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.

* **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.**

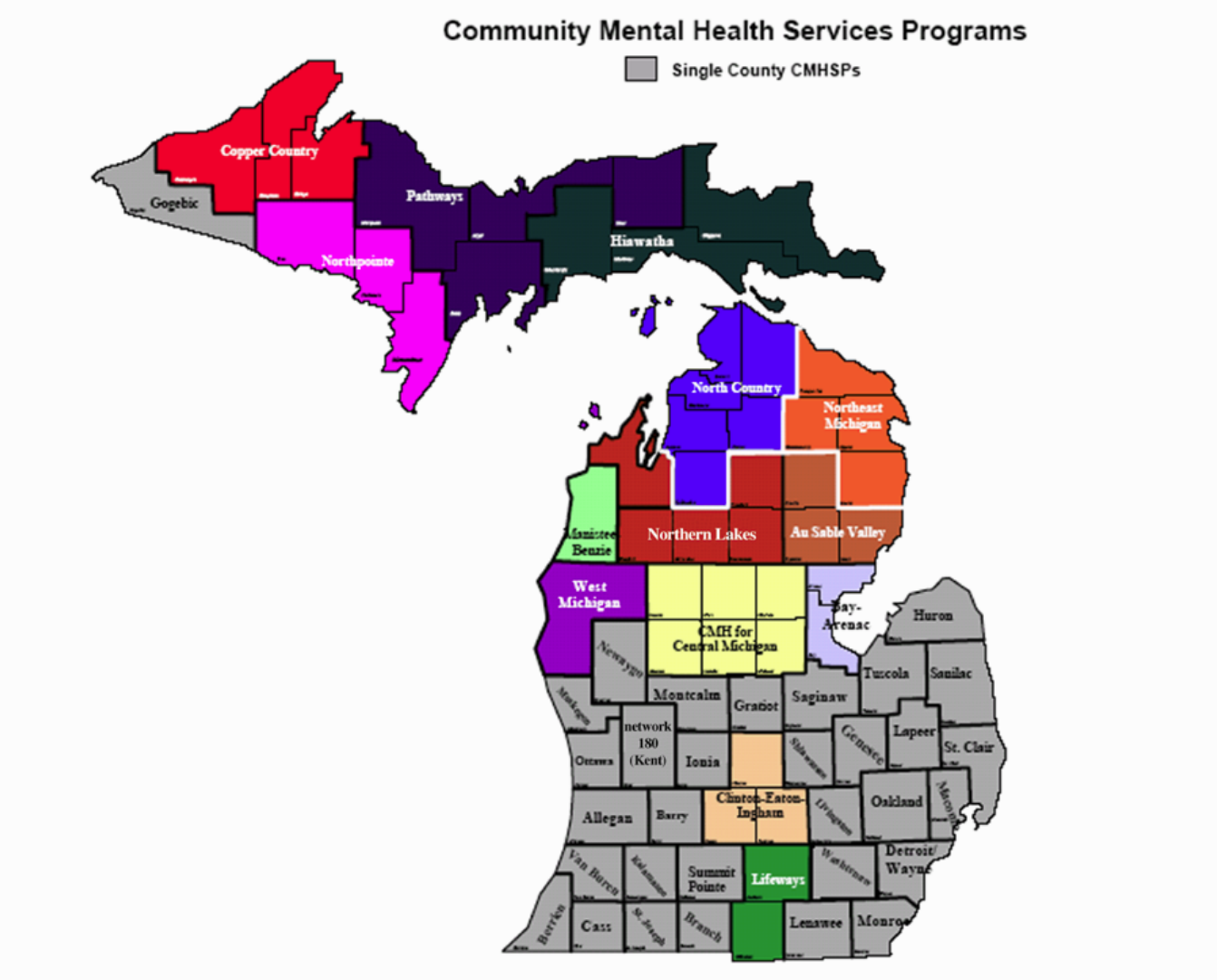
Evolution of the CMH System

1965	1991	2014
12 County Community Mental Health Boards covering 16 counties – 7 in the planning process	55 Community Mental Health Boards covering all 83 counties	46 Community Mental Health Service Programs & 10 PIHPs covering all 83 counties
41 state operated psychiatric hospitals and centers for persons with developmental disabilities – about 29,000 residents	20 state psychiatric hospitals and centers for persons with developmental disabilities – 3,054 residents	5 state operated hospitals and centers on January 24, 2018 – 772 residents. Adult Hospitals: Caro (148), Reuther (167), Kalamazoo (141) Forensic: CFP (262) Children: Hawthorn (54)

