# Section 298 Progress Report

(FY2019 Appropriation Act - Public Act 207 of 2018)

## November 1, 2018

***Sec. 298. (7) By November 1 of the current fiscal year, the department shall report to the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office on the progress toward implementation of the pilot projects and demonstration model described in this section, and a summary of all projects. The report shall also include information on policy changes and any other efforts made to improve the coordination of supports and services for individuals having or at risk of having a mental illness, an intellectual or developmental disability, a substance use disorder, or a physical health need.***

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MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

## INTRODUCTION TO THE REPORT

The Section 298 Initiative is a statewide effort to improve the coordination of publicly-funded physical health and behavioral health services. Under Section 298 of FY 2019 Appropriations Act (PA 207 of 2018), the Michigan legislature directed the Michigan Department of Health and Human Services (MDHHS) to implement pilot projects and a demonstration model to test the integration of publicly-funded physical and behavioral health services. As part of the Section 298 Initiative, MDHHS will be working with the Kent County Community Mental Health Service Provider (CMHSP) and willing Medicaid Health Plans (MHP) within Kent County to pilot a full physical and behavioral health integrated service demonstration model. In addition to the demonstration model, MDHHS will implement up to three other pilot projects to achieve fully financially integrated Medicaid behavioral health and physical health benefit and financial integration demonstration models.

As part of implementing the pilots and demonstration project, MDHHS is required under Sub-Section 7 of Section 298 to produce a report for "…the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office on the progress toward implementation of the pilot projects and demonstration model described in this section, and a summary of all projects." The report shall also include "…information on policy changes and any other efforts made to improve the coordination of supports and services for individuals having or at risk of having a mental illness, an intellectual or developmental disability, a substance use disorder, or a physical health need."

MDHHS is therefore submitting the following report to the legislature in accordance with PA 207 of 2018. This report includes the following information:

- A summary of the pilots and demonstration project;
- An update on the current progress in implementing the pilots and demonstration project;
- An update on the implementation of policy changes related to the recommendations from the final report of 298 Facilitation Workgroup.

## SUMMARY OF THE PILOTS AND DEMONSTRATION PROJECT

MDHHS developed the following summary of the pilots and the demonstration project based upon the current status of the implementation process. MDHHS also provided a brief overview of the current system to offer appropriate context for understanding the models for the pilots and demonstration project. Finally, MDHHS provide an overview of the proposed approach for the unenrolled population within the pilot sites.

### Overview of the Current System

Specialty behavioral health services in Michigan are delivered through county-based CMHSPs, 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. These 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 and other substance use disorder treatment services (e.g. residential, detoxification, and inpatient rehabilitation).

CMHSPs contract with PIHPs which serve as the state's publicly-operated managed behavioral health system for Medicaid-funded behavioral health specialty services and supports. PIHPs are also the responsible entities for directly managing Substance Abuse Block Grant funding and local substance use disorder funding. Ten regionalized PIHPs operate throughout the state and contract directly with MDHHS.

Services for individuals with mild to moderate mental illness are covered by Michigan's MHPs separate from the PIHPs. MHPs have developed a network of private providers to serve the needs of those with mild to moderate behavioral health problems. Mild to moderate behavioral health services are a benefit that is provided as part of the contracting process for Medicaid health services, including physical health services, by MDHHS.

### Summary of the Pilots

As part of Public Act 107 of 2017, the Michigan legislature directed MDHHS to "…implement up to 3 pilot projects to achieve fully financially integrated Medicaid behavioral health and physical health benefit and financial integration demonstration models." PA 107 also stipulated that "…[these] models shall use single contracts between the state and each licensed Medicaid health plan that is currently contracted to provide Medicaid services in the geographic area of the pilot project." Finally, the PA 107 also requires that each pilot site "…allows the CMHSP in the geographic area of the pilot project to be a provider of behavioral health supports and services."

