MINORITY REPORT AND COMMENTS REGARDING

SECTION 298 BOILERPLATE DRAFT INTERIM REPORT TO THE LEGISLATURE

I. Overview

Movement Toward a Comprehensive Model—Why Section 298 Evolved.

Managed care is the predominant financing model for state Medicaid programs, with nearly 40 states contracting with managed care organizations (MCOs) to provide all or some physical health benefits for beneficiaries Although the Medicaid population has a complex array of behavioral and physical needs and high associated costs, many are served in fragmented systems of care with little to no coordination across providers, often resulting in poor health care quality and high costs.

Increasingly states are seeking ways to better coordinate physical and behavioral health services with the goal of improving outcomes and reducing unnecessary utilization. One strategy gaining traction is the move to integrate behavioral health services within a comprehensive Medicaid managed care environment that traditionally covered physical health services only.

More states in recent years have adopted integrated payment and delivery models that cover all or some combination of physical, behavioral health, long-term services and supports (LTSS), and other social supports needs. A rapidly growing number of states are adopting managed care models in which a single entity is responsible for both behavioral and physical health services, thus "carving-in" behavioral health services.

As of January 2016, 16 states currently provide or are planning to offer behavioral health services through an integrated managed care benefit — up from just a handful a few years prior. By combining physical and behavioral health services in a comprehensive managed care arrangement, Medicaid programs can align system incentives and increase accountability for managing a more complete range of services. In doing so, states can provide more seamless care for beneficiaries.

To be sure, administering integrated systems of managed care for high-need beneficiary populations is a complex undertaking. These programs require: (1) specialized clinical expertise at the health plan level; (2) state capacity for robust oversight and monitoring; (3) innovative strategies for advancing whole-person care to address beneficiaries' complex

needs; and (4) mechanisms for achieving and maintaining provider and other stakeholders' support.

Creation of Section 298

With the above commentary as backdrop, the Snyder Administration recommended that Michigan join many of the other states and develop a more comprehensive approach for serving all of the physical and behavioral needs of the Medicaid beneficiary in an integrative manner. Unfortunately, the proposed changed took form in the executive budget for fiscal year 2017 without significant and meaningful prior public discussion and review.

As we know, many interest groups objected to the proposal. This led to a creation of an ad hoc group convened by Lt. Governor Calley. Several representatives of Medicaid Health Plans were represented on this group as well as the Michigan Association of Health Plans. The total membership (in excess of 100) of the Calley Group was dominated by behavioral interest representatives (consumers and providers) and the final "Calley Report" recommendation reflected that bias.

It is important to note that while there was value in the production of the "Calley Report", the legislature was not seeking to endorse the report—and they did not. Rather, the legislature adopted replacement boilerplate to that proposed by the Governor that would inform and guide the legislature on a future path toward integration through MDHHS and the Section 298 Facilitation Workgroup. It is important to note that while the membership of the Facilitation Workgroup is significantly less than the Calley Group, it continues to represent the bias of behavioral health interest. The workgroup consists of twenty-three voting members, with the following make-up:

- three individuals representing private behavioral health providers who currently contract with the existing PIHP and CMHSP financing model
- three individuals representing the existing PIHP and CMHSP financing model
- three state employees
- eight behavioral health advocates
- one Medicaid Health Plan representative
- one Association of Health Plans representative
- one Hospital representative
- one Hospital Association representative
- one representative from the Primary Care Association
- one Tribal representative

It is the provisions of this Boilerplate (Section 298) that the current draft recommendations are based upon. A quick review of the Boilerplate requirements will help the reader understand if the intent of the legislature has been achieved:

Boilerplate Provision	Response	Comment
The department shall work with a workgroup to make recommendations regarding the most effective financing model and policies for behavioral health services	A much smaller group (about 20) than the 100+ Calley Group was convened by MDHHS and met the compositional requirements of the boilerplate. MDHHS had "voting" members on the group as well as staff.	MDHHS determined that the workgroup would make decisions; a voting or consensus process was followed for the most part.
The workgroup shall consider the following goals in making its recommendations: • ***Core principles of person-centered planning, self-determination, full community inclusion, access to CMHSP services, and recovery orientation.*** • ***Avoiding the return to a medical and institutional model of supports and services for individuals with behavioral health and developmental disability needs.*** • ***Coordination of physical health and behavioral health care and services at the point at which the consumer receives that care and those services.*** • ***Ensure full access to community-based services and supports.*** • ***Ensure full access to integrated behavioral and physical health services within community-based settings.*** • ***Reinvesting efficiencies gained back into services.*** • ***Ensure transparent public oversight, governance, and accountability.***	Universal agreement on core principles Total Agreement among group Point of service coordination Part of Mental Health Code Agreement on this point by all Objective of the recommendations Agreement	These principles have evolved in all of managed care and are part of the requirements of the new Managed care rules Many believe point of service is part of the continuum of integration but not end point. Integration provides that single point of accountability
The workgroup's recommendations shall include a detailed plan for the transition to any new financing model or policies recommended by the workgroup	Not Included	Any Transition plan toward integration requires this.
The workgroup shall consider the use of 1 or more pilot programs in areas with an	Not Included….Intent is to solicit for inclusion in	Legislature should

appropriate number of consumers of behavioral health services and a range of behavioral health needs as part of that transition plan.	supplemental report	consider seeking models as well.
The workgroup's recommendations shall also recommend annual benchmarks to measure progress in implementation of any new financing model or policy recommendations over a 3-year period and ensure that actuarially sound per member per month payments for Medicaid behavioral health services are no less than the per member per month payments used for Medicaid behavioral health services in the fiscal year ending September 30, 2017.	Not Included	Funding is tied to legislature and revenue. New rules to implement and the change in National Administration may make this difficult.
The department shall provide, after each workgroup meeting, a status update on the workgroup's progress and, by January 15 of the current fiscal year, a final report on the workgroup's recommendations to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office.	Report/Recommendation are intended to be submitted by MDHHS on or before January 15th.	

The format and the structure of the Draft Report and Recommendations however is based on the Calley Report Design elements and provides a method to link the work of the Calley Workgroup to that of the Section 298 Workgroup.

II. General Commentary of Document

Because of timing and delays in reaching this set of recommendations the draft report that was circulated for public comment **did not include the following**:

- Any proposed new or revised pilot or demonstration model to pursue;
- Any fiscal note that describes the cost and/or savings of any of the recommendations;
- Any discussion regarding operational issues/concerns; and of course
- Any discussion on potential impacts to the overall Medicaid program and thereby these recommendations of federal reform on Medicaid that may be adopted by the Trump Administration.

That does not diminish the value of the recommendations if the reader sees the set of recommendations as a series of consumer driven and designed elements for delivering behavioral

services. In that sense, this is extremely valuable report and the recommendations should be part of the new vision for service delivery by any publicly or privately supported program.

The one clear message from the report's summary of findings from the various stakeholder (affinity group) meetings is that the status quo is unacceptable.

While not discussed in any detail during the workgroup meetings, there was an understanding that there will be significant and dynamic change taking place in Medicaid over the next year—many of the changes were taking place regardless of the national election. However, the future direction of Medicaid is now part of the national discourse. Therefore, we believe that the reader should also be aware of the underlying context of the recommendations as noted in the selection below from the Report—a caveat that MAHP endorses:

> **Preface to Recommendations:** ***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 integration should be 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 are established as part of the Section 298 Initiative. Finally, the workgroup recommends that the State of Michigan make every effort to achieve the goals and fulfill the values that are identified as part of the report regardless of changes at the federal or state level.***

This is a prudent and appropriate statement and may in part define why some of the omission from the expectations stated in the boilerplate we noted earlier, regarding fiscal impact, operational detail and related transition steps are not yet in place. We fully expect there will be significant public debate at the national and state level regarding Medicaid, Medicaid Expansion, and funding of Medicaid. The outcome of this debate may fundamentally change the nature of how Michigan and other states approach the Medicaid program.

