
# Michigan's Mental Health and Substance Use Disorders System

# Community Mental Health Association of Michigan

The Community Mental Health Association of Michigan is a trade association, representing the 46 community mental health boards, 10 Prepaid Inpatient Health Plans, and over 90 provider organizations that deliver mental health, substance use disorder, and developmental disabilities services in every community across thus state. Last year over 350,000 persons received services from Michigan's community-based mental health and substance use disorder system. Those services assist individuals in achieving, maintaining and maximizing their potential and are provided in accordance with the principles of person centered planning.

# Michigan Constitution

Community Mental Health Organizations are required to serve individuals with a severe mental illness or disability regardless of their ability to pay. An individual can not be denied a service that is medically necessary because of inability to pay or lack of insurance. The **Michigan State Constitution** lays out the state's commitment and responsibility for mental health services.

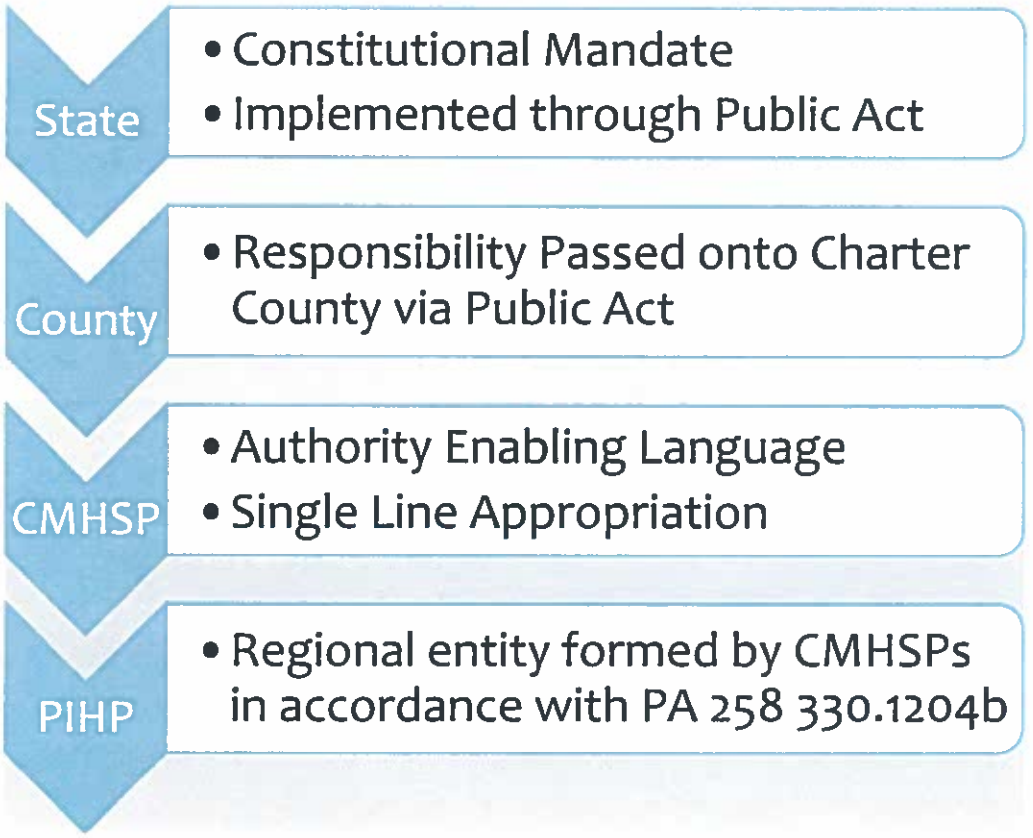
- **1850** XIII/10 **1908** XI/15, **1963** VII/7, VIII/8

- **Article 8 – Section 8 of the Michigan Constitution reads: Institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously disabled shall always be fostered and supported.**

