Community Mental Health Association of Michigan

Recommendations related to MDHHS proposal for the structure and operation of Michigan's public mental health system[1]

Adopted February 3, 2020

Principles upon which analysis and recommendations are grounded

This analysis and the recommendations presented below are designed around a set of principles that have made Michigan's public mental health system the envy of the nation. These principles are contained as Attachment A to this document. [2]

Recommendations of CMHA relative to MDHHS system design proposal

Recommendations by design element: Below is a listing of the major design elements contained in the MDHHS proposal, with the CMH Association's recommendations related to each design element.

A. Design element: Goals of any redesign effort should center around key public policy aims and the accurate portrayal of the strength and effectiveness of Michigan's public mental health system.

CMHA recommendations:

1. The effort should center around the following aims and not around an inaccurate portrayal of Michigan's public mental health system:

    - What is best for those served by Michigan's public mental health system
    - Fostering the quality of life of persons served across a range of whole-person orientation dimensions, including: housing, employment, academic performance, family relations, social connections, and health outcomes
    - Ready access to mental health and related supports and services
    - Increasing public behavioral health investment and financial stability for the public system
    - Strengthening the ability of the public mental health system to meet the mental health and related needs of the members of their communities
    - Strengthening Michigan's mental health safety net
    - Fostering real primary and mental healthcare integration and coordination via clinical integration (where the client/patient receives services and supports) and the infrastructure and technology necessary to support it

[1] This document reflects the discussions, revisions, and recommendations generated during the following CMHA policy setting and guidance venues: January 10 and 14, 2019, of the CMHA System Design Advisory Group (a group of over 30 representatives of CMHA members representing the full diversity of that membership); the January 10 CMHA Steering Committee; the January 21 meeting of the CMHA Officers; the January 21 meeting of the CMHA Directors Forum; the results of a poll of Directors Forum members during the week of January 20; the February 3 meeting of the CMHA Executive Board; and the meetings of the CMHA Officers during the weeks of January 27 and February 3.

[2] Whenever the words "mental health system" appear in this document, they are shorthand for the system that serves persons with mental illness, emotional disturbance, intellectual and developmental disabilities, and substance use disorders.

2. It is key that MDHHS measure the performance of any system design relative to the original set of four goals identified by MDHHS and those recommended, by CMHA, above.

Basis for CMHA recommendations: Any system redesign should be centered on the core constituency of Michigan's public mental health system and the strengthening of the system that serves them.

B. Design element: Prevent the fragmentation of Michigan's public behavioral health system by developing one public Specialty Integrated Plan (SIP) per region with a minimum of three regions without the development of a number of private SIPs in addition to the public SIP.[3]

CMHA recommendations:

1. That the behavioral health safety net and population health focus of the state's public mental health system be strengthened, and its fragmentation be prevented, through the development of only one SIP per region, within at least three regions, and that this SIP be the public SIP. [4]

   Basis of CMHA recommendations: A single SIP per region – with at least three regions, (with that SIP being the public SIP) ensures the safety net, population health, and organized system of care and accountability that sets Michigan apart from other states.

   A single SIP per region, with at least three regions, with that SIP designated as the public SIP:

   - Prevents the fragmentation of the system that will occur with the formation of private SIPs
   - Foster a strong community-wide mental health safety net and population health focus currently provided by the state's public mental health system
   - Prevent the syphoning off of public dollars from the public SIP, leaving it unable to serve as the state's only public common-good focused care management structure.
   - Fosters the partnering of a private health plan with the public system in the formation of the public SIP per region
   - Prevents adverse selection leading to low need and low-cost enrollees enrolled in private plans, leaving high need and high cost persons as enrollees in public SIP
   - Avoids the misperception that the formation of private SIPs represents real choice for persons served (most Michigan Medicaid enrollees do not select their health plans based on discernible differences in service and supports offerings, managed care practices, nor quality)
   - Allow for the development of regional public SIPs, uses the existing regionally organized behavioral health managed care skill and experience base

[3] The phrase "public Specialty Integrated Plan" or "public SIP" is shorthand for the Specialty Integrated Plan formed as a joint venture between Michigan's public mental health system, its stakeholders, and one private physical health managed care/health plan.

[4] The term "region" when applied to a regional public SIP means those communities linked by geography or aligned by common principles of operation or other partnership forming and strengthening factors.

