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.

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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
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Matt Lori	Michigan Department of Health and Human Services
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Sam Price	1016 Recovery Network
Tiffany Stone	Michigan Association of Health Plans

Workgroup Alternates	
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Sherri Boyd	The Arc Michigan
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Other Workgroup Participants	
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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.

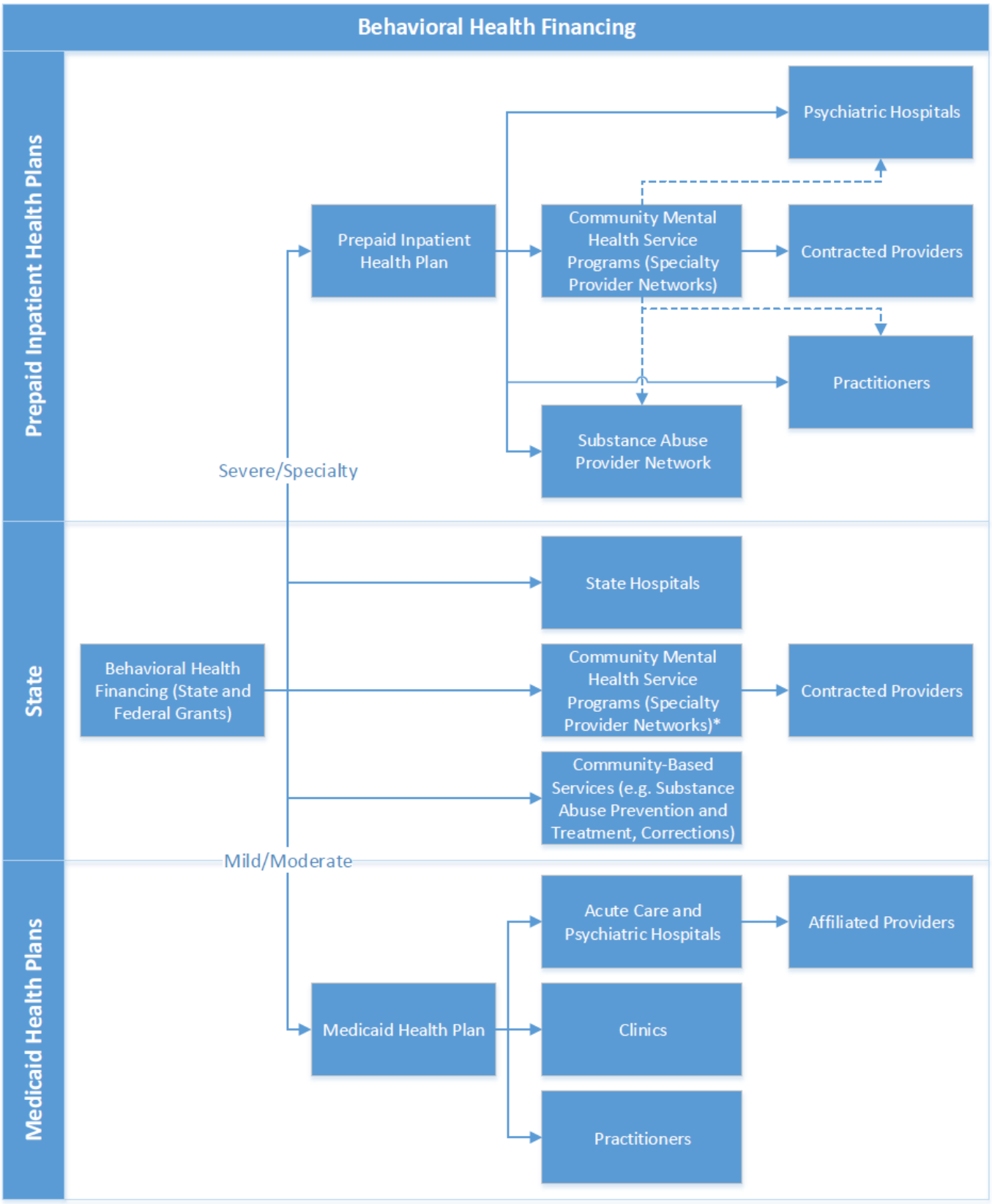
- Public oversight and accountability to ensure the public interest.
