A Better Mental Health System (BMHS)

Fred A. Cummins

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Preliminary Draft

This document presents conceptual design changes for reform of the Michigan public mental health system that would improve the efficiency, quality and integrity of the system, and more effectively meet the needs of Michigan citizens. It extends the earlier document, "Building a Better Mental Health System," August 28, 2016 (http://www.amioakland.org/documents/16-08-22BuildingaBetterMentalHealthSystem.pdf). This document proposes changes to the public mental health system organizational relationships and responsibilities. The focus is on services to persons with mental illness, but the changes apply to the other mental health populations with adjustments reflecting differences in symptoms and service needs.

The following paragraphs highlight the major changes:

1. **Governance by the Legislature**. In general, governance is accomplished by the activities and controls of a governing body to represent the interests of the enterprise stakeholders in budgets, investments, adoption of policies, operational directives and oversight of performance. The governing body must ensure that the enterprise is doing the right thing and doing it well. The governing body of the Michigan mental health system is the Michigan legislature. The stakeholders are the Michigan citizens and, particularly, the persons in need of mental health services and their families. Unfortunately, the legislators do not know the scope of need for mental health services nor the extent to which that need is not met with the appropriation they adopt. Furthermore, they do not have the time nor the resources to achieve effective oversight, particularly with term limits. This oversight must be provided by an independent Mental Health Oversight organization (below).
2. **Independent Mental Health Oversight (MHO) organization**. An organization that is independent of the mental health administration must support the legislature with the information needed for effective governance and accountability to the public by (1) assessment of state-wide needs for mental health services, (2) evaluation of the needs that will and will not be satisfied by the scope of services of a mental health budget, (3) observation and measurement of the performance of the system—including over and under-utilization review—against the scope of services of an adopted budget, (4) identification and measurement of cost shifting (e.g., costs of incarceration or nursing home care for persons qualified for mental health services) and recipients homeless, missing or deceased, (5) investigation, evaluation and development of corrective action and meaningful remedies for substantiated grievances and rights violations arising from mental health treatment or services. The MHO should have an advisory board with a representative from each RMHA (described below). The MHO may have regional offices for services oversight and investigations that is close to service delivery.
3. **Needs-based mental health budget**. The legislature must approve a budget based on a needs-based specification of qualified recipients and services, and with a clear understanding and public disclosure of the needs that the budget will not cover.
4. **Needs assessment**. Needs assessment by the MHO will be accomplished through objective investigations, surveys and analyses considering services currently being

provided, persons who previously have been disqualified for services, persons in jails, prisons, homeless, or waiting lines or other delays in access, and unsatisfied needs of existing recipients. In addition, needs should reflect the potential for intervention when symptoms first appear—including children, and the need to support and sustain recovery. The Regional Mental Health Authorities (RMHAs—ransformed PIHPs) must participate in the needs assessment based on current services, persons who have not qualified for the current scope of services, waiting lines, liaison with schools, criminal justice, shelters and other community organizations, and projected demand for services based on changes in the qualifications and population.

5. **State Mental Health Services department**. A substantially expanded Behavioral Health and Developmental Disability Administration (BHDDA) of the Michigan Department of Health and Human Services (MDHHS) must be responsible for the leadership, management, quality of care and much of the administrative operations of the mental health system. BHDDA must be responsible for statewide standards for systems, policies and practices, including consistency of psychiatric formularies of hospitals, jails, prisons and nursing homes. For economies of scale, accountability and consistency, this department will consolidate much of the administrative operations for accounting, personnel, purchasing and information systems that are currently performed by multiple CMH organizations and providers. State-wide information systems—in addition to enabling rapid and efficient system advances—must integrate service operation supports and records management to (1) provide consistent interfaces for service provides serving multiple regions, (2) support collaboration and coordination of care, and (3) enable freedom of movement of recipients of services around the state.
6. **Provider contract management**. The BHDDA must directly negotiate and manage master contracts of all mental health service providers including services provided by the RMHAs thus eliminating duplicated contracting activities and ensuring quality and consistency across the state. A provider can support multiple RMHAs under the same contract. Contract management can facilitate management of vacancies in programs that serve multiple recipients (such as ACT and group homes). Contracts must require consistent payments for services, certification of compliance with state services specifications, employment (or engagement) of state licensed or certified service delivery personnel, and competitive wages to support acquisition and retention of quality personnel. Furthermore, providers must be subject to FOIA and open meetings requirements for public accountability. Recipients of services must have easy access (e.g., Internet) to information on all relevant providers in order to make informed choices.
7. **Adequate and appropriate services**. Within the scope of services defined for the mental health budget, the services must be adequate and appropriate, delivered by qualified and certified personnel who are paid a competitive wage. Recipients must have food, clothing and safe housing in addition to other supports to enable their successful treatment and recovery. The mental health code calls for persons in need of care to receive services regardless of their ability to pay. Medicaid is described as an "entitlement" for medically necessary services, but the entitlement is not enforceable. Budget reductions have resulted in denial of services otherwise covered by Medicaid (services dependent on Medicaid funding), and denial of services not covered by Medicaid but required for persons in need of treatment under the Michigan mental health code. The result is risk of dire consequences due to unserved or underserved persons with mental illness. In the future, recipients must have an enforceable right to the

