Fall 2021 Public Policy Update

Overview

- Budget
  - FY22 Budget
  - COVID Supplementals
- Senate Integration Proposal
- House ASO Proposal
- What does the future hold?

Budget Items

Figure 1

A Legislator's Guide to Michigan's Budget Process
Page 8

House Fiscal Agency
October 2014

FY22 Conference Report

Specific Mental Health/Substance Abuse Services Line items

	FY'20 (Final)	FY'21 (Final)	FY'22 (Final)
-CMH Non-Medicaid services	$125,578,200	$125,578,200	$125,578,200
-Medicaid Mental Health Services	$2,487,345,800	$2,653,305,500	$3,124,618,700
-Medicaid Substance Abuse services	$68,281,100	$87,663,200	$83,067,100
-State disability assistance program	$0	$2,018,800	$2,018,800
-Community substance abuse (Prevention, education, and treatment programs)	$108,754,700	$108,333,400	$79,705,200
-Health Homes Program	$3,369,000	$26,769,700	$33,005,400
-Autism services	$230,679,600	$271,721,000	$339,141,600
-Healthy MI Plan (Behavioral health)	$371,843,300	$589,941,900	$603,614,300
-CCBHC	$0	$0	$25,597,300
-Total Local Dollars	$20,380,700	$20,380,700	$15,285,600

FY22 Conference Report

Other Highlights of the FY22 Final Budget:

Direct Care Worker Wage Increase

- Conference concurs with the Senate budget and reflects a full year implementation of a **$2.35/hour direct care worker wage increase** on an ongoing basis after revising annual costs cost estimates to $414.5 million Gross ($146.1 million GF/GP), Sec. 231 is related boilerplate.

CCBHC Implementation

- **Conference report concurs with the FY22 Executive Budget and includes $26.5million gross, $5.0million general fund(6.0FTEs) to support a two-year implementation of the Centers for Medicare and Medicaid (CMS) Certified Community Behavioral Health Clinic (CCBHC) Demonstration program.** Proposed funding will be used to:

- **Establish 14 CCBHC sites**, through 11 Community Mental Health Programs and 3 non-profit behavioral health entities, to provide comprehensive access to behavioral health services to vulnerable individuals.

- Create a new Behavioral Health Policy and Operations Office to oversee the implementation of the CCBHC demonstration, Medicaid Health Homes, and other behavioral health integration initiatives The new office will comprise 6 new FTE positions and 9 reassigned FTE positions responsible for policy, operations, technical assistance, and quality monitoring support.

FY22 Conference Report

KB vs. Lyon lawsuit

* **Conference report concurs with the FY22 Executive budget and includes $91 million gross ($30 million general fund) to recognize new costs related to the implementation of policy changes associated with the KB v. Lyon lawsuit settlement.** These caseload costs will come from program changes aimed at increasing consistency in access to behavioral health services for Medicaid enrollees and those served through the child welfare system.

Local Match Draw Down

* Conference report includes funding for the second year of a five-year phase-out of the use of Local CMH Local Match funding to support the Medicaid Restricted Mental Health Services line. **$5,095,100 GF/GP**

Five-Year Inpatient Psychiatric Plan

* Conference includes $300,000 GF/GP for DHHS to create a 5-year plan to address adult and children inpatient psychiatric bed needs using both public and public-private partnership beds. Sec. 1062 is related boilerplate.

Federal State Opioid Response (SOR) Grant

* Conference report concurs with the Executive budget and includes $36.4 million in federal SOR grant funding to increase access to medication-assisted treatments, addressing unmet treatment needs, and reducing opioid overdose deaths. Federal opioid grant funding also separated out into a separate opioid response activity line item.

Behavioral Health Community Supports and Services

* Conference report concurs with the House budget and adds $2.3 million Gross ($138,500 GF/GP) and directs these community supports to crisis stabilization units and psychiatric residential treatment facilities and authorizes 2.0 FTE positions. Sec. 1010 is related boilerplate.

Supplemental Budgets

Congress passed two large COVID relief packages:

* December under the Trump Administration - $900 billion
* March under the Biden Administration - $1.9 Trillion

Michigan received a TON of federal money from the recent COVID packages.