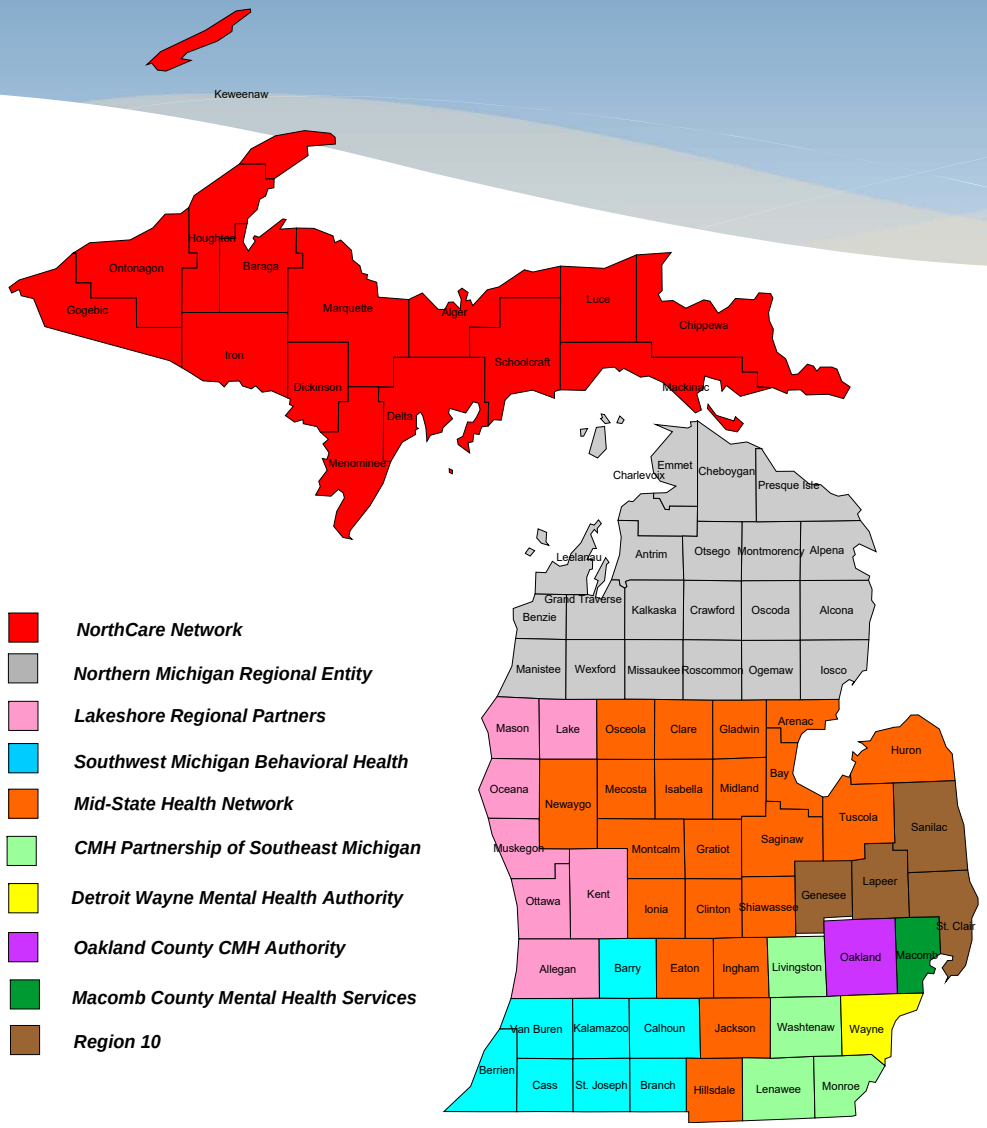
Community Mental Health Service Structure

- **Community Mental Health Services Programs (CMHSPs)** – The forty six (46) CMHSPs and the organizations with which they contract provide a comprehensive range of mental health services and supports to children, adolescents and adults with mental illnesses, developmental disabilities and substance use disorders in all 83 Michigan counties.
  - Providers, purchasers and managers of a comprehensive array of services and supports across a network of providers in fulfillment of statutory roles to serve the individuals, families and communities regardless of the ability to pay
  - Community conveners and collaborators – initiating and participating, often in key roles, collaborative efforts designed to address the needs of individuals and communities
  - Advocates for vulnerable populations and a whole-person, social determinant orientation
  - Sources of guidance and expertise, drawn upon by the public, to address a range of health and human services needs
- **Medicaid Prepaid Inpatient Health Plans (PIHPs)** – Ten (10) PIHPs manage the services and supports for persons enrolled in the Medicaid, MIChild, Healthy Michigan Plan, Autism services and substance use disorder programs.
  - Seven (7) of these regional entity PIHPs are made up of an affiliation of multiple CMHs (as few as 4 and as many as 12). These affiliations were created in order to realize administrative efficiencies in managing services and to provide a sufficiently large base of Medicaid enrollees to manage the risk-based, capitated funding system used to finance the system of care for Medicaid beneficiaries.
  - PIHPs contract with the CMHs and other providers within the region to deliver necessary services.