MDHHS commenced the process for implementing the pilots by conducting an analysis of statutory and regulatory provisions at the state and federal level that may impact the structure of the pilots. MDHHS identified three primary sets of statutory and regulatory provisions as a result of this analysis:

- Social Welfare Act – Sub-Section 400.109(f) of the Social Welfare Act has historically required that "…Medicaid-covered specialty services and supports shall be managed and delivered by specialty prepaid health plans chosen by the department." The Social Welfare Act also historically mandated

that “The specialty services and supports shall be carved out from the basic Medicaid health care benefits package.” This provision would have prohibited MDHHS with contracting with MHPs for the management of specialty behavioral health services for the purposes of the pilots. The Michigan legislature passed Public Act 224 of 2017 to create an exception to this statutory requirement to allow for the implementation of the pilots.

- Mental Health Code

  - PA 107 of 2017 indicated that CMHSPs must be allowed to serve as a provider within the pilot site. However, Sub-Section 330.1116.2(b) of the Mental Health Code mandates that “it shall be the objective of the department to shift primary responsibility for the direct delivery of public mental health services from the state to a community mental health services program whenever the community mental health services program has demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of that service area.” Based upon this statutory provision, the MHPs must contract with the CMHSP(s) within each pilot site for the delivery of Medicaid-funded specialty behavioral health services.

  - PA 107 of 2017 directs the department to contract with MHPs for the management of specialty behavioral health services, which is inclusive of substance use disorder treatment. However, the Sub-Section 300.1210(2) of the Mental Health Code requires MDHHS to designate a Community Mental Health Entity in each region to “coordinate the provision of substance use disorder services in its region” and to “ensure services are available for individuals with substance use disorders.” Additionally, Sub-Section 300.1100(a)(22) stipulates that only a “community mental health authority, community mental health organization, community mental health services program, county community mental health agency, or a community mental health regional entity” may serve as a community mental health entity and likewise be designated by the Department to coordinate the provision of substance use disorder services. A MHP does not qualify as any of these entities permitted to serve as the managing entity for substance use disorder services. Therefore, another entity, such as the CMHSP in each pilot region, will need to be designated by the Department as a CMHE. While the MHP is prohibited from serving as the CMHE for substance use disorder services, the MHP is not prohibited by the Mental Health Code from receiving state administered Medicaid funds to distribute to the CMHE for the provision and coordination of substance use disorder services. Therefore, the CMHSP could be designated by the Department as the CMHE for substance use disorder services and the costs of these services could be built in the capitated rates with the MHP. MDHHS will directly contract with the pilot CMHSPs with non-Medicaid funds for substance use disorder services and related responsibilities.

- Unenrolled Population – PA 107 of 2017 directs the department to contract with MHPs for the management of specialty behavioral health services. However, MDHHS has identified that approximately 25% of Medicaid population is not enrolled in an MHP for management of their physical health services, and individuals in this sub-population (also known as the unenrolled population) receive physical health care services through a fee-for-service payment approach. Concurrently, Michigan requires all specialty behavioral health services be managed by a PIHP, and Michigan’s PIHPs therefore manage the specialty behavioral health benefit for the unenrolled

population within their respective regions. Due to federal regulations, it is not possible to integrate the behavioral health and physical health payments through the MHP for purposes of the Section 298 Pilots. MDHHS therefore has indicated its intent to select and contract with an existing PIHP to manage the specialty behavioral health benefit for the unenrolled population across the three pilot sites. The proposed approach for the unenrolled population is described in a separate section.

Once MDHHS completed the regulatory and statutory analysis, the department developed and executed a Request for Information (RFI) to select up to three pilot sites. Because the Mental Health Code requires that CMHSPs serve as the provider of specialty behavioral health services, MDHHS structured the application in a way that designates CMHSPs as the primary applicants. MDHHS required the CMHSPs to obtain a signed Memorandum of Support from at least 50 percent of the MHPs within the proposed pilot region as part of the application process. MDHHS received and evaluated proposals from five CMHSPs, and the department ultimately selected three pilot sites, which are listed below:

- Pilot #1: Muskegon County CMH (dba HealthWest) and West Michigan Community Mental Health
- Pilot #2: Genesee Health System
- Pilot #3: Saginaw County Community Mental Health Authority

