TESTIMONY TO:
Health Policy Subcommittee on Behavioral Health
Michigan House of Representatives
Chairperson – Rep. Felicia Brabec

PRESENTED BY:
Sam Price, President/CEO
sprice@1016.org
Ten16 Recovery Network
www.1016.org

Introduction

Good morning, chairperson Brabec and members of the Committee. I am Sam Price, President/CEO of Ten16 Recovery Network, a nonprofit with staff in 20 different locations across 10 different counties in mid-Michigan. Our organization does prevention in schools, has a collegiate recovery program on four campuses, has embedded recovery coaches in 10 hospital Emergency Departments and two Federally Qualified Health Centers, operates recovery housing programs, and a residential facility, runs four outpatient recovery centers, and has been an active member of a pilot of Opioid Fatality Review team. We hold a prevention license, a treatment/recovery support license, and a residential license. We are accredited by CARF and our recovery houses are accredited with the Michigan Association of Recovery Residences.

Additionally, my colleagues and I today are members of the Provider Alliance Substance Use Disorder Subcommittee. Our combined footprint is close to representing the entire State's experience with substance use disorders. We are sharing the feedback and insights from our local expertise and those of our other members.

I appreciate the opportunity to provide testimony today regarding the priorities within the SUD portion of the behavioral health sector. There are ways that this body can help improve access to care and strengthen our system of care.

SUD Crisis in General

As members of this Committee are well aware, our State has not been immune to the extended opioid crisis and its devastating impact on communities and families. However, I would venture to say that we have moved well beyond an opioid epidemic to a drug poisoning crisis. With over 70% of fatal overdoses having fentanyl involved and the increased danger of xylazine, the hazards on the street for those trapped in active addiction go beyond the citizens we used to target with our efforts 5 years ago. Many of these overdoses are driven by the rising level of tainted methamphetamine and not heroin either.

On top of that, the opioid epidemic has been distracting from a larger addiction epidemic exacerbated by the pandemic. Alcohol continues to cause the most significant number of fatalities

in the State and country. Our agency has staff embedded in 10 different hospital Emergency Departments, and 70% of the patients we work with are there for alcohol-related adverse events. As mentioned, methamphetamine is dangerously back on the rise. When comparing 2019 to 2022 in the MDHHS records for the public sector, treatment admissions for methamphetamine dependence were the only classification of substances that rose during the pandemic, up by 2,200 admissions, while heroin and prescription painkiller dependence went down by 10,000 admissions.

Current Experience

While strained to capacity, the SUD Provider System remains resilient and steps into the gap for those struggling with addiction. Robust programs are in place, and creativity and innovation are constantly taking shape with new community partners. For example, our continuum of care allows us to see patients in the Emergency Department, connect them with our residential program, and then transition down to our drop-in recovery center, where they work with a therapist and a recovery coach. Our outcomes show that we talked with over 1300 patients (who would not normally walk through our treatment doors) and that 45% of them follow up with care (which is in line with the national benchmarks set by Boston Medical, who trained our staff when we brought it to Michigan 7 years ago), and that over 60% of those who fully engage in our recovery center model will complete their treatment (compared to 45% which is the state average for OP completion).

Much like others, the degree of response and access has been blunted by the behavioral health workforce. Across the spectrum of the public behavioral health safety net, the State's SUD safety net is the only one fully privatized to a network of primarily private nonprofit providers. As scrappy as we are, it leaves us in the enviable position of competing with CMH, hospitals, and school systems for the same limited pool of social workers and counselors. This leads to growing wait lists and staff who get burned out carrying excessive caseloads as they wait for vacancies to be filled.

There is a healthy tension between harm reduction services and treatment providers. This tension is a necessary dynamic to ensure that we are maintaining a "both-and" perspective rather than an "either-or" in our continuum of care. Indeed, a person cannot recover if they die from an overdose of a tainted product. It is equally valid that a person will not be able to change unless we offer hope when we meet people where they are. Our systems are rightly focused on harm reduction and survival, yet we have not been able to bring equal energy and resources to prevention, treatment, and recovery services. Maintaining that balanced macro-level perspective is critically important when establishing healthcare policy. We have a robust system and need to ensure that we are equally and equitably investing in all providers along the continuum of care. It does not serve us well when we can save lives, but we don't have the same degree of strength and depth for treatment and recovery support providers.

Recommendations for Change

1. **As the steward of the State's public SUD safety net, we recommend you create a clear, coordinated pathway for using all opioid and SUD-related funding.**

With the flood of State and federal funds poured into fighting the opioid epidemic, there has been a flurry of effort and activity. Often this creates programs that work at cross purposes or supplant existing publicly funded practices. These competing programs turn into confusion and frustration at the community level. It is imperative that these public dollars, including general fund dollars, be directed to the existing contracted SUD provider system. These providers are vetted, credentialed, accountable to licensing and national accreditation standards, and accountable for both cost and outcomes to MDHHS and the PIHPs.

