Interim Report of the 298 Facilitation Workgroup

Draft for Public Review

Michigan Department of Health and Human Services
December 14, 2016

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 version of the report will include recommendations on changes for policy, integration models and 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 1,000 Michiganders during 44 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 have developed the following interim report to provide an update on the status of statewide discussions and the development of recommendations. The interim report reflects the progress of the workgroup to date. The interim report focuses on recommendations for potential policy changes; the final report will incorporate policy recommendations from the interim report as well as additional recommendations on models, pilots, and benchmarks for implementation.

MDHHS and the 298 Facilitation Workgroup will submit the interim report to the Michigan Legislature by January 15, 2017. MDHHS has posted the interim report for public review. MDHHS and the 298 Facilitation Workgroup will update the interim report based upon the results of public review and will launch the next phase of the process in late January 2017. This will focus on the development of recommendations on models, pilots, and benchmarks for implementation. MDHHS and the 298 Facilitation Workgroup will submit a final report to the legislature by March 15, 2017.

The 298 Facilitation Workgroup has approved 69 policy recommendations for inclusion in the interim report. The recommendations address the following areas: 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; and 13) financial incentives and provider reimbursement. The 298 Facilitation Workgroup also approved the following overarching recommendation.

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.

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Workgroup Participants

Workgroup Members:

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Linda Burghardt	Mental Health Association of Michigan
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Other Workgroup Participants:

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Mission, Vision, and Values

Mission Statement

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."

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. MDHHS and the newly created 298 Facilitation Workgroup will use the values that are identified by the workgroup to guide the development of the Section 298 report. The list of values is included in Appendix 2 of this report.

Background

Description of Current Behavioral Health System in Michigan

In Michigan, behavioral health prevention, early identification, treatment, and recovery support systems are the primary responsibility of the state's mental health and substance use disorder services authorities, which are collectively known as the Behavioral Health and Developmental Disabilities Administration (BHDDA). BHDDA is located within the Michigan Department of Health and Human Services (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, inclusive of outpatient mental health, for individuals with mild to moderate mental health needs through Medicaid Health Plans (MHP) that contract with MDHHS.

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

CMHSP's contract with Prepaid Inpatient Health Plans (PIHP) which, on behalf of MDHHS, serve as the state's publicly-operated managed behavioral health system for Medicaid-funded behavioral health specialty services and supports. PIHPs are also the responsible entities for directly managing Substance Use Block Grant funding and local substance abuse funding. Ten regionalized PIHPs operate throughout the state and contract directly with MDHHS.

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

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 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."

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, ideas, and comments to inform the development of potential recommendations. More than 1,000 Michigan residents participated in Affinity Group discussions during 44 separate meetings.

The number of Affinity Group meetings, participants, and written comments are summarized in Table 1. A list of Affinity Group meetings is included in Appendix 5, and a map of Affinity Group meetings is included in Appendix 6.

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	11	1	1	44
Affinity Group Participants	767	249	48	12	1076
Written Responses	82	16	9	0	107
Estimated Total Respondents*	849	265	57	12	1183

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

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.

Ongoing Process

After the completion of the interim report, MDHHS will collaborate with the 298 Facilitation Workgroup to launch the next phase of the Section 298 Initiative. This phase of the process will involve the consideration of (1) integration models and pilots and (2) benchmarks for implementation. The development of models, pilots, and benchmarks for implementation will build upon and align with the policy recommendations that were proposed in the interim report.

During this phase, MDHHS and the 298 Facilitation Workgroup will collect model proposals from stakeholders for further review and consideration. MDHHS and the 298 Facilitation Workgroup will evaluate the proposed models and identify several models for further consideration. The chosen models will be posted for public review and consideration. MDHHS will host several public forums around Michigan to facilitate a statewide discussion on the different models. Stakeholders will also have the opportunity to provide written comments on proposed models. MDHHS and the 298 Facilitation Workgroup will then update the models based upon public review and identify models that have the most support for potential implementation.

The 298 Facilitation Workgroup will also simultaneously develop benchmarks to support the successful implementation of the recommendations in the report. The benchmarks will address recommendations for policy changes and for potential models.

MDHHS will incorporate the following elements into the final report: 1) the policy recommendations from the interim report; 2) the integration models and pilots that are proposed through the next phase of the process; and 3) the benchmarks for implementation that are developed by the 298 Facilitation Workgroup. MDHHS will submit the final report to the Michigan Legislature by March 15, 2017.