46 CMH Regions



10 PIHP Regions



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.

Public Safety Net

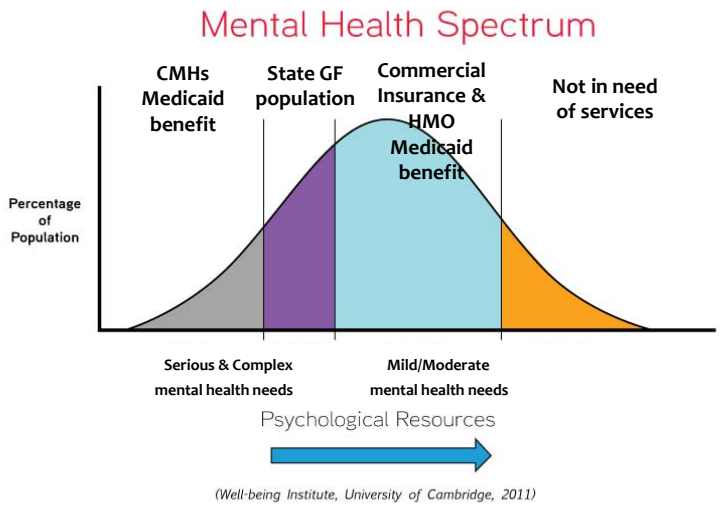
* The CMH network provides 24 hour emergency/crisis response services, screens admissions to state facilities, acts as the single point of entry into the public mental health system, and manages mental health benefits (for persons not eligible for Medicaid enrollment) funded through the state's general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

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.



Who We Serve

Section 208 of the mental health code establishes service priorities for CMHSPs as to who receives services (for General Fund Resources).

* **MUST SERVE**
  1. persons in emergent / crisis situations
  2. persons with more severe forms of severe mental illness (SMI), serious emotional disturbance (SED), and developmental/intellectual disability (DD)

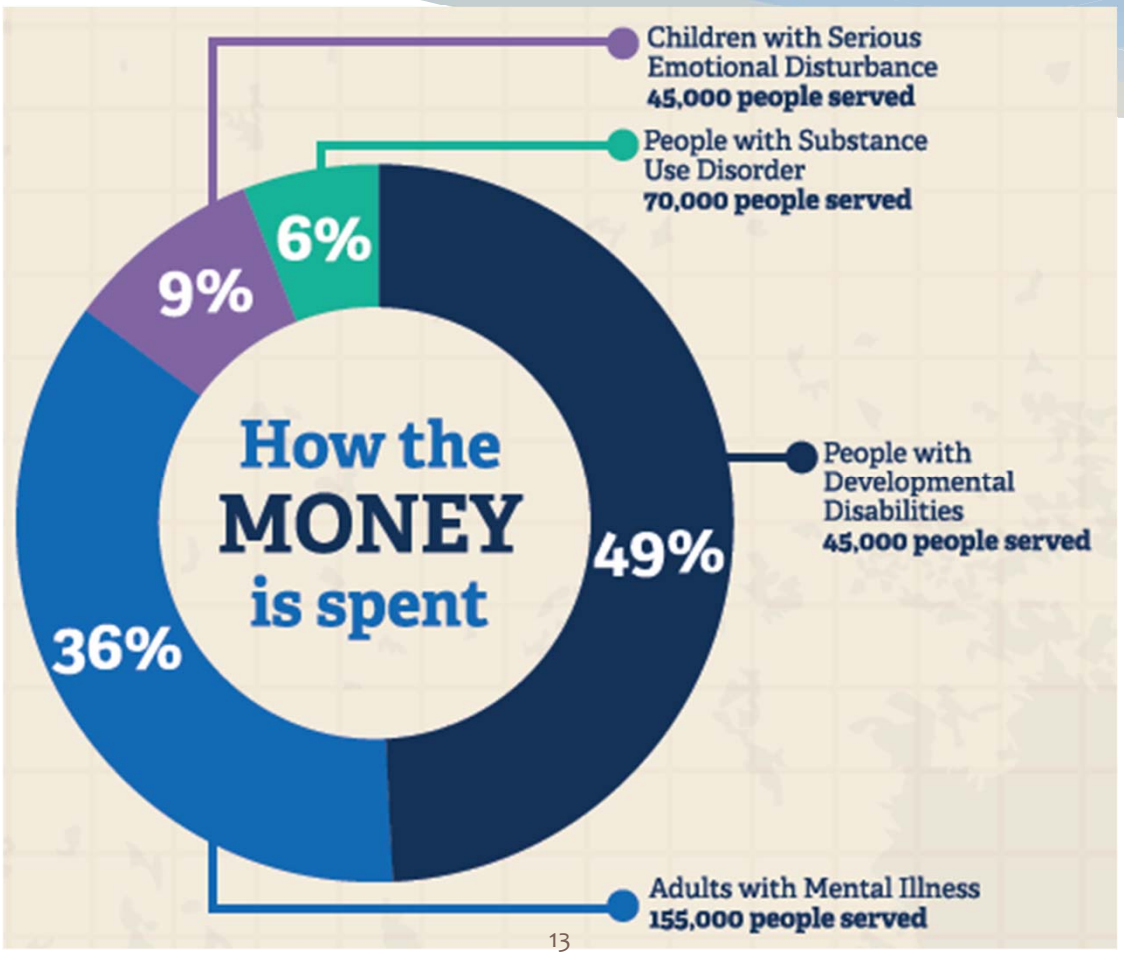
* ***IF* FUNDING EXISTS**
  3. persons with SMI, SED, and DD
  4. mild/moderate mental illness,
  5. the general community including prevention.
     * Due to dramatic general fund shifts in recent years those persons in categories 3 – 5 for most parts of the state are not receiving services.

