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'Section 298' pilot programs move ahead

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- Crain's panel explained different approaches to delivering and paying for care in behavioral health and physical health systems
- Progress made in developing integrated approach, but panelists say more is needed before pilot programs begin next October 2019
- Advocates for behavioral health and developmental disabled population say they have been left out of discussion of how to test integration

The differences in philosophies were evident when Lisa Williams, executive director of the West Michigan Community Mental Health, met last summer with Sean Kendall, president of Detroit-based Meridian, a WellCare company, and members of the Section 298 Medicaid leadership group.

Williams represented behavioral health providers and Kendall Medicaid health plans. For more than two years, the two industries have been players in a political battle over how the state of Michigan might restructure now separate $11.6 billion Medicaid physical and behavioral health financing and delivery systems.

Under the existing 20-year Medicaid scheme in Michigan, the state has two separate delivery systems. Physical health for Medicaid patients is managed by 11 health plans in a $9 billion prepaid managed care system. Behavioral health services are managed by 10 regional public authorities known as prepaid inpatient health plans, or PIHPs, in a $2.6 billion system. The PIHPs receive state Medicaid dollars for covered behavioral health services and contract with mental health agencies and their providers.

During a breakout panel at *Crain's* Health Care Leadership Summit last week, Williams described how behavioral health providers and the health plan

executives began to work out their differences to integrate the two systems in three regional pilot programs in Genesee, Saginaw, Muskegon, Lake, Mason and Oceana counties.

"When I think about where we started back last December with process of drafting" the initial integration plan, Williams said, "What I am most proud of are the relationships we have built through the process. We all have an overarching commitment to figure out a way to make (the pilots) operationally functional. Citizens deserve to have the best outcomes."

Williams said the health plans and the community mental health providers went from a "this is our way and this is your way" of doing things to "how can things be done together?"

Kendall said the two sides developed a consensus model for how to coordinate and pay for care that was radically different in the end from each starting point.

"When we started, we were far apart," Kendall said. "The HMOs offered a fee-for-service model and the community mental health (providers) wanted a sub-capitated (per member per month payment) model. We met in the middle. We have a mixed model to develop the program and allow for person-centered directed care. There was a big barrier at first for true financial integration. It was a big win to get it done."

But not everybody was happy. Kevin Fischer, executive director of the National Alliance on Mental Illness, which represents advocates and users of the systems, said behavioral health providers have the best interests of people in mind, but clients and families have been left out of the planning process.

"The concern I have is the limited role advocates have played for people we serve," Fischer said.

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Phil Kurdunowicz, a manager who is designing the pilots with the Michigan Department of Health & Human Services, acknowledged there have been

acrimonious discussions at times about how financial integration of physical and behavioral health should work. The state Legislature, however, was prescriptive in how the pilots should be set up, he said.

"Despite various problems, (we have) an opportunity to test these models. To Kevin's point, there is a need to engage consumers and advocates at the local level and there also is a need to have a conversation about is this the best direction for the state to go. We are open to other ideas how to do this to extend our conversation," said Kurdunowicz.

Earlier this year, MDHHS awarded contracts for three pilot programs to community mental health agencies in six counties. The agencies will contract with Medicaid HMOs, which will be responsible to coordinate and pay for physical and behavioral health services. The pilots are slated to begin in October 2019.

Medicaid health plans participating in the pilots include Meridian, Blue Cross Complete, Molina Healthcare, UnitedHealthcare, McLaren, Health Alliance Plan and Priority Health.

Panel moderator Jason Radmacher, CEO of TBD Solutions LLC in Kentwood, asked Fischer what more can be done to involve advocates in the process that primarily involves the HMOs and the behavioral health providers and agencies.

"Have advocates at the (planning) table," Fischer plainly said. "We fear things (will be) dictated down to us. We understand change is inevitable. I need to be able to go back to people and calm those fears. Show us our concerns are being addressed, not just 'we heard you, now we are moving on.'" with the financing and delivery plan.

Fischer said he isn't blaming the state health department or the health plans. "It is betrayal by the state Legislature," he said. During last year's stakeholder meetings, advocates recommended more than 70 suggestions to improve the system that the Legislature ignored when it approved the pilot programs, he said.

Kendall said he hopes the community mental health providers are representing their clients in the leadership meetings. "They (clients) are our neighbors. Our goal is to develop a program and integrate care holistically," he said, adding: "We are trying to supplement (mental health services), not take it away."

As Kendall said, and other HMO executives echoed multiple times during the summit: "We believe there will be more services in the community because (of financial) savings on the physical side. Change is hard; it never is easy. (People) are used to doing things in one way. There will be bumps in the road. ... We have great people highly invested in the program, and hopefully we will come up with better outcomes."

Radmacher asked Williams about the reaction from her peers in the behavioral health community to West Michigan joining the pilot process.

"It was quite mixed," Williams said. "A number of CMHs (community mental health agencies) said to keep us posted (because) we want to start building now (and do) it the best way. Other CMHs very adamantly challenged us on participation in the pilot. Others were saying wait and see."

Elmer Cerano, retiring executive director of the Michigan Protection & Advocacy Service Inc., said the designs of the pilot programs were not what advocates wanted.

"You are dealing with people's lives," he said. "The agenda (pilot structure and solution) was wrong. ... It was your agenda, not ours."

Williams said the overwhelming consensus among her peers is to ensure that the needs of the people are met in any redesigned behavioral health system.

Kurdunowicz encouraged participants in the integration process to "hold us accountable. We are working very well with CMHs, listening, forming groups, investing time and resources. We are trying to report out as much as we can. We have great HMOs and great CMHs. It will be a better program once we get it up and going."

Radmacher also asked a number of other questions during the 45-minute discussion.

How will care coordination work?

Kendall said health plans already do care coordination on the physical health side for mild and moderate mental health services. "For serious mental illness, we need to work on that. We are looking for ways to use the resources the CMHs have developed in the community with our back end support" of data collection and case management.

For example, Kendall said when combining physical and behavioral health data, Meridian found in other markets that 20 percent of people were identified for additional case management. "Maybe they were not getting the services" they needed and could benefit from, he said.

By coordinating care, Kendall said physical health costs went down by one-third by reducing acute-care admissions.

"We can reinvest that and putting more resources on the behavioral health side," he said. "We are working with community resources to help and support them."

What about the intellectually and developmentally disabled population?

For now, the IDD population will not participate in the pilots, Kurdunowicz said. Instead, the state will contract with a single PIHP to manage about 61,000 people unenrolled in managed care plans, which includes 70 percent of the IDD population, he said.

"It has hard to manage a community-based model under managed care," he said. "There are long-term issues. Costs don't decline over time, over years or decades."

Williams said access to primary care services is a real challenge in rural areas for the IDD population. For example, some women in their 50s who live in rural areas have never had mammograms. "We won't see savings on the behavioral health side, but earlier access to care on the physical side will (reduce costs)," she said.

Is the state and leadership group learning by mistakes made in other states?

The Section 298 leadership group has been working with colleagues and consultants in other states that have integrated physical and behavioral health, Williams said.

"We can't afford to screw up," she said. "HMOs have experiences in some states where not gone well. We are building on collective knowledge. We are absolutely mindful. But the reality is Michigan is different than other states because of the inclusion of IDD population. We also have public system. It doesn't mean we ignore the lessons."

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