

Behavioral Health Section 298 Workgroup

Final Report

July 2016

INTRODUCTION

At the request of Lt. Gov. Brian Calley, the Michigan Department of Health and Human Services (MDHHS) convened the Behavioral Health Section 298 workgroup for five meetings between March 30, 2016, and June 22, 2016. More than 120 stakeholders were invited to participate in the workgroup. These stakeholders represented individuals in service and their advocates, as well as various organizations, including community mental health service providers (CMHSPs), prepaid inpatient health plans (PIHPs), Medicaid health plans (MHPs), behavioral health providers, statewide advocacy organizations, and tribal nations.

The purpose of the workgroup was to help provide MDHHS with information that will help it with the design of a strengthened system that fulfills the following 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 health¹ 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.”

The following final report offers a list of key points about the workgroup’s efforts, an overview of the workgroup process, and MDHHS’ next steps related to Section 298 and the public behavioral health system. The items created through the workgroup process—including the core values, recommended boilerplate modifications, and design elements—are included as appendices at the end of this report.

KEY POINTS

- The desired End Statement defines the behavioral health system’s target populations, uses a set of core system values to guide its work, and assumes the World Health Organization’s definition of health.
- A diverse set of stakeholders participated in the process, representing individuals in service and their advocates as well as numerous organizations.
- Through a consensus voting process, the workgroup developed:
 - A set of core values that a better system should embody
 - Replacement concepts and language for MDHHS and the Michigan Legislature to consider in its Section 298 boilerplate language for the FY 2017 budget, many of which were subsequently adopted by the legislative conference committee
 - Design elements for a reimagined behavioral health system, including those related to service delivery, administration and oversight, and payment and structure
- MDHHS will continue to work with multiple stakeholders to strengthen its public behavioral health system in an effort to reach its desired End Statement.

¹ 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.

WORKGROUP PROCESS

Each workgroup meeting was led by Lynda Zeller, deputy director for MDHHS' Behavioral Health and Developmental Disabilities Administration, and facilitated by Peter Pratt, president of Public Sector Consultants (PSC). A Facts Group was created and met separately to identify background information to the workgroup. MDHHS put all information related to the Section 298 workgroup on a publicly available website (www.michigan.gov/Stakeholder298), including background information identified by the Facts Group and the materials for each meeting (agendas, presentations, and summaries).

Decisions by the workgroup were reached by consensus, defined as approval by two-thirds of the attending members. Each participant received red, yellow, and green notecards, which were used to assess consensus. A green card meant total approval of the item being discussed, a yellow card meant approval with reservations or questions ("I can live with it"), and a red card meant the person could not support that item at all. Two-thirds approval was reached through a combination of green and yellow cards, not through green cards alone.

Over the course of the five meetings, the workgroup reviewed and revised a list of core values, identified aspects of the behavioral health system that are working well and those that are not working well, proposed recommended changes to HB 5274 Section 298 boilerplate language for the FY 2017 budget, developed a set of design elements to consider in a redesigned behavioral health system, and made recommendations to MDHHS on how the process should continue.

NEXT STEPS

The final FY 2017 budget boilerplate language, which passed the House and Senate in early June, requires MDHHS to collaborate with the workgroup to submit a report by January 15, 2017, that will include a recommendation on how to implement behavioral and physical health service integration. Four MDHHS staff members—Farah Hanley, Elizabeth Hertel, Chris Priest, and Lynda Zeller—will form an executive policy group that will report directly to Nick Lyon, the director of MDHHS. The group will draft the final report required in the boilerplate language, but all stakeholders will have the opportunity to provide their input before recommendations are finalized and submitted to the Legislature by the January deadline. The workgroup, however, approved a motion that requires the group responsible for drafting the report to include consumers, family members, advocates, and providers, along with the MDHHS staff.

In addition to forming an executive policy group, MDHHS will set up three small external response groups representing three different stakeholder categories: consumers and their families; providers; and state association representatives. The workgroup also approved a motion recommending that the process going forward will include federal and state recognized tribal communities, and represent as broadly as possible the racial and ethnic diversity of Michigan. Phil Kurdunowicz from the MDHHS Office of Policy will act as a liaison between the internal executive policy group and the external response groups.