* $5.6 billion from December
* $18 billion from March

Supplementals to move after the budget is finalized

September 14 – Governor proposed $1.4 billion plan to expand care for families, build up facilities and invest in local public health:

- $335 million to increase capacity for **community-based behavioral health and substance use disorder treatments**. Grants will improve access across the state for:
- Interventions for people with autism spectrum disorder
- Mental health crisis supports
- Residential and community-based services for children
- Community-based wrap-around behavioral health services
- Substance Use Disorder detoxification
- Inpatient hospital services

Legislature is planning on moving 4-5 supplementals – October/November

* **$300-500 million invest in Mental Health (more 1-time investments)**

Key Budget Items for CMHA Members

Direct Care Worker Wage Increase

* Retain a minimum $2/hour increase for DCWs.

CCBHC Implementation

* **Includes $26.5million gross, $5.0million general fund(6.0FTEs) to support a two-year implementation of the Centers for Medicare and Medicaid (CMS) Certified Community Behavioral Health Clinic (CCBHC) Demonstration program.**

Substance Use Disorder Funding

* Include funding of the recently approved federal dollars to help smooth the recent reductions in the SUD block and federal SOR grant programs.

Local Match Draw Down

* Include funding for the second and third year of a five-year phase-out of the use of Local CMH Local Match funding to support the Medicaid Restricted Mental Health Services line. **$10,190,200 GF/GP**

Michigan Constitution

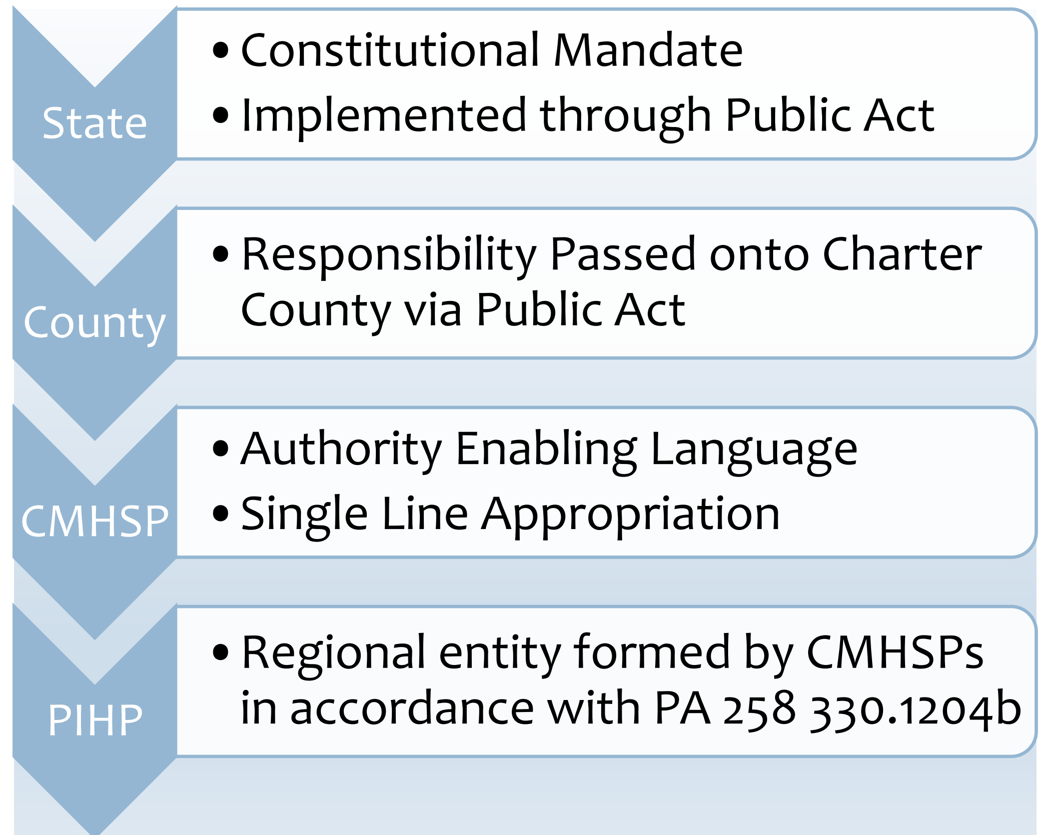
Community Mental Health Organizations are required to serve individuals with a severe mental illness or disability regardless of their ability to pay. An individual can not be denied a service that is medically necessary because of inability to pay or lack of insurance.

* **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.**

Transfer of Authority

Transfer of Authority

- The State duty begins with the constitution as implemented in PA 258
- The County duty begins with PA 258 section 202.
- The PIHP duty is created in PA 258 Section 204 when CMHSPS are permitted to form a Regional Entity .
- The State may contract with a duly formed PIHP to manage the Medicaid benefit.
- The PIHP may then contract with the participating CMHSPs for delegated and provider functions.