C. Design element: Public Specialty Integrated Plan (SIP) formed as joint venture between Michigan's public mental health system and one private physical health plan

CMHA recommendations:

1. A public SIP, one and only one in each region, holds promise for system design success with the following components:

- a strong the role of the public system (persons served, advocates, CMHs, Regional Entities, and county government) in the formation and governance of the public SIPs with over 51% of the governance seats filled by public system representatives
- a strong role for the public system partner in operations
- the interests of the persons served, the local communities served, the public system, and the private health plan are addressed via the governance and operational agreement developed for the SIP. ·

2. It is critical that MDHHS play a strong and active role in the design and development of the public SIP, in partnership with the public mental health system (its CMHs, Regional Entities, and providers), those served, and the private health plan that will be the private partner in the SIP.

3. The immediate pursuit of legal guidance to determine the legality, against state and federal statutes and regulations, for the formation of public SIPs and the ability of Michigan counties, CMHs, and CMH Regional Entities to form and be an active party in their governance and operation.

4. Because considerable design, partner development, financial and clinical analysis, changes to state statute (Mental Health Code and Insurance Code), state rules and regulations, and federal Medicaid waivers are needed to make the formation of these public SIPs possible, it is key that experienced subject matter experts from within the public behavioral health care system, stakeholder groups (including persons served, advocates, counties, and public mental health system representatives), knowledgeable legal counsel, nationally experienced healthcare consultants, and other knowledgeable parties be involved in this effort – involved early in and throughout the system design process.

Basis for CMHA recommendations:

- Ensures that the management of the Medicaid mental health benefit remains with the public sector, linked to local county-government-based CMH system and those served by that system
- Savings generated on physical health side of system is available for use in the behavioral healthcare side
- Brings best of public sector (sophisticated and proven statewide provider network; strong whole-person orientation with a focus on social determinants, person-centered planning;

deep roots in community and health and human services networks; longstanding mental health managed care experience) together with best of private sector (longstanding physical health managed care experience; Michigan health insurance/HMO license; access to capital to pair with public capital to cover risk exposure)

- Fosters statewide or regional uniformity of benefit, provider contracts and standards, across mental health and physical health systems
- The system design statutory, regulatory, and waiver changes that will be needed to make this design possible are complex and multi-faceted and demand that the expertise and interests of range of stakeholders and subject matter experts to ensure that they are done well.

D. Design element: Medicaid capitation payments to the public SIP based on the enrollment of the specialty population with each regional public SIP and not the total number of Medicaid nor Healthy Michigan eligibles in the region

CMHA recommendations:

1. This payment structure, based on the enrollment of the specialty population with the public SIP and not full Medicaid nor Healthy Michigan enrollment, should be a key component of the system design.
2. That the capitation payments developed via this construct be adequate to meet the historic needs – both mental health and physical health needs – of the enrolled population and the growth in demand for and intensity of needs that will emerge with the formation of the regional public SIPs.

Basis for CMHA recommendations: This payment structure represents an improvement over the current capitation system and will stabilize funding for the system, in spite of variability in Medicaid enrollment, given that the demand for the Medicaid mental health services provided by the public system does not diminish with reduced Medicaid rolls

E. Design element: Provider network of public SIP.

CMHA recommendations:

1. That the CMH/Regional Entity in each community, and through the CMH/Regional Entity, its provide network, be the exclusive behavioral health provider network of the public SIP, with the exception of primary care providers providing prescription psychotropic medications.

2. Other behavioral healthcare providers can be added to the network and well-performing providers incentivized and poor-performing providers managed and, if needed, removed from the CMH/PIHP network, through the mutual agreement of the public SIP and the CMHs and Regional Entities within the public SIP network.

Basis for CMHA recommendations: The highly organized CMH and Regional Entity provider networks, which have been built by the public mental health system over decades of hands-on relationships, represent providers with: proven expertise and experience in working with the persons who would be enrolled in the SIP, directly and concretely addressing a wide range of social determinants, a demonstrated whole-person orientation, deep community roots, cost effective services and supports, and the proven ability to work collaboratively with other providers and the CMH/Regional Entity.

Contracting outside of those networks, without the guidance of the CMHs and Regional Entities who know the quality of the work of private providers, unravels this highly organized system of care.

F. Design element: Payment method to be used by the public SIP.

CMHA recommendations:

1. A sub-capitated payment structure, akin to what has been used with Michigan's CMHs since 1997, should be used by the public SIP, with MDHHS and the public SIP working to develop actuarially sound sub-capitation rates for the CMHs in the public SIP region.

