Testimony at

House Health and Human Services Appropriations Sub-Committee November 6, 2019

The Honorable Mary Whiteford, Chair

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Introduction

Greetings Chairwoman Whiteford and Committee Members. I am Bradley Casemore, CEO of Southwest Michigan Behavioral Health. I am joined by Joe Sedlock, CEO of Mid-State Health Network. We represent two of the ten Michigan Prepaid Inpatient Health Plans (PIHPs) which collectively serve more than 325,000 persons with Medicaid and Healthy Michigan Plan coverage recovering from a severe mental illness (adults), serious emotional disturbance (youth), Autism Spectrum Disorder, Intellectual / Developmental Disability (one of the most vulnerable and costly populations) or Substance Use Disorder. Our scope also includes individuals in what is referred to as "fee for service" Medicaid, also known as the "Health Plan Unenrolled" population.

PIHPs are benefits managers with responsibility for Access, Quality Assurance-Performance Improvement, Program Integrity-Compliance, Customer Services, Provider Network Management, Information Systems-Information Technology, Utilization Management, Finance and Accounting, and other roles as guided by federal regulations and the 728-page MDHHS-PIHP Agreement which you see before you here.

From October 2002 through December 2013 there were 18 PIHPs. The state-mandated move from 18 to 10 PIHPs, 7 of which were required to be brand new organizations known as Regional Entities under Mental Health Code 330.1204b, was complex, expensive and caused lost momentum in PIHP and CMHSP healthcare information exchange, healthcare data analytics, and integration & quality efforts. We suggest that policy leaders avoid underestimating the costs and timeframes related to significant system change, and to recognize that the number of PIHPs in and of itself is not directly related to improved outcomes or reduced costs; the roles and responsibilities specified in the PIHP Agreement must be effectively and efficiently performed regardless of the number of PIHPs.

With the consolidation into the new PIHPs in 2014 came PIHP responsibility for the substance abuse treatment and prevention activities of many types and several hundred million dollars, previously performed by the Coordinating Agencies. PIHPs stand at the forefront of the response to Michigan's opioid crisis.

PIHPs have readily accepted all roles determined and expanded by MDHHS. Our system has successfully evolved over decades of legislative and executive branch led initiatives resulting in the design and engineering of today's system. While there is always room for

improvement hundreds of thousands of individuals every year find success in their recovery from one or more behavioral health disorders, achieve improvements in their quality of life, have their housing, food and income insecurities addressed, and enjoy full participation in their communities. These gains are a direct result of the efforts and successes of many contributors, including persons served, their loved ones and allies, and the PIHP-led Medicaid public behavioral health system. ***What matters now is well-meaning knowledgeable and dedicated people working together to improve the public specialty behavioral health system to better address the imperatives and realities of tomorrow – not of today and not of yesterday.*** We and our PIHP colleagues stand ready to continue to be constructive and productive contributors to improvement efforts in an atmosphere which focuses on achieving well-defined health and specialty behavioral health outcomes of value to the citizens of our state.

Michigan's public behavioral health system is a national leader. Elements which distinguish Michigan's public behavioral health system for the benefit of persons served and taxpayer value, include but are not limited to a. local governance and accountability; b. all savings remain in the community for services; c. lack of expensive marketing and competitive edge expenses; d. system-wide collaboration amongst PIHPs with CMHSP partners and the state to share comparative data, improve systems and implement best clinical and administrative practices; and e. active identification, engagement and provision of supports and services to our most troubled citizens.

PIHP Contributions

PIHPs have hit their stride working with CMHSP partners and thousands of other providers to serve the citizens of our state to improve the public behavioral health system. Examples include significant enhancements in:

- Substance use disorder provider quantity and units of service since 2015, especially expansion of Medication Assisted Treatment (MAT).
- Autism Spectrum Disorder provider quantity, quality and units of service since the benefit was introduced and expanded.
- Efficiencies and cost reductions across the system such as
    - Implementation of state-wide inpatient psychiatric hospital review/audit sharing and recognition. We will soon be adding additional levels of care to this reciprocity.
    - Development and implementation of direct care worker training standards, tracking, sharing and recognition.
    - Establishment of a web-based state-wide PIHP communications and project management tool.
    - Collective purchasing arrangements resulting in reduced overall expenses.
    - Improving uniformity of benefit. In partnership with MDHHS PIHPs are taking individual and collective steps in using common assessment tools to improve

Parity and service consistency. This approach individualizes functional status with service needs, is complementary to person-centered planning and self-determination and is readily personalized based on changes in natural supports, health status, social determinants of health, and the needs, preferences and goals of persons served. PIHPs are establishing state-wide utilization criteria for inpatient psychiatric hospital services to improve access and consistency of services. Disparities in access and service levels seen across the state are no doubt due, in part, to the multi-year reductions in CMHSP General Fund, lesser availability of providers in low density population areas, and unpredictable Medicaid/Healthy Michigan funding from year to year.