MDHHS subsequently established a new workgroup to guide the implementation of the pilots. The "Leadership Group" is composed of (1) the Executive Director of each CMHSP and the CEO of each MHP within the pilot sites and (2) MDHHS representatives. The Leadership Group is responsible for finalizing and implementing the model for the pilots within a set of defined parameters established by the department. The key aspects of the structure of the pilot model are outlined below:

- Medicaid Funding
    - The pilot participants must assure access to the required service array as defined in current contracts, applicable waivers, and the Medicaid Provider Manual. Pilot participants must demonstrate that (1) they are able to provide the required continuum of specialty behavioral health services and (2) that they have an adequate provider network to deliver these services. Pilot participants must also ensure continuity of authorized and medically necessary services during the period of transition.
    - In accordance with the Mental Health Code, the MHPs must contract with the CMHSP(s) within the pilot sites for the delivery of specialty behavioral health services when the CMHSP(s) has (have) demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for Medicaid enrollees within the pilot sites.
    - MDHHS will designate the CMHSP(s) within the pilot sites as the Community Mental Health Entity as articulated under the Mental Health Code. MDHHS would also incorporate the Medicaid funding for substance use disorder services into the capitation payment for the MHPs in the pilot region. The MHPs would be required to sub-contract with the CMHSP as the Department-designated Community Mental Health Entity for the management of the Medicaid-funded substance use disorder benefit. The CMHSP must demonstrate the necessary capacity and competency to manage the substance use disorder benefit.

- MDHHS will make a capitation payment to the MHPs which will include funding for Medicaid-funded physical health and behavioral health services for individuals within the pilot regions. MDHHS will apply the same risk corridor that is in the PIHP contracts to financing arrangements for the MHPs within the pilot sites.

- The CMHSPs and the MHPs with the Leadership Group have proposed the use of a three-tiered model as the basis of financing arrangements for the pilots. The three tiers are listed below.

  - An administrative per member per month (PMPM) payment to the CMHSP pilot sites for purchase of administrative functions by each MHP.

  - A capitation payment made to the CMHSP pilot sites for delivery of core services to specific populations and/or sub-populations.

  - A fee-for-service payment will be explored for other populations presuming fair rates and reasonable incentives.

- Non-Medicaid Funding – MDHHS will directly contract with the pilot CMHSPs to provide specialty behavioral health services with non-Medicaid funds. This funding is inclusive of General Fund dollars, block grant funds, and liquor tax funding.

- Public Policy Requirements – The public behavioral health system has been designed to meet several public policy requirements to achieve best practice and to assure quality of care. The current PIHP contracts include a series of attachments which detail these policies and are listed below. MDHHS has contractually required the PIHPs to ensure that these policies are appropriately applied to the delivery of Medicaid-funded specialty behavioral health services. In the pilot locations, this responsibility will fall to the MHPs as the new contract holder. Pilot CMHSPs will work with all the MHPs within their geographic area to determine how ongoing implementation and compliance will be monitored and verified. The CMHSPs will also be responsible for fulfilling all policies that are related to the provision of substance use disorders treatment, prevention and recovery services.

  - Technical Requirement for Behavior Treatment Plans

  - Person-Centered Planning Policy

  - Self Determination Practice & Fiscal Intermediary Guideline

  - Technical Requirement for SED Children

  - Recovery Policy & Practice Advisory

  - Reciprocity Standards

  - Inclusion Practice Guideline

  - Housing Practice Guideline

- Consumerism Practice Guideline
- Personal Care in Non-Specialized Residential Settings
- Family-Driven and Youth-Guided Policy & Practice Guideline
- Employment Works! Policy
- Jail Diversion Practice Guidelines
- School to Community Transition Planning

- Managed Care Functions – Federal regulations set specific requirements for the performance of most managed care functions. In the PIHP system, performance of many of the managed care functions are delegated to the CMHSPs within the region. This delegation is intended to support the community behavioral health management role of the public behavioral health system. In the physical health delivery system, the MHPs have well developed systems and structures for performing the required managed care functions in a way that is consistent with both regulatory and accreditation requirements. The CMHSPs and the MHPs within the Leadership Group are currently engaged in discussions about the potential purchase of administrative services from the CMHSPs by the MHPs in a way that meets the accreditation requirements of the MHPs.