2. CMHs, paid via capitation, should be allowed to retain any savings generated within their sub-capitation, to meet the mental health and related social determinant needs of Medicaid enrollees and those without Medicaid coverage in their communities.

Basis for CMHA recommendations: Sub-capitated payments, as an advanced form of an alternative/value based payment method, provides the clinical and fiscal flexibility to address social determinants and whole person health – representing the direction in which health care, across the nation, is headed, and that have allowed Michigan to lead the nation in the provision of community-based traditional and non-traditional approaches to providing mental health supports and services.

G. Design element: Establishment of defined functions with earmarked General Fund and, potentially, Medicaid dollars, to CMHs, for fulfilling their safety net and community benefit functions

CMHA recommendations:

1. This is a very strong component of the design and should be part of any system design.
2. It is key that these General Fund and Medicaid dollars be built around the full set of safety net and community benefit roles played by the state's CMH system (organizer of care, community conveners and collaborators, advocates, and sources of guidance and expertise).
3. Include, in these safety net and community benefit functions, the nine essential functions contained in the federal Certified Community Behavioral Health (CCBHC) initiative, in the Michigan Mental Health Code, and the community leadership and convening roles of Michigan's CMHs provide a good start for identifying those roles and functions.
4. The General Fund allocation should be sufficient to support a range of the mental health services and supports expected by Michiganders, including, but not limited to: crisis services (phone, center-based crisis center, mobile crisis teams, inpatient screening, jail diversion and jail-based services, state hospital admission and discharge services, short term intensive crisis stabilization and casemanagement/supports coordination.
5. It is key that CMHs, CMH Regional Entities, persons served, and community stakeholders be involved in defining those roles.

Basis for CMHA recommendations: Individuals, families, and communities across the state rely upon the state's CMHs to fulfill all of their mental health safety net and community benefit roles, including the roles of organizer of care, community conveners and collaborators, advocates, and sources of

guidance and expertise. These roles are appropriately expected to be fulfilled by the state's CMHs for all of the community's residents, whether or not they have Medicaid coverage.

The CCBHC constructs, given their development and endorsement by the federal government, provide a sound basis from which to build this full safety net and community benefit system, including the development of the funding needed to support it.

H. Design element: Assigning the party responsible for the management of:

- unenrolled Medicaid beneficiaries (those for whom the state's PIHPs currently managed the Medicaid benefit but who are not enrolled in physical health managed care)
- the substance use disorder services funded by non-Medicaid sources (PA-2 and federal block grant dollars)
- the mild to moderate mental health benefit

CMHA recommendations:

1. That the public SIP manage:
    - the Medicaid benefit for the unenrolled Medicaid beneficiaries (those for whom the state's PIHPs currently managed the Medicaid benefit but who are not enrolled in physical health managed care)
    - the substance use disorder services funded by non-Medicaid sources (PA-2 and federal block grant dollars) in addition to the Medicaid and Healthy Michigan Substance Use Disorder benefit
    - the Medicaid mild to moderate mental health benefit

2. Enrollees with mild to moderate mental health needs should be allowed to select enrollment in the public SIP or the benefit managed by the state's Medicaid Health Plans.

Basis for CMHA recommendations: The inclusion of the behavioral health benefit for the state's unenrolled Medicaid beneficiaries and the full publicly funded substance use disorder benefit retains the public management of the system that cannot be managed by the private health care plans

The movement of the management of mild to moderate mental health needs to the public SIP eliminates the artificial divide in the provision and risk management of the mental health services

Additionally, this recommendation fosters recovery, to what is deemed a mild-moderate condition, without the loss of the supports necessary to sustain recovery.

Attachment A

Community Mental Health Association of Michigan
Core system integrity principles and design elements
Passed unanimously by the CMHA Executive Board, December 6, 2019

The following principles and design elements – proposed by the Community Mental Health Association of Michigan for any system refinement effort pursued by Michigan's policy makers and elected officials - have, as their foundation, the set of values that are so fundamental to Michigan's public mental health system, that they do not need explanation beyond their listing:

- **an individual's right to self-determination, person-centered planning, full community inclusion, cultural competence in the services and supports provided them**

- **system design should always start with what is best for those served by the system**

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1. **Recognize and build on the current system's strengths:** Build on the nationally-recognized strengths and accomplishments of the state's leading edge public mental health system

2. **Foster real primary and mental healthcare integration and coordination via clinical integration (where the client/patient receives services and supports)and build structural and financial supports from there:** : Foster real health care integration, via clinical integration (where the client/patient receives services and supports) and not simply the consolidation of funding. Support the current and emerging clinical integration models in local communities, often led by the CMH/provider system. Once these clinical integration efforts are designed, structural and financing arrangements would then be designed to foster clinical integration.

