

## **Commentary on Section 298 Processes & Reports**

**March 2017**

**The Arc Michigan  
Association for Children's Mental Health  
Epilepsy Foundation of Michigan  
Mental Health Association in Michigan  
Michigan Developmental Disabilities Council  
Michigan Protection & Advocacy Service  
National Alliance on Mental Illness - Michigan  
United Cerebral Palsy (UCP) of Detroit  
United Cerebral Palsy (UCP) of Michigan**

## Introduction

In his FY-17 budget proposal, the Governor called for all Community Mental Health (CMH) Medicaid funding and clients to be transferred to the state's 11 Medicaid Health Plans (MHPs) by September 2017. There was great opposition to this recommendation, and many people have spent the last year involved with the issue. That work culminated with a Final Report to the Legislature March 15, 2017. The report was issued by the MDHHS 298 Facilitation Workgroup.

This Commentary describes steps along the way since February '16; key elements of the report to the Legislature (and its Part One predecessor transmitted January 13 of '17); and some of the myths that have been perpetuated to legislators and the public in recent weeks. While we wish there had been more time to spend on certain elements of the Final Report, we commend it, along with the positive and helpful role MDHHS played in convening and facilitating the effort.

## Steps Along the Way

### Calley Workgroup

After the initial uproar in early '17, Lt. Governor Calley convened a related workgroup. Because of the great interest generated, he appointed approximately 120 members. The group met five times through June of '16; after the first meeting, approximately 65 individuals were generally in attendance. **It is important to note that the groups authoring this report – the leading behavioral health advocacy groups in the state – held less than 15 seats on this body.** (For purposes of this Commentary, “behavioral health” is inclusive of mental illness, emotional disorder, intellectual and developmental disability, and substance use disorder.)

The Calley Workgroup developed values and recommendations for publicly funded health care in Michigan, all of which required at least two-thirds voting support from members. The Governor's proposal was overwhelmingly rejected; in fact, it was recommended that all Medicaid funding and management responsibility for clients shared by CMH programs and MHPs be given to the former.

### Affinity Groups

In July, MDHHS formed a 298 Facilitation Workgroup to follow up on the efforts of the Calley Workgroup. More about the former will be in the next sub-section. But one of its first tasks was to assist MDHHS in holding Affinity Group sessions across the state on a series of issues related to the 298 project.

In the fall of '16, 45 sessions were held, attended by 1,113 people. Commendably, MDHHS saw to it that more Affinity Groups (31 of the total 45) were held for consumers and families (767 of the total 1,113) than for providers and payers. This inclusive and transparent person-centered approach recognized that health care

policies and services are best built by empowering those who depend on the policies and services to have a significant voice in their design.

**No Affinity Group, including those held for providers and payers, recommended that MHPs be given control of CMH Medicaid money and clients. Meanwhile, the consumer/family participants overwhelmingly went on record that they don't want MHPs in charge of their behavioral health supports and services.** (Reasons for the great antagonism for such an approach are provided later in this Commentary.)

*MDHHS 298 Facilitation Workgroup*

The Department appointed 23 voting members to this body. **Only 8 of the 23 were advocates. The remainder of the workgroup were Department staff and provider/payers. As a two-thirds super-majority was required for recommendations to be adopted, there was no way the advocate members could get through anything on their own.**

After the Affinity Group sessions, the 298 Facilitation Workgroup began developing its first set of recommendations. In January, a report with the first 70 recommendations was sent to legislators. Among the many issues targeted were:

\*Giving consumers of public health care service (and their families) meaningful dispute resolution options.

\*Requiring greater statewide uniformity of CMH services and practices.

\*Improving person-centered planning and self-determination options and practices for beneficiaries.

\*Better working conditions for direct care staff.

\*Identifying and acting upon redundancies and duplication in public health care administration.

\*Codifying in statute state protective policies from the last 13 years on prescription access for behavioral health beneficiaries.

A number of the first 70 recommendations focused on the public behavioral system, which the workgroup recommended to remain largely in place, in order to improve it.