- MDHHS and PIHPs have tentatively agreed that PIHPs and their substance use disorder treatment providers will soon inherit responsibility for parolees/probationers who require substance use disorder treatment from the Michigan Department of Corrections. This action which recognizes the value of PIHPs should save the State millions of dollars in General Fund outlays once fully implemented.

Care Integration

Much has been said and written about care integration, both clinical and financial. Several prior Committee guests have shared views, including Mr. Betlach from Arizona. Varying financial integration models have been attempted across the nation, with mixed results. PIHPs have embraced care integration at the payer-payer, payer-provider and provider-provider levels for decades. Non-exhaustive evidence of this includes:

- Support for the many local community-based care integration initiatives, including but not limited to Certified Community Behavioral Health Clinics (CCBHC), the State Innovation Model (SIM), Opioid Health Homes (OHH), and nearly 750 other local care integration initiatives.
- Active support of shared contract language for PIHPs and Medicaid Health Plans (MHPs), including shared accountability for specifically defined population health improvements using national HEDIS measures.
- Partnership with Integrated Care Organizations (ICOs) with four PIHPs in the MI Health Link Duals (Medicare-Medicaid) federal demonstration.
- Material investment by PIHPs in healthcare information exchange with other payers and providers via national standard transactions and Michigan's Health Exchange Networks.
- Active PIHP support for the establishment, evolution and widespread use of the state data warehouse healthcare application known as Care Connect 360 (CC 360) to improve physical/behavioral healthcare coordination and health outcomes for persons served as well as to reduce avoidable healthcare services and costs.
- PIHP care coordination activities in collaborations with MHPs for persons with complex healthcare and social service needs.

- Ongoing system improvement efforts between all PIHPs and MHPs who have met frequently for several years resulting in with significant product and process improvements in healthcare status and costs.
- Numerous creative and effective PIHP, CMHSP, primary care, hospital and specialist collaboratives with multiple community partners too numerous to mention.

Principles for Change and Change Management

As PIHPs, legislative and executive leaders work with persons served and their allies and advocates, CMHSPs and other behavioral health and physical health experts, we endorse the following key concepts as foundational for our public behavioral health system:

- Self-Determination
- Person-Centered Planning
- Trauma-informed competencies across the health and human services provider spectrum
- Public Governance
- Effective, plentiful and appropriately compensated workforce
- Meaningful involvement of person served in governance and management
- Leverage successful foundations and public investments; do not lose the precious resource of specialty behavioral health expertise we have in Michigan.
- Adequately fund system restructuring/reforms that occurs.
- Provide adequate time and resources for transition and evaluation.
- Address the large percentage of dual eligibles (Medicare and Medicaid) and large percentage of unenrolled ("fee for service") individuals in any reform efforts of the health system.
- Ensure that all systems (e.g., law enforcement, criminal justice, education, employment, housing, etc.) especially physical health payer and providers implement best practices in addressing social determinants of health, trauma-informed care, Adverse Childhood Experiences, and specialty populations bio-psycho-social care needs.
- Recognition of and payment for the service provision contributions of person served who are trained as Peer Support Specialists, Recovery Coaches, and provide reimbursement for proven care coordination and care integration activities.
- Person-first system reform which defines the health, behavioral health and social service outcomes desired by persons served and then Policy makers.
- A period of implementation and objective evaluation, with reforms found proven to be successful against those Aims implemented.

Policy Suggestions

Legislative support of the following efforts and objectives via policy and funding and supporting a statutory and regulatory environment conducive to system change are:

- Create openings for unique public-private solutions.
- Assure adherence to all Mental Health Code and related Medicaid specialty populations guidelines.
- Enhance funding for MDHHS capacity and competencies in related policy and program change management tasks.
- Support establishment and use of Medicaid Care Coordination codes for PIHPs and CMHSPs.
- Continue policy and resource support for Healthcare Information Exchange (HIE) and healthcare data analytics.
- Continue policy and resource support for Specialty Courts.
- Consider revising Michigan's spend-down rules which are a barrier to access to care as well as federal funds.
- Consider revising jail status rules to reduce loss of Medicaid while incarcerated and not yet adjudicated.
- Continue Legislative support for Medicaid tele-health, direct care wage increases, healthcare professional education and training, recruitment and retention.
- Pursue fact-based reform designs. Remain attentive to the flaws and successes of other state's Medicaid reforms or privatizations and incorporate analyses of physical health status of specialty populations.
- Focus on desired outcomes, alignment of incentives, beneficiary choice, shared savings and other Alternative Payment Methods and increased accountability using current delivery system methods first. The types, amount and duration of emerging and effective care integration initiatives is very promising and should not be jeopardized.

On behalf of Michigan's PIHPs, we thank you for having us as well as for your interest in and support for the vulnerable specialty populations we serve.

Respectfully,

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