* Ability to Pay (ATP) is taken in account for those that do not have insurance (Medicaid or private insurance).
  * People cannot be denied services because of an inability to pay.
* **Mild to Moderate mental health outpatient benefit is covered under the Medicaid Health Plans contract.**

Who We Serve

* Due to significant GF budget reductions over the past several years if a person does not have Medicaid or private insurance their ability to receive services is based on the severity of their condition.
  * If condition is *NOT* considered severe, individuals will be placed on a waiting list.
    * Many on wait lists never receive services.
  * In order for those individuals on waiting lists to receive services their condition must worsen to a crisis state where they become a threat to themselves or the community. Many instances these individuals will seek treatment in more costly settings such as emergency rooms and/or county jails.
* **Anderson Economic Group Study published in 2011 showed the state spends 20 times more on mental health services for individuals in emergency situations vs. early intervention - $626 vs. $13,037.**

How the Money Is Spent

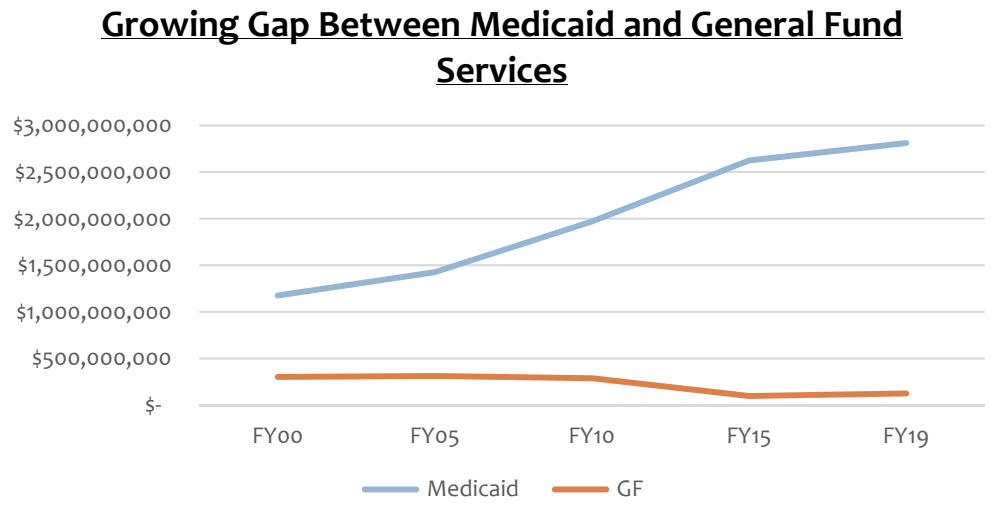


Challenges Facing Public Mental Health System

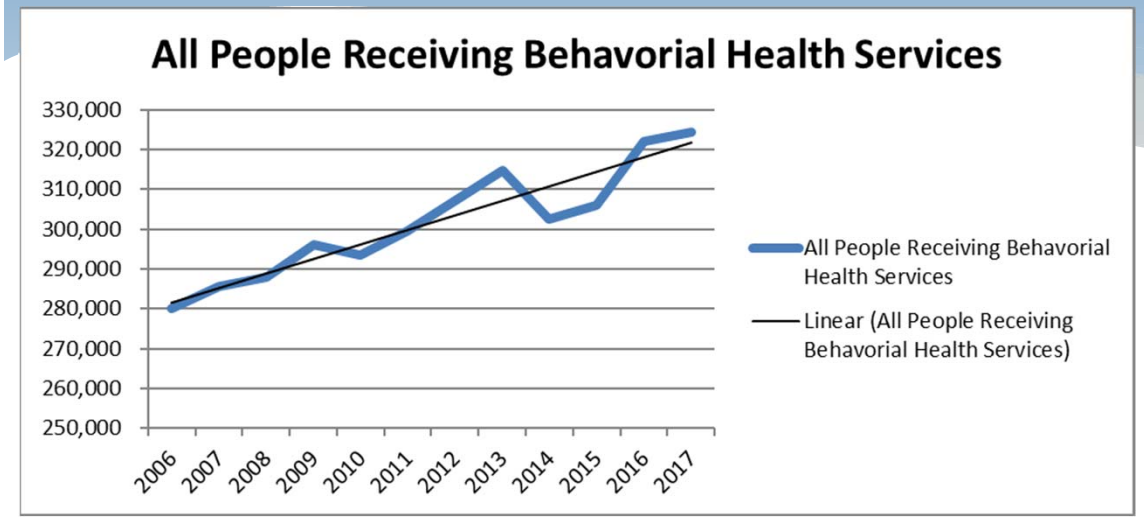
- Death by a thousand cuts – demand for services and increased responsibilities have outpaced funding for the system. Current funding and risk methods must be updated.
  - PIHP & CMH financial and risk arrangements were developed back in the late 90's (1998 managed care started)
  - Michigan's Behavioral Health has changed dramatically since the late 90's, as has healthcare in general
    - Substance Use Disorder services – Opioid Epidemic
    - Healthy Michigan – Medicaid expansion
    - Medicaid Autism
    - Home and Community Based Waiver changes (more independent living)
    - Staffing costs – Minimum wage increases
    - Increased/duplicative reporting requirements
    - Unfunded mandates