# Transfer of Authority

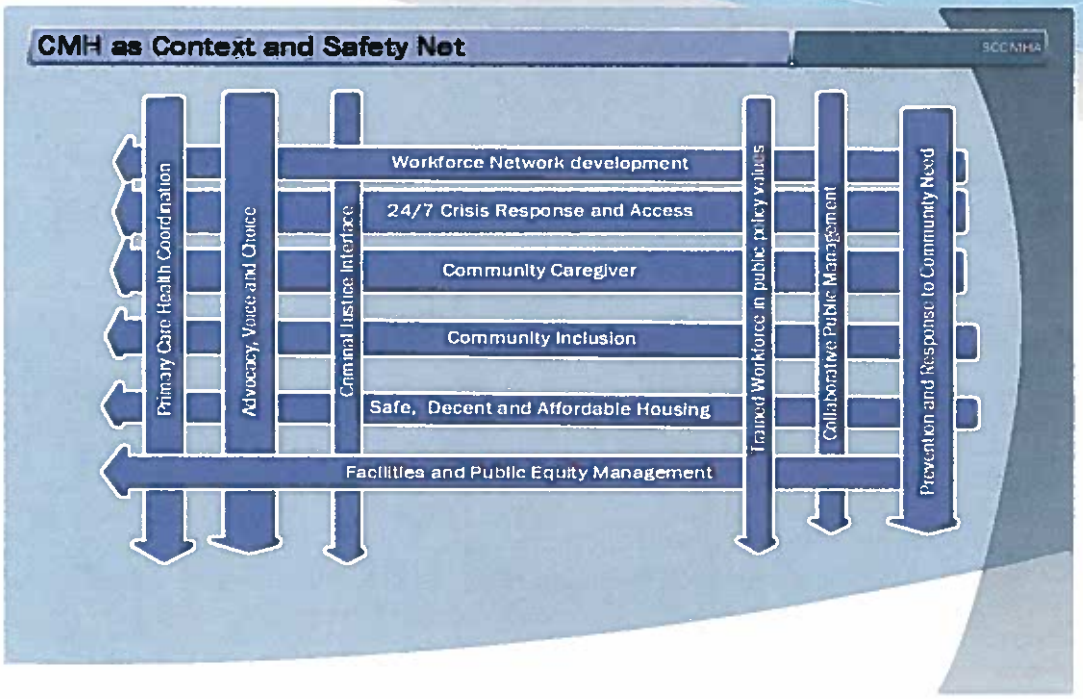
## Transfer of Authority

- The State duty begins with the constitution as implemented in PA 258
- The County duty begins with PA 258 section 202.
- The PIHP duty is created in PA 258 Section 204 when CMHSPS are permitted to form a Regional Entity .
- The State may contract with a duly formed PIHP to manage the Medicaid benefit.
- The PIHP may then contract with the participating CMHSPs for delegated and provider functions.



# Specialized System of Care

**Your local CMH manages a very complex specialized system of care with many community partners through interwoven funding streams, collaborative alignment of public resources and public policy roles.**




***"This Targeted Populations /Local Management/Consolidated Funding Model has successfully concentrated community interest, stakeholder involvement, professional expertise, service delivery development, and resource deployment on the specific needs and interests of persons with mental illness, developmental disabilities and addictive disorders. The focus on local collaboration has forged necessary linkages for care coordination and cooperative community solutions to complex situations."***



***MDHHS: Application for Participation Implementation Guide, October 2001***

# Public Safety Net

The CMH network provides 24 hour emergency/crisis response services, screens admissions to state facilities, acts as the single point of entry into the public mental health system, and manages mental health benefits (for persons not eligible for Medicaid enrollment) funded through the state's general fund allocation.

- The local CMH system has the **unique statutory roles of public safety net and state facility gatekeeper.**

- CMHs provide community based care, addressing a wide range of human needs. Some of the social care services include:
  - Behavioral health care (including developmental/intellectual disabilities and substance use disorder services).
  - Physical healthcare
  - Housing, employment, and income supports
  - Extensive use of health care integrators (case managers/supports coordinators)
  - Peer support services
  - Community linkages and collaboratives