In order to ensure transparency, the Section 298 website (www.michigan.gov/Stakeholder298) will be maintained with new information uploaded as it becomes available, and the listserv used during the Section 298 workgroup meetings will continue to be used to send out information and to get valuable feedback from the larger workgroup.

Appendix A: Core Values

The following list of core values were agreed upon through the consensus process at the April 11, 2016, meeting. The core values are listed in no particular order.

- 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. The older youth are, 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 too often who and what are in a person's life.
- Full community inclusion, engagement, and participation reflecting individuals' desires
- Meaningful participation and engagement defined by the person (including education and employment and choice of residence), ensuring that each individual reaches her/his fullest potential
 - People should be supported to gain and maintain meaningful integrated employment at competitive wages.
 - Integrated educational opportunities with needed supports
 - Business ownership and self-employment
- Positive outcomes for the person
 - When children are in services, the outcomes are often family-based.
 - Outcomes- and data-driven system based on evidence or best practices
- Individuals' satisfaction with care
- Community-based
 - All services and support are local, with strong collaboration among organizations and people delivering supports and services.
 - Community is defined as including tribal nations
 - Providers should be community-based, with behavioral health and provider leadership coming from local communities.
 - People have choice of home and community-based services that are consistent with state and federal rules.
 - Community is defined as inclusive of where people choose to live, work, go to school, play, and worship. It encompasses the elements of daily life that an individual chooses to participate in and should embrace race, ethnicity, faith, gender, age, LGBTQI status, and all other subcategories of our population.

- Community-based should reflect the unique ability of Michigan communities to define and build supports and services that address community- and person-defined needs and expand a community's capacity to nurture and support its members.
- Linguistic and cultural competence and relevance (rural, urban, race, ethnicity, gender, faith, age, LGBTQI status, and all other categories of the population) to assure that all community members are well served.
 - All cultures are of equal value and merit equal respect
 - The system need to recognize, work with, and respect tribal nations
- Optimal availability and access to a full array of effective care driven by people's needs and desires
 - Individuals' need for the level and frequency of services must be considered (sufficiency).
 - There must be a community safety net for vulnerable persons
- Availability of a coordinated, seamless, trauma-informed system of supports and services that integrates all care for the whole person
 - Coordination has to focus on the whole person, which is more than physical health and behavioral health services: social determinants of health, social supports and services—anything a person needs to be successful. For example, people may need help with finding housing, getting a driver's license, or applying for insurance, among other services.
 - Persons who receive supports and services should have the support necessary to have healthy relationships
 - The integration of whole person care can be best achieved when the model of care supports linkages among physical, behavioral, and social elements and promotes optimal health.
 - Real- and full-time coordination of care
- Highest quality of care, supports, and services delivered by a robust, trained, and experienced workforce and volunteers
 - The workforce should be well trained, well compensated, and honored for their work.
- Invest in peer supports and peer-led organizations and recognize their value
 - Peer supports are a growing and important group of professional providers. People are often willing to share information with their peer supports that they would not share with their clinicians.
 - This value should include the use of recovery coaches, peer support specialists, peer-led programs and organizations, and parent support partners.
- Focus on prevention and early intervention
 - Prevention and early intervention services can help avoid the need for intense behavioral health services.
 - Promotion of community health and wellness and stigma reduction
- Public oversight and accountability to ensure the public interest
 - Transparency (access to information, open meetings)
 - Array of services and supports accountable to the public and the persons and families receiving services
 - People with disabilities should not be segregated in communities
 - There should be community engagement through representation of persons or parents and caregivers in publicly funded health care systems on the board/governance of any managing entity
 - Serves as social safety net for the community

