**MPA Advocacy Update – October 2017**

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# Integrating Medicaid Physical Health and Mental Health Services in Michigan: The Section 298 Process and Its Aftermath

## The Stakeholder 298 Process

Early in 2016, Gov. Rick Snyder proposed boilerplate language in Section 298 of the Fiscal 2017 budget that aimed to integrate Medicaid physical health and mental health services by shifting mental health funding and service delivery to private Medicaid HMOs, which were already managing physical health care for Michigan's Medicaid recipients. While there was widespread agreement about the merits of integration, the boilerplate came as a shock to stakeholders who, unlike in previous years, were not involved in the crafting of this budget language.

In the face of strong objections to the language in Section 298, Lt. Gov. Brian Calley (himself the parent of an autistic child, and a contender for the Governor's seat) convened a "Stakeholder 298 Work Group" charged with clarifying the core values for MDHHS's service delivery, recommending improved boilerplate language to the Legislature, and proposing design elements for an improved, more integrated system for delivering public mental health/substance use/developmental disability services. Thanks to the efforts of MPA's leadership, our Association had a seat at the table, along with over a hundred other stakeholders from a wide array of constituencies.

The Stakeholder 298 Work Group met five times during the spring of 2016. The meetings were chaired by Lynda Zeller, MDHHS's Deputy Director for Behavioral Health, and were facilitated by Peter Pratt of Public Sector Consultants; in addition, Lt. Gov. Calley attended two of the meetings. The process followed a loosely defined consensus model, and the stated expectation was that this consensus model would drive all end products to the Legislature.

Many of the work group's products can be found on HHS's website.[1] As MPA's representative to the work group, I can attest that it was a privilege to be part of this diverse, passionate and incredibly hard-working stakeholder group that reached strong consensus-based decisions on a comprehensive set of proposals to the Legislature. The overwhelming agreement in this initial work group was that, for this Medicaid population, physical health services should be integrated into existing behavioral health settings (known as Prepaid Inpatient Health Plans, or PIHPs), and not the other way around.

[1] http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_76181---,00.html

The Legislature accepted the initial report of the Section 298 work group and put any changes to Medicaid mental health funding on hold pending receipt of the subsequent work groups' final report.

Following the five stakeholder meetings that I attended, the next phase of the process involved a "298 Facilitation Workgroup,"[2] which was tasked with developing official recommendations for improving the coordination of physical health and behavioral health services for MDHHS to submit to the Legislature. This phase included affinity group meetings statewide, and opportunities to submit pilot program models that addressed the end goals and core values delineated by the original work group.

**The 298 Workgroup Final Report to the Legislature**

MDHHS issued an interim report (subject to public review and comment) in January 2017, and a Final Report to the Legislature on March 15, 2017.[3] The report's overarching recommendation was that future state policymaking on physical and mental health financing and integration should be informed and guided not by ideology but by the goals and values of the work group and – importantly – by the results of demonstrations and pilots that would compete with each other to show which models would yield the best results in health outcomes and finances alike.

In keeping with these recommendations, the final report included proposals for 42 unique pilot projects. Of these, the vast majority were submitted by Community Mental Health and other non-profit entities, while 10 were submitted by private health plans.

The proposals coming from the public/non-profit sector tended to have a granular understanding, based on decades of experience, of the needs of the populations they served. They invoked as guiding principles such modern behavioral health concepts as recovery, resiliency, system-of-care supports, person-centered planning, and self-determination. They referenced the unique challenges of, say, their rural populations. They spoke of the need to address the social determinants of health through collaboration with housing, transportation, educational, and employment agencies. They described how pursuing partnerships with such entities, as well as with private agencies, would allow them to focus together on defined high-risk, high-cost individuals, and to develop innovative, flexible supports leveraging the resources and expertise of all the partners. They proposed that a comprehensive set of primary care services be carved into the existing CMH system. They promised to partner with key representatives to form a Governance Committee chaired by public entities.

