Dennis M. Bott
7980 Detroit Boulevard
West Bloomfield, MI 48323
586-850-9516
dennis.bott@morcinc.org

Testimony to the Michigan House of Representatives – MDHHS Subcommittee on Appropriations
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Chairperson Whiteford and members of the committee:

Thank you for this opportunity to address the committee. Today, I would like to share some observations about the public mental health system's current structure, as well as some of the proposed reform efforts, and, importantly, how both impact the unique population we serve.

I am the Chief Executive Officer at Macomb Oakland Regional Center, Inc. (MORC), a private, non-profit human services agency that coordinates long-term care supports for individuals with intellectual disabilities in Southeast Michigan. We have proudly operated as a leading voice in offering person directed, community based care in Michigan for nearly 50 years. We currently serve approximately 10% of those with intellectual disabilities supported within the State's publicly funded system.

As you know, Michigan's behavioral health system has operated under the Pre-paid Inpatient Health Plan (PIHP) structure since the early 2000s. The original intent of the PIHPs was to facilitate a regional approach to the delivery of public behavioral health care. Despite good intentions, one of the biggest challenges we face from a provider standpoint is a lack of standardization. MORC primarily operates in the Southeast Michigan region and has contracts with the three PIHPs serving Macomb, Oakland and Wayne counties. Despite serving in the same geographic area and operating under the same State contract requirements, there is little to no commonality among the three PIHPs in terms of audits, contracts, reporting requirements, and especially, technology systems. By way of example, we are working with three distinct computer systems and under three different sets of processes and procedures in order to provide similar services in all three counties. None of these systems makes use of standard interface language, forcing us to either custom build unique and expensive solutions for each, or relying on manual data entry as our only method to input information. The amount of administrative time, resources and cost required to maintain these duplicative processes is tremendous and would be much better spent providing improved care to our population. Just as important for the State, the multiplicity of systems doesn't always produce usable data, thus making it difficult to correlate, analyze and leverage the information. As has been pointed out to this committee already, the standardization of some of these processes is a way to make

better use of available service dollars without increasing total allocation. It is an example of working smarter, not harder.

As we examine new models for system reform, I ask you to keep in mind the key issue of choice. A great source of pride in Michigan is that services for persons with intellectual disabilities are based on the twin expectations of person-centered planning and self-determination. Over the years, the public system has done a good job of implementing these core principles and it is our hope that they will continue to be at the forefront of any reform efforts. As we look to the future, we support a model that does not just feature person-centered plans but whose service delivery system is, in fact, structured around the person. When we talk with families and even with many legislators, most are surprised to learn that if they have an adult child with an intellectual disability who is receiving services in Oakland County and they decide to retire to Traverse City and take their adult child with them, the same array of services, support options, and choice of providers may not be available to them. This is because access to care and choice of support options is currently determined solely by the PIHP as the singular source of Medicaid funding for behavioral health and is influenced by geography, a finite network of providers in any given area, and any specific regional philosophy that may be prevalent. Incorporating benefit portability within an integrated system of care that sets a state defined core benefit requirement would greatly simplify access to services, enhance choice and rationalize the system for those receiving services.

Finally, in serving individuals with intellectual disabilities, many of whom have co-morbid health care issues, we have seen first-hand the value of integrated care and have worked diligently to promote such care within our population. The individuals we serve have a relationship with a primary care physician that we strive to establish upon initiation of the long term supports covered under our PIHP contracts. We regularly coordinate care with other health care providers and we know that when done well, we see a reduction in ER visits, improved overall health and increased longevity within our communities. The question of why this isn't happening across the State remains problematic for us to understand. I think a couple of things may have hampered Michigan's efforts to move towards greater integration. First, the focus has been on integrating only at the funding level while preserving a behavioral health carve out at the service level. The debate around this has been mostly framed as being a binary choice between a 100% public system or a 100% private system without talking about viable options in between. Second, although the Michigan Mental Code is forward thinking in codifying terminology such as person-centered planning, the funding model for services (and much of the state's budget) relies on the federal Medicaid program. Medicaid, in turn, remains anchored in a medical model of care that is often at odds with the social compact that Michigan's Constitution and Mental Health Code envision. A couple weeks ago, representatives from the Community Mental Health Association testified about the importance of integrating care at the service level rather than at the funding level. They mentioned models like Arkansas which feature public-private partnerships wherein 49% of the system's governance is controlled by the health plan functioning as the managed care organization and 51% is controlled by providers and other key stakeholders as a way to achieve integration and financial efficiency while still preserving transparency and a focus on the persons receiving services. Models such

as this, as well as those in other states like North Carolina and Arizona, could offer valuable insight as we look to find compromises on the road to integration.

In summary, as we move away from the rancor created by the Section 298 debates and look toward true reform efforts, I hope you will keep in mind some of the ideas I discussed today. These include: looking for ways to standardize processes as much as possible; incorporating more choice and portability into the system so that access to care isn't dependent on where a person lives; and finally, focusing integration efforts at the point of service in a way that truly builds upon Michigan's long-standing tradition of person-centered care.

I thank you for this opportunity to provide testimony and I look forward to this committee's ongoing efforts to improve behavioral health services on behalf of the citizens of Michigan.