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Michigan House of Representatives
MDHHS Subcommittee on Appropriations
Weds October 2, 2019, 10:30 am
Representative Mary Whiteford, Chairperson.

Presented by:
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Director, Michigan Department of Mental Health January 1991-December 2010
Director, Michigan Department of Community Health August 2012-September 2014

Thank you Chairperson Whiteford and members of the committee:

I would like to start with a few of my ending points. There will never be enough money to meet all the needs. Mental Health is health and it is the last remaining carve out of the overall healthcare system and we should not marginalize it as a carve out. After the year 2000 we all began to realize that behavioral health should be an integrated part of a healthcare delivery system.

The Michigan Department of Health and Human Services is a great investment for Michigan. With a total budget of $26 Billion and $4.9 billion GF, this department touches almost every citizen of this state and provides health care to almost 3 million people. The integration of behavioral health with physical care is inevitable. It's been integrating incrementally, the assessment of persons seen in the behavioral health system has changed over the years. The $230 million for autism in the budget this year was non- existent six years ago and we just recently began talking and budgeting for the opioid crisis.

There are important roles for consumers, advocacy groups, parents, foundations, hospitals, federally qualified health centers, private agencies, courts, judges, associations, municipalities, media, corporations, legislature, health care professionals and MDHHS.

I encourage you to look at non-financial issues that would make the system more efficient, cost effective and with improved outcomes...i.e. duplication of audits, contracts, reporting and look at more standardization of services, training, reciprocity of credentials, best evidence and increased pass though funds for basic caregivers. Therapist's reporting requirements are way too demanding so that less and less time is being spent with families and consumers. We need more scope of practice legislation to improve quality...it will not diminish the quality, but rather enhance it.

The recent proposed LARA licensing rules for counselors is an example of how the rules can limit access to services in a time we need increased access.

We should require cross Department investment in economic/social determinants of care and form treatment coordination.

Do not be threatened with word privatization, there is a long and valued history in Michigan. When budgets are tough, I would rather be creative with new models of a streamlined delivery of services than cut rates and benefits.

1832 to 1963:

This was the era of large institutions and poor farms who took in anyone who did not fit the description of normal. Alcoholics, homelessness, anger management issues, TB, epilepsy, syphilis, drug and morphine addicts, dementia and Alzheimer's, deaf, organic brain damage, PTSD, Senile elderly, incorrigible youth, Autistic, mentally ill, developmentally disabled, sexual deviant, and those who just couldn't adjust to societal living. All living together in one place.

The Eastern Michigan Asylum for the Insane in Pontiac was authorized for construction in 1855 by the Michigan Legislature for $400,000 the same year as Michigan's Capitol was authorized for $1.4 million. Elijah Myers was the architect of both.

Community based serves were almost nonexistent, hardly any family engagement and once you arrive you might never leave. Over 35 institutions housing over 50,000 Michiganders. The names of the institutions were derogatory by today's standards...often including terms like feeble minded, mental retardation, asylums and insane.

The Superintendents of these facilities went directly to Legislature for funds and this continued until 1963. Those who in lived in districts of influential legislators got more funds.

Things began to change in 1950's with the introduction of medication such as Thorazine. In the 50's and 60s a history of investigations was brought to the Department of Justice via Michigan ARC. The situation was so bad at Plymouth Regional Center that Governor Milliken shut it down. The institution in Ypsilanti housed 3000 people, Traverse City 2500, Kalamazoo over 2500 and Newberry over 1500.

1961 to 1991
The constitutional convention of 1961 shrunk the number of Departments from 70 and consolidated them into 20, one being the Department of Mental Health. The direction was put in place for the new era of community- based services. With the passing of the Community Mental Health Act of 1963 as championed and signed by President Kennedy. Services were to be closer to home and plans to close large state institutions began. There were still 90/10 expenditures in Michigan, 90% institutions and 10% community based.

Governor Romney signed PA 54 enabling legislation in 1963. There were 55 Community Mental Health (CMH) Boards were permitted for 83 counties. Counties were given up to 60% of state funds and counties funded 40%.

In 1974 Public Act 54 258 that codified existing statutes and regulations in one place...the Mental Health code. Representative Joyce Symons (30 district) was key in making this happen. The Code really dealt with tough issues and set the direction of consumer rights and expectations of the community-based system. It also required the state to provide 90% of funds and local funds of 10%.

The CMH boards started to get organized about 47 plus and slowly began returning consumers from state institutions to creative community alternatives.

I can honestly tell you most of what is in your budget expenditures today came from the creative work of the various administrations, advocacy groups and the legislature. With the result being the array of services and line items in your budgets today.