Gearing Towards Integration

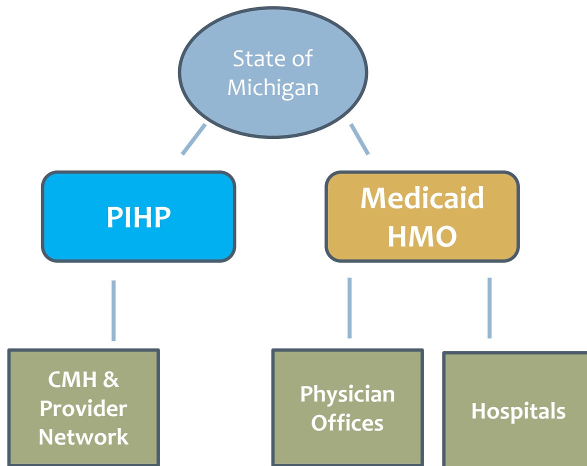
https://www.youtube.com/watch?v=vUi1PdYn5nk

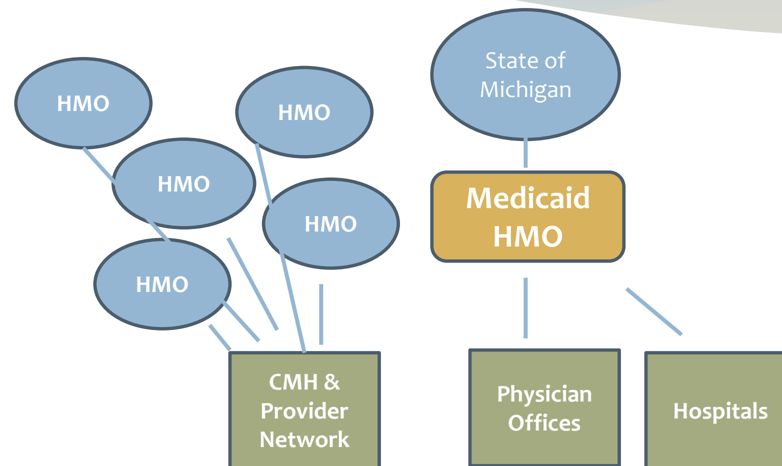
Gearing Towards Integration

Observations

* VERY serious threat – Sen. Shirkey is planning on moving this forward
* Up hill climb so far, but still a lot of time
* House is working on their own proposal
* Where is the DHHS?
* Where is the Governor, will she veto??

Current system vs. Section 298



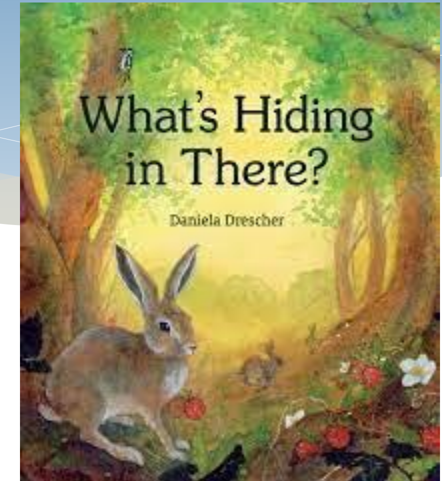


Behavioral Health Services provided include:
Housing, employment supports, transportation, intensive case management & other social determinates of health.

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

SBs 597 & 598: Gearing Towards Integration

What's in the proposal?



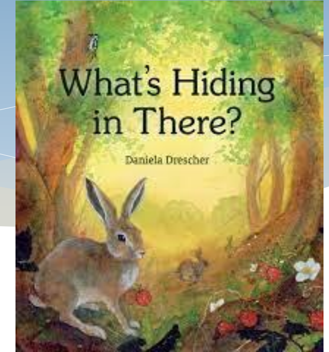
Essentially 298 with a little of Robert Gordon's SIP (specialty integrated plan) redesign language.

Plan is described as:

- Person-centered
- Consumer choice
- High quality & comprehensive
- Transparent
- Efficient
- Good stewards

- Proposal would create new entities – Specialty Integrated Plans (SIP)
- Bid process for SIPs
- SIP licensing requirements:
- Essentially the definition of a health plan (including insolvency coverage = reserves)

SBs 597 & 598: Gearing Towards Integration



What's in the proposal?