- Maximize percent of invested resources reaching direct services
 - Efficient and effective delivery of services and supports from providers and administrators should produce gains that remain in the system and go to providing services and supports to people.
- Readily available information/outreach about care, services, and supports
 - People cannot find information about the behavioral health system when they need it.
- Equity of care, services, and supports across the state
 - The array of services and supports available should be consistent across counties
 - Policies and procedures related to authorization of supports and services should be consistent across counties
 - Where you live should not determine which Medicaid-funded or Mental Health Code required services and supports you receive

Appendix B: Boilerplate Modifications

The Section 298 workgroup voted to use the original House subcommittee (HB 5274) Section 298 as its starting point its discussion about boilerplate language. The workgroup then recommended several modifications through a consensus voting process during the May 19, 2016, meeting. Many of these recommended changes were subsequently adopted by the legislative conference committee.

The original House subcommittee language for HB 5274 Section 298 is provided in its entirety below, followed by the workgroup's consensus-based recommended changes, which are organized by HB 5274 subsection. There were no recommended modifications for HB 5274 subsections (4) and (5).

ORIGINAL HOUSE SUBCOMMITTEE (HB 5274) SECTION 298

- (1) The department shall work with a workgroup to make recommendations regarding the most effective financing model and policies for 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, the Michigan Association of 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, 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.
- (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 in order to prevent current customers of behavioral health services from experiencing a disruption of 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 department shall provide, after each workgroup meeting, a status update on the workgroup's progress and, by December 1 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, and the state budget office.
- (5) 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.

CONSENSUS-BASED MODIFICATIONS

Stakeholders approved the following changes through the consensus process during the May 19, 2016 workgroup meeting.

Overall Modifications

CHANGE: Replace the word “consumer” with “INDIVIDUAL” throughout the boilerplate language.

Modifications to Subsection (1)

Stakeholders approved the following edits to the language for subsection (1), addressing the workgroup’s overall charge:

CHANGE	The department shall work with 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.
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Modifications to Subsection (2)

Stakeholders approved one change and three additions to subsection (2):

CHANGE	(a) Core principles of person-centered planning, self-determination, FULL COMMUNITY INCLUSION, ACCESS TO CMH SERVICES, and recovery orientation.
ADD from Senate language (SB 789); approved at April 27 meeting	(D) INCREASE ACCESS TO high-value COMMUNITY-BASED SERVICES CONSISTENT WITH THE CORE VALUES OF THE WORKGROUP AND RESIDENT CHOICE OF PROVIDER. (E) INCREASE ACCESS TO INTEGRATED BEHAVIORAL AND PHYSICAL HEALTH SERVICES WITHIN COMMUNITY-BASED SETTINGS.
ADD	(F) REINVEST EFFICIENCIES GAINED BACK INTO SERVICES.
ADD	(G) ENSURE TRANSPARENT PUBLIC OVERSIGHT, GOVERNANCE, AND ACCOUNTABILITY.

Modifications to Subsection (3)

Stakeholders approved the following changes and additions to subsection (3), organized in two categories. The first category, “Senate Language,” replaces subsection 3 with language from the Senate version (SB 789), but also makes changes to the Senate version. The second category addresses pilots.

Senate Language (SB 789)

<p>REPLACE CHANGE (from Senate language in SB 789)</p>	<p>BY FEBRUARY 1, 2017, the workgroup shall submit a report to the senate and house appropriations committees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office detailing a proposal to enhance services to persons currently eligible for services provided by PIHPs, CMHSPs, and the Medicaid Health Plans through the Medicaid mental health services, Medicaid substance use disorder services, general fund appropriation, and Healthy Michigan plan – behavioral health and autism services lines and reform payment processes with the result of more money going to high-value patient care. AS PART OF THE REPORT THE DEPARTMENT SHALL CONDUCT AN ADEQUACY STUDY TO IDENTIFY ANY UNMET NEED AND GAPS IN THE CURRENT FUNDING AND SERVICE STRUCTURES. IN ADDITION TO THE ADEQUACY STUDY, the report must SHALL include, but is not limited to, proposals on how to do the following:</p> <ul style="list-style-type: none"> (a) Ensure full access to community-based services and supports. (b) Ensure full access to integrated behavioral and physical health services within community-based settings.
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Pilots