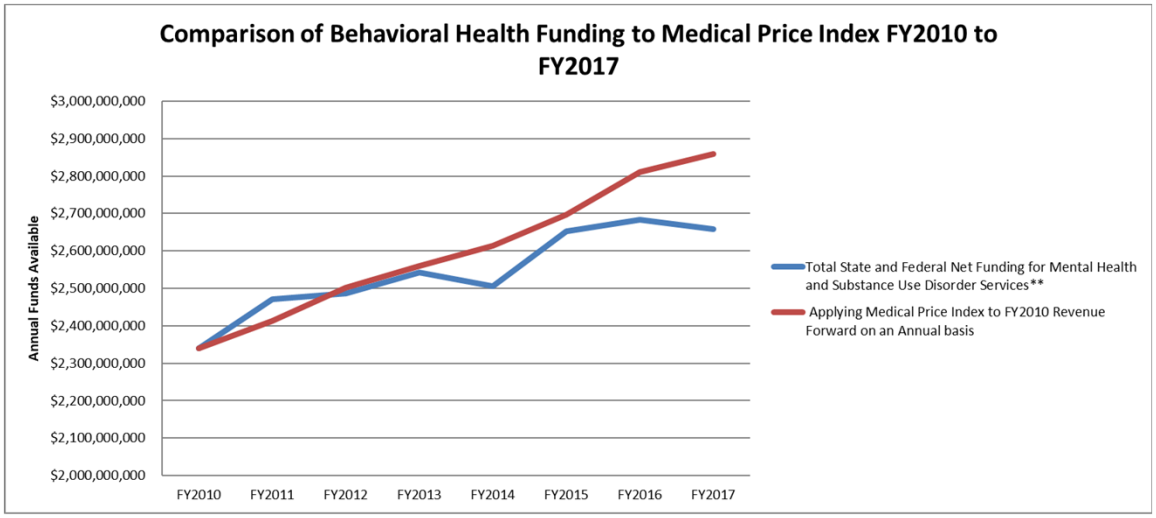
Medicaid vs GF Gap

- Gap between Medicaid and general fund dollars continues to grow: FY00 (70/30 Medicaid vs GF) and FY19 (95/5 Medicaid vs GF).
- With limited abilities to save Medicaid dollars the smallest actuarial error causes financial stress on the system.
    - In FY17 state actuaries found a $133 million funding gap for PIHPs & CMHs.
    - Roughly $16 million GF has been given to 2 PIHPs the last two year to help cover losses, if this money was added on the front end with improved Medicaid rates it would have been over $50 million.



Demand for Services Outpacing Funding





Ways to Update Financing System

* 1. **Set Medicaid rates to match demand and costs:** Set the Medicaid rates to reflect the actual and projected growth in demand for and the real costs of providing the services associated with Michigan's Medicaid mental health benefit.

* **2. Medicaid rates to include contribution to risk reserve:** Include, in the Medicaid rates the federally required contribution to risk reserves at a level sufficient to allow for the fiscal soundness of the public mental health system,

* **3. Allow the public mental health system to hold sufficient risk reserves:** Allow the state's public Prepaid Inpatient Health Plans (PIHPs) to hold risk reserves of the size that would be held by any risk-bearing organization. Allow the CMHs to retain and reinvest any Medicaid savings that they generate through efficiencies and effective clinical practices.

