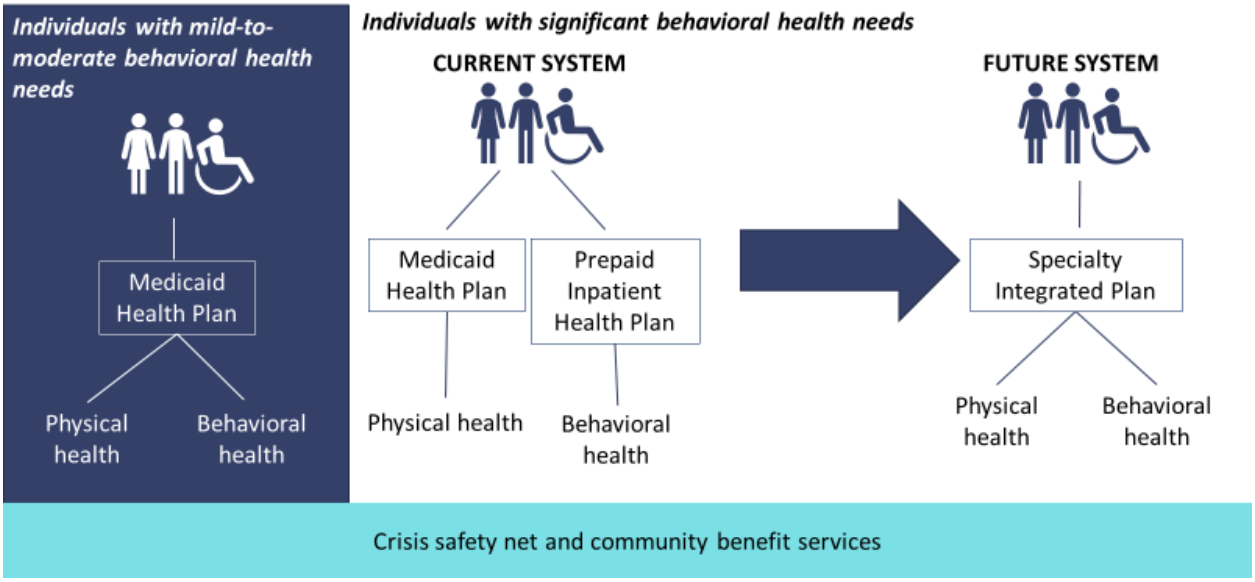
**What is the vision MDHHS is proposing?**

MDHHS has outlined a vision for a whole person approach to providing care for people in Medicaid with significant mental health, substance use disorder, and intellectual or developmental disabilities. Currently, this population receives their physical health benefits and care management from the Medicaid Health Plans (MHPs), and their behavioral health benefits and case management from the Prepaid Inpatient Health Plans (PIHPs).

This bifurcated system is difficult for people to navigate. Likewise, it creates extra hurdles for providers trying to coordinate and integrate services. The current system does not incentivize providers and managed care organizations to make investments in keeping people well, when they have no way of capturing and reinvesting those savings to sustain these services. The design means that there is no single point of accountability for the health and wellbeing of the whole person. This leads to cost shifting, finger-pointing, and challenges with communication and data-sharing.

To help address these issues, MDHHS is proposing a future integrated system that reduces complexity, lowers barriers to care, and makes it easier for individuals to navigate. Instead of each person having two separate health plans, each person will have just one — a *specialty integrated plan (SIP)*. This means that just one entity will pay for and manage all of their needs. And people will have choices between multiple integrated care management organizations, including one statewide choice of a plan led by public entities currently responsible for behavioral health care.




**What is a specialty integrated plan?**

SIPs bring together the management skills of traditional insurance companies, with the expertise, enhanced services, and commitments of behavioral health organizations. SIPs will be provided by qualified managed care entities, which will maintain provider networks, manage claims, conduct utilization management, and do individual care coordination for members – like MHPs and PIHPs do today. These entities will bear risk, and receive a capitated payment for every enrolled member. The plan will include all of the benefits available today through the MHP and PIHP systems, including supports services and investments to address social determinants of health, not just traditional medical services.

