Mental Health Association in Michigan

LETTER FROM LANSING

A monthly public policy newsletter from the
Mental Health Association in Michigan (MHAM) | Vol. 2 No. 12

Happy New Year from your friends at the Mental Health Association in Michigan (MHAM)! Welcome to the January 2020 edition of MHAM's monthly newsletter that provides you with public policy updates and other matters that impact the behavioral health care of you and those you love.

"And now let us welcome the new year, full of things that never were." - Rainer Maria Rilke

Message from MHAM Board Chair - Oliver Cameron, MD, PhD

A big change is happening at the Mental Health Association in Michigan (MHAM). After decades of sterling service, Dr. Mark Reinstein is stepping down as President/CEO. He will continue to work at MHAM, consulting on advocacy and related matters.

As of January 1, 2020, a new decade, MHAM has a new President/CEO, Marianne Huff. As part of this change-over, we at MHAM wish to be sure that all who attend to and care about MHAM and its activities know who we are: prior and present Presidents/CEOs, Board members and staff. Let me start in today's Newsletter by briefly introducing myself. I am now serving my second time as MHAM Board Chair; the prior time a number of years ago. I am a psychiatrist, retired after about 35 years of doing clinical care, teaching, research and administration on the faculty at the University of Michigan Medical Center. I also now serve on three other boards, keeping me busy, but also connected to what the State and the mental health community are doing. I will be stepping down myself as Board Chair as of July 1, 2020, but I hope to continue to be a member of the Board. In subsequent Newsletters we will be introducing the rest of us to you, including who will be my replacement as Chair. Be well.

Oliver G. Cameron, MD, PhD

Message from Incoming MHAM CEO/President - Marianne Huff

Happy New Year! My name is Marianne Huff and I am the new CEO/President of the Mental Health Association in Michigan (MHAM). I wish to say “thank you” to all of you for your support of the work MHAM does!

We have the Trifecta for January: New Year. New Decade. New Fiscal Year for the Mental Health Association in Michigan. And, in some respects, a new beginning as I begin my tenure as the President/CEO of the Association. The “new” often springs forth from that which has gone before and as such, I am standing on the shoulder of “giants,” having been chosen as a candidate for the position by an advocacy icon, Dr. Mark Reinstein. I am aware of the amount of work that has been ongoing since the Mental Health Association in Michigan was incorporated in November of 1936 and as MHAM continues its mission “to improve care and treatment of mental illness; promote positive mental health; and prevent the onset of mental disorders”. This mission has not changed and has withstood the test of time. Despite the fact much has been done by the Association and other advocacy organizations to address the stigma associated with psychiatric disorders, the lack of access to quality behavioral health care and other public policy issues that impact the care and treatment of our constituents continues to be problematic. The work MHAM is doing to address the need for true mental health parity in this state is important. As you know, even in 2020, there is no true “mental health parity” although it is required by federal law. All of these things (and many more) make MHAM’s mission as critical as ever. And the work must and will go on!

Marianne Huff, LMSW

Section 298 & the Public Mental Health System

2019 proved itself to be an interesting year as the community mental health system witnessed the decision on the part of the state of Michigan Department of Health and Human Services (MDHHS) to end what has been known as “Section 298”. In essence, the three pilots that were chosen as part of “Section 298” which included Saginaw (which withdrew from the pilots earlier in 2019); West Michigan and Muskegon CMHSPS (community mental health services providers); and Genesee Health Systems (CMHSP), were terminated when Governor Whitmer vetoed the part of the 2019 budget that would have allowed private health plans to contract with other providers and not necessarily with the local community mental health services provider.

On December 4, 2019, MDHHS Director Robert Gordon unveiled a new plan to reinvent the community mental health system in Michigan. Dr. Mark Reinstein, Ph.D., MHAM Public Policy Consultant, has written a description of the new plan that is being proposed by the state of Michigan. Dr. Reinstein reports:

The mental health community is once again engulfed in a poorly conceived, unvetted executive branch plan on how publicly funded services should be structured and delivered.

It was four years ago that Governor Snyder and MDHHS leadership announced the so-called Section 298 – that Medicaid specialty mental health dollars should be transferred from Community Mental Health to private Medicaid Health Plans.

Now, after 298 was finally defeated, here comes MDHHS again with complicated and highly questionable new plans for public behavioral health in Michigan.

These plans, just like the original 298, were not developed in concert with the mental health community. That is a huge political mistake. One would think lessons had been learned, but obviously not. The outcry in 2016 was enormous, and we predict the same thing is going to happen.

The current magic potion driving this is integration. It is the flavor of the month (or decade); that publicly funded health care can’t succeed if behavioral and other medical services

aren't better coordinated, and that they can't be effectively coordinated unless all the money for health care is in the hands of a single-payer (but the single-payer won't be state government). This is known as "financial integration."

MDHHS, like so many entities around the country, has become fixated on integration for integration's sake, not for better service outcomes. The lack of focus on these outcomes is most especially glaring in the realm of behavioral health. Proponents say this can improve the general medical health of consumers and save money in non-behavioral medical care. Proponents also say that if there are such savings, they could be reinvested in behavioral care. Beyond that possibility, proponents have offered little for how public mental health services and outcomes, presently in crisis mode in Michigan, would be improved under a newly integrated world.

So, what is the department proposing?

The proposal is that, by 2022, we would have 4-5 statewide Specialty Integrated Plans (SIPs) serving as single payers of publicly funded health care. The Medicaid consumers entering them would be most of the current PIHP/CMH clients in Michigan. (Possibly excluded would be those in both Medicaid and Medicare, and those who have Medicaid but are not in a Medicaid Health Plan – roughly 25% of Medicaid beneficiaries statewide are not in Medicaid Health Plans.) The department also says it wants a more effective public mental health safety net, presumably through the CMH system. Further, the department says Medicaid managed care individuals with "mild-to-moderate" health conditions would remain the responsibility of Medicaid Health Plans; they would not go into the SIPs. Finally, numerous state laws (unspecified) would have to be changed.

Here are the 4 SIPs that the department has described to date:

1. Public Option – A statewide SIP run by the current public mental health system. Most people presently interpret that to mean CMHSPs. Does that mean all of them or some? Could the current PIHPs bid to become this "public option" instead of the CMHSPs? We don't know. The entities putting this together would have to become licensed as a Managed Care Organization and assume various functions and processes of private insurers.

2. Medicaid Health Plans (MHPs) – This is what Section 298 was. One of the SIP options (the department says consumers could choose their single payer) is a plan managed by MHPs. As you know, the mental health community has no confidence in MHPs being able to successfully manage severe mental disorders (or even mild-to-moderate ones