- Savings – PA 207 of 2018 stipulates "…the department shall require that contracts between CMHSPs and the Medicaid health plans within their pilot region mandate that any and all realized benefits and cost savings of integrating the physical health and behavioral health systems shall be reinvested in services and supports for individuals having or at risk of having a mental illness, an intellectual or developmental disability, or a substance use disorder." PA 207 also further specifies that "…[any] and all realized benefits and cost savings shall be specifically reinvested in the counties where the savings occurred in accordance with the Medicaid state plan and any applicable Medicaid waiver." MDHHS is currently developing the methodology for calculating savings and providing appropriate guidance to the Leadership Group on this issue. The CMHSPs and MHPs within the Leadership Group will be responsible for defining the anticipated strategy for reinvesting savings in services and supports for individuals having or at risk of having a mental illness, an intellectual or developmental disability, or a substance use disorder.

**Unenrolled Population**

Approximately 25% of the Medicaid population is not enrolled in an MHP for management of their physical health services. However, the PIHPs manage the specialty behavioral health benefits for this sub-population. Examples of individuals in the unenrolled population include but are not limited to:

- Individuals who recently became eligible for Medicaid but are not yet enrolled in an MHP
- Individuals who are dually eligible for Medicare and Medicaid
- Individuals who have third-party insurance
- Individuals who are Tribal citizens

- Individuals who are receiving services in a nursing facility or state psychiatric hospital

- Individuals who are eligible for coverage based upon a deductible (also known as spenddown)

Due to federal regulations, it is not possible to integrate the behavioral health and physical health payments through the MHPs for purposes of the Section 298 Pilots. However, MDHHS must contract with some form of a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) to manage the specialty behavioral health benefits for the unenrolled population because certain types of behavioral health services (e.g. services within an Institutions for Mental Disease) can only be offered under a managed care arrangement. MDHHS staff have therefore been evaluating options for the past several months to manage the specialty behavioral health benefits for the unenrolled population during the implementation of the pilots.

The department's initial plan was to procure the services of an Administrative Services Organization (ASO) or Managed Behavioral Health Organization (MBHO) as described in the 298 Pilot Request for Information (RFI). Based upon stakeholder feedback and further review of procurement timelines, MDHHS staff determined that the procurement of an ASO/MBHO was not feasible by October 1, 2018. MDHHS issued a "Concept Paper on the Unenrolled" in March 2018 to provide an update on the results of the department's research and indicate its intent to procure the services of a single existing PIHP to manage the specialty behavioral health benefit for the unenrolled population in the pilot sites. Based upon additional stakeholder feedback and approval of a request for extension of the Section 298 Pilot implementation date, MDHHS determined that additional options could be considered. In June 2018, MDHHS prepared an assessment of strengths and weaknesses, which was shared and reviewed with key stakeholder groups. For each proposed option, MDHHS considered the related strengths and weaknesses and the feasibility of successful implementation in the time available.

Based upon the results of this process, MDHHS has decided to issue a Request for Proposal (RFP) no later than January 2019 to select a single existing PIHP to manage the specialty behavioral health benefit for the unenrolled population in the pilot sites. Consistent with normal procurement practices, the RFP period will include an opportunity for questions. MDHHS will consider applications from all candidates meeting the mandatory minimum requirements and would expect to commence a contract for the defined scope of work by October 1, 2019. The key aspects of this approach are outlined below:

- New Contract – MDHHS will complete a new contract with the selected PIHP for the management of Medicaid-funded specialty behavioral health services for the unenrolled population within the pilot regions. The selected PIHP would fulfill all necessary managed care functions and assume shared financial risk for the assigned population. The selected PIHP would also be required to meet all service array and public policy requirements of the current PIHP contract. The selected PIHP will be required to contract with the CMHSPs with the pilot sites for the delivery of Medicaid-funded specialty behavioral health services.