* **4. Remove the Local Match drawdown obligation, section 928 in appropriations boilerplate:** This language earmarks $25.2 million of local money given to CMHs by their counties to draw down additional Medicaid funds. This language was added back in the 1980's when the state needed additional Medicaid revenue and before other financing mechanisms were in place.

CMH Historical Funding

	FY09	FY10	FY11
CMH Medicaid Line	$1,770,128,000	$1,970,775,800	$2,019,515,600
CMH GF Line	$322,027,700	$287,468,000	$282,275,100

	FY12	FY13	FY14
CMH Medicaid Line	$2,149,977,900	$2,160,013,200	$2,152,917,100
CMH GF Line	$273,908,100	$274,136,200	$283,688,700

(FY14 GF was increased by $9.5 million, however it reflects adjustments to paid days in State facilities (a decrease), catch-up over the last few years of $9.0 million. There was a corresponding $9.0 million reduction in the Purchase of State Services line.)

	FY15	FY16	FY17
CMH Medicaid Line	$2,323,857,900	$2,383,364,300	$2,336,960,100
CMH GF Line	$97,050,400	$117,050,400	$120,050,400
Healthy MI Plan	$274,331,900 (partial year)	$355,432,600	$247,822,900
Autism Medicaid	$25,171,800	$36,418,500	$61,168,400

	FY18	FY19
CMH Medicaid Line	$2,315,608,800	$2,319,029,300
CMH GF Line	$120,050,400	$125,578,200
Healthy MI Plan	$288,655,200	$299,439,000
Autism Medicaid	$105,097,300	$192,890,700

Integration – Section 298

298 Intent

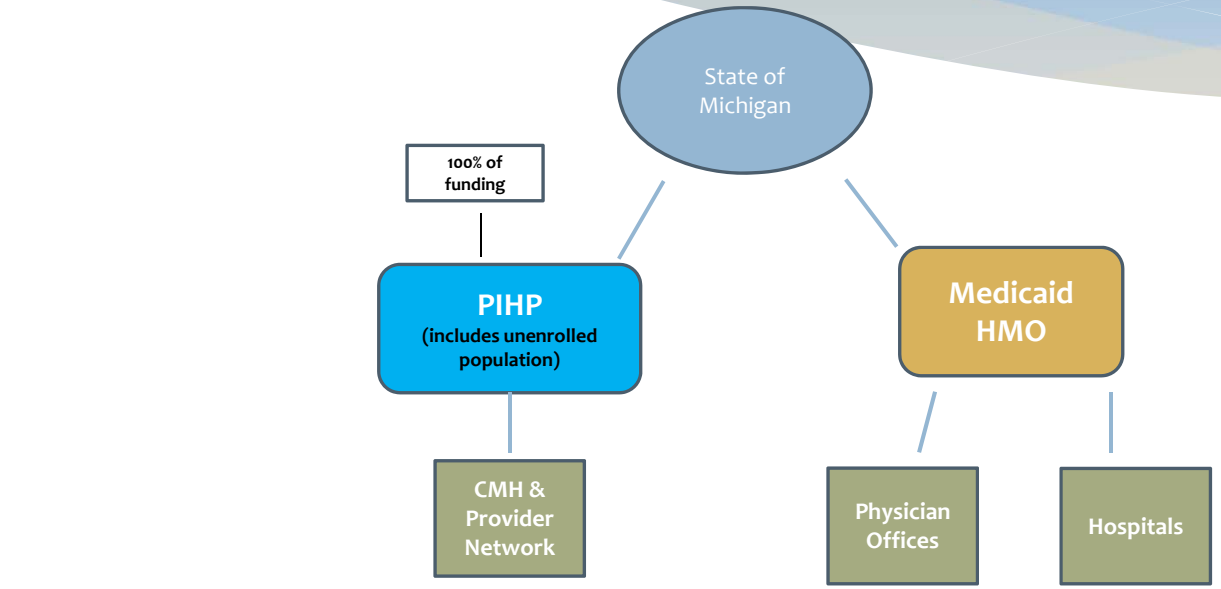
* In 2016 MDHHS officials described the original intent behind section 298 was way to **encourage more coordination of physical and mental health services**. The proposal is "not pulling money out of the mental health system," but is "**reinvesting more to direct services" for patients**, "