Additionally, the first 70 recommendations have been characterized by some as "policy proposals." But Recommendation 1.1 was more than that. It was a broad structural and financial blueprint for funding Medicaid health services.

**The base concept of 1.1, which was co-drafted by the Michigan Association of Health Plans (MAHP), which represents most of the state’s MHPs, called for the public behavioral health system and our MHPs to remain in place largely as we know them today. The workgroup added a closing sentence that proposals for financial models and pilots could come from “competent, public, risk-based configurations.” MAHP voted for Recommendation 1.1 in its entirety.**

*In the second half of January, MAHP issued a “minority report” objecting to Recommendation 1.1 and ten others. Interestingly, of the eleven recommendations objected to, it had voted to support nine of them (including 1.1).*

That same month, MDHHS began soliciting proposal for service coordination/integration “financial” models/pilots. Should the Department have specified that it would not entertain proposals from non-public entities, or proposals for an MHP or a behavioral health entity to receive all money for shared-enrollment beneficiaries? This is a question for the Department to answer. **But the Request for Information document that went out statewide asked how “a competent public body would be engaged in managing the model.”**

Forty-two proposals were received. MDHHS determined that thirteen were not “financial.” With less than two months left for the workgroup, it was concluded that such proposals would not be reviewed.

The Department and workgroup also determined that eleven proposals violated Recommendation 1.1, for one or both of two reasons: (1) a non-public entity (e.g., an MHP) was proposed to be the lead; (2) an MHP or a behavioral health entity was suggesting that it get all Medicaid money for shared enrollees (i.e., beneficiaries served by both sides). By a more than two-thirds vote, the workgroup decided it would not review these (which would also be a legal nightmare to try implementing, even on a demonstration basis).

The above steps left eighteen proposals. In retrospect, the workgroup should have evaluated each individually, but the Department grouped them in five clusters for evaluation based on perceived commonalities. The workgroup spent precious time on this generalized exercise (which took the workgroup into its last week of meetings) that could have been better devoted to analyzing each proposal.

Additionally, MDHHS did not schedule an official vote on recommendations about “financial” models/pilots till the workgroup’s very last meeting. Thus, there were only six recommendations, and two of them were for next-step procedural matters.

It is critical to examine the four substantive recommendations from the workgroup about models/pilots.

*1. 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 vote).*

A small number of proposals were received directly and clearly calling for this. By citing the concept for special attention, the workgroup was, in effect, prioritizing it as the most important type of proposal submitted. If we're going to have both MHPs and CMH programs (as recommended by the workgroup), the two sides must be formally working together on care coordination for persons with both behavioral and other medical needs. This approach would likely not require new appropriations, and it is consistent with Recommendation 1.1 from the workgroup's January report.

*2. The workgroup recommends contract provisions to encourage integration of behavioral and other medical care at the point of service delivery, which should be driven by local coordination rather than statewide integration of financing (14-5 vote).*

This recommendation recognizes that giving all involved money to the MHPs or the CMH programs does nothing to assure service coordination. It can only be achieved at the local provider level, and those providers will still have respective contracts with MHPs and CMH programs, regardless of where the state first sends its appropriations. The recommendation immediately above (shared formal coordination by MHPs and CMH programs) also recognizes and accounts for this reality. People receive their supports and services from local providers (who are often contract agents), not from the headquarters of an MHP or CMH program.

*3. The workgroup recommends development of models that focus on individuals who are vulnerable and at risk of increased morbidity and premature death as well as persons who are high utilizers of emergency rooms and inpatient services (14-5 vote).*

This recommendation recognizes that the high-risk/high-utilizer concept appeared in some of the proposals submitted. But because the Department's strategy did not allow for specific evaluation of individual proposals, instead focusing on groupings of proposals that didn't prominently capture this concept, the fear is that it could be lost moving forward. Research tells us that persons with serious mental illness die 25 years earlier than the rest of the population, and that certain disability group subsets represent disproportionately high service utilization/costs.

*4. A special fund should be established to support local/regional integration efforts, with emphasis on arrangements at the provider level (17-2 vote).*

It is unknown how many models the state will decide to test. But it would be naïve to think that none of them will need any extra financial support. Additionally, once certain models test positively and are ready for statewide long-term use, they may require special funding for full implementation and maintenance. And once again, the importance of provider coordination is emphasized.