    - For purposes of this contract, MDHHS will require managed care functions that are delegated by the PIHP be consistent with the delegation approach defined by the pilot participants. To the extent possible, the PIHP will work with pilot participants to assure consistency and eliminate redundancy in pre-delegation review and ongoing monitoring of delegated functions.

- To assure consistent practices in the pilot sites, MDHHS will require the PIHP follow a contracting, management, and payment structure that is consistent with the arrangements between the MHPs and CMHSPs for the management of substance use disorder benefits for the unenrolled population. The selected PIHP will therefore not be the department designated CMHE for the pilot counties.

- The rate development for the unenrolled population will be separate from the current rate development process utilized for the PIHPs. The rates will be developed specific to the covered benefit to the unenrolled population in the pilot sites. Current review of historic spending patterns statewide indicates that this population generally presents a higher need and includes a disproportionate share of the Habilitations Supports Wavier enrollees in the state. MDHHS expects that the rate development process will result in actuarially sound rates to be paid to the selected PIHP for this population.

- The current contracting process with the PIHPs includes a defined risk corridor. The existing corridor makes the PIHP responsible for (1) expenditures between 100 and 105% of the capitation and (2) responsible for half of the expenditures between 106 and 110% of the capitation. Similarly, savings between 95 and 100% of the capitation may be retained by the PIHP, as well as half of savings between 90 and 94% of capitation.

- The PIHP may retain an actuarially sound risk reserve for purposes of meeting this risk. MDHHS does not expect that any of the selected PIHP's current risk reserve will be utilized for the Pilot site contracts. Further, any risk corridor calculations will be specific to each contract and will not be blended.

- The selected PIHP would not be required to include pilot CMHSPs in the Shared Governance requirement for the Application for Participation (AFP) attachment to the PIHP contract but would not be prohibited.

- The selected PIHP will be responsible to meet reporting and performance monitoring requirements that are similar to the current PIHP requirements. The selected PIHP will 1) establish and maintain separate reporting for the unenrolled population from, 2) permit department and External Quality Review for the unenrolled population concurrent to other monitoring activities, and 3) design and conduct required pre-delegation and ongoing monitoring of managed care functions with pilot partners.

- All current public policies included in the PIHP contract will apply to the contract for the unenrolled.

As the pilots proceed, MDHHS will continue discussions with stakeholders about potential longer-term options for managing the specialty behavioral health benefit and improving the coordination of care for the unenrolled population. MDHHS will also use the experience and lessons learned that are accumulated during the pilot period to inform this discussion.

**Summary of the Demonstration Project**

As part of Public Act 107 of 2017, the Michigan legislature directed MDHHS to "…work with a willing CMHSP in Kent County and all willing Medicaid health plans in the county to pilot a full physical and behavioral health integrated service demonstration model." MDHHS has initiated discussions with the Total Health Collaborative (Kent County CMHSP, Priority Health, and Lakeshore Regional Entity) in regards to the demonstration model under Subsection 2 of the boilerplate. A history of the development discussions between MDHHS and the Total Health Collaborative (TTHC) participants is outlined in the "Progress To Date" section of this report.

The Total Health Collaborative has proposed the use of a Behavioral Health Home model for individuals with mental health or substance use disorder needs. The Behavioral Health Home model will involve the use of a multi-disciplinary team that is able to flex in service type and intensity as the individual's needs change. Network180 and Priority Health have proposed focusing on a group of Priority Health Choice (PHC) Medicaid consumers who received their care at three Kent County clinics.

The Care Management team will be made up of nurse and social work care managers from Priority Health as well as an MSW (Master of Social Work) clinical supervisor and peer support specialists/recovery coaches at Network180. This team works with shared complex consumers regardless of where they receive their care, coordinating with intensive and routine services in both medical and behavioral health settings. Nurses and social workers coordinate physical and behavioral health care and serve as a direct resource for providers. At the same time, peer support specialists and recovery coaches work face-to-face with consumers, educating and encouraging, to increase the self-management capacity of consumers.