Additionally, regional and local collaborative structures are in place to minimize duplication of effort and coordinate resources. This is not to say that new organizations cannot be added to that existing network, but all should be working through the same procurement and contracting process. It is the best way to ensure you get the best return on your investment of these dollars.

2. **Ensure parity between the Mental Health and Substance Use Disorder system and re-engineer the reimbursement structure**
Even though attempts have been made to integrate the public behavioral health systems, a wide gap exists between the resources and funding mechanisms of the different specialty populations served. While the mental health system moves forward with the CCBHC and moves toward value-based payment, the SUD providers are stuck with outdated reimbursement rates that have been unable to keep pace with inflation and the cost of being competitive in the labor market. We are recommending that there be an emphasis on MDHHS to move toward parity between the two systems and adopt more value-based, cost-reimbursement models of funding.

The SUD system has been a collection of muddled, antiquated funding/reimbursement models that are no longer relevant to achieve collective impact and population health. It is proposed that traditional "fee for service" mechanisms be shelved and move the system be in line with the growing trends of value-based/performance-based contracting and SUD-focused Health Homes. Fee-for-service breeds competition among providers instead of collaboration and often promotes a volume of activities rather than any accountability toward improved health and sustained recovery. It also must be recognized that fee-for-service was not an appropriate funding model during the pandemic. Providers have been unable to operate effectively under a reimbursement mechanism predicated on people's ability to participate safely and physically, and that volume has been slow to return to 2019 levels. While a helpful addition, Telehealth is not a suitable replacement because of broadband/technology inequities in rural and urban areas.

When providers have stable funding, it allows them to focus on quality and change instead of volume; it lays the seeds for innovation. Working with those who struggle with a Substance Use Disorder requires disease management strategies that don't fit into an acute care, fee-for-service model. When providers are paid for and accountable for care episodes, new service lines can be created "in lieu of" mandated services, as allowed under managed care laws.

3. **Increase administrative efficiency and reduce the paperwork burden**
   Many SUD providers have to contract with multiple PIHPs to maintain financial stability. In like fashion, many PIHPs have to contract with SUD providers outside their region to maintain network adequacy. Since the ten PIHPs have their own credentialing, authorization, utilization review, payment, and monitoring practices, it creates an unnecessary administrative burden on providers. It enables redundant, inefficient systems on the PIHP side. The additional layer of complication that this structure adds is the transfer of data to MDHHS and the legislature. Because each data collection system is slightly different, precious time and resources are lost working by MDHHS to ensure that there is data integrity across the board before compiling and reporting to the federal government and the state legislature. The ironic element to all of this is that each PIHP is held to the same master contract with the Department, and the majority all use the same data platform. These fundamental elements lead to confusion and frustration among providers and are ultimately carried down to the persons served.

   This burden has a direct impact on the workforce issue that we are experiencing. The weight of paperwork and data entry falls on our clinicians and recovery coaches, and it cuts into time providing direct services and drives many people out of the workforce. The imbalance between the data points collected by a commercial health plan versus the public system is untenable, and we need to find out the value brought by those data points.

Resources Needed

Recently, MDHHS offered an RFP for an investment in infrastructure for the SUD system. It was a competitive bid process and allowed providers to identify opportunities to upgrade their technology and facilities. As a field, we were grateful for the opportunity. This was the first time in my 20 years in the field that I have seen something like this being offered, and we encourage this to become a standing practice of the Department. Under fee-for-service, most providers have such narrow margins that there are few opportunities to keep up with these expenses, and they often get deferred to provide reasonable wages and benefits. Another benefit is that it allows for equity in the opportunity because only some agencies are connected in ways to get special projects recognized and supported.

Therefore, I suggest the creation of an Integration Innovation Venture Capital Fund.
The Provider Alliance has advocated establishing an Integration Innovation Venture Capital Fund, managed by MDHHS, and provides start-up capital for new cross-system initiatives. Think of it as Shark Tank for the public good. Many larger-scale initiatives require venture capital to cover the infrastructure needs to bring these programs to market. It could be an identified location for the re-investment of some system savings. Some of the rationale and thoughts behind this needed concept include:

a. Much like Blue Cross/Blue Shield has done with the Michigan Health Endowment Fund, this fund can be used to enhance or develop integration arrangements at the provider level. This

can serve as an incubator of integration that could not be achieved through a state-wide, macro-level policy.

b. This allows for actual integrated service delivery at the community level, provides for the unique nuances of that region, and is the way to best impact health outcomes.
c. The success of healthcare integration is significantly impacted by the relationships held between providers. This local issue can only be managed and facilitated at the local level. This allows the State to create opportunities for willing, innovative partners without forcing structural changes based on external pressure.
d. Allows the existing Medicaid Health Plans, PIHPs, and providers to identify ways to braid funding and explore creative funding methodologies while managing risk.