Recommendations for Policy Changes

The 298 Facilitation Workgroup developed the following set of policy recommendations based upon the comments from Affinity Group process. As part of developing the policy recommendations, MDHHS and the 298 Facilitation Workgroup summarized the comments from Affinity Group participants. Summaries of the comments from the Affinity Group process can be found in Appendix 7 (Eligible Populations and Families), Appendix 8 (Providers), Appendix 9 (Payers), and Appendix 10 (Tribal Health Organizations).

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; and 13) financial incentives and provider reimbursement.

The 298 Facilitation 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 298 Facilitation Workgroup also 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.**

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.

Section 1: Coordination of Physical Health and Behavioral Health Services

The coordination of services is critical to 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 sub-sections to address specific topics regarding access to services and continuity of services. These sub-sections 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; (4) the use of Screening, Brief Intervention and Referral to Treatment (SBIRT) as an evidence based practice across encounter points; (5) improved access for justice-involved individuals and veterans; and (6) 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 includes:

- **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 is 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.

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[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. The following recommendation seek to implement a statewide approach for improving the resolution of complaints.

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. Payers also supported an independent centralized entity and noted the potential to minimize duplication, increase accuracy and individual satisfaction, reduce bias, decrease miscommunication, and align complaint processes across physical health, behavioral health and substance use services.

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 take a proactive role in ensuring PIHP and MHP compliance with new federal regulations related to adverse benefit determinations and grievances within these plans.

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 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.)

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[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.

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[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 Medicaid beneficiaries. 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 2016-201717 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 wellbeing. 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), certified community behavioral health clinics (CCBHCs), 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 an MHP, but not more than one).

Section 11: Administrative Layers in Both Health Systems

In Michigan's health care 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 design 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.**

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

Recommendations for Integration Models and Pilots

The interim report does not include recommendations for integration models or pilots. MDHHS will incorporate recommendations for integration models and pilots as part of the final report. MDHHS will collaborate with the 298 Facilitation Workgroup to facilitate a statewide discussion on the development of potential models and pilots. The development of models and pilots will build upon and align with the policy recommendations that are proposed in the interim report.

During this process, MDHHS and the 298 Facilitation Workgroup will collect model proposals from stakeholders for further review and consideration. MDHHS and the 298 Facilitation Workgroup will evaluate the proposed models and identify several models for public consideration. The chosen models will be posted for public review and consideration. MDHHS will host several public forums around Michigan to facilitate a statewide discussion on different models. Stakeholders will also have the opportunity to provide written comments on proposed models. MDHHS and the 298 Facilitation Workgroup will then update the models based upon public review and identify the models that have the most support for potential implementation.

Recommendations for Benchmarks for Implementation

The interim report does not include recommendations for benchmarks for implementation. MDHHS will incorporate recommendations for benchmarks as part of the final report. MDHHS will collaborate with the 298 Facilitation Workgroup to facilitate a statewide discussion on the development of benchmarks. The development of benchmarks will build upon and align with the policy recommendations that were proposed in the interim report. The recommendations for benchmarks will address recommendations for policy changes and potential models.

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

- Appendix 2: Final End Statement and Core Values

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

- Appendix 4: Overall Timeline for the Section 298 Initiative

- Appendix 5: List of Affinity Group Meetings

- Appendix 6: Map of Affinity Group Meetings

- Appendix 7: Summary of Affinity Group Feedback (Eligible Populations and Families)

- Appendix 8: Summary of Affinity Group Feedback (Providers)

- Appendix 9: Summary of Affinity Group Feedback (Payers)

- Appendix 10: Summary of Affinity Group Feedback (Tribal Health Organizations)

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.

- o Persons who receive supports and services should have the support necessary to have healthy relationships
  - o 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.
  - o Real- and full-time coordination of care.

- Highest quality of care, supports and services delivered by a robust, trained and experienced workforce and volunteers.
  - o 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.
  - o 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.
  - o 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.
  - o Prevention and early intervention services can help avoid the need for intense behavioral health services.
  - o Stigma reduction and promotion of community health and wellness.

- Public oversight and accountability to ensure the public interest.
  - o Transparency (access to information, open meetings).
  - o Array of services and supports accountable to the public and the persons and families receiving services.
  - o People with disabilities should not be segregated in communities.
  - o 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.
  - o 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.
  - o People cannot find information about the behavioral health system when they need it.