<p>ADD</p>	<p>The workgroup shall consider THE EXPERIENCE OF PARTICIPANTS WITH AND EXISTING DATA ON THE MI HEALTH LINK PROJECT AND OTHER POTENTIALLY RELATED PILOTS.</p>
<p>CHANGE</p>	<p>The workgroup shall consider the use of one or more ADDITIONAL pilot programs WITH WILLING PIHP AND MHP PARTNERS in areas with an appropriate number of consumers of behavioral health services, and a range of behavioral health needs AND CHRONIC CO-MORBID PHYSICAL HEALTH CONDITIONS as part of that transition plan.</p>

Appendix C: Design Elements

The workgroup, through small subgroups, developed and presented their preferred design elements at the May 19, 2016, meeting. Between June 2 and June 15, workgroup members voted online for (a) the five design elements that they thought would best reach the desired end statement and (b) two elements that would least move the system towards its desired end statement. Seventy-two workgroup members participated in this online voting. The entire list of elements was sent to the workgroup, along with the number of votes for and against each item, with the elements that received votes from more than 10 percent of those voting (i.e., eight or more votes) in bold. In the new listing, design elements were organized by theme (e.g., person-centered care, service integration) rather than by small group category (delivery, administration and oversight, payment and structure), as several elements crossed categories.

During the June 22 workgroup meeting, members voted first by theme on each of the bolded elements, and then members were able to request a vote on any unbolded element under that theme. Members were able to provide clarification about the design elements. Using green, yellow, and red voting cards, members voted for as many design elements as they wanted to. Design elements achieved consensus if they received at least two-thirds of the green and yellow cards from the workgroup members present. This created three sets of design elements:

- Those that received more than 10 percent of the vote in the online vote *and* received a consensus vote during the workgroup meeting. These design elements are bolded below under Consensus Design Elements.
- Those that did not receive more than 10 percent of the online vote, but *did* receive a two-thirds consensus vote during the workgroup meeting. These design elements are listed in unbolded text under Consensus Design Elements.
- Those that were developed and presented as preferred design elements by the small groups during the May 19 workgroup meeting, but did not receive two-thirds of the vote from the larger workgroup during the June 22 meeting, regardless of whether or not they received more than 10 percent of the vote during online voting. This group of elements also includes those that were not requested by a member for a vote during the June 22 meeting. These design elements are provided under Other Design Elements.

CONSENSUS DESIGN ELEMENTS

The following design elements received consensus votes from the workgroup members during the June 22 workgroup meeting. Sixty-four people participated in the voting, requiring 42 yellow and green cards to pass. The bolded items are those that also received more than 10 percent of the online vote, when members could only vote for five items. The design elements are divided into the three categories: service delivery, administration and oversight, and payment and structure. Where clarifying information was offered by a workgroup member, it is provided in italics. The theme of each element is provided in parentheses.

Service Delivery

- **Integrate at the level of the person needing treatment or services (i.e., deliver services when and where they are needed and provide care coordination.)** (Service Integration)
- **Require all providers to coordinate care with other providers, regardless of the health system or who is paying for the services. Coordinated care should use a statewide standard release form between physical health and behavioral health (including substance use disorders [SUD]) to allow the individual receiving services to agree and consent to information sharing. Coordinated care needs to treat the whole person, no matter their needs, which may change over the course of**

treatment. *This should not supersede an individual's privacy rights, if he/she opts to not share his/her information with others.* (Service Integration)