The proposals coming from the private health plans appeared to recognize the experience and expertise of the current PIHPs and proposed contracting with them for delivery of

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[2] http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_76181_78071---,00.html

[3] http://www.michigan.gov/documents/mdhhs/Final_Report_of_the_298_Facilitation_Workgroup_-_Version_for_Publication_554605_7.pdf

care, but proposed combining the 10 existing PIHPs into one super-agency. The health plans emphasized their experience in population-based care management, and on financial management and oversight. Blue Cross Complete, for example, noting that 25% of Medicaid enrollees have co-existing behavioral health and/or substance use disorders, argued that carving behavioral health care into their current physical health care programs would give practitioners a more complete picture of patients, and would improve efficiencies by making services more uniform across geographic regions and by instituting a standardized statewide formulary for medication management. Blue Cross Complete predicted improved health outcomes based on streamlining the financing model and enabling the health plans to cover the full range of services and supports. Their proposal called for MDHHS to pay the Medicaid Health Plans an all-inclusive per member per month capitation rate, and they said they would collaborate with the PIHPs for the provision of care. While this proposal invoked similar models in other states, it acknowledged a learning curve in several categories, including workforce development, which was a key value in the original work group report.

In brief, the proposals from the public and private sectors used different lenses. The former used the lens of the nuts and bolts of providing care to high-complexity patients, and the latter used the lens of financing. Regardless, the great beauty of these 42 proposals was that they offered the legislature a rich array of choices from which to "seed" a true marketplace competition.

**Responses to the Workgroup Report**

In the aftermath of the interim report, stakeholder advocacy efforts commenced. The Michigan Association of Health Plans, representing the private insurance companies, issued a dissenting "minority report," arguing against the work groups' consensus and lobbying for the privatization of Medicaid mental health services. To many members of the work groups, this action dishonored the letter and spirit of the consensus decisions that were intended to inform the legislature.[4]

Kevin Fischer, president of the Michigan chapter of the National Association for the Mentally Ill (NAMI), voiced his concerns about this in a Michigan Radio interview in February 2017.[5] The Michigan Association of Community Mental Health Boards issued advocacy talking points encouraging the legislature to honor the 298 process. And Fred Cummins, the director of the Association for the Mentally Ill in Oakland County, issued a position paper that he submitted to the Legislature. Michigan Psychological Association endorsed Mr. Cummins' statement.

[4] http://www.crainsdetroit.com/article/20170126/NEWS/170129868/mental-health-organizations-hit-back-on-hmo-plan-for-reform

[5] http://michiganradio.org/post/insurers-move-control-mental-health-care-if-they-don-t-hear-voice-people

**Time Line of Subsequent Events**

Following receipt of the final 298 report, the State Senate budget subcommittee approved language submitted by Sen. Mike Shirkey (R-Clark Lake) that directed MDHHS to develop pilot projects to move Medicaid health care integration toward a single privatized conracting model by September 30th, 2020. To that end, only demonstration projects proposed by the private health plans were to be funded, thus discarding the work group's core recommendation that any final financing and provision of care system stem from side-by-side comparisons of costs, administration, access, and health outcomes stemming from competing models. Subsequently, the House budget subcommittee joined the Senate's in approving privatization language.

As Crain's Detroit Business stated in an April 23rd report, "Instead of approving the…multi-stakeholder…298 Workgroup's [recommendation] to retain and improve the current public Medicaid mental health system, the appropriations subcommittees rewrote budget language that could lead to more Medicaid health plan involvement in the current public system and consolidation of the 10 [PIHPs] into one superagency."[6] House Appropriations Subcommittee Chair Edward Canfield argued that creating a statewide PIHP could improve clinical services and generate administrative savings. Willie Brooks, then CEO of the Oakland County CMH Authority (and more recently named as the new director of the Wayne County Mental Health Authority), retorted that moving to a statewide PIHP would be a disaster for vulnerable people served by mental health organizations because they would lose the benefits of local administrative control. No fewer than fourteen mental health advocacy organizations declared that they disagreed with the idea that turning over state behavioral funding to Medicaid health plans could be accomplished without loss of key services and personal touch. Officials with MDHHS declined Crain's invitation to comment.