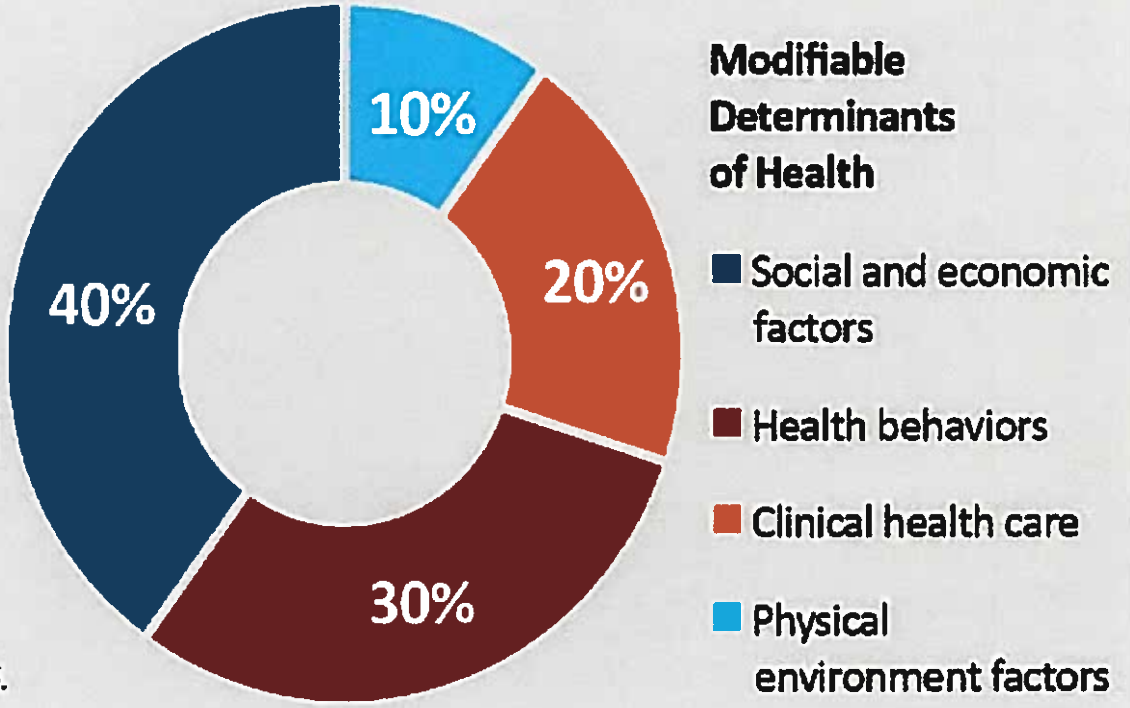
# Social Determinants

Healthcare makes up only 20% of the modifiable determinants of health. The other 80% are linked to social determinants of health.

## What Affects Health?

Researchers at the University of Wisconsin Population Health Institute estimated the percentage of people's health—including length and quality of life—that is affected by factors that can be changed or modified (i.e., excluding genetics).

*Source: Park, H., Roubal, A.M., Jovaag, A., Gennuso, K.P., and Catlin, B.B., 2015.*



# Social Determinants

Michigan's public mental health system has a long history of addressing social determinants. The rest of the health care world is only now catching up.

- Income level/poverty
- Housing
- Access to food
- Employment
- Race
- Family functioning
- Violence/crime in environment
- Access to transportation
- Education

# Local Oversight & Public Accountability

- Local CMHs are public entities, either an official county agency or an authority, which is a public governmental entity separate from the county or counties that establish it.

- Local County Boards of Commissioners appoint each of the CMHs' 12 person Board.
  - The composition of a community mental health services board shall be representative of the populations they serve.
  - At least 1/3 of the membership (4) shall be primary consumers or family members, and of that 1/3 at least 1/2 of those members (2) shall be primary consumers.

- PIHP boards are made up of appointees from the CMHs within their respective regions.
  - Additionally, local County Boards of Commissioners are responsible for appointing local representatives to the substance use disorder advisory council for each PIHP.