- **Ensure that person-centered plans (PCPs) are developed with integrity. *The plan should be developed based on the needs, hopes, and dreams of the consumer, not on the resources available, staff or financial, to implement it.*** (Person-Centered Care)
- **Provide person-centered care coordination supports to ensure connection to as well as provision and utilization of needed and desired services to promote a good quality of life as defined by the person.** (Person-Centered Care)
- **Workforce: Recruitment and retention of a high-quality workforce through investment in professional development, adequate compensation, appropriate credentialing, scope of practice, and career ladders.** (Workforce)
- **Elevate peer supports and peer voice as a core service and include this in all service delivery options, including planning, prevention, and early intervention. Peer supports should be offered at intake in the initial authorization of services.** (Access to Services)
- **Person-Centered Planning: Shared development of an integrated care plan from the beginning, in an evidence-supported, trauma-informed system of care. *A trauma-informed system of care includes those who receive services and providers who may be traumatized by the work they do.*** (Person-Centered Care)
- **Offer individualized, person-centered care plans for everyone, regardless of ability or illness.** (Person-Centered Care)
- **Educate behavioral health and physical care professionals to enhance their knowledge of people-first language, person-centered care principles, and trauma-informed care.** (Person-Centered Care)
- **Certify and adequately compensate direct care staff. *Direct care staff refers to anyone who does direct care work. Certifications could provide protections to direct care staff who work in a non-licensed settings and would provide greater assurance to individuals that direct caregivers will be able to perform the work needed in their homes.*** (Workforce)
- **Consider a certification process for direct care staff for specialized services with training and wages that are commensurate.** (Workforce)
- **Capacity: Local and rapid access to all levels of care, including emergency, intermediate, long-term, and step-down care, in keeping with full mental health parity with appropriate efficiencies from integrated electronic health records (EHRs) and telehealth.** (Access to Services)
- **Increase scope and availability of SUD services to all persons at all sites.** (Access to Services)
- **Increase early intervention services (i.e., physical health, SUD, trauma, mental health) for adolescents prior to crises occurring.** (Access to Services)
- **Implement and incentivize outcome-based service delivery models rather than encounter-driven service delivery models.** (Other Service Delivery)
- **Standardize behavioral health screening, assessment, and treatment in primary care.** (Other Service Delivery)

Administration and Oversight

- **Carve in physical health services to the community mental health service providers (CMHSPs) for people with behavioral health and physical health care needs.** (Administrative Structure)
- **Have an independent, state-level entity for all grievances, appeals, and rights complaints of CMHSPs and MHPs service applicants and recipients.** (Administrative Structure)

- **Retain state administration of all Medicaid mental health and epilepsy drugs.** *The state categorizes mental health drugs in this way; it is not meant to indicate a preference for one type of mental health drug over others.* (Administrative Structure)
- **Create savings in administrative costs by streamlining administrative requirements, reducing paperwork, and providing uniform training. Redirect those funds into the services to individuals.** (Savings Reinvestment)
- **Implement electronic sharing of information between agencies in order to ensure smooth transitions for individuals receiving services across counties and statewide.** (Other Administration)
- Evaluate the value of multiple tiers of administration and oversight (i.e., the state, prepaid inpatient health plans [PIHPs], regional intermediary administrators [e.g., Wayne and Oakland Counties], and local administrators) to guarantee access and address unmet need. (Administrative Structure)
- Develop uniform policies, procedures, and operational definitions for the entire public behavioral health system. (Administrative Structure)
- Find a way to standardize administrative functions without diminishing services (e.g. credentialing crisis line, training, rates). (Administrative Structure)
- Ensure efficiencies and savings are reinvested in the system. *The “system” means service delivery.* (Savings Reinvestment)
- Streamline paperwork and administrative requirements to reduce administrative burdens. (Paperwork and Reporting)
- Include geographic, consumer, and provider representation to ensure public oversight is tied to local communities. (Governance Structure)

Payment and Structure

- Maximize the use of community resources to ensure efficiencies with community mental health (CMH) funding. For example, learning to cook can be achieved through outreach to a community college, rather than hiring a nutritionist. (Funding Flexibility)

OTHER DESIGN ELEMENTS

The remaining design elements below are those presented by the small groups during the May 19 workgroup meeting, but did not receive a consensus vote during the June 22 meeting, regardless of whether or not they received more than 10 percent of the online vote. These are organized into the three categories: service delivery, administration and oversight, and payment and structure. Clarifying information about a design element is provided in italics, when available. The theme of each element is provided in parenthesis.