We would also argue that reasonable pilot and demonstration projects make more sense in this environment and will encourage our members and those interested groups to make well thought out suggestions for integration and how that may be tested.

The boilerplate clearly calls for consideration of Pilot/demonstration models. **The report does not yet include such recommendations.** It is also unclear at this time how they may be solicited or evaluated for its inclusion and whether that should be a responsibility of the MDHH to do the technical aspects of review and evaluation that go into pilot development and administration.

III. Specific Recommendations and Objections by MAHP

The Michigan Association of Health Plans has been an active member of the Section 298 Workgroup through attendance, participation in discussion and development of the public process, group facilitation of meetings, and voting to establish the final draft recommendations. In taking the position during this process, MAHP and its members have been very consistent due to a board-adopted position on Integration that governs our comments. The principles of the Board position and consistency with the many of the draft recommendations are noted below:

MAHP recommends that Behavioral Integration must be inclusive of:

- Recommended core values developed by consumer Stakeholder process; (Included in the draft Recommendations)
- Requirements for core principles of person-centered planning, self-determination, and recovery orientation; (Included in the Draft Recommendations)
- Provisions to assure continuity of care for consumers of behavioral services during any transition and avoidance of disruption of services and supports; (Included in the draft Recommendations)
- A definition of Integration at both the service and payment level; (Point of service integration included—payment level recommendations for integration are not included)

Under a new MDHHS Integrated Contract, MAHP expects that Medicaid Health Plans will:

- Have a fully contracted behavioral health provider network consistent with the requirements of the Mental Health Code. (Consistent with the draft recommendations)
- Explore innovative reimbursement models for value-based contracts, credentialing, care coordination and quality incentives. (Consistent with the Draft Recommendations)
- Support consumers living in the homes of choice and fully participating in their communities across their life-span (Consistent with the draft recommendations)

MAHP Recommends that MDHHS assure progress toward full implementation of Integration through:

- Annual benchmarks to measure progress toward complete implementation of Medicaid payment and system integration by September 30, 2020; (Boilerplate requirements as well—not included in the draft report)
- Assurance that no less than the resources used for Medicaid behavioral services in fiscal year 2016-2017 continued to be allocated for such purposes on a go forward basis. (Consistent with Boilerplate and Draft Recommendations)
- Promotion of incentives for early adopters. (Not included in draft recommendations)

MAHP Objections to Specific Draft Recommendations

The deliberation of the Section 298 Workgroup was to seek consensus. By definition, that means not unanimous and on some issues there were strong and opposing positions. Early in the

process, representatives from several of the advocate groups took an approach to "walk out" when the "consensus" approach didn't work for them. Others, including MAHP could have chosen the same path to emphasize points—but chose to continue to participate within the workgroup structure. Early discussion also led many to believe there would be a section of the report to reflect a minority view of the recommendations. However, at the end, MDHHS indicated there would be no minority report within the submitted document to the Legislature—but members were absolutely free to submit their views. In that vein, the following specific points are being raised by MAHP regarding several of the report's recommendations.

Objection to Recommendation # 1.1

This section initially proposed to move the "mild to moderate" behavioral benefit currently provided by Medicaid Health Plans to PIHPs and to adopt language that would permanently secure support for a publicly funded and governed delivery system for behavioral services. That approach would fundamentally eliminate any flexibility to consider the use of other delivery systems, such as those administered by Medicaid Health Plans. Further, the initial draft recommendation to move the "mild-moderate" benefit violates one of the sections of the Boilerplate regarding transfer of programs and funds.

Through joint agreement, and in recognition of the overall "preface statement" a recommendation was proposed by MAHP and MACMHB that would minimize disruption and sustain current funding streams for both systems at this time. Further, there was joint agreement, to extend that recommendation to sustaining the public system for NON-MEDICAID services, and support for further point of service coordination. It was understood that the recommendation for movement of mild-moderate recommendation was to be deleted. This recommendation would then give time for the public debate on Medicaid to take shape as well as the selection of various pilots and demonstration models and implementation before final determination of overall administrative models.