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

Appendix 3: Diagram of Current Behavioral Health System in Michigan
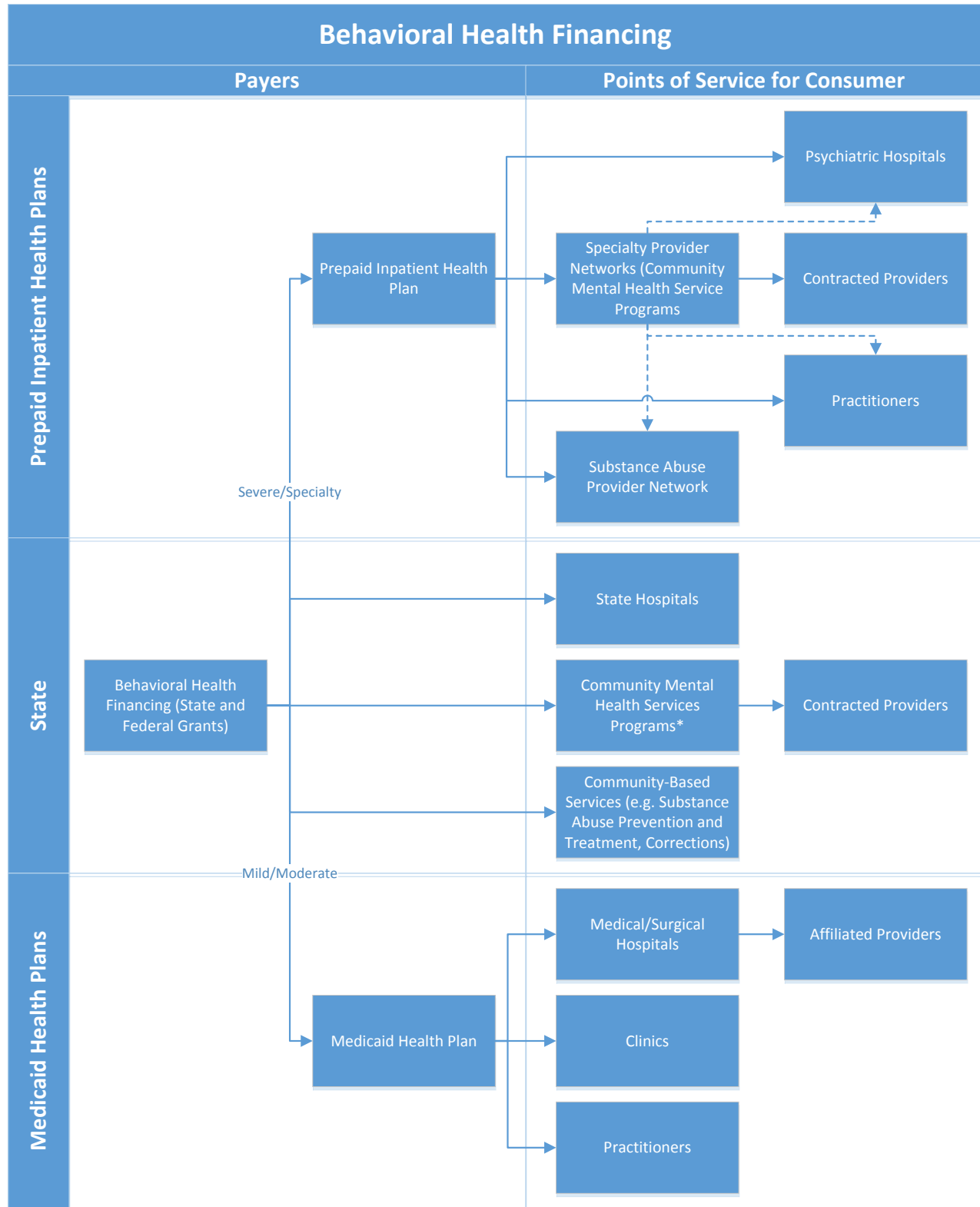
Appendix 4: Overall Timeline for the Section 298 Initiative