- At least 2 SIPs per region (unless rural exception)
- Phased in process – 1st SMI and kids (KB lawsuit), 2nd SUD, 3rd I/DD
  - After phased in process is complete the PIHPs would be eliminated by the SIPs
  - A phase must be determined successful before the state can move to the next phase

CMH role

- Department would require a contract with CMH and SIP
- BUT SIPs can contract directly with other behavioral health providers as they deem appropriate
- SIP care coordinators will serve as the main point of contact for beneficiaries (not CMH or providers)
- SB 598 inserts language into the MHC allowing plans to take on the unique safety net role of a CMH.

Timeline

- Very aggressive timeframe originally outlined that this would be completed and sent to the Governor by mid-June.
- NEW Timeline – this will likely follow the budget process timeline (meaning late summer / early fall)
- ??

Why we OPPOSE SBs 597 & 598

1. COST – Our fear is this proposal will dramatically increase costs WITHOUT an increase in services delivered or quality and will ultimately lead to an overall reduction in services – NOT an increase

- Milliman study that shows Michigan Medicaid Health Plans have the 2nd WORST Medical Loss Ratio (MLR) in the country: 79%, meaning they have an overhead or administrative rate of 21%, which includes a 3% profit margin.
- MI PIHP system has an average of 6% overhead / admin rate.
- 21% - 6% = 15% difference, doing simple math on $3 billion = **$450 million COST difference**
- Not to mention the fact that these bills will increase the number of managed care entities per region from 1 where it is now to 4, 5, or 6 or more? There is NO doubt this change will cost the state and tax payers significantly MORE and for what?
- State of Iowa – 3x the amount

2. Bills **do nothing to ACTUALLY integrate care.** Real health care integration occurs on the ground at the point of service delivery. SBs 597 & 598 only integrate the funding. **(CCBHBC & BHH/OHH models)**

- Financial integration – this proposal does nothing to actually integrate care other than giving the managed care functions and funding to one entity (New Dartmouth Study Shows That Greater Financial Integration Generally not Associated with Better Healthcare Quality)
- https://geiselmed.dartmouth.edu/news/2020/new-dartmouth-study-shows-that-greater-financial-integration-generally-not-association-with-better-healthcare-quality/
  - This is not a 1 door solution – physical and behavioral health will still be siloed.
  - MHPs do NOT provide services – they simply authorize care and pay the bills.

Why we OPPOSE SBs 597 & 598

3. **Eliminates ALL public governance, oversight and accountability**.

- While Medicaid health plans may hold a contract with the state to manage this population that is dramatically different than LOCAL accountability and oversight which will be eliminated by these bills.
- Make no mistake, these bills eliminate our PIHP system whose members are appointed by local board of county commissions…
- It makes our CMHs just another provider by allowing plans to contract with any other provider and inserts language into the MHC allowing plans to take on the unique safety net roles of our CMHs – all but eliminating the CMH as the community collaborator/ convener
- Michigan Medicaid Health Plans show record profits in 2020; https://www.crainsdetroit.com/health-care/michigan-health-plans-post-rosy-profits-first-half-2020-blues-cross-income-lower-2019
    - For the Michigan health plans, net income increased 54 percent to $551.3 million from $353.8 million, said Baumgarten, who used data from the state Department of Insurance and Financial Services. Average profit margins increased to 6.2 percent from 4.2 percent.

Why we OPPOSE SBs 597 & 598

4. Health plans do not have a good track record on behavioral health

As you know, Medicaid health plans already manage Medicaid MH services – they are responsible for the Medicaid mild/moderate benefit:

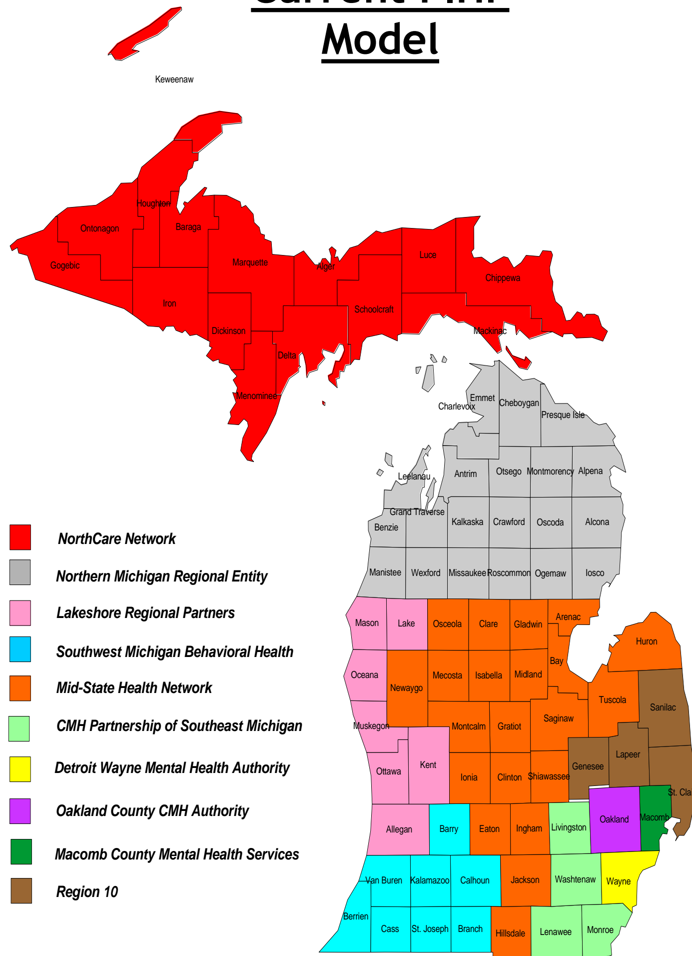
- For 20+ years there has not been any required reporting data on this benefit (outcomes / results), I have been pushing to add requirements in the budget for this benefit. It seems reasonable to get proof that they can do the job before we just hand this over?
- No date or outcomes on mild/moderate benefit. According to MDHHS, the average number of mental health visits authorized for qualifying MHP enrollees in 2014 was ONLY 4. In 2015, only 10% of all contacts for Medicaid recipients seeking behavioral health services were with a behavioral health professional.
- Altarum_Behavioral-Health-Access_Final-Report.pdf – July 2019, Health Endowment Fund Commissioned a report – Access to Mental Health Care in MI, below is from page 8:
  - **Unmet need for AMI (Adults with mental illness) in Michigan is greatest for the more prevalent, mild-to-moderate conditions.**. More serious conditions such as bipolar disorder, recurrent depression, and post-traumatic stress disorder (PTSD) and other stress disorders are less prevalent among Michiganders and show lower shares going untreated

5. Headlee Implications – Shifting spending away from the local PIHPs to the new entities would reduce State payments to local units of government by at least $1.2 billion by the time the population was shifted fully from the PIHPs to the SIPs.

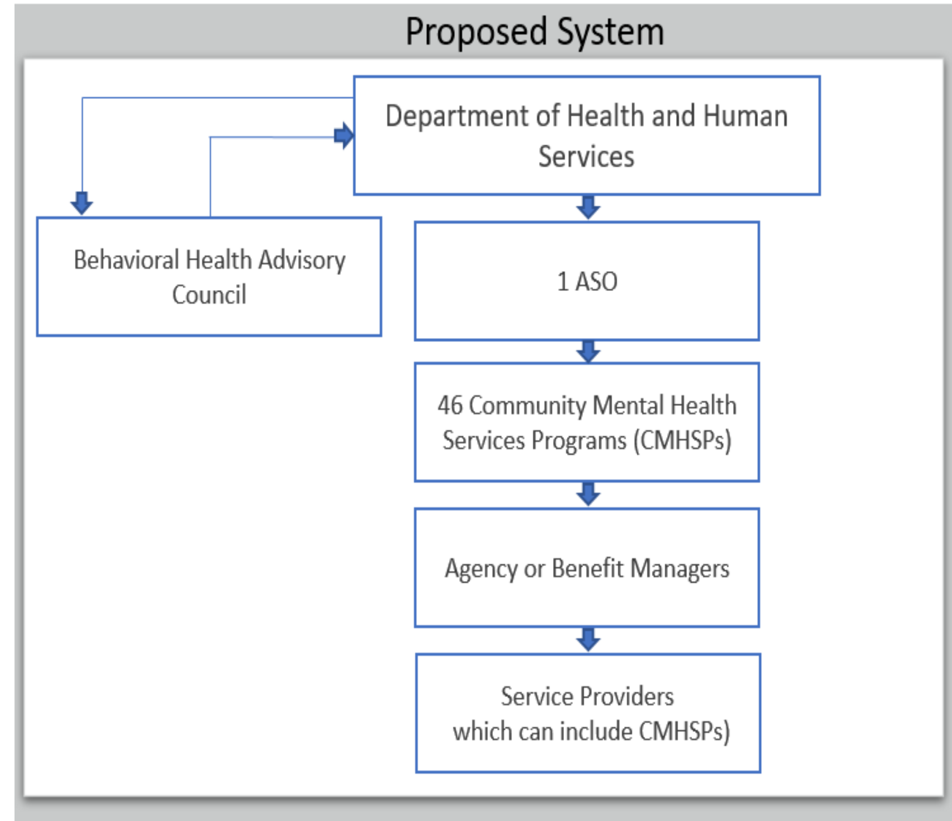
- **BTW – Why are we making this change in the middle of a pandemic????**