> While most of the proposal by MAHP/MACHMB was agreed to, the final version for the draft report extended the recommendation of sustaining a public system for Medicaid as well as "Non-Medicaid". It is this point that is contrary to the agreement reached with MACMHB in our recommendation as this "clarification" would appear to lock-in a public model and limit the future discretion of the Legislature and future administrations.
>
> **Objection to Recommendation # 4.1**
>
> This is a recommendation, curiously labeled, "Protection for mental health and epilepsy drugs" that if implemented will do the opposite. For that reason and more, MAHP opposes the inclusion of this recommendation. To be very clear, we believe that all consumers should have access to the psychotropic and epilepsy pharmaceutical products as they do today. Our objection is related to seeking further legislative provisions to limit the ability of health plans to managed those products. Those supporting this recommendation are very clear that their intent is to extend to all of Medicaid the prohibition on the use of any prior authorization or utilization management technique

employed by those responsible for the management and payment for these products. We believe that position is misguided and not consistent with sound health policy.

The rapid increase in pharmacy costs over the past several years continues to "crowd out" services and benefits that would be otherwise available to meet consumer needs. Extending the current prohibition on prior authorization for all Medicaid programs and services is a budget-busting proposal. Hundreds of millions of dollars have been spend on psychotropic products in Medicaid over the past decade since the limit on prior authorization. There has been no evaluation of this policy, nor a review of future cost exposure. MAHP believes at the very least this assessment should take place and if any legislation should be introduced it should be to assure the provision of all of the pharmacy benefit with the prudent administration of prior authorization requirement. For those currently receiving the pharmacy benefit, this can be accomplished and coupled with "grandfathering" of the current prescriptions for those currently on Medicaid.

Because of the diminishing revenue available to support Medicaid, if the legislature and the administrative do not take action on the overall pharmacy pricing and management, the limited resources that are expected to be available for Medicaid will be consumed by just this benefit. We believe it is time to review this issue in the context of the hundreds of millions of state resources being used (which crowd out other purposes of those dollars). Further our concern is that any further legislative action may enable other pharmaceutical classes from being identified as protected and eliminate health plan ability to manage the benefit.

Objection to Recommendation #9.1 & 9.2 & 9.3 & 9.4

The recommendations in this section focus on several key issues related to health information sharing. We appreciate that this was an issue raised by many consumers and providers during the affinity group meetings. Rightfully so, the state of Michigan must address the ability to communicate "informed consent".

There are strong differences from a consumer perspective (as expressed by the advocate groups) and those representing provider groups and the recommendations did not find consensus. Therefore, we continue to believe this is a problem still in search for a solution and the report highlighted the various views. This section will need further work before any meaningful recommendations can be established.

Objection to Recommendation # 11

The objection by MAHP to the recommendations in this section is not related to those included in the report as they are well stated. The objection relates to the failure of the report to address recommendations that were raised in affinity group meetings, and other submissions regarding the need to have the overall administrative structure of MDHHS organized to manage an integrated benefit.

While the recommendations in this section focused on the all too many layers that consumers find in navigating through the behavioral system they do not address the need for overall assessment to arrive at an administrative simplified structure that will enable the type of state oversight desired and assessment of performance by contracting entities. There is the recognition that MDHHS is still working through the initial reorganization from the merger of MDCH and MDHS but this administrative feature is the nexus to achieving any of the recommendations in the report.

Objection to Recommendation #12.1

As this section of the report surfaced, critical concerns of benefit uniformity appeared. That is, the need to assure that the same Medicaid benefit is being offered across the state and not simply a facet of that some consumers received services and others didn't due to geography. On that point, MAHP agrees.

However, the initial recommendation focused also on an aspect of access to care that inappropriately raised expectations of consumers and would place providers in a defensive posture. This was a recommendation to have "on demand" services—not just for the behavioral program but also for all Medicaid services.