TTHC will provide low risk individuals with appropriate, individualized low intensity assistance, such as support in accessing or linking to outpatient behavioral health or medical services, telephonic case consultation and care coordination between behavioral health and physical health providers, or ongoing monitoring to ensure individuals can access care as needs arise.

Individuals with higher needs and utilization of intensive services will be invited to partner with a Care Management Support Specialist (peer or recovery coach), who will engage with them face-to-face and via phone. Care Management Support Specialists encourage individuals in their wellness journey, accompanying them to appointments, educating them on health conditions and system navigation, advocating with providers, and empowering individuals to take steps to manage their own health.

Individuals with serious behavioral health issues who are not yet connected to ongoing treatment will be invited to receive care in a Behavioral Health Home. This model emphasizes evidence-based therapy along with case management, psychiatry, peer support, and an augmented nursing component that provides enhanced coordination with physical health care. In this project individuals whose behavioral health conditions stabilize over time to a mild/moderate level of need will be maintained by the Behavioral Health Home team to

provide treatment that is continuously available to the individual. Instead of being discharged, the individual will be able to reach out to their Behavioral Health Home team for as much or as little care as needed as recovery ebbs and flows.

## PROGRESS TO DATE

MDHHS has made significant strides towards the implementation of the demonstration project and pilot projects. The following summary describes the progress that has been made to date:

- MDHHS established an internal structure to manage the work related to the Section 298 Initiative. The structure has evolved as the project transitioned into the pilot development and implementation phase. The internal structure includes the following components:
  - Core Team: The Core Team includes the Deputy Directors from multiple administrations within the MDHHS. This group provides guidance and authority to the Action Team. It meets regularly to receive recommendations, review progress, and provide approval as needed and appropriate.
  - Action Team: The Action Team is the primary group that is responsible for the implementation of the Section 298 Initiative. This group includes representatives from various administrations within MDHHS. This group meets weekly and manages the project.
  - Operations Team: The Operations Team provides the project management for the department's implementation activities for the pilots. The Operations Team has established the eight sub-workgroups listed below, and its membership includes the co-leads of each sub-workgroup as well as various other staff form BHDDA and MSA. This group meets at least monthly.
    - Rate Setting and Finance
    - Waiver Authority
    - Reporting
    - Contracting
    - Data Sharing
    - Systems
    - Encounter Reporting
    - Monitoring and Compliance
- MDHHS contracted with the Michigan Public Health Institute (MPHI) to serve as the project facilitator and onboarded the MPHI team.
  - MDHHS and MPHI met and provided regular updates to the three councils that were identified under PA 207 of 2018, which includes the Medical Care Advisory Council, Behavioral Health Advisory Council, and Developmental Disabilities Council.
  - MDHHS and MPHI also convened several groups of key stakeholders to provide updates on crucial developments for the Section 298 Initiative.

- MDHHS and MPHI also convened and continue to facilitate the discussions of the Leadership Group for the pilots. The Leadership Group is composed of (1) the Executive Director of each CMHSP and the CEO of each MHP within the pilot sites and (2) MDHHS representatives. The Leadership Group is responsible for finalizing and implementing the model for the pilots within a set of defined parameters by the department. MDHHS and MPHI are also provided ongoing logistical and facilitation support for the sub-workgroups of the Leadership Group.

- MPHI assisted MDHHS with the development and ongoing maintenance of a project plan for implementing the pilots and demonstration project.

- MDHHS contracted with the Institute for Healthcare Policy and Innovation (IHPI) at the University of Michigan to serve as the project evaluator and onboarded the IPHI team.

  - MDHHS, IHPI, and MPHI convened several groups of key stakeholders to provide an initial overview of the structure of the evaluation plan and describe the anticipated next steps for the evaluation process.

  - IHPI developed and published a high-level summary of the evaluation process for the purposes of informing stakeholder discussions.

  - IHPI staff are participating in the discussions of the department's internal and external sub-workgroups for the pilots and examining the impact of the pilot structure on the design of the evaluation.

  - MDHHS and IPHI completed a data use agreement to allow for the IHPI team to access data from the department's Enterprise Data Warehouse for the purposes of the evaluation.

