Measuring Service Delivery and Access to Care.

Our affiliate MLTSS plans monitor an array of performance measures that specifically look at aspects of Utilization, Timeliness of Service Delivery, and Rebalancing of Services. Examples include but are not limited to: Hospitalizations (Non-Psych & Psych), ED Visits (Non-Psych & Psych), All Cause Readmissions within 30 Days of Hospitalization (%), Home Health Aide/Personal Care Assistant Hours (PMPM), Mandated Contacts Conducted Timely (%), New Participant Orientation Visits Conducted Timely (%), Number of members transitioned from institution to community setting, Number of members transitioned from community to institution setting. For populations similar to those that we would include in this pilot, MCH considers measures associated with quality of life, rebalancing of services, and clinical quality to be the most meaningful when looking at an integrated, whole-health approach to physical health, behavioral health and measuring LTSS. We look to achieving better performance through the lens of the Triple Aim: improving the health of our Participants and their experience of care and services while lowering costs. We fundamentally believe that performance on physical health and behavioral health measures also is key to improving quality of life and tenure in preferred settings.

For this Pilot, MCH would work with all providers to ensure access through compliance with established ADA accessibility standards. As needed we would provide training and assistance to providers in meeting ADA requirements. MCH will collaborate with providers to ensure all Participants have access to effective communication for best outcomes in service delivery and auxiliary aids such as assistive technology, interpreters, readers, and materials in large print or in braille or with print/imagery appropriate for people with cognitive impairments.. MCH will further promote access to services by conducting annual appointment access audits to ensure provider compliance. In addition, for those providers who are receiving incentives, such as a Care Coordination PMPM, we will assess their level of compliance with care coordination/office accessibility requirements annually, or as indicated.

Define “success” for the model? How will the model’s success be measured? What types of benchmarks would be appropriate for evaluating the model?

Strategies for Success.

Success of MCHs proposed integrated pilot will be driven by a specific program characteristics that should be considered in the design of managed care for specialty populations. First, mandatory enrollment in managed care for the entire population (regardless if one is living in an institution or the community) in combination with a capitated rate for all medical and non-medical services based on members’ risk level (rather than setting) provides MCOs the ultimate flexibility to serve people based on need and in the setting of their choice. In conjunction with this, we recommend the State develop and implement transition of care/enrollment processes that encourage ongoing care of members, regardless of which MCO is serving them. Limiting enrollment windows to the federal requirements (e.g., switching pilot MCOs within the first 90 days without cause, and no more than annually thereafter) allows members to have choice in MCOs while emphasizing continuity in care and minimizing MCO risk for their members who are admitted to a hospital or facility. Finally, the MCOs’ authority to design and implement strategies necessary to experience optimal coordination, de-fragmentation, and cost savings. For example, MCOs should design case management models for specialty populations that are fluid and are driven by data specific to the population served, the environment in which they are being served, and MDDHS-defined quality outcomes. Also, MCOs should have the authority to choose, incentivize, and monitor vendors who are critical to state programs and desired outcomes (e.g., vendors for participant direction, Money Follows the Person, and electronic visit verification). MCOs must also have the authority (and willingness) to work with any willing provider and pay providers, at minimum, Medicaid rates to ensure members have access

to providers they rely on and that MCOs develop the provider capacity necessary to effectively meet members' needs.
Defining Success.
MDHHS and MCOs should work with stakeholders to develop a range of measures that assess the impact managed care has on specialty populations' access to appropriate care and overall quality of life. Member quality of life and satisfaction measures should assess, at minimum, members' level of choice and control (e.g., their direct influence on assessment, goal setting, and service planning); preferred setting and existing setting; level of community integration; satisfaction with MCO and provider services; and informal caregivers' satisfaction and/or stress. Additionally, MCOs should implement a quality improvement program that carefully examines interventions and processes implemented to achieve the goals of the pilot.
Enhancing and Developing Benchmarks.
We also recommend MDHHS' use of the National Core Indicators in addition to examining other promising national efforts to standardize measures across specialty populations and home and community-based (HCBS) supports. This could include, but not be limited to, improved transitions, decreasing waiting lists and HCBS CAHPS surveys to measure Participant satisfaction. MCH recommends that MDHHS continue to collect the rich data required to inform the growth and improvement of participant direction models (e.g., the number of people who self-direct and their medical, functional, quality of life, satisfaction, and cost status).

Section VIII: Pilots and Other Considerations

Could the model be piloted? If so, how would you propose a pilot?

MCH has developed our recommendation for a managed care program for integration of physical health, behavioral health and LTSS services for TBI Participants eligible for LTSS as a pilot program. In order to best ensure the success of the pilot, and effectiveness of value-based purchasing programs to help achieve quality improvement, the pilot would need to be implemented in a region with a critical mass of eligible membership.

Could this model be implemented statewide (i.e. is the model is replicable in different communities)? If so, how would you propose statewide implementation?

While MCH has developed our recommendation for a managed care program specifically designed for integration of TBI Participants physical health, behavioral health and LTSS services, we also believe this could be implemented as a statewide program. If implemented as a statewide program we recommend the State develop and release an RFP with no more than two statewide awardees. Limiting the number of awards enables MCOs to have a mix of Participants with varying risk stratification and critical mass to be able to implement effective, efficient and innovative practices to produce improved quality outcomes.

(Optional) Are you aware of any changes that would need to be made to statutes, regulations, policies, or waivers in order to implement the model?

In order to implement this integrated pilot, the State would likely need to amend their existing 1915(c) and/or 1115 Demonstration Waiver.

(Optional) Are you aware of any other states or communities which have implemented this model?