Integration Efforts in CMH system

* Many CMHs work collaboratively with physical healthcare partners in order to better treat their clients. **In 2017 there were nearly 600 healthcare integration initiatives across Michigan in CMH system**, some of those efforts included:

  * Identifying patients without a primary care provider to regularly engage them in more preventative care and achieve better health outcomes
  * Screening patients to prevent untreated chronic diseases—a major factor in driving up costs of care for people with behavioral health issues or substance use disorders
  * Addressing the needs of high/super-utilizers through targeting, assertive outreach and case-management approaches, while working collaboratively with other support systems such as transportation, housing support, vocational services and advocacy
  * Co-locating services (either in primary care offices or primary care in behavioral health offices)

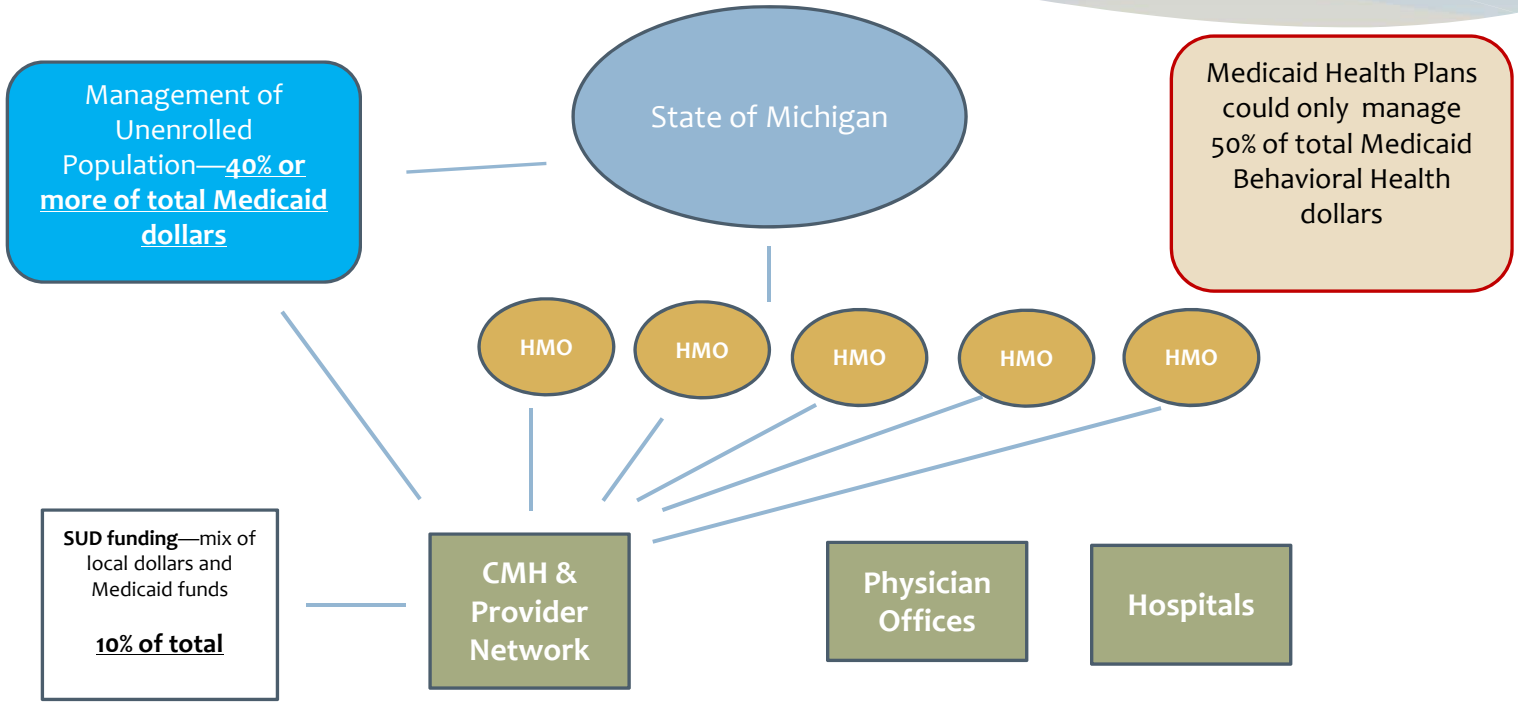
Current System



Behavioral Health Services provided include:
Housing, employment supports, transportation, intensive case management & other social determinates of health.

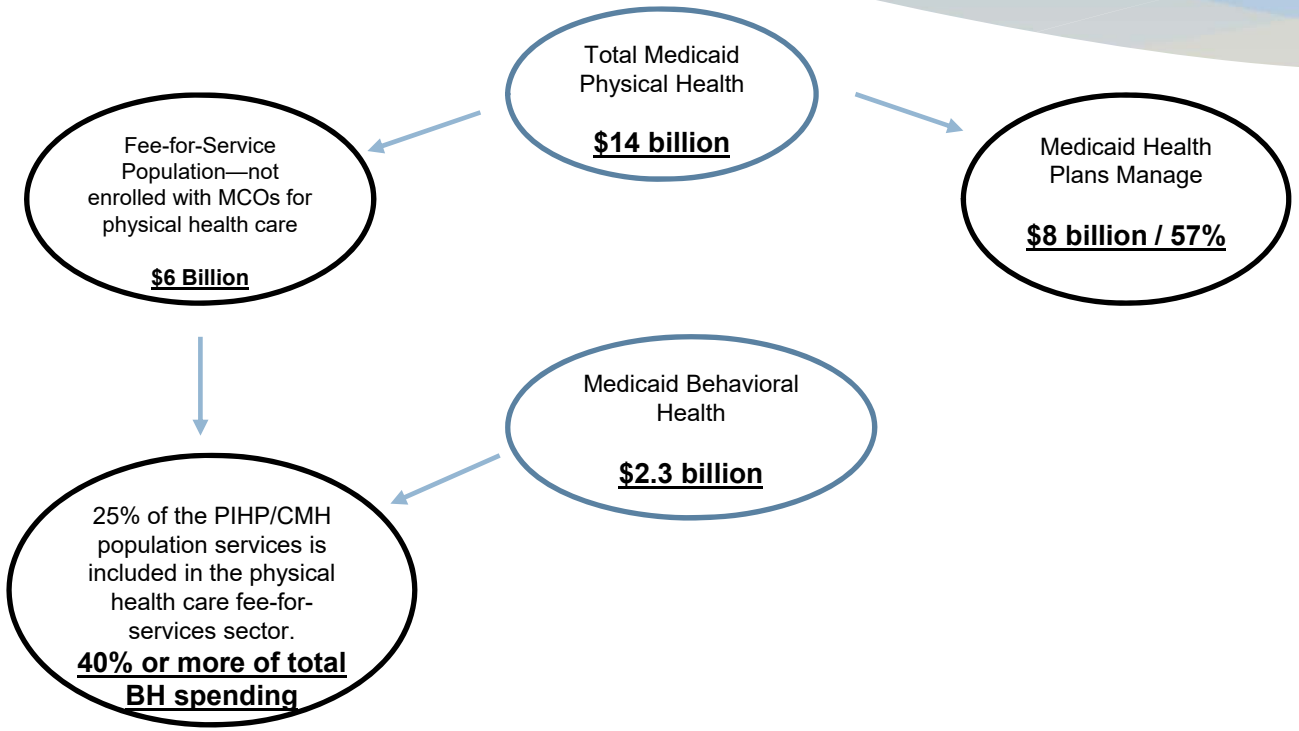
Traditional Healthcare Services provided include:
Traditional medical care—wellness visits, prescription drug, hospital care, etc.

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.

Medicaid Unenrolled / Fee-for-Service



Other Key Issues

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