  - The IHPI team are working on identifying performance metrics for the evaluation of the pilots and demonstration project. MDHHS and IHPI will be conducting outreach to stakeholders to solicit input on the potential performance measures.

- MDHHS initiated discussions with the Total Health Collaborative (Kent County CMHSP and other potential partners) on the demonstration model under Subsection 2 of the boilerplate.

  - MDHHS provided a list of parameters to the Total Health Collaborative to guide the development of the demonstration project. The parameters included a provision that the Total Health Collaborative "…present a written description of the proposed demonstration project by January 15, 2018 that includes but is not limited to: services to be provided, parties to be involved, intended project outcomes, proposed stakeholder engagement strategy, and proposed evaluation strategy."

  - The Total Health Collaborative submitted a written proposal to MDHHS on January 3, 2018 MDHHS reviewed and discussed the proposal with the participants in the Total Health Collaborative during a meeting on January 4, 2018. MDHHS also provided a set of written comments on the proposal to the Total Health Collaborative. Based upon the results of the review, MDHHS provided initial approval of the Total Health Collaborative proposal for the

demonstration project. As part of this initial approval, MDHHS communicated its expectation that the Total Health Collaborative will review and address the key issues that were identified in the formal written comments from MDHHS. MDHHS noted that final approval of the Total Health Collaborative proposal is contingent upon the submission of an operational plan that meets all of the established parameters.

- The Total Health Collaborative has continued to work towards developing an operational plan and Memorandum of Understanding between the various members. The Total Health Collaborative submitted a progress report to MDHHS on April 30, 2018 to provide an update on the development of these deliverables and the overall status of implementation. MDHHS provided feedback on the progress report to the Total Health Collaborative to inform the development of the upcoming project plan.

- Based upon the memo and subsequent discussion, the Total Health Collaborative created an updated proposal to further clarify the key elements of the model, which was submitted to the department on October 12, 2018. MDHHS is currently conducting a review of the updated proposal based upon the boilerplate requirements and the parameters that were previously outlined by the department.

- MDHHS has continued to make progress on developing and implementing the pilots.

  - MDHHS and MPHI convened several groups of key stakeholders to provide an overview of the process for developing the pilots.

  - MDHHS and MPHI developed and published a legislative report that identified a timeline for implementing the pilots and demonstration project, any identified barriers to implementation, and the remedies to address any identified barriers. The report also included information on policy changes and any other efforts made to improve the coordination of supports and services for individuals having or at risk of having a mental illness, an intellectual or developmental disability, a substance use disorder, or a physical health need. Ongoing pilot planning has included focused attention to address and identify solutions to identified barriers.

  - MDHHS published a concept paper that provides an overview of the anticipated structure of the pilot model.

  - MDHHS worked with the Michigan legislature to inform discussions around PA 224 of 2017, which amended the Social Welfare Act to allow for the department to contract with the MHPs for the purposes of managing the specialty behavioral health benefit for the pilot regions.

  - MDHHS developed and issued an RFI to identify prospective pilot sites and successfully selected three sites through this process.

  - MDHHS formed the Leadership Group to support the ongoing implementation of the pilots. MDHHS has continued to participate in these discussions and coordinate with the pilot participants on developing and implementing the pilots.

- MDHHS secured guidance from the Centers for Medicare and Medicaid Services on the best approach for integrating new authorization for implementing the pilot sites into the department's waivers for the Medicaid program.

- The Leadership Group has continued discussions regarding the duration and scope of the pilots, and MDHHS is collaborating with the Leadership Group to develop a communication to the legislature regarding these issues and potential solutions.

- MDHHS conducted extensive research and stakeholder outreach to identify the most appropriate approach for managing specialty behavioral health benefits for the unenrolled population within the pilot regions.

  - MDHHS identified several options for managing the benefit for the unenrolled population and conducted a regulatory analysis of these options.

  - MDHHS communicated its intent to procure the services of an ASO or MBHO with the RFI for selecting the 298 pilots.