  - Transparency (access to information, open meetings).
  - Array of services and supports accountable to the public and the persons and families receiving services.
  - People with disabilities should not be segregated in communities.
  - 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)

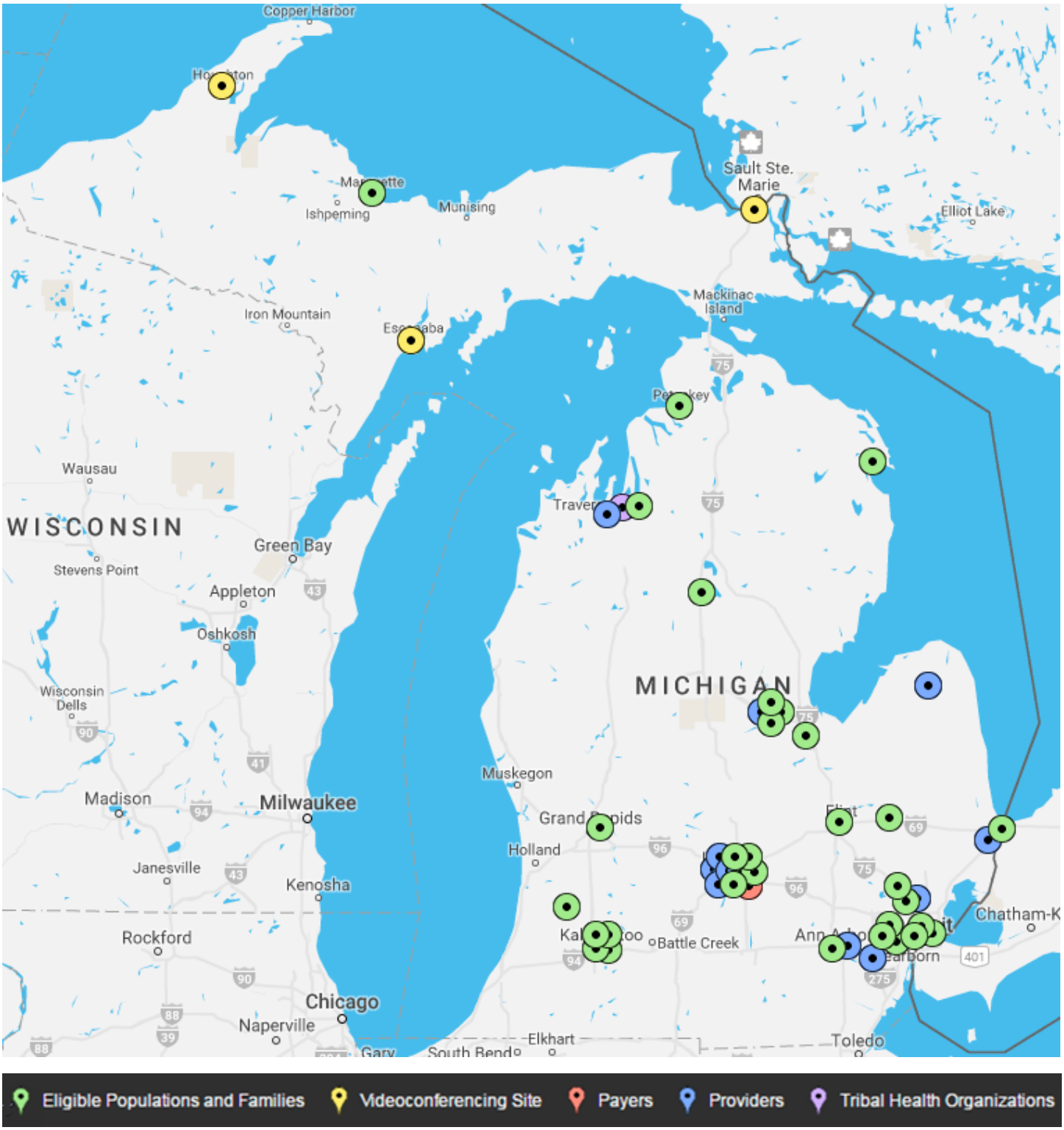
- Develop an integrated system per enrollee that is made up of a number of parties that have specialized managed-care expertise that is tightly coordinated. This would be similar to the current system but with better coordination. This system would include:
  - A standard integrated Medicaid fee schedule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

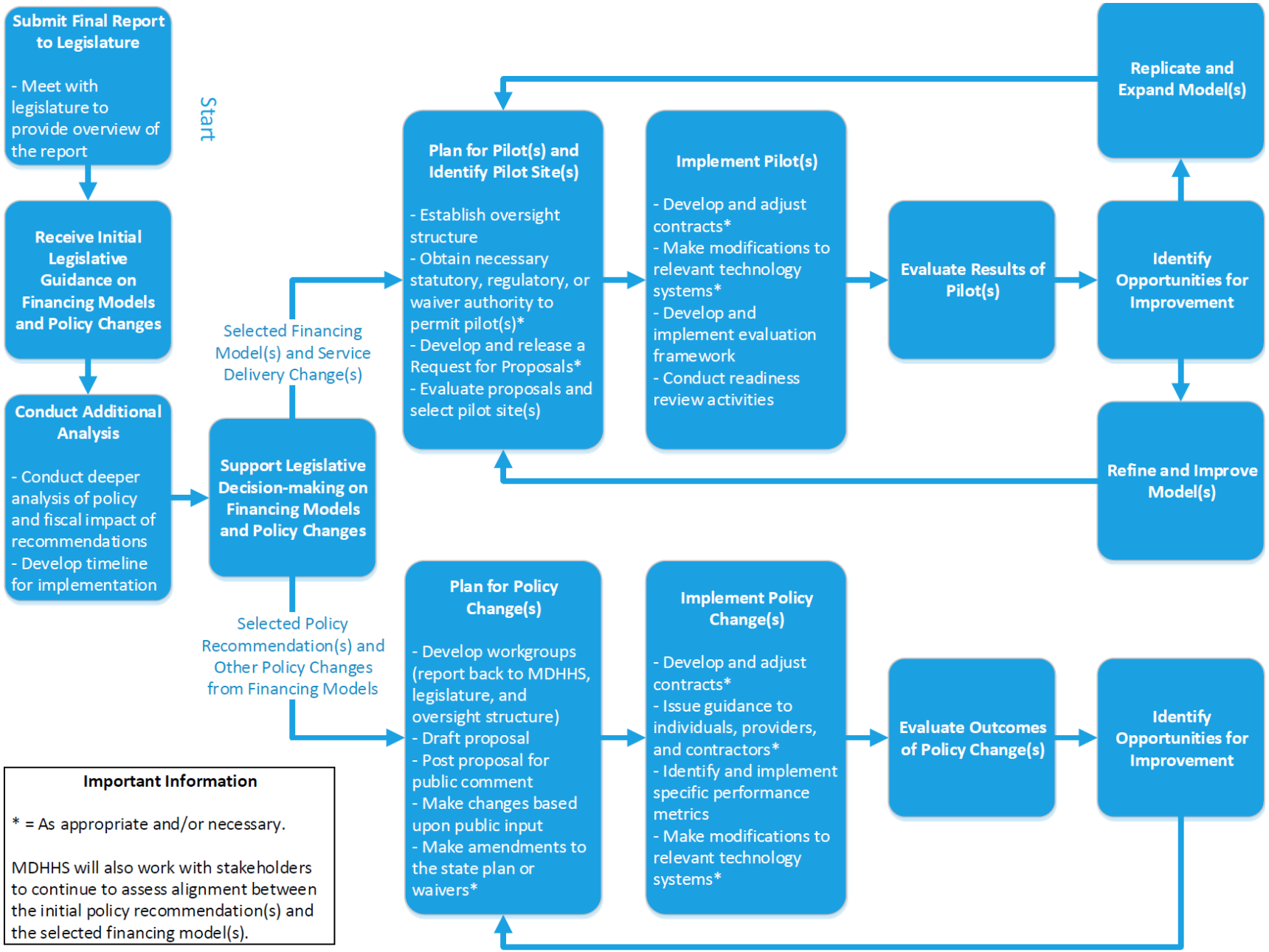
Several stakeholders asked about whether the recommendations apply to all behavioral health services or only Medicaid-funded services. Several stakeholders expressed concern about access to services for individuals who are not Medicaid eligible or are not currently receiving Medicaid services. A few 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.