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 – February 2017	MDHHS and the 298 Facilitation Workgroup will facilitate a statewide discussion on the development of recommendations for potential financial models and benchmarks.
February 2017 – March 2017	MDHHS and the 298 Facilitation Workgroup will create a set of recommendations on models and benchmarks for the final report. MDHHS will post the report for public review and conduct several stakeholder forums. MDHHS and the workgroup will use the feedback from public review to revise the report. MDHHS will submit the report to the legislature by March 15, 2017

Appendix 5: 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 3, 2016	Eligible Populations and Families	Ann Arbor
November 7, 2016	Providers	Lansing
November 7, 2016	Providers	Maryville
November 8, 2016	Providers	Troy
November 8, 2016	Providers	Midland
November 8, 2016	Providers	Lansing
November 8, 2016	Providers	Lansing

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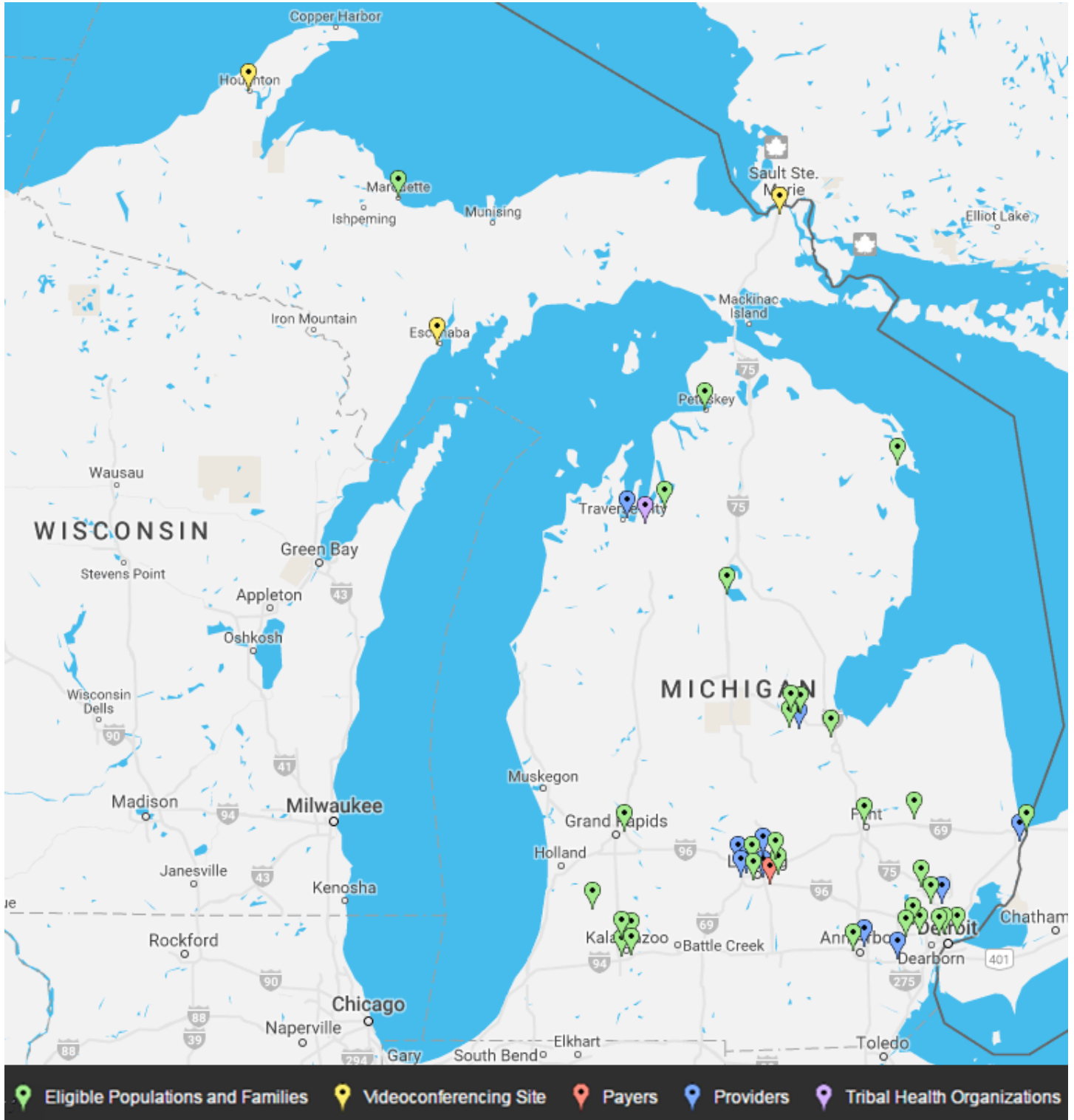
*The Affinity Group meeting for Eligible Populations and Families in Marquette included a videoconferencing option. Individuals and families from three other community mental health service providers teleconferenced into the meeting. These three remote sites are marked on the map as "Videoconferencing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

Appendix 7: 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

Section 1: Coordination of Physical Health and Behavioral Health Services

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.