House ASO Proposal

Current PIHP Model



House Proposed Model



House – ASO Proposal

- Bills proposed by Rep. Mary Whiteford – chair of the House DHHS budget committee.
  - HB 4925-4929

- Creates a single statewide – Administrative Services Organization – ASO to manage the BH Medicaid benefit.
  - Remains carved out from physical health – does not transfer $$ to Medicaid health plans.
  - Describes ASO as a nonprofit, public or quasi-public entity.
  - Proposal does eliminate current PIHP structure.

- **Big Sweeping changes**

- Moves financing from a capitated system back to a fee-for-service system (paying for volume)
  - Eliminates state managed care regulations
  - Eliminates contract with Milliman

- Adds additional responsibilities onto the department
  - rate setting
  - clinical guidelines
  - quality assurance
  - network management

- Moves 100% risk back to the state

House – ASO Proposal

- Our Observations on House proposal

- Rep. Whiteford is much more open minded about her proposal and is willing to work on the bills.
  - Her bills are much more person focused – how do we improve services, funding, quality for people.

Oppose in the Package:

- Non-public ASO model
  - ASO must be a public or quasi-public entity.
  - ASO MUST have public governance – not an advisory council.

- Elimination of PIHP structure
  - Uniformity could be accomplished under PIHP structure with any number of entities (10 or 1)
  - Admin reduction could be accomplished by removing non-value added regulations & requirements (new ASAM), reports, audits.
    - PIHP and CMH system are REQUIRED to follow hundreds of pages of federal rules and regulations, state guideline and contract requirements, and budget boilerplate requirements (Section 904 for example).

House – ASO Proposal

Oppose in the package:

- Role of the CMH system.
  - CMHs MUST be considered THE safety net provider.
  - MUST allow ASO to delegate management functions to CMHs (as is currently done)
  - MUST eliminate the new type of organizational class "public behavioral healthcare provider".
    - Does the public behavioral health provider have to comply with all of the Mental Health Code requires, like a CMH?
    - How does this potential change impact the arrangement with local counties and matching funds counties are required to provide to their CMHs?

- Shift from county-based system to state run system
  - ASO model lacks county oversight and input, while still requiring county financial contributions.
    - Behavioral Health Advisory Council appointments are largely made at the state level not county level.
  - If ASO is NOT a public entity can counties be required to send PA2 SUD dollars (local liquor tax sales earmarked for substance use disorder treatment) to a private entity?

- Shift from managed care capitation to a fee for service financing system
  - Paying for value vs volume MUST continue – many CMHs are able to provide MORE services to people under a capitated system vs a fee for service system.
  - Fee for service incentivizes billing not outcomes.

House – ASO Proposal

Support in the package:

- Allows for mild/moderate to be managed by ASO
- Retains behavioral health carve out – does not integrate funding with health plans
  - Does not separate populations – maintains management of SMI, SED, SUD, & I/DD all together.

If we REALLY want to improve care

One of the biggest frustrations for me in the process has been terms like, we NEED TO DO BETTER, must fix it, broken system, BUT nobody say give us examples of what IT is… what do we need to fix, what exactly is broken, where do we need to do better??

We believe these legislative proposals miss the mark, rather than focusing efforts at the PIHP level we believe the legislature should take this opportunity to address the following areas:

- Address & expand access to mental health and addiction services
  - For those individuals who are not in the current CMH system, but those on the outside looking in – MHP mild/moderate benefit and those with commercial insurance.
- Address the desperate need for more inpatient care settings for those most in need and
- Find ways to dramatically expand and increase the mental health and addiction workforce shortage
  - From front line DCWs to psychiatrists

Improving these areas would have an immediate impact on communities across this state.

- CCBHC & BHH/OHH must be part of the solution – patient-centered initiatives

What does the future hold?

What are the other factors that could play into the outcome of system redesign?

* COVID
* New redistricting committee – legislative boundaries will come out this fall
* 2022 Campaign season (Governor, Senate and House all up)
* Economy & budget
  * Headlee issue
* Lame Duck Session – late 2022

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