Community Mental Health Association of Michigan

MI Health Link: Review of evaluation findings by RTI International and Alan Newman Research

November 2019

Background and summary

Recently the Michigan Department of Health and Human Services (MDHHS) issued two reports evaluating the state's MI Health Link program. These reports were developed by RTI International and Alan Newman Research and can be found RTI International Report and Alan Newman Research Report .

While the MI Health Link evaluations showed positive results in a number of areas, the evaluation findings provide valuable insights into the improvements needed in the current pilots as well as changes that should be incorporated into any future efforts involving persons dually enrolled in Medicaid and Medicare.

Below is the analysis of those evaluations, by the Community Mental Health Association of Michigan (CMHA), underscoring the accurate reading of the utilization and beneficiary experience results, the factors/design elements that led to the positive results, as well as a number of fundamental concerns in the pilot's design and implementation.

We recommend that these insights inform any future system design effort by MDHHS.

Benefits of clinical coordination

Several benefits to clinical coordination – where the client/patient is served resulted in pilot communities:

- **Health care information exchange, between behavioral healthcare clinicians/providers/PIHPs/CMHs and physical healthcare providers/ICOs improved** as a result of the closer working relationship between the public mental health system and the ICOs and their provider network.

- When the **PIHPs, CMHs, and the providers in the PIHP and CMH network were invited into the Integrated Care Teams (ICT),** the behavioral health care providers were able to receive more accurate and complete physical health information and the care, across physical and mental health care and across Medicare and Medicaid, is improved.

Appropriate reading of the service utilization findings

The positive utilization results seen in the pilots include the following:

- 13.9 percent reduction in the probability of inpatient admission
- 17.8 percent reduction in monthly preventable emergency room visits
- 12.8 percent reduction in the probability of overall ambulatory care sensitive condition admission
- 13.8 percent reduction in the probability of chronic ambulatory care sensitive condition admission.

These results are encouraging and point to one of the advantages of moving a formerly fee-for-service non-managed system to a managed care system

Changes in utilization are modest: However, as RTI points out, "Although these relative percentage changes may seem large, they are based on small changes (less than 1 percentage point) in the monthly counts or probabilities of service use**. Because utilization of these services is typically infrequent, absolute changes in monthly service use are smaller than the relative differences imply."**

Control group and demonstration group unlikely to be comparable: Those beneficiaries who opted out of the pilot are likely to be those with more complex and serious needs than those who remained in the pilot. These differences may account for the differences in projected utilization between these two groups.

Lower utilization of care did not result in savings: Additionally, even with these lower utilization patterns, the evaluation found that no significant cost savings resulted from the pilot. In fact, the Integrated Care Organizations (the private managed care firms managing the Medicare and physical health Medicaid benefit) reported, anecdotally, that they, as a group, lost money during the pilot. **This mismatch of reduced utilization of health care services without resulting in savings is a concern.**

Appropriate reading of the beneficiary experience

The **measures of beneficiary experience were positive around a number of variables**:

- improved access to behavioral health
- improved access to personal care and dental services
- improved reliability of transportation services
- elimination of cost sharing by enrollees

Causative design elements: These findings underscore the value of a number of key system design elements.

- **The direct contract/carve-out between MDHHS with a well-experienced and advanced specialty behavioral health care system - the PIHP, CMH, and providers within the PIHP nd CMH network** – to serving the mental health and intellectual/developmental disability needs of the enrollees in these pilot communities
- The provision of mental health services, by the public mental health system (PIHP, CMH, and providers within the PIHP and CMH network) **across the full behavioral health care spectrum**, eliminating the benefit boundary that has existed for the past two decades and continues to exist between the benefit managed by the public mental health system and the Medicaid Health Plans.
- The **provision of transportation assistance** as key to beneficiary health and access to care – a non-traditional service long seen as essential for Medicaid and Medicare beneficiaries.
- The **elimination of cost sharing by the beneficiaries**.

Replication of causative design elements: It is the replication of these elements, and not others that are unrelated to beneficiary satisfaction, that should be the goal of any future efforts to integrate Medicaid and Medicare as well as any other system design efforts.

Dissatisfaction by program opt-out a key measure of beneficiary experience: Additionally, it is important to see the satisfaction expressed by the pilot participants who stayed in the program in the context of the high number, **64%, of the potential participants opting out of the pilot** due to their dissatisfaction with the system design and its performance.

Flaws identified in the pilot project

While it is key to recognize and applaud the successes of the pilot – when seen as **the result of the causative variables** and **in light of the high levels of program departure by beneficiaries**, as noted above – the flaws that were found through the RTI analysis should give Michigan policy makers pause and guidance as they plan future system design efforts.

Resistance to core person centered planning concepts and practices: The ICOs were resistant to engage in person centered planning, citing: the time required for person centered planning, the cost of retooling their clinical and payment systems to support person centered planning, the difficulty in providing person centered planning via face-to-face contact with beneficiaries, the difficulty in traveling to the homes or beneficiaries as part of the person centered planning process. Reviews of the person centered plans conducted by the ICOs indicated that a medical model was used as the basis for the plans rather than one that centered around beneficiary goals and preferences. The inability of the ICOs to embrace the fundamentals of person centered planning, as demonstrated by the resistance to employing these core constructs of person centered planning, is one of the core concerns expressed by beneficiaries and advocates during the initial planning phases of the pilot.

HCBS waiver slot application delayed and incomplete: RTI found that a significant number of HCBS waiver applications, developed by the ICOs and their network, were submitted late, were inaccurate, contained services that did not match the beneficiaries needs; and contained not HCBS services. More than half of the HCBS applications submitted by ICOs were returned to the ICOs by MDHHS as a result of being incomplete.

Lack of standardization, within each community, across ICO practices: The differing healthcare information portals, encounter reporting formats, and practices of the ICOs and between Medicaid and Medicare caused unnecessary costs and delays for HCBS waiver providers and the PIHPs, CMHs, and the providers in the PIHP and CMH systems. As might be expected, providers in demonstration communities with fewer ICOs reported fewer problems than those with a greater number of ICOs.

Weakening of community-based HCBS provider network: ICOs showed signs of moving to larger vendors to provide HCBS services and away from smaller "mom-and-pop" HCBS providers, thus weakening the network of community-based well-experienced and proven smaller HCBS providers.

Mixed experiences in timeliness of payments to PIHPs and providers: Providers and PIHPs reported mixed experiences in the timeliness of payments, by the ICOs, to the PIHPs and the HCBS provider network. While some found the payments to be provided on a timely basis some found them to be often late, and difficult to reconcile, with extended periods of delayed payment.

High turnover and large caseloads for care managers: Very high turnover rates (averaging 20%; as high as 30%) and large caseloads (from 170 to 205 beneficiaries per FTE) were reported for the ICO's care coordinators.