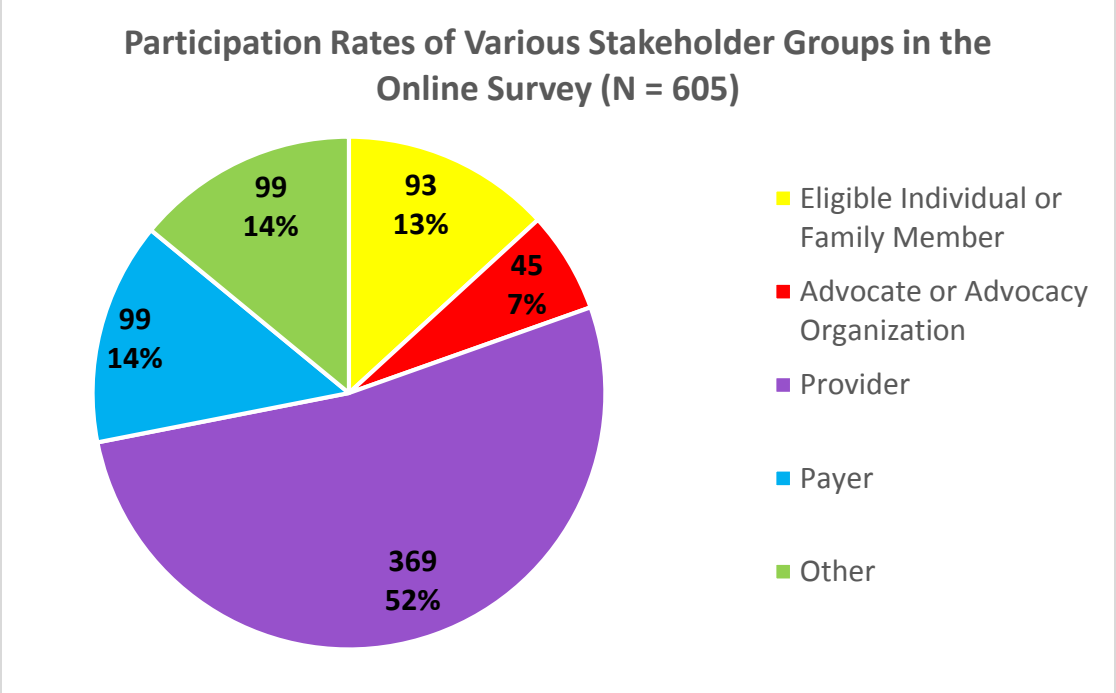
This appendix summarizes the comments that were provided by various stakeholders through the survey and through the forum. MDHHS and the workgroup used the comments from the public input process to refine and improve the evaluation of the individual financing models.

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.