1991-Today:

In 1991, one of my first discussions with Governor John Engler was to determine if we would be institutional based or community based. We could not afford one or the other. We decided to be a community-based and made sure funding followed the consumer from state institutions to community-based services. Services would then be 90/10, with 90% community and 10% institutional-based services. The facts are clear...either spend all the money in institutions with limited number of persons receiving services or serve over 300,000 per year by CMH and providers.

In the 1990s we began to use the atypical drugs that were coming on the market like clozapine and Risperdal

During the 1980's Department of Corrections had a total lack of mental health services for those in Prison. The Department of Justice had been fining the Blanchard administration $10,000 per day, it was cheaper according to the previous administration to pay the $10,000 per day than to offer comprehensive services to the Mentally Ill who were incarcerated. We changed all that and in 1993 and 1994, we took over all newly designed treatment services in DOC. The Granholm administration undid that vital service about a decade later.

In 1995 the Governor asked us to merge mental health, drug control, aging, substance abuse and Medicaid into one department ...the Dept of Community Health by executive order.

Between1995-96 we Updated Mental Health Code at that time the carve out was needed given reality of health care delivery at the time. There were 116 amendments on the floor of the house!

In 1997 we moved the 700,000 fee for service recipients to managed care and saved about $200 million. The number of health plans originally approved were 35, today the number is about 13. All HMO's are regulated by the state and are expected to have the necessary reserves.

When I left in 2002 the budget was $10 billion. Between 2002-2010 the department was under the leadership of Janet Olszewski, those were tough years financially and she kept the ship moving forward.

I came back in 2012 for two years. Prior to that the former director put in place Prepaid Inpatient Health Plans (PIHPS) to facilitate regional standardization, financing and coordination of services. Now we had 47 CMH boards wanting autonomy but part of 10 regions. When I left in 2014 the budget was $18 Billion primarily the result of Medicaid Expansion that happened under Governor Snyder.

Under Director Lyon's leadership Governor Snyder asked the Director to merge the Department of Human Services into the Department of Community Health, thus forming todays Michigan Department of Health and Human Services (MDHHS). A couple of years ago MDHHS recommended the integration of physical and behavioral health within the health plans, as you know the situation got very polarized.

From that came Section 298. Now this brings my comments up to today with Governor Whitmer and Director Gordon carrying the polices and budget forward along with the Michigan Legislature.

Let me add a few additional thoughts:

I don't fault those of the past, they did the best they could with the knowledge and science that they had, over the years the consumers have changed to include more substance abusers, methamphetamine addicts, opiate addicts, gambling addicted and the lists goes on. We must start more risk- sharing, contracts need to put more emphasis on quality and health care outcomes.

I am dismayed with fact that children and adults cannot have access to needed treatment - especially crisis and impatient beds. We are smart enough to fix it and part of it is holding funders and providers accountable. We have over 800 public beds managed by the MDHHS and 58 free standing and hospital based psychiatric units with over 2400 beds for adults and over 300 for children. This does not include the thousands of other residential beds in our state for children and adolescents.

We do not need 10 PIHPs we could legally go with one. The 10 PIHPs just haven't met their original intent.

We need to incrementally allow the Health plans to take over CMH dollars...let CMH's compete with private agencies with the health plans integrating payments and accountability. The Legislature can assure accountability.

The future focus should be on risk sharing, valued based payments, pharmaceutical costs, social and economic determinants, health literacy and levels of reimbursement.

I support the work of Governor Whitmer's office to coordinate Opioid spending and examine the results of the Jail Study with interest.

Substance use and abuse disorder providers must be required to have a place at the table.

Technology and its applied use must integrate files in the health delivery system. We are still way to fragmented/siloed and the consumer suffers.

There must be early intervention at all levels with families, children and adults.

We need to get to integrated care and there are many models you can look at. I ask you to keep moving ahead on models that don't just rearrange the seats but really encourage and work to introduce new models of integrated care to Michigan consumers and families.

We always talk about the integration of mind, body and spirit...let's get on with it! I was happy to read this week a recent report by UM who has been evaluating the Healthy Michigan Plan that shows over 51% with behavioral health conditions responded that their physical health had improved in the first year of coverage. Over 76% of those with a behavioral health condition who were employed said their Medicaid coverage had improved their ability to perform well at work.

I was struck when reading the recent Health Endowment Fund study on Behavioral Health Access in Michigan that many of their 15 strategies to improve access to Behavioral Health in Michigan most would not take a lot of money. One of the major recommendations was to integrate primary care and behavioral health delivery. Let us all strive to always put the consumer first!
Thank you Chairperson Whiteford for this opportunity.