<u>Section 2: Administration of Complaints, Grievances, and Appeals</u>

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.

Section 3: 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.

Section 4: 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.

Section 5: 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.

<div align="center">Section 6: Workforce Issues</div>

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).

<div align="center">Section 7: Peer Supports</div>

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.

<div align="center">Section 8: Person-Centered Planning and Trauma-Informed Care</div>

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.

<div align="center">Section 9: Health Information Sharing</div>

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.

<div align="center">Section 10: Access to Substance Use Disorder Services</div>

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."[6] 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.

<u>Section 11: Services for Children, Youth and Families</u>

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.

<u>Section 12: Incentives and Outcome Measures</u>

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 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

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

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 8: 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	11
Number of Affinity Group Participants	249
Number of Written Comments	16
Estimated Number of Total Respondents	265

<u>Section 1: Coordination of Physical Health and Behavioral Health Services</u>

MDHHS asked providers several questions about the coordination of physical and behavioral health services. The first question asked providers 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:

- Establish consistency within the system and across systems by streamlining services, processes and procedures.
- Improve and enhance information sharing through the following methods:
  - Standard Consent Form.
  - Standardized electronic medical record or more robust health information exchange.
  - CareConnect360.
- Embed primary care providers into behavioral health settings and vice versa (service-level integration) to ensure co-located, coordinated, and bi-directional care.
- Promote the use of a health home model.

Some participants suggested improvements in financial reimbursements through the following methods:

- Allow for reimbursement for services not currently covered like care coordination, care management, and services covered through the health and behavior codes.
- Use 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:

- Boost education and training at all levels (participant, provider, and health plans).
  - Educate plans and providers on person-centered planning, motivational interviewing, and social determinants.
  - Educate persons served on the importance of care coordination.

The second question asked providers 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.

The third question asked providers for recommendations to improve coordination between behavioral health and primary care providers at points of service. Participants again highlighted the importance of streamlining processes and standardization of care through the following methods:

- Improve access to integrated care settings and provide financial incentives to improve coordination.
- Ensure seamless care transitions by standardizing and sharing processes, billing, contracts, and forms.
- Improve and eliminate barriers to sharing health information.
  - Address health information sharing restrictions in the Mental Health Code.
  - Integrate Medicare and substance use disorder information into the clinical record.
  - Develop and build upon mechanisms for real-time information sharing.
  - Encourage participation of physical health and behavioral health providers in statewide health information sharing efforts.

Participants also reinforced the need for financial solutions that support coordination of care, along with increased education and training:

- Address reimbursement issues that serve as a barrier to coordination (e.g. care coordination, care management, funding for training, etc.).
- Boost education and training at all levels (participant, provider and health plans) to better align culture, language, and understanding.

<u>Section 2: Administration of Complaints, Grievances, and Appeals</u>

MDHHS asked providers 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 the following strategies for improving the administration of complaints, grievances and appeals:

- Improve data collection is needed on grievances and appeals.
- Establish a method for providers to appeal negative actions.
- Improve existing rights offices across state.
- Increase training and possible consolidation.
- Standardize processes between PIHPs and MHPs.

Section 3: Streamlining Processes

MDHHS asked providers for recommendations on streamlining administrative processes, reducing paperwork and creating uniformity across the states. Participants suggested the following strategies:

- Eliminate duplication in administrative functions like credentialing and auditing.
- Utilize contractual mechanisms to clearly delineate requirements and promote additional uniformity across systems.
- Determine best practices and use as a guide to standardize policies, processes, and procedures for MHPs, CMHSPs, and PIHPs.
- Enhance and standardize the technological infrastructure and capabilities across systems.
  - o Consider the potential of universal or statewide systems.

