TESTIMONY TO:

Health Policy Subcommittee on Behavioral Health
Michigan House of Representatives
Chairperson- Representative Felicia Brabec

PRESENTED BY:
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Southwest Solutions

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Introduction

Good morning, chairperson Brabec and members of the Health Policy Subcommittee on Behavioral Health. I am Sean de Four, President and CEO of Southwest Solutions, a nonprofit organization dedicated to improving the quality of life, success and self-sufficiency of individuals and families in Detroit. I appreciate the opportunity to provide testimony today regarding the priority needs for our behavioral health sector, and to highlight ways that this body can help improve access and quality of care for Michiganders.

As the members of this committee are well aware, behavioral health issues continue to impact individuals and families across our great state and the need for accessible and high-quality care has never been more pressing. As a nonprofit serving the diverse population of Detroit, every day we witness firsthand the devastating effects of untreated mental health conditions on our community members, which exacerbate social and economic disparities, increase the likelihood of chronic disease onset, and often result in premature death.

The demand for services has continued to grow and while our ability to meet the need is limited by a behavioral health workforce shortage and inadequate resources, there are steps that we can take which have proven to expand access to care, save cost and improve outcomes. **I would like to highlight three**, which I believe this esteemed body can help advance, to ensure that every Michigander has access to the care they need and deserve.

1. **First is to support the Michigan Department of Health and Human Services (MDHHS) efforts to expand the number of Certified Community Behavioral**

Health Clinics (CCBHC) across the state, especially in Michigan's most populous area- Southeast Michigan

Southwest Solutions is one of several Wayne County based organizations that received a CCBHC expansion grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), over the past three years. These grants have allowed nonprofit organizations like ours to develop and enhance their capacity to deliver high-quality, integrated care to vulnerable populations. I'll give you a few examples of how this model has benefitted our community:

- As a result of our CCBHC grant, we were able to add nurse practitioners who assess and treat the physical health needs of our clients in conjunction with their behavioral health care. For many children with anxiety and asthma, unhoused individuals with severe mental illness and unmanaged or undiagnosed diabetes, parents with depression and COPD, etc., they finally received the type of comprehensive and integrated treatment they went without for most of their lives. As a result, we tracked and documented improvements in symptoms for multiple conditions simultaneously.
- We expanded our services to include comprehensive substance use disorder treatment, including Medication Assisted Treatment. We treated over 80 individuals we couldn't previously serve with opioid use disorder, at a time when addiction and overdose deaths have never been higher in our state.
- Finally, we were able to treat over 500 more children who were struggling with mild-to-moderate behavioral health challenges, like depression, anxiety, or substance abuse, who otherwise would not have qualified for services because their symptoms weren't severe enough to qualify for publicly funded care and their parents couldn't access or afford private care.

Our organization has been working to implement the CCBHC model over the last several years and couldn't be more pleased with the impact our communities have experienced as a result; however, these gains in access and quality are at risk. While we applaud MDDHS' plans to expand the state CCBHC demonstration, according to the released criteria, private non-profit organizations are currently not eligible for consideration. Because our existing federal grant funding runs out in September, if the Michigan Legislature does not appropriate funds to support MDDHS' expansion of the CCBHC demonstration AND ensure that private non-profit organizations like Southwest Solutions can be included in the expansion, we will be forced to eliminate these added services in the fall.

By expanding the State CCBHC Demonstration Program to include nonprofit organizations with SAMHSA CCBHC expansion grants, we can preserve their expanded services and enhanced access to care gained through these federal initiatives. Moreover, we can capitalize on the strong community relationships and deeper understanding of local needs these organizations have, which enables them to effectively address the diverse and complex challenges faced by individuals seeking behavioral health support.

2. **Second is to introduce and/or pass legislation to expand access to telehealth, including audio only services, and reduce the administrative burden clinicians bear in our public mental health system.**

While MDHHS recently issued revised policy that made permanent some of the telehealth flexibilities offered during the Public Health Emergency, there are still significant limitations on the use of telehealth, particularly for audio only services. For many of our clients in Southwest Detroit, where our headquarters is located, access to reliable internet, especially broadband, is severely limited. In fact, only approximately 42% of households in our area have internet access. In addition, we serve a significant number of older adults, and individuals in poverty, many of whom struggle to use video conferencing technology, lack proper devices, or have limited access to transportation to make in-person appointments. For them, telehealth, including audio only was a godsend. And, for our limited number of clinicians, this technology helped reduce dead time caused by no-shows and missed appointments. Currently, many codes for which telehealth should be allowed, including audio only, are not supported by policy; including case management and targeted case management services, which are especially common services for our most complex and challenged individuals.

The shortage of licensed behavioral health clinicians is felt most acutely in human services organizations that serve the public mental health system, which creates inequity in accessing behavioral health care for the Medicaid population. We know that metropolitan areas with high Medicaid populations like Detroit and Benton Harbor have the highest percentage of residents with untreated mental illness, at 48 percent and 47 percent, respectively (Bridge Magazine, 2022).

The paperwork in public mental health is so heavy compared to other areas that many staff who leave our organizations have identified the documentation, not wages or the clinical work, as a determining factor in their exits. Many authorizations are problematic and unnecessary, and consumers are often frustrated by the time spent on documentation and related redundancies. Clinical staff are leaving public mental health

to go into private practice or other sectors because they can spend a much higher percentage of their time on clinical care, rather than paperwork.

If we can mandate a statewide effort to reduce administrative burdens, including paperwork requirements, to align more closely with private and commercial systems' standards, we can instantly expand capacity and improve access to care. Further, if this body supports legislation to expand billing codes for telehealth, allowing audio-only services, and letting individuals self-determine the best medium for care, in consultation with their clinician, we can improve access for many of our most vulnerable individuals.

3. **The third and final area I want to highlight is the need to preserve and advance efforts to integrate care, which are currently at risk due to proposed recommendations from the Conflict Free Access and Planning (CFAP) workgroup within MDHHS.**

The benefits of integrated and coordinated care have been well documented and form the basis of nearly all forward-looking models that show reduced costs and improved outcomes for behavioral health consumers. Models like the CCBHC, Opioid Health Homes, Wraparound services and Patient Centered Medical Homes are all based on approaches that tightly integrate services, and they show some of the best outcomes, particularly for highly complex cases; however, a workgroup within MDHHS (the Conflict Free Access and Planning Workgroup) is seeking to separate service access and planning from service delivery, due to a perceived potential for conflict of interest. In other words, one organization or administrative entity would be responsible for assessing need, eligibility for services and creating a person-centered plan and a completely separate agency or administrative structure would be responsible for providing the services.

What is being proposed by the workgroup will create additional barriers for people seeking services, weaken continuity and integration of care, increase administrative costs, and make an already complex system more complex.

I encourage this committee to explore what is being proposed by the workgroup and review alternative recommendations and legal opinions that have been developed by the Community Mental Health Association of Michigan, which validate that the current safeguards and structure in place to prevent conflict of interest meets federal requirements while supporting integrated care.

By advancing these three common sense recommendations we can help ensure that many more Michiganders have access to the high-quality integrated care they need and deserve.

Thank you, chairperson Brabec and members of the committee for the opportunity to testify before you today. I am happy to answer questions you have now or provide additional information outside of the hearing.

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