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MI Behavioral Health Reform FAQs

1. *The MI Behavioral Health Reform bills are predicated on Connecticut's delivery system for public behavioral health services.*
    - The behavioral health reform bills are predicated upon the values and vision entrenched in the history of Michigan's public behavioral health system with the ultimate goal of seeking to improve access to and quality of services--putting persons and their families/loved ones first. The ideas delineated in the bill are reflective of the following non-exhaustive list:
        - Listening to individuals and families served by Michigan's current system;
        - Lawsuits against MDHHS and its current system for the inability to provide essential services to persons in need;
        - The desire to increase the percentage of funding going directly to services received by Michiganders;
        - Research indicating Michigan significantly lacks access to mental health and substance use disorder services (a 2019 Altarum study showing half of Michigan Medicaid beneficiaries with mental illness go without treatment and nearly 70 percent of Michigan Medicaid beneficiaries with SUD go without treatment);
        - Lack of uniformity among the provision of services across the State;
        - The structural inability for Prepaid Inpatient Health Plans (PIHPs) to be managed care entities due to governance requirements;
        - Redundant layers of administration and duties between PIHPs and Community Mental Health Services Programs (CMHSPs) (in fact, some CMHSPs are solely network managers and not providers of services);
        - Feedback received through the House CARES Task Force;
        - Findings from the MDHHS Michigan Psychiatric Admissions Discussion Report;
        - Findings from the MDHHS 298 Stakeholder Workgroup Report;
        - Researching other state approaches (including Alaska, Connecticut, Maryland, Georgia, New Mexico, Vermont, and Washington);
        - Researching Michigan's Constitution, Mental Health Code, Social Welfare Act, and Public Health Code.

2. *Removing "Department-designated community mental health entity" diminishes or eliminates the role of the Community Mental Health Services Programs (CMHSPs).*

- The "Department-designated community mental health entity" definition is redundant to the other definitions in the Mental Health Code that reflect CMHSPs (i.e., "Community mental health authority", "Community mental health organization", "Community mental health services program", "County community mental health agency"). Therefore, removing the "Department-designated community mental health entity" would have no impact on CMHSPs and their analogues on their roles, duties, function, etc. The bill does not change the definitions that comprise CMHSPs, including “community mental health authority”, “community mental health organization”, “community mental health services program”, and “county community mental health agency”.
- The intent on removing “department-designated community mental health entity” was to clean up the reference to ensure the department and its ASO (if applicable) were authorized to administer the substance use disorder funding.

3. *The addition of the “public behavioral health provider” diminishes the role of the CMHSPs.*
    - The “Public behavioral health provider” was added to allow for the department and its ASO (if applicable) to directly contract with non-licensed SUD providers (i.e., SUD providers that are not “approved service providers,” but are nonetheless authorized to provide certain treatment and recovery services), Crisis Stabilization Units, and/or Psychiatric Residential Treatment Facilities.
    - In this light, the department and its ASO (if applicable) would emulate the current role of the PIHP and utilize its current authority under the Michigan Mental Health Code at MCL 330.1116.
    - Philosophically, CMHSPs are and will continue to be the foundational elements of Michigan’s public behavioral health system. The changes in the bill strengthen their role as providers, relieves them as network managers/administrators, and allows the department to create economies of scale in administration, which translates into more money going directly for services.

4. *The Administrative Services Organization (ASO) seems like it would be a direct provider of services.*
    - No, MDHHS would utilize the ASO as an extension of itself to self-administer the public behavioral health system. The ASO would not be a direct provider of services.

5. *The Administrative Services Organization (ASO) must be a public or quasi-public body.*
    - It is the intent to charge MDHHS as the public body responsible for administering the system while providing them the authority to utilize an ASO as their extension to ensure they have the proper resources and expertise needed to execute the provisions of the Mental Health Code.
    - MDHHS, by virtue of its place in the Executive Branch, is a public body and fully subject to public accountability with checks and balances provided by the Legislative and Judicial branches of government.
    - Added to the above, the Behavioral Health Oversight Council is appointed by the Executive and Legislative branches with assurance of regional equity and participation of persons served by the system. The purpose of the council is to advise MDHHS to ensure

it and its ASO (if applicable) are carrying out its duties in functions in providing public behavioral health services. This council is supplemental to the public oversight already inherent in the bill given MDHHS' definition of a public body within the Executive branch.

6. *What does a self-insured system mean?*
    - Self-insured means that the State (i.e., MDHHS) holds the risk and is responsible for providing public behavioral health services to Michiganders.

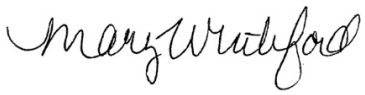
7. *What is the point of moving to a self-insured system?*
    - Today, MDHHS "shares" financial risk with its contracted Prepaid Inpatient Health Plans (PIHPs). However, this is a misnomer -- after a certain threshold is met requiring PIHPs to cover costs of services, the State (e.g., MDHHS) is responsible for covering all costs. Therefore, the State is the risk-holder, regardless of how much initial sharing may take place. In other words, at the end of the day, if a PIHP can't cover costs to provide essential services, the State must step in and covers those costs. This process requires MDHHS to request additional legislative appropriations, tension between MDHHS and PIHPs, legislative questioning, and extra administrative action needed to properly move the needed money from the State to the PIHP.
    - Behavioral health and I/DD are not suited to traditional modalities of health insurance and managed care -- they are conditions that require continuous engagement over years, decades, or lifetimes. From an insurer standpoint, it is difficult to predict utilization and costs; in other words, they are "bad risks". Many delivery systems and States create a patchwork of coverage containing carve-outs for select services or supports due to the unpredictability. At best, this creates a nightmare for providers to navigate; at worst, it results in providers choosing not to provide services, harming our most vulnerable Michiganders and our population health. For Michigan's PIHPs, there are invariably, year after year, PIHPs that operate at financial deficits requiring the State to step in.
    - The current arrangement is inefficient at best. Given the state's constitutional duty to serve all Michiganders with behavioral health needs and the fact that the State is the ultimate risk-bearer, the PIHPs reflect a redundant layer of administration that could be much more efficiently provided by the State and its single ASO (if applicable). Not to mention, much of the PIHP administration is carried out by the CMHSPs that govern it, which is dually inefficient.
    - In the proposed system in the bill, the State assumes the role of a managed care entity -- allowing for efficiencies in administration, more uniformity of services and processes, and greater public accountability as one entity, MDHHS, would be responsible for the system.

8. *Moving to a managed fee-for-service model is a step back in time that compromises innovations and value-based purchasing.*
    - Managed fee-for-service is not the same thing as "fee-for-service". In other words, the State would be able to retain and utilize myriad financing arrangements to pay its

providers, including but not limited to full capitation, partial capitation (risk sharing), shared savings, pay-for-performance, and traditional fee-for-service.
- The State would negotiate directly or via its ASO (if applicable) the payment arrangement best suited to ensure optimal access to and quality of behavioral health services.
- The State would be able to fully continue service delivery level innovations and integration models such as Medicaid Health Homes, Certified Community Behavioral Health Clinics, value-based payments, pay-for-performance, and other incentive-based arrangements.

9. *These bills are set in stone and key players will not have a voice at the table.*
    - From day one, I have made it clear that these bills must reflect the needs of all Michiganders, but chiefly those that receive services through Michigan's public behavioral health system. To that end, I am committed to listening to concerns, seeking expert input, and amending the bills until they reflect our collective values and gain optimal alignment from all essential stakeholders.

Sincerely,



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