It is interesting to note that the two MAHP members on the workgroup voted against the above recommendations, yet voted to support the final version of the March 15 report to legislators.

### **Why MHP Control of Behavioral Health \$ Has Been Constantly Rejected**

1. MDHHS has continually pointed out that Medicaid beneficiaries with behavioral disorders have more negative “physical” health outcomes than the rest of the population. **And where have many Medicaid beneficiaries gotten their “physical” health care the past two decades? From the Medicaid Health Plans.**
2. The MHPs have had, in effect, an almost 20-year “pilot” on handling mental health-related cases considered “moderate or mild.” The MHPs are allowed and funded to provide up to 20 annual outpatient visits for these cases. **According to MDHHS, the average number of mental health visits authorized for qualifying MHP enrollees in 2014 was four. The Department also reports, for 2015, that among MHP beneficiaries experiencing behavioral health “specialty” provider contacts, only about 10% of such contacts were with a psychiatrist, neurologist, psychiatrist, or social worker. These figures are extremely alarming re MHP behavioral health performance.**
3. Unlike CMH programs, the MHPs are profit-driven. Health care profits (and covering “administrative costs”) are achieved by rationing care. **No one except the MHPs wants to see increased rationing of supports and services for behavioral health.**
4. MHPs are connected to government primarily through contracts. CMH programs are connected to government through law. Their board members are appointed by elected officials, and they must comply with FOIA and Open Meetings laws. As such, **CMH programs have greater transparency and public accountability than do MHPs.**
5. MHPs have little experience dealing with severe behavioral disorders or the unique needs of children and youth with serious emotional disorders and their families. **The CMH programs have over 40 years experience with severe behavioral disabilities as well as the special needs of children and youth.**
6. **Many of the services available through CMH programs today recognize and rely on the importance of non-medical social supports to foster recovery and the capacity to deal with one’s circumstances and life situations.** This includes legal requirement for person-centered planning and self-determination choices regarding beneficiary preferences and needs. It further includes, for children and youth, family-driven/youth-guided planning, early identification/intervention, peer supports for parents and minors, and emphasis on home- and community-based

initiatives. **The MHPs don't have this experience or perspective, relying instead on an older "medical model for dictating treatment decisions.**

**7. The Governor's proposal from early 2016 could require tens of thousands of state residents to leave their current doctors and providers for new ones that are imposed on them.** This violates all modern thinking on consumer choices in behavioral health care.

8. Michigan has been running a demonstration project on financial integration in four regions for persons enrolled in both Medicaid and Medicare. Eligible individuals are automatically enrolled in an MHP-like entity, with the option to subsequently un-enroll. So far, **after almost two years, over 60% of people that the state automatically placed with MHP-like managed care entities have chosen to dis-enroll from the program.**

### **In Summation**

After a year, virtually no one, including provider and payer Affinity Groups, has supported the Governor's early 2016 proposal. Only the MHPs, which have a financial conflict-of-interest regarding this matter, want it to happen.

And, except for the MHPs, everyone has recognized that giving one entity all Medicaid health care money does nothing to necessarily improve care coordination for persons with both behavioral and other medical needs. Rather, the keys to improved coordination rest at local service provider levels.

Matters now rest in the hands of the executive and legislative branches. State officials can side with the lonely voice of the MHPs, who have a financial interest in this issue. Or they can side with the overwhelming voice of consumers, their families, and their advocates, whose interest isn't financial but instead life-and-death personal.

MHPs have resources and power to influence ongoing debate. And they will continue to perpetuate myths, including the canard that advocacy groups have naively and unfairly ganged-up on them to block their aspirations. They will also continue to bemoan recommendations of the MDHHS 298 Facilitation Workgroup that they voted for.

Consumers, families, and advocates bring one thing to the table: the unified voice of Medicaid beneficiaries and their families, whose lives are on the line when it comes the availability and accessibility of quality supports and services for their health conditions.

Where our elected and appointed officials choose to go will speak volumes about Michigan.