services for which they are qualified. Policies and funding must eliminate gaps in healthcare coverage such as between Healthy Michigan, Medicaid and general funds so that mental health services are consistently available to those in need without being impoverished.

8. **All services billed to the state**. The MDHHS must directly pay all service providers for the mental health services they deliver as authorized by the RMHA treatment plans. Under one master contract a provider may provide services in multiple regions without duplicated contract negotiation, different policies and complex billing. There must be no delegation of risk by MDHHS. The budget for services is state-wide. The RMHAs have distinct budgets only for their administrative and community collaboration activities.
9. **Regional management of service delivery**. RMHAs are responsible for managing mental health services to the geographical area they serve. They employ or engage the work of professionals (e.g., doctors, case managers, nurses, therapists) billed to the state, and, under state master contracts, establish agreements with providers to authorize specific services to recipients based on individual plans of service.
10. **Individual treatment planning.** Case managers must have primary responsibility for developing treatment plans, working with other professionals and individual recipients to determine the needs, facilitate coordinated care, and support the interests, goals and choices of each recipient as the needs and circumstances evolve. Treatment plans must include meaningful and achievable goals to achieve and sustain a reasonable level of recovery appropriate to the individual's illness and circumstances. Evaluation of goals must recognize that the illness may have occasional setbacks and some people are doing the best they can and must be sustained.
11. **Oversight of services to individuals**. The case manager must be primarily responsible for ensuring that services are delivered as required by the treatment plan, and for resolution of changing needs with service adjustments or corrective actions. Case managers must be independent of direct care providers to prevent conflicts of interest in planning and oversight of services. Currently, with managed care and budget cuts, case managers are encouraged to minimize the levels of service and do not have the time nor the motivation to identify and resolve service quality problems. State contract managers and the MHO must be responsive to problems and implementation of corrective actions, and must promote appropriate, individualized care. State BHDDA, senior professionals must review exceptional cases and professional practices to optimize treatment plans, improve practices and assess performance.
12. **Community role of the RMHA**. Each regional mental health authority (RMHA) must focus on the quality of life of its regional community from a mental health perspective. This requires assurance of quality and timely services to individuals, along with collaboration, coordination, intervention and engagement of appropriate services to mitigate the adverse effects of mental illness on members of the community. The RMHA is responsible for management of outreach to new or separated recipients, crisis response services, admission and discharge of recipients, liaison with community organizations including criminal justice, schools, shelters, churches, development of housing, transportation, and so on. The RMHA is responsible for continuing care for persons incarcerated, particularly those who are not convicted but are awaiting trial or in the Forensic Center for treatment after acquittal as "not guilty by reason of insanity." The community mental health board must function as the governing body of the RMHA and must represent the interests of the citizens of the region through public transparency and

to the state through oversight by the MHO. As representative of the community, the RMHA participates in development of the state budget to meet the needs of the community and the state development of standards, systems, practices and certification criteria.