Why did the legislators turn their backs on funding projects from competing sectors? The advocacy groups pointed to lobbying. According to a May 1st Michigan Radio report,[7] Michigan lawmakers received about $1 million in contributions from committees and executives connected to the private health plans. Sen. Shirkey (the author of the budget language aimed at full privatization by 2020) received over $76,000 in contributions from health plan donors – more than any other individual lawmaker. That total included a $25,000 contribution to his leadership PAC on April 19th, one day after the meeting in which he introduced his amendment. That same day, his PAC, in turn, received $25,000 from Jon Cotton, president of Meridian Health Plan.

On the House side, Rep. Laura Cox (R-Livonia) also received a $25,000 contribution from the Cotton family to her leadership PAC, and over $34,000 in contributions from other health plan-connected donors – more than any other individual House member.

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[6] http://www.crainsdetroit.com/article/20170423/NEWS/170429948/integration-of-behavioral-physical-health-systems-moves-forward

[7] http://michiganradio.org/post/health-plans-big-campaign-donors-press-lawmakers-more-control-mental-health-services

While it is true that everybody lobbies (for instance, the Michigan Association of CMH Boards PAC reported spending over $31,000 on lobbying last year), the expenditures by non-profit groups amounted to a pittance compared to the combined spending power of the various private health plans. Last year, Michigan Association of Health Plans' PACs gave over $154,000 in donations, and over $250,000 in lobbying. In addition to the association, groups connected to it also do their own political giving. Since January 2016, Molina's PAC has given over $41,000 to current lawmakers, United Health's PAC has given over $20,000, and Meridian's Cotton family has given over $77,500.

Tom Watkins, CEO of the Detroit Wayne Mental Health Authority, told Michigan Radio that the discussion shouldn't be "about who's making the best and the biggest political contributions" but about the people and family members whose lives depend on this care, adding, "That is not something that should be up to the highest political bid. I think that would be a travesty."

Watkins said that the language advancing in the Senate seemed to ignore the 298 work groups' recommendations, which he said came after a year of preparation and more than 100 people working on them. "The Senate bill took that, tossed it in the trash heap and said, 'No, we're going to give the money to the insurance companies by 2020.' I think that's bad politics, bad policy, and a bad process for our democracy." His is a credible voice to heed: in the 298 work group, Watkins was a paragon of moderation and reason, and he was among the most collaborative in speaking for both the realities and the merits of public/private partnerships.

**Where We Stand Now**

The final budget for Fiscal 2018 directs MDHHS to oversee as many as four integrated mental/physical health care pilot projects over the next three years, under the aegis of the private health plans. On August 25, 2017, MDHHS's Section 298 team sent an e-mail to all the work group participants announcing that these pilot projects will be facilitated by Michigan Public Health Institute, an organization whose stated mission is to "advance population health through public health innovation and collaboration."[8] Subsequently, MDHHS announced that the pilot projects will be evaluated by the University of Michigan under the leadership of Kara Zivin, Ph.D. of U-M's School of Public Health.

The Stakeholder 298 process gave the appearance of transparency and consensus, but in the end, this important policy, which will have a profound effect on Michigan's most vulnerable citizens, emerged not from a consensus process, nor from the voice of the recipients of care, nor from competition among on-the-ground demonstrations spanning public and private sector initiatives, but rather from the influence of special interests.

One mystery that was solved late in the 298 process was who wrote the original privatization language at the behest of the Governor. It turned out to be

[8] https://www.mphi.org/

Nick Lyon, the director of MDHHS.[9] Furthermore, per state regulations, the pilot project facilitator, Michigan Public Health Institute, has Director Lyon as the chair of its board of directors.

Watch this space. MPA's Insurance Committee will continue to keep you informed.

[9] http://www.crainsdetroit.com/article/20161027/NEWS/161029835