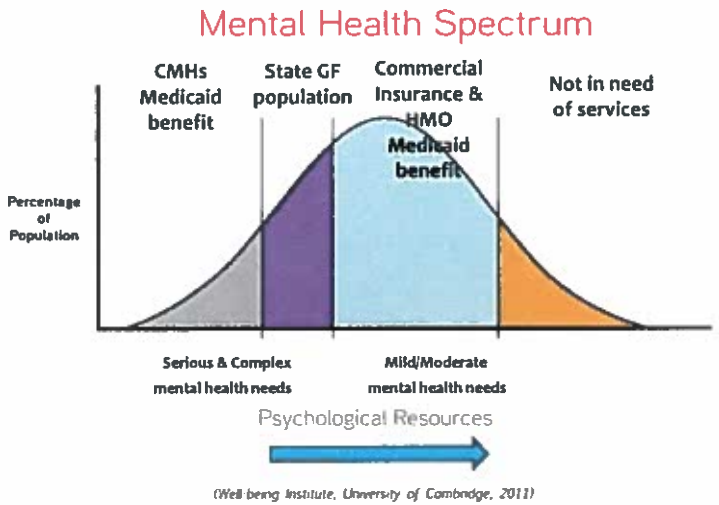
# Who We Serve

Michigan's Public Mental Health System Serves 4 Main populations:

- Children with Serious Emotional Disturbances (examples: Obsessive-Compulsive Disorder (**OCD**) or Attention Deficit Hyperactivity Disorder (ADHD)
- People with Substance Use Disorders
- People with Developmental/Intellectual Disabilities
- Adults with Mental Illness.

Michigan is the ***ONLY*** state that serves all 4 populations in a managed care setting.

- Managed care was established in 1998 for behavioral health services.



# Cost control and ROI

CHI²
Center for Healthcare Integration & Innovation
Community Mental Health Association of Michigan

A.Cost control ability of the public system:CHI2 study: Bending the cost curve

https://cmham.org/wp-content/uploads/2019/03/CHI2-bending-the-cost-curve-final.pdf

Bending the Healthcare Cost Curve:
The success of Michigan's public mental health system in achieving sustainable cost control
March 2017

# Cost control and ROI

- When compared against Medicaid rate increase in the rest of the country, **Michigan's public mental health system saved over $5 billion dollars** since 1998

- When compared against the rate increases of commercial health insurance companies, **Michigan's public mental health system saved over $13 billion dollars**

# Return on investment

- Michigan's public mental health system converted a system dominated by state hospital care to a community-based system of care

- If the CMH/PIHP budget of $2.5 billion were used to fund inpatient care in the state psychiatric hospitals and developmental disability centers, **8,500 persons would be served each year**

- The CMH/PIHP/Provider system serves over **350,000 persons each year**

# Return on investment

- This represents a **35 fold increase** in the number of persons who can be served through community-based care when compared with state institutional care

- **For every person provided community-based care rather than state facility care, 34 other people can also be served**

- This rate of return, unheard of in most healthcare arenas, greatly expanded the ability of the system, even with serious fiscal constraints, to reach those previously unserved

# Where is the future headed?

# Healthcare Integration

- Applies a whole person approach to healthcare
- Recognizes that healthcare costs can be controlled and health status improved through the integration of primary and behavioral healthcare
- Real health care integration is not the consolidation of funding
- Real health care integration is provided at the clinical level, where the client/patient receives services and supports
  - Integration can NOT be a one-sided conversation – the focus CAN NOT simply be moving behavioral health into a traditional physical health care model.
    - The more complicated one's care is the less coordinated their care will be.

# Integrated Funding vs Integrated Care

## Integrated Funding Vs. Integrated Care

**Integration is a range of specific clinical work behaviors**

- Single point of accountability for overall care coordination and management
- Single treatment plan
- Treatment team that is both medically and behavioral health competent

**Integrated funding can be helpful, but is neither necessary nor sufficient**

- Separate funding can be effectively blended
- Integrated funding all too frequently ends up funding separate care

# CMHs leading the healthcare integration movement in Michigan

CHI²
Center for Healthcare Integration & Innovation
Community Mental Health Association of Michigan

- Annual survey of integrated work of Michigan's public mental health system
- Most recent study found over 570 healthcare integration efforts
- https://cmham.org/wp-content/uploads/2019/04/2018-2019-CHI2-Healthcare-integration-FINAL.pdf

Healthcare Integration and Coordination – 2018/2019 Update: Survey of Initiatives of Michigan's Public Mental Health System
January 2019

# Fundamentals of sound integration in the publicly funded healthcare system

- Real health care integration is not the consolidation of funding
- Real health care integration is provided at the clinical level, where the client/patient receives services and supports
- Structures and financing approaches are then designed to support clinical integration