13. **Expanded system scope.** The current mental health system admits individuals in need of treatment when their illness has progressed to a crisis. Then, if and when the individual attains a stable level of recovery, services and supports are often reduced or terminated to cut costs. This mode of operation increases both costs and human suffering. Instead, the scope of mental health system responsibility must be expanded to provide intervention as early in the development of the illness as possible to mitigate the severity of the illness and the system must promote and sustain recovery. This includes working with schools to intervene for students at high risk or exhibiting early signs of illness. In the long term this will improve the quality of life of people with mental illness as well as their families and the community in general, and it will save tax dollars and lives
14. **Culture of professional care.** Leaders at all levels must develop a culture of professional care. The people who best understand the needs and have the necessary skills to deliver services are those who are involved in direct care and treatment, and must be recognized as professionals in their respective mental health services roles. Professionals must represent their peers in state initiatives relevant to their professions. At the same time, they must support the authorized scope of services specified in the current budget, and provide care with dignity and respect for recipients and their families. As professionals, they must be paid a competitive wage and empowered to exercise their professional judgement without being burdened by bureaucratic controls and hurdles. This includes unrestricted prescription of medications with mental health effects. Furthermore, they must be paid for whatever care they determine appropriate to provide so that they freely meet the needs of challenging recipients. This includes hospitals that currently deny admission to difficult patients whose needs exceed coverage of bundled rates or discharge patients before they are ready to be stable in the community. Excessive treatment or services will be identified and resolved in utilization review. The result will be improved quality and efficiency of care.

Compiled by

The Alliance for the Mentally Ill of Oakland County

Fred A. Cummins, President

Summary of the Perils of Mental Health System Privatization

Governance

- Privatization will require a substantial MDHHS staff increase for needs assessment, oversight, contract management and rights protection.
- State must have oversight offices in every PIHP region to ensure contract compliance
- HMO financial stakeholder priority conflicts with public interest
- Private corporations are not open to public and advocate scrutiny—no FOIA and open meetings
- Rights enforcement must be separated from corporate operations
- Restricted oversight of HMO performance
- No accountability for cost shifting
- No commitment to long term—HMO will leave if budget is tight.

Community responsibility

- No responsibility for to address community needs (unlike CMH)
- Loss of representation of community interest—responsibility beyond individual recipients
- No community collaboration and cooperation—law enforcement, courts, schools, public health shelters, recreation, housing, transportation, food banks, employee assistance programs, more.
- Unclear HMO role in jail diversion and Kevin's Law (court ordered outpatient treatment)

Limited scope of services

- No HMO experience with direct care oversight
- No HMO experience linking and coordinating ancillary services: housing, transportation, recreation, supported employment
- No objective, individual under-utilization review
- CMH system remains without meaningful capacity to serve non-Medicaid recipients
- Responsibility for spend-down unclear

Fragmented system—multiple HMOs

- No county-wide responsibility for crisis resolution
- The mental health system must still provide services for non- Medicaid recipients. [Mental Health Code, Section 810. An individual shall not be denied services because of the inability of responsible parties to pay for the services.]
- HMO service area limits ability to travel or relocate across the state
- HMO competition is not consistent with the best interest of patients or community
- Fragmented coordination with criminal justice—increased criminal justice cost

Inadequate funding for services

- Privatization cannot cure inadequate funding
- Administration cost doubles with HMOs
- Funding diverted from services to private company financial stakeholders
- No assessment or accountability for funding of unserved community need.
- No solution for recruiting and retention of quality personnel

Incentives to avoid services

- Competition for low-cost recipients
- No early intervention incentive
- No long-term recovery incentive
- Treatment choices and planning biased to minimize costs
- Criminalization as cost diversion.
- State hospitals as free (non-Medicaid) care.

Programs may close when underutilized (excessive cost per recipient)

- ACT teams based on number of recipients
- Group homes inefficient with open beds
- Drop-ins, clubhouses not efficient if not shared across HMOs

Diversity of standards and protocols

- Diversity of information systems barrier to coordination and collaboration
- Inconsistent measures of performance for accountability
- Providers interacting with multiple systems add administrative cost and confusion

Quality care

- Restricted formulary limits doctors' discretion and access to best treatment
- No expectation of wage increases for personnel quality improvement
- No attention to basic needs that are outside scope of Medicaid
- No objective assessment of under-utilization that would enforce adequate services
- No enforcement of rights to services since Medicaid is not a true entitlement
- Difficult patients will fall through the cracks—hospitals currently refuse difficult recipients.
- Self determination not comprehended by HMOs and budget increases are needed.

See also "Building a Better Mental Health System" and town hall videos at http://www.amioakland.org select "Advocacy"