Section 4: Oversight and Administration of Health Care

MDHHS asked providers two questions about the administration and oversight of health care. Providers were first asked what changes to the current system would they recommend be made to improve efficiency and efficacy of the administration and oversight of the CMHSP system. Several participants cited standardization and streamlining of process and reduction of duplication as strategies to improve efficiency and efficacy of the administration and oversight of the CMHSP system:

- Reduce redundancies between CMHSPs, PIHPs, and MHPs.
- Develop uniform processes, procedures and performance metrics with the goal of reducing regulatory requirements.
- Implement value and outcome-based payment models.
- Streamline the audit process.

Providers were also asked to make recommendations to improve access to physical health and behavioral health services. Many of the responses from participants suggested various models for integrating service delivery:

- Allow CMHSPs to provide services to the mild or moderate population.
- Ensure transportation is accessible by improving and aligning transportation policies across systems.
- Increase access to integrated care settings and support these settings with the financial resources needed to assure sustainability.
  - o Consider incentives to improve coordination and individual outcomes.

- Equip providers with the skills or resources to complete behavioral health screenings in the primary care setting.
- Standardize processes, procedures and performance metrics across systems and counties.

Section 5: Uniformity and Administrative Efficiency

MDHHS asked providers several questions about developing uniformity and creating effective quality improvement efforts. Providers were asked to make recommendations to develop uniform administrative, service and other policies, procedures and operational definitions for the entire public behavioral health system. Participants made the following recommendations:

- Create one system to administer the full behavioral health benefit versus bifurcating the system between mild/moderate and severe.
- Standardize policies, processes, procedures and performance metrics across systems.
    - Consider statewide system or, minimally, requirements that are uniform across responsible counties.
    - Alternately, some commenters suggested that geographical differences make uniformity difficult and, potentially, not ideal.
- Review paperwork required of persons served to streamline, reduce unnecessary forms and develop uniform requirements.

Providers were asked to prioritize any of their recommendations. The most significant priorities identified by the participants include:

- Focus on the persons served and improve choice, access, and experience for individuals.
- Promote integration at the provider level.
- Simplify and streamline policies, processes, and procedures.

Providers were asked for recommendations to enhance the uniformity and effectiveness of quality improvement efforts on a statewide level. Participants encouraged the following strategies to promote a statewide level of uniform and effective quality improvement efforts:

- Consider uniform standards and performance measures for CMHSPs, PIHPs, and MHPs. Minimally, these standards should be reviewed to ensure they align and promote outcomes valued in each system.
- Improve coordination and communication across systems in regards to quality improvement efforts and measures utilized by the state to measure performance.
- Use outcomes from pilots and the State Innovation Model to inform delivery system redesign and changes.

Section 6: Governance, Transparency, and Accountability

Providers were asked two questions regarding governance, transparency, and accountability.
First, providers were asked how they would ensure the continuation of a strong individual and family voice (not merely advisory) in governance. Participants made the following recommendations:

- Support continuing with at least one-third representation on CMHSP boards. However, some providers suggested greater representation for individuals on the board.
- Actively recruit individuals and their families to participate in meetings. Steps should be made to facilitate individual participation in meetings if necessary.

Providers were asked for recommendations to foster transparency of information and operations. Participants recommended the following strategies:

- Provide greater access to information. This recommendation includes the streaming of meetings and posting materials online.
- Update recipient handbook and other materials more frequently.
- Strengthen reporting requirement for payers.

Section 7: Coordination at the Point of Service

MDHHS asked providers for recommendations for promoting coordination of care, recognizing that when individuals desire integration, they want it to occur at the point of service delivery. Participant responses centered on the use of financial strategies to:

- Provide flexible funding (i.e. something in addition to fee-for-service payment for specific services) to support local provider partnership/integration including expanding care team membership to include health professionals with multiple areas of expertise or implementing interdisciplinary service planning.

Section 8: Workforce Issues

MDHHS asked providers for recommendations that would promote the recruitment, retention and continuity of quality staff, especially direct care staff and clinicians. Participants provided the following recommendations:

- Provide 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.
- Ensure 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.
- Allow for greater flexibility for provider organizations in the application of disciplinary action to staff as a result of a recipient rights complaint
- Systematically develop strategies that increase engagement, provide meaningful recognition, and reduce the incidence of staff burnout including making paid leave more widely available.