- System fosters public-private partnerships and the best that these sectors bring to the table while retaining public sector's majority role in governance
- System fosters person-centered planning
- Supports a clinically and fiscally strong provider network
- The full range of roles of the public safety net system remain strong (system organizer, community convener and collaborator)

- Modern and adequate subcapitated payments rather than fee-for-service fund the local public system – allowing for shared risk, flexibility and focus on whole person care

- Full breadth of persons covered:
  - Persons with mental illness – mild through serious
  - Persons with intellectual & developmental disabilities
  - Persons with substance use disorders

# Medicaid integrated care across the country

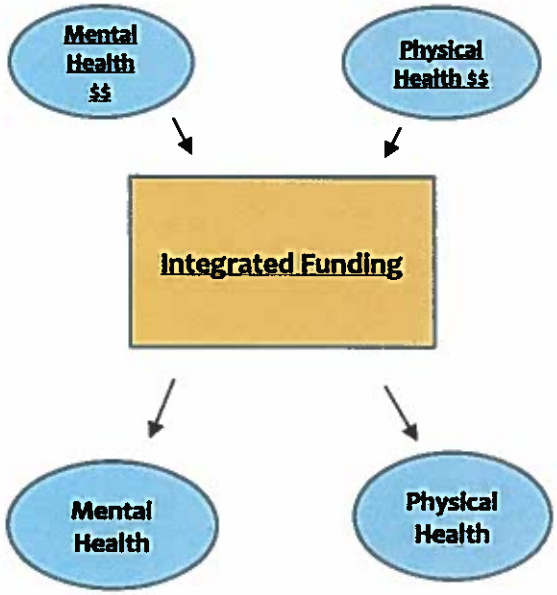
- Recognizing that statewide Medicaid integration efforts are in their early days:

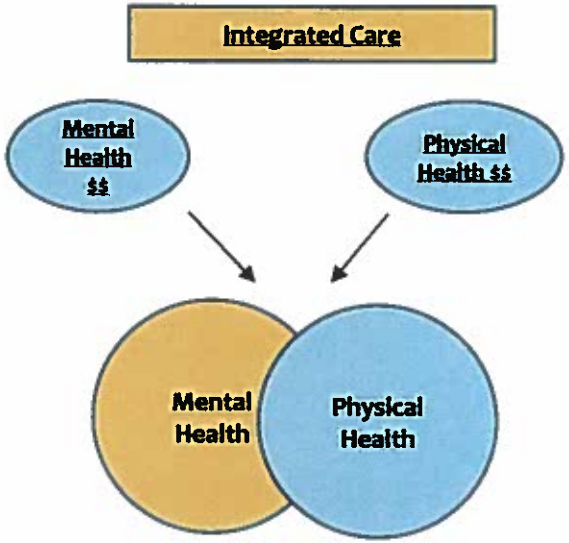
- Some states seem to be meeting some or all of these standards
  - North Carolina
  - Arkansas

- Some states that focused on INEGRATED FUNDING have seen dramatically weakened provider network, weakened access and quality of care, loss of public oversight, loss of cost control
  - Iowa
  - Kansas