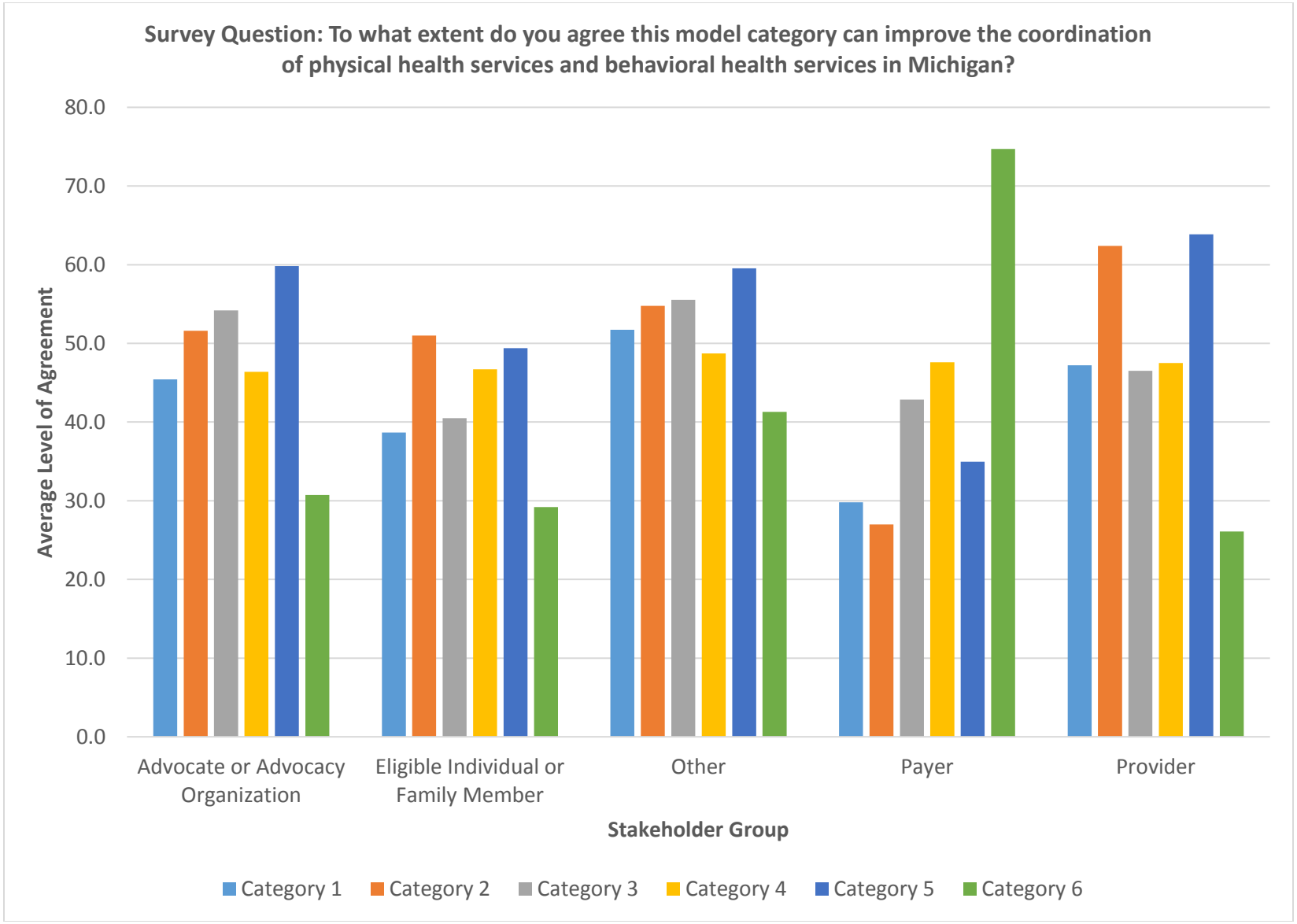
A wide variety of respondents also advocated for implementing models that focus on supporting integration of services at the local level. Several stakeholders argued against the view that system restructuring is necessary in order to achieve integration. One respondent noted that CMHSPs and other providers 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.			