3. **Ensure strong local public governance**: Ensure that the governance of the managed care, provider, and collaborative convener roles of the state's public mental health system remain local and public; embedded and linked to the counties served by the system. This recognizes the statutory basis of the county role in Michigan's public mental health system. (This would mean that if a new structure (Integrated Specialty Plan, Special Needs Plan, etc.) was formed, the counties or CMHs would need to be **owners (co-owners), where ownership is required, governing body members, and creators (or co-creators) of that new structure.**

4. **Persons served in key governing roles**: Ensure that the persons served are mandated members of the local governance bodies (not advisory).

5. **Direct contract with the state:** The governance role includes the fiscal control of the system via a direct contract, of the county, CMH, or county- or CMH-created body (such as a PIHP) with the State of Michigan and not through a private entity, unless the counties/CMHs are owners (or co-owners), governing body members, and creators (or co-creators) of that private entity.

6. **Protect and strengthen the full set of safety net roles played by Michigan's public mental health system:** The community mental health system's role as the population-based and place-based resource and public safety net committed to the common good, population-health, social determinants, and community collaboration.

   The safety net role played by the state's CMHs is made up of several components:

   - **Organizers of care** - Providers, purchasers, and managers of a well-organized comprehensive array of services and supports across a **network of proven providers** in fulfillment of statutory role to serve the individuals, families, and communities regardless of the ability to pay.

     For this statutorily-defined safety net role to be retained and strengthened, the CMH in each community and, through the CMH, the provider network organized by the CMH, must serve as the **exclusive provider network** of any system redesign. **Additional providers can be added to the network** as needed and as requested by persons served through the joint work of the risk-bearing care manager and the CMH in each community.

   - **Community conveners and collaborators** – initiating and participating, often in key roles, collaborative efforts designed to address a broad range of social determinant-related 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

7. **Adequate financing:** Ensure adequate and sustainable funding to the public system to ensure that it is sufficiently strong to meet the growing demand and expectations for access to mental health services by all Michiganders.

   This growing demand centers around the full range of mental health needs including: ready access to crisis services for all the Michiganders, fostering the ability of those with a range of mental health needs to live a full and productive life, treatment of substance use disorder (with opioid treatment being the highest profile SUD treatment currently), prevention of incarceration, prevention of homelessness, and the provision of services to children and adolescents with mental health needs and their families.

8. **State retaining central role in public mental health system**: The State of Michigan should retain its longstanding risk-sharing involvement in the state's public mental health system.

9. **Competition only when it fosters the common good and public interest**: If competition is considered for a potential design element in any restructuring of Michigan's public mental health system, the competitive structure must ensure that cost, risk, regulation, marketing, enrollee and/or client assignment, and other factors be controlled to ensure that the competition takes place on a "level playing field" and that the individuals and persons served by the system benefit from competition. Where the system cannot be designed to control such factors, competition should not be included as a design element.

10. **Risk management:** Provide for foundational risk management tools:

    Financing of risk reserves: The Medicaid capitation rates must include an annual and sufficient contribution to the risk reserves of any CMH-centered risk bearing organizations. Federal regulations required that the payments to risk-bearing entities, such as PIHPs, in a capitated/risk-based financing model, include a component for contribution to risk reserves.

    Sub-capitation payments to the CMHs: with incentive and shared saving structures and the ability to retain savings parallel to risk reserve component of rates to care management entity: Parallel to the changes needed to allow for the development of risk reserves by the care management entity, the payments to the CMHs should be in the form of sub-capitation payments, allowing CMHs to retain savings from their Medicaid line of business, as is allowed for all other Medicaid providers, all of which will be retained in the public system for use in meeting unmet community need and invest in system improvements.

    Sharing of savings across the physical-mental health care line: Require shared savings agreements across mental health and physical health systems to foster the development of cost controlling, quality of life enhancing practices.

11. **Retain and expand the groups served by the public mental health system:** Retain and expand the populations served by the system (to meet the expectations of the community):

    Current groups served by the system:
    - adults with serious mental illness
    - children and adolescents with serious emotional disturbance
    - children, adolescents, and adults with intellectual/developmental disabilities
    - children, adolescents, and adults with substance use disorders

    Group to be added to responsibility of the public mental health system
    - children, adolescents, and adults with mild to moderate mental health needs