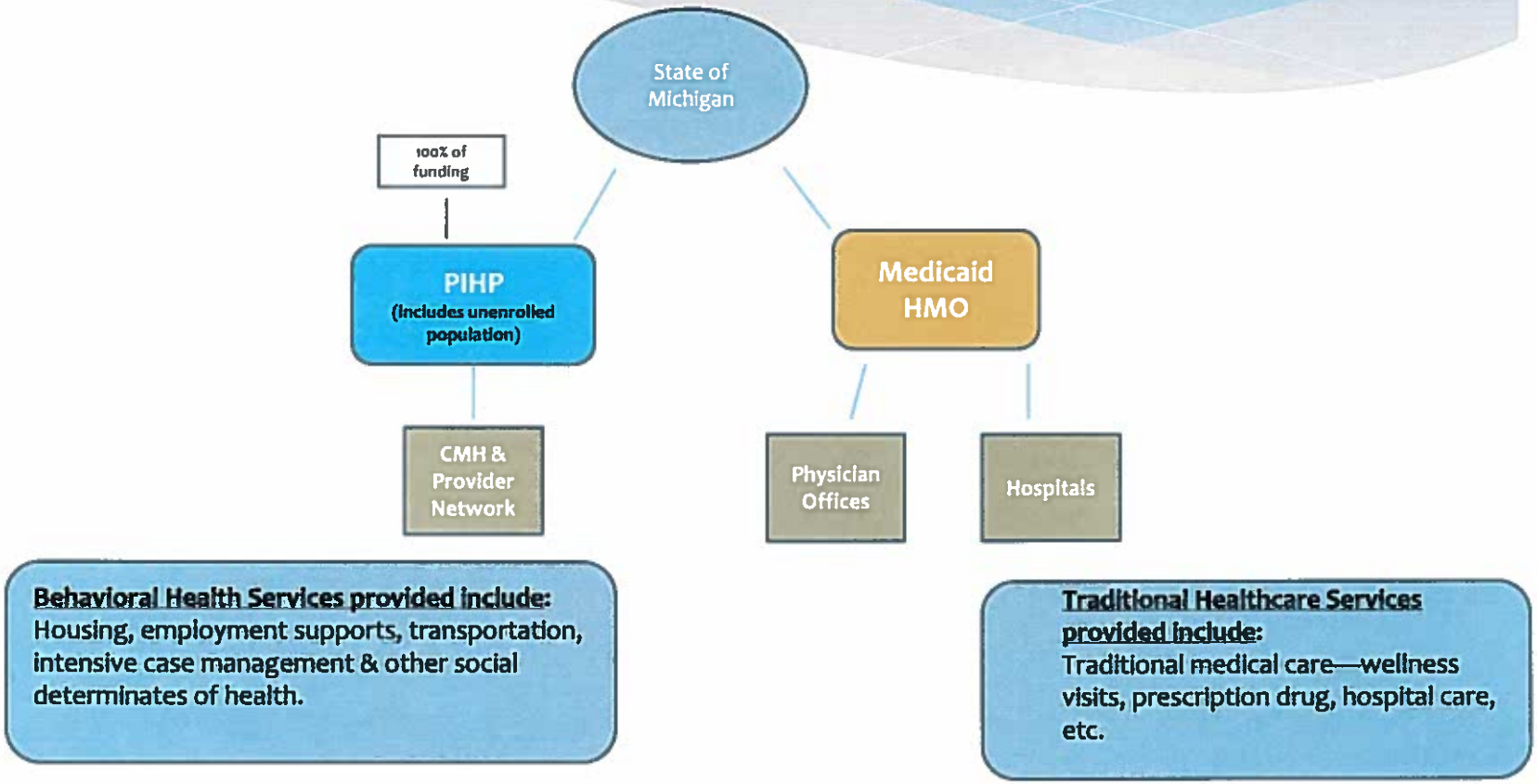
# Section 298 – Integrated Funding

- As an integration concept/model, Section 298 simply moved funding from the PIHP to the Medicaid Health Plans.
  - It did very little to integrate care - the focus was integration of the funding.