  - Based upon stakeholder feedback and further review of procurement timelines, MDHHS staff determined that the procurement of an ASO/MBHO was not feasible by October 1, 2018. MDHHS issued a "Concept Paper on the Unenrolled" in March 2018 to provide an update on the results of the department's research and indicate its intent to procure the services of a single existing PIHP to manage the specialty behavioral health benefit for the unenrolled population in the pilot sites.

  - Based upon additional stakeholder feedback and approval of a request for extension of the Section 298 Pilot implementation date, MDHHS determined that additional options could be considered. In June 2018, MDHHS prepared an assessment of strengths and weaknesses, which was shared and reviewed with key stakeholder groups. For each proposed option, MDHHS considered the related strengths and weaknesses and the feasibility of successful implementation in the time available.

  - Based upon the results of this process, MDHHS decided to issue an RFP no later than January 2019 to select a single existing PIHP to manage the specialty behavioral health benefit for the unenrolled population in the pilot sites.

- MDHHS is working with the CMHSPs and PIHPs within the pilots to develop a strategy for transitioning responsibilities for managing specialty behavioral health services as part of implementing the pilots.

  - MDHHS initially met with the CMHSPs and PIHPs separately to understand the key issues and concerns with the transition process.

  - Based upon this input, MDHHS developed a draft transition strategy document and is currently incorporating additional feedback from the CMHSPs and PIHPs. MDHHS will also convene a joint meeting between MDHHS, the CMHSPs, and the PIHPs to discuss the transition strategy and potential next steps.

- MDHHS analyzed, prioritized, and initiated implementation of the recommendations that were included in the final report of the 298 Facilitation Workgroup. Additional details on this activity are included in the next section.

## UPDATE ON POLICY CHANGES

MDHHS continues to act upon the recommendations that were identified in the final report of the 298 Facilitation Workgroup that was established in Section 298 of article X of 2016 PA 268. In April 2018, MDHHS published a progress report and set of detailed action plans for the policy recommendations, which included:

- Assessment of the relationship of recommendations to the demonstration project and pilots established under section 298 of PA 107 of 2017;
- Determination of priorities for action;
- Identification of subject matter experts to analyze the various recommendations;
- Assessment of the current state of state programs and policies related to the recommendations;
- Identification of barriers to implementing the recommendations;
- Detailed action that is required to enact the recommendations, including legislative and public policy changes; and
- Assignment of responsibility and determination of due dates for action.

MDHHS reviewed the progress report with several groups of stakeholders including the 298 Facilitation Workgroup. MDHHS also received written feedback regarding the following recommendations:

- ✓ Administration of Complaints, Grievances and Appeals
- ✓ Protection for Mental Health and Epilepsy Drugs
- ✓ Person-Centered Planning.

MDHHS distributed the feedback to assigned staff, which was used to update the action plans for individual recommendations. These changes are reflected in the following actions plans:

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| 1) Consideration of Financial Models<br>2) Coordination of Physical and Behavioral Health Services<br>3) Access to Services:<br>a. Substance Use Disorder Services<br>b. Services for Children, Youth and Families<br>c. Services to Tribal Members<br>d. Continuity of Service<br>4) Administration of Complaints, Grievances and Appeals<br>5) Protection of Mental Health and Epilepsy Drugs | 6) Self-Determination and Person-Centered Planning<br>7) Governance, Transparency and Accountability<br>8) Workforce Training, Quality and Retention<br>9) Peer Supports<br>10) Health Information Sharing<br>11) Quality Measurement and Quality Improvement<br>12) Administrative Layers in Both Health Systems<br>13) Uniformity in Service Delivery<br>14) Financial Incentives and Provider Reimbursement |

The action plans can be accessed through the department's webpage by visiting www.michigan.gov/stakeholder298 >> Policy Recommendations

MDHHS categorized the current status of each recommendation as: 1) Complete, 2) Partially complete, 3) Not started, 4) Other, or 5) Not implemented at this time. A progress status of "Other" is used to indicate recommended changes to the action plan or an action item not yet due. Sixty-seven percent of planned action is either complete or partially complete while thirteen percent are not started. Moving forward, departmental efforts to implement the policy recommendations are a key discussion topic for transition planning for the next administration.