Service Delivery

- Increase colocation and other models of integration at the service provision level (i.e., SUD, physical health, mental health, and social services). Require this integration of all payers. (Service Integration)
- Provide, system-wide, 1) independent facilitation of PCPs—independent of the provider network and independent of the budget; 2) independent case management that will find the most efficient ways to deliver independent facilitation of the PCP; 3) PCP that follows the person. (Person-Centered Care)
- Allow the financial process to follow the PCP. (Person-Centered Care)

Administration and Oversight

- Restructure the PIHP system to include three to five PIHPs. Create regional Offices of the Inspector General with investigative and subpoena powers. (Administrative Structure)

- Create a rewards-based system allowing departments that are creating savings to redirect those savings into improving services. (Savings Reinvestment)
- Ensure compliance with state and federal regulations through the use of standardized reporting, rules, and regulations. This will help eliminate duplication in those items, as well as eliminate non-value-added services. (Paperwork and Reporting)
- Streamline the quality reporting process and ensure timely access to performance monitoring data across the system. (Paperwork and Reporting)
- Restructure the governance board appointment process to reduce conflict and increase competence. *This is intended for PIHP and CMH boards to look at conflicts and the level of competence needed to be an effective member of the board.* (Governance Structures)
- Provide oversight to ensure that supports around the individual are based on self-determination with benchmarks for living skills and skill development. (Governance Structures)
- Align behavioral health and physical health care requirements. This requires creating mechanisms for shared costs and shared savings and expanding integrated health information systems. (Other Administration)
- Ensure that safety net protections are in place, in part, by maintaining mechanisms for horizontal or cross-system planning. (Other Administration)

Payment and Structure

- Utilize one integrated system per enrollee for payment, benefits, and administration for physical and behavioral health, managed by one entity that holds the contract with the state. This system should include:
 - A standard integrated Medicaid fee schedule that covers both behavioral health and physical health payments to providers, regardless of who provides the service;
 - Direct contracts with local, county partners and public entities, including CMHs, local health departments, and provider groups;
 - A baseline fee for service with reimbursement and value-added services, such as quality bonuses, delegated credentialing, utilization efficiency, risk sharing, care coordination, and network management. (System Integration)
- Develop an integrated system per enrollee that is made up of a number of parties that have specialized managed-care expertise that is tightly coordinated. This would be similar to the current system but with better coordination. This system would include:
 - A standard integrated Medicaid fee schedule that covers both behavioral health and physical health payments to providers, regardless of who provides the service;
 - Direct contracts with local, county partners and public entities, including CMHs, local health departments, and provider groups;
 - A baseline fee for service with reimbursement and value-added services, such as quality bonuses, delegated credentialing, utilization efficiency, risk sharing, care coordination, and network management. (System Integration)
- Create a financing model that recognizes the needs of each population (any mental illness, serious emotional disorders, intellectual and developmental disability, and SUD), the severity of the individual's diagnosis, and the individual's outcomes. Refer to the financing model that was used, before managed care began (1990–2003), which used a case rate instead of fee-for-service payment. (Funding Flexibility)
- Employ a flexible financial system that can adjust to a person's changing needs. (Funding Flexibility)
- Ensure that funding mechanisms support desired local or culturally-based practices, even if not an evidence-based practice or covered by Medicaid. (Funding Flexibility)

- Ensure that payment mechanisms reflect ability to identify any unmet needs for specific populations. (Funding Flexibility)
- Establish incentive and penalty contracts to ensure integrated care through value-based design contracts. (Other Funding)
- Incentivize a payment system that places primary care elements in behavioral health treatment settings. (Other Funding)
- Promote coordination of services and appropriations of health, human services education, and corrections, as is done in Massachusetts' model. (Other Funding)
- Utilize a condition-based alternative payment methodology that is reflective of services and costs, and which covers both behavioral and physical health care needs. (Other Funding)
- Hold the payment methodology accountable to local communities and the individual and families being served. (Other Funding)