Section 9: Peer Supports

MDHHS asked providers 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. Participant responses highlighted the importance of removing the current barriers to the use of peer supports:

- Provide better pay and incentives for peer support.
- Review billing/reimbursement practices for peer support.
- Coordinate peer supports with an individual's care team.
- Provide localized training should be offered to peer support workers.
- Review evidence-based practice to promote and effectively use peer support.
- Review contract requirements to promote or require use of peer support.

<u>Section 10: Person-Centered Care</u>

MDHHS asked providers two questions regarding person-centered care. Providrs were asked 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 plans:

- Encourage independent facilitation of person-centered plans.
- Review administrative requirements and standards for person-centered plans.
- Re-emphasize pre-planning meeting for person-centered plans.
- Review reimbursement practices for person-centered plans.
- Enable person-centered plans to follow individuals across boundaries.

Providers were also asked for recommendations to promote and improve access to and use of trauma-informed interventions. Participants suggested the following strategies:

- Train providers and others community partners, such as schools and law enforcement agencies, on trauma.
- Follow evidence-based practices in screening for trauma, which may include adverse childhood experiences.
- Promote and fund trauma screenings through MDHHS policy.

<u>Section 11: Health Information Sharing</u>

MDHHS asked providers for recommendations to foster the coordination of care across all provider systems and the sharing of electronic and hardcopy records. Participants identified several points of opportunities for increased access:

- Support greater access to health records between providers.
- Expand access for providers to the Michigan Health Information Network.
- Expand access to admission, discharge, and transfer notifications.
- Provide trainings on privacy laws for individuals who use services and providers.
- Reduce legal barriers to sharing data between providers.
- Reduce cost barriers for technology upgrades for small practice providers.

<u>Section 12: Substance Use Disorder Services</u>

MDHHS asked providers to make recommendations for changes at the state, regional, and local levels to increase the scope and availability of substance use disorder services. Participants offered several strategies including:

- Provide greater access to care to substance use disorder services. Providers were interested in expanding access to medication-assisted treatment and detoxification. Providers also emphasized the importance of increasing access to services at correctional facilities and schools.
- Provide greater provider education and training on substance use disorder treatment.
- Review payment rate and structure for substance use disorder services.
- Increase participation in health information exchange among substance use disorder providers.

Section 13: Services to Children, Youth and Families

MDHHS asked two questions about services for children, youth and families. The first question asked providers for 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 the following strategies:

- Provide early intervention by increasing greater access to care at schools, which includes greater utilization of child and adolescent health centers and federally-qualified health centers.
- Work to actively reduce stigma.
- Review reimbursement practices for early intervention and trauma.

The second question asked providers to offer other recommendations (beyond adolescent pre-crisis) for meeting support and service needs of children, youth, and their families. Participants suggested greater education and coordination among levels of care:

- Provide greater education and training of primary care providers on behavioral health and trauma.
- Improve coordination with an individual's care team.
- Improve coordination with juvenile justice.

Section 14: Incentives and Outcomes Measures

MDHHS asked providers several questions about alternative payment models. Providers were asked to recommend changes to foster the use of alternative payment models (not fee-for-service). Participants suggested some of the following strategies:

- Develop mechanisms for cost savings that are generated as a result of more effective care. 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, providers were asked 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 the following strategies:

- Provide 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, providers were asked 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:

- Adapt 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.

<u>Section 15: Standardizing Behavioral Health Screening, Assessment, and Treatment</u>

MDHHS asked providers 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:

- Develop direct reimbursement mechanisms for screening and intervention services rendered by primary care providers. 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.)
- Provide 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.
- Provide 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 9: 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 (Participants)	
Number of Affinity Groups	1
Number of Affinity Group Participants	48
Number of Written Comments	9
Estimated Number of Total Participants	57

Section 1: Coordination of Physical and Behavioral Health Services

MDHHS asked participants several questions about the coordination of physical and behavioral health services.

The first question asked participants how they would recommend coordinate care for those individuals who want their behavioral and physical health needs coordinated by the CMHSP system. 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.

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 to enhance access to critical information and allow for alerts and outgoing communications. 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 encouraged MDHHS to support the use of innovative reimbursement models such as value-based contracts, shared savings and incentives for care coordination and quality.

Several participants also encourage 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) promoting routine consultations with primary care providers; (2) embedding direct care providers in CMHSPs; (3) providing funding to support the inclusion of nurses on care coordination teams; and (4) promoting the use of wellness visits. A few participants emphasized the importance of breaking down barriers to integration such as NCCI 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.