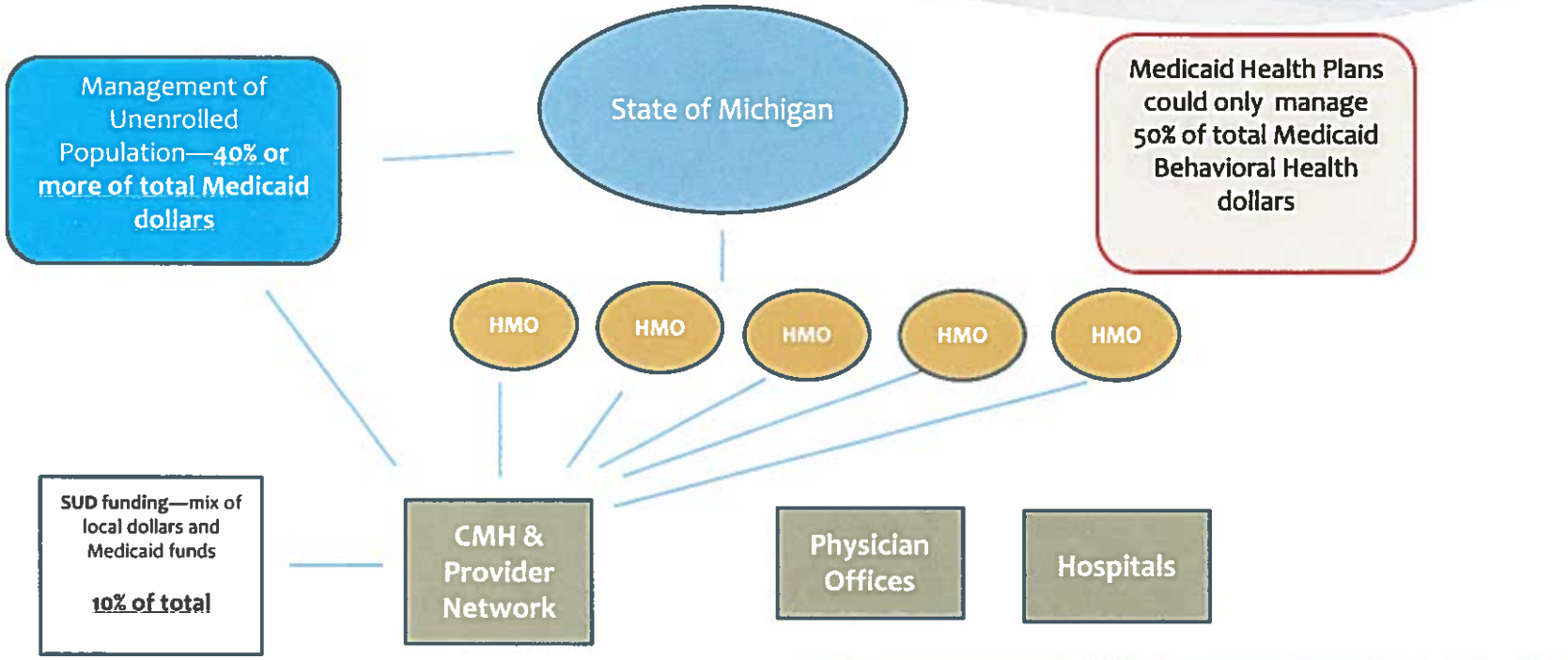


# Current System



# Section 298 Pilot Sites




Of the total $14 billion of Medicaid physical healthcare Medicaid Health Plans manage $8 billion/57%, the remainder are unenrolled/fee-for-service.

# Funding Challenges

# Key Factors to Funding Crisis

- Michigan moved behavioral services into managed care back in the late 90's.
  - Michigan created PIHPs in the early 2000's to manage behavioral health and development/intellectual disabilities services and supports.
  - From 2002 – 2014 there were no funding crisis or questions about long-term stability
- **WHAT CHANGED?**
- 2 Key Factors – Healthy Michigan Plan (HMP) & Medicaid Autism benefit
- Medicaid Autism benefit began on April 1, 2013 and HMP began on April 1, 2014

# Key Factors to Funding Crisis

## Unintended consequences from Healthy Michigan

1. State savings for Healthy Michigan was $200 million reduction in CMH GF (going from $300+ million to $97 million).

2. HMP provided a venue for 40,000+ individuals who were previously on traditional Medicaid as Disabled, Aged or Blind to shift to HMP or TANF during their redetermination process – result was over $100 million loss.

3. Underestimated both demand for benefit and the intensity of services needed.
   - Original estimates for HMP were 425,000 people vs. almost 700,000 in the benefit currently.
   - HMP rates were built on the assumption that people seeking services would have modest needs and service requirements.
     - SUD services have far outpaced demand and intensity of services.

4. People entering into Medicaid through HMP are staying and not moving to traditional DAB/Medicaid program.
   - Avoid hassles of traditional Medicaid and DAB determination process, etc

# Key Factors to Funding Crisis

## Medicaid Autism benefit

- Benefit started on April 1, 2013 for children 0-5
- January 1, 2016 program went to 0-21

- Lack of provider networks for ABA services and underestimating demand for services.

- Autism rates were prematurely developed without a full understanding of the cost of the program for a 0-21 benefit. (program started out being cost settled at the end of the year)

  FY16 – budget appropriation $36.4 million, state funding provided $61.9 million, Autism service spending reported $76.1 million = ($14.1 million loss).

  - Fy17 - budget appropriation $61.1 million, state funding provided $88.4 million, Autism service spending reported $119.2 million = ($30.8 million loss).

# Contact Information

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