The plan will come with all of the protections and the higher-touch model of care from the public behavioral health system. This includes person-centered planning, recipient rights, and case management. It will have rigorous network adequacy standards for both physical and behavioral health services to ensure the same or greater access than people have today. It will have a high bar for performance, contract requirements, and other features that provide additional safeguards and a higher degree of oversight by MDHHS.

Furthermore, the organizations offering specialty plans will not just be traditional managed care entities. These plans will have to demonstrate expertise in managing complex physical and behavioral health needs, including relevant clinical experts on staff. They will need to show their experience with and commitment to the core values of our public system, including self-determination, person-centeredness, recovery orientation, and community inclusion.

**Who can offer a specialty integrated plan?**

We will allow all organizations that can meet these challenging requirements to compete to offer a SIP. We will support the establishment of at least one statewide public plan run by the leaders of our public behavioral health system. In addition, we invite health plans, providers, hospitals, and others to step forward and sponsor SIPs, encouraging all parties to form partnerships that bring in complementary expertise, networks, and relationships. MDHHS will be seeking public input on the detailed application requirements that will ensure every organization is anchored in the necessary expertise and commitments. Examples of what this could look like:


**Why does MDHHS think this change is a good idea?**

It is time for Michigan to move towards truly integrated health care that serves the whole person. We are committed to making services better for people: easier to access, more consistent across the state, simpler to navigate, and better coordinated. Changing our overall funding structure will enable greater investment in behavioral health services and supports by capturing savings from improved physical health outcomes. Ensuring one entity is accountable for each person will improve results and reduce complexity. Supporting multiple plans will give people choices they do not have today, and it will enable much greater public accountability for results than in our current system. The goal of this change is to improve outcomes for people, and keep them healthy, stable and in long-term recovery, in their homes and communities, living self-directed meaningful lives.

**How is this different from the Section 298 model of financial integration?**

We have learned a great deal from the Section 298 pilots about how financial integration can be done in a way that draws on the strengths of all of the parts of our system. In 298, individuals with behavioral health needs were folded into Medicaid Health Plans, where all funding and ultimate responsibility for care management rested. Here, new entities are established that combine the management skill of health plans with the expertise, enhanced services, and commitments of behavioral health organizations. A new, more diverse set of organizations will have the opportunity to lead, including at least one plan led by public entities currently responsible for behavioral health. We believe that allowing diverse, self-directed partnerships to emerge is a better idea than forcing one model from the department.

**What will happen to the safety net and services for non-Medicaid members?**

This plan will preserve and strengthen the safety net and community benefit system, including our commitment to serving all people in crisis, regardless of insurance. These services will continue to be funded and managed through the CMHs, with greater statewide consistency, while retaining flexibility and responsiveness to meet local needs. We will ensure a clearly defined set of core services are available everywhere, and that there's separate dedicated funding to support those activities.

**What will be different in the future system for people served?**

The ultimate goal of these changes is to improve service-level integration. Everyone will have one entity managing their care and responsible for all of their needs – not two or none, as happens too often today. The Department expects new offering entities will bring new providers into the Medicaid network. Individuals with mild-to-moderate needs will be better able to access services from CMHs and other specialty providers. Individuals will have more consistency in approved and provided services, and there will be stronger requirements and oversight by the state. People will not have to re-write their person-centered plan or change providers if they move across county lines. There will be more investment in prevention and living supports that keep people stable and well, paid for by savings from keeping people out of emergency departments and hospitals. We also expect there will be more innovation in care management and delivery – for example, expansion of health home models – enabled by integrated financing.

**What will happen next? How will people have an opportunity to provide input on these plans?**

To move forward, we will work in a collaborative partnership among MDHHS, the state legislature, providers, payers, and—most importantly—people served. Over the next few months, we look forward to conversations with all of you about the direction for the future of our system. We will be working with the legislature to identify statutory changes that will need to be made and pass any necessary bills. Following agreement on the overarching vision, we anticipate leading a collaborative process throughout 2020 to make detailed design decisions. There are many critical questions still to answer, and we hope to do so with full public and stakeholder input.

If you would like to weigh in on our proposal, MDHHS will be scheduling four open forums in January 2020. Details about forums, updates about this effort, and an opportunity to submit thoughts electronically are available at www.michigan.gov/futureofbehavioralhealth.