A few participants highlighted the importance of improving the experience of individuals by supporting community-based living, community participation, and the use of person and family-centered models.

The second question asked participants how they would recommend coordinating care for those individuals who do not want their behavioral and physical health needs coordinated by the CMHSP system. Several participants also encourage the department 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. One participants also encouraged the use of a pilot to inform the implementation of new integrated service delivery models.

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 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 to enhance access to critical information and allow for alerts and outgoing communications. Other participants asked for the department to accelerate Care Connect 360 efforts and extend access to include more providers.

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

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 emphasized the importance of strengthening relationships with providers by enabling direct coordination.

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 emphasized the importance of breaking down barriers to integration such as same day services exclusions.

Some participants encouraged the department to support care delivery reforms by providers. Some of these reforms included: (1) improving behavioral health screening, brief intervention and referral to treatment in primary care settings; (2) improving immediate, same day, and urgent referral participant times at CMHSPs and other behavioral health providers; (3) providing incentives to providers to fully integrate services; and (4) expanding the use of participant-provided training and education on integration.

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.

The third question asked participants how they would improve coordination between PIHPs and MHPs. Several participants 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 encouraged the use of models that include the implementation of shared savings arrangements. One participants also encouraged the use of a pilot to inform the implementation of new integrated service delivery models.

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 emphasized the importance of improving coordination at the point of service. Some of their recommendations included: (1) improving behavioral health screening, brief intervention and referral to treatment in primary care settings; (2) improving immediate, same day; and urgent referral participant times at CMHSPs and other behavioral health providers; and (3) requiring CMHSPs and MHPs to share assessment and care plans.

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. Another participant suggested building upon the experience of the MI Health Link Demonstration.

Several participants highlighted the importance of improving health information exchange. Several participants emphasized the need for greater clarity around guidelines and standards for sharing information between PIHPs and MHPs. Another participant mentioned the need to enable access to alert, discharge and transfer notifications for admissions for substance use treatment. Another participant highlighted the importance of consent management.

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 to enhance access to critical information and allow for alerts and outgoing communications. Other participants asked for the Department to accelerate Care Connect 360 efforts and extend access to include more providers.

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

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>Section 2 Administration of Complaints, Grievances, and Appeals</u>

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

First, participants were asked 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. One participant suggested the use of a peer program. 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.

Second, participants were asked 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.

Section 3: 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

Section 4: Oversight and Administration of Health Care

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

First, participants were asked how they would recommend improving efficiency in the Community Mental Health 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, participants were asked 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.

Section 5: Uniformity and Administrative Efficiency

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

First, participants were asked for recommendations to develop 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.

Section 6: Governance, Transparency, and Accountability

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.

Participants were also asked about 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.

Section 7: 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 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.

Section 8: 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 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 suggested expanding their utilization through changing contracts and billing procedures/codes.

Section 9: 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.

Section 10: Person Centered Care

MDHHS was asked 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 recommended incorporating primary care providers and physical health services in the person-centered plan. Several participants recommended contracting with an independent agency to facilitate the planning process and monitor the system/recommend improvements. Several 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.). Also, several emphasized using training that implements evidence-

based treatment such as standardized assessment tools and Mental Health First Aid. Several recommended improving public awareness about available services. One recommended using an independent agency to monitor trauma-informed interventions. Another recommended adding trauma-informed interventions to licensing requirements.

Section 11: 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. To achieve better coordination of care, almost all participants supported increased use of electronic health records. 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.

Section 12: 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 state level administrative integration, coordinate funding streams and update laws and regulations to address this public health crisis.

Section 13: 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. Again, this includes medical providers, law enforcement and schools. Additionally, efforts should be made to reduce stigma.

Section 14: 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.

<div align="center">Section 15: Standardizing Behavioral Health Screening, Assessment, and Treatment</div>

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 10: 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

<u>Access to Services for Tribal Members</u>

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.

<div align="center">Financing and Reimbursement for Tribal Health Services</div>

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 SAMSHA 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.

<div align="center">Barriers to Service Delivery and Opportunities for Collaboration</div>

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.

<div align="center">Provider Training and Readiness</div>

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.

<div align="center">Data Collection and Aggregation</div>

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.