Of course all consumers want to have access for services at the point they need them—however, provider supply, scheduling, and resources are reality. Those consumers in the commercial and Medicare environment face this reality as well and Medicaid – on this point – should be no different.

What is necessary and essential is to assure that urgent and emergency services are available 24/7—that is required under current contracts, that is required under federal rule and that principle should not be questioned. MAHP was successful in amending those recommendations to assure that "on demand" only referred to urgent/emergent care, but felt this issue of sufficient importance to include in this document.

Objection to Recommendation #13.1

The recommendations initially focused on "risk incentives" and fears of the advocate community that incentives would drive providers and payers away from serving needs of beneficiaries. That is, incentives are used to deny services or access to care. The final set of recommendations tied the use of incentives to contract requirements. While MAHP believes this is an appropriate recommendation that we supported, we also believe that several underlying issues continue to be erroneously used. This includes the discussion on "risk".

Medicaid Health Plans operate under "full risk" contracts with the state of Michigan. This means that not only must they accept all the enrollment of Medicaid beneficiaries into their health plans; they must also cover 100% of the cost of their health care.

Performance in this area is rigorously reviewed and monitored through performance contracts and capitation withholds.

To be successful, Medicaid health plans must quickly identify the health care needs and conditions of their enrollee and develops coordinated care management plans. Otherwise, the beneficiary will seek services in the most expensive setting after opportunities for prevention and maintenance are gone.

This is absolutely contrary to the "myth" communicated by several that Medicaid health plans avoid risk. It should be noted that Prepaid Inpatient Health Plans do not have full risk contracts with the state as they are not licensed by the state, do not have financial reserves to guard against insolvency and are prohibited (under the Insurance code) to enter into such arrangements. Instead, MDHHS has shared risk arrangements with PIHPs.

The use of incentive programs and contracts between the state and Health Plans also extends to the same type of incentives built into provider contracts that stress performance objectives. This was a key feature included in the expansion of Medicaid—the Healthy Michigan Plan.

MAHP Summary and Considerations for Next Steps:

1. The Section 298 Report is a good representation by consumers of the failures within the current system. "Status quo not acceptable". However, by all measures, the "report" is not yet a roadmap for integration.

2. We agree with others, including consumer groups who have commented that the report does not address the administrative or financial solutions necessary to take the next steps nor does it give a road map yet for how pilot or model programs can be selected and used.

3. Several specific recommendations are noted by MAHP as either being inappropriate, or through final drafting, created an acceptable—but not preferable approach. We must do better and MAHP encourages the Legislature to consider the MAHP commentary on those points.

4. As others will do, MAHP is encouraging members to communicate to MDHHS and the legislature proposed models and pilots. This is healthy and part of an innovative phase that should be embraced. We have seen several of the proposals from members and are encouraged by the direction and comprehensive of approach as we encourage the legislature to view them in that direction as well.

5. The preferred future role for the Section 298 workgroup is to recommend a common format or template for organizations to submit model/pilot proposals. Once the pilot/models have been received by the MDHHS within a prescribed

time frame, they should be included in the second report submitted by MDHHS to the Legislature. Neither the MDHHS or the Section 298 workgroup should screen or eliminate for consideration any proposal submitted at this time.

6. It is recommended that the Legislature create incentives for "early adopters" in the approval of models/pilots that include system and payment integration as well as clinical integration.

7. MAHP will collaborate with others in working through the dynamics of new Medicaid mega rule, Medicaid payment reform, and population health initiatives and will encourage a healthy dialogue with the legislature on the future of Medicaid. This will start with a "Medicaid 101" series in early February that MAHP is sponsoring and hosting at the State Capitol. All of these individually and collectively will influence future delivery of Medicaid and the behavioral benefit within Medicaid.

8. Finally, while no one wants to repeat the countless sessions that took place by the Section 298 workgroup, there has been much goodwill that has been generated by this process. It is important for dialogue to continue into the future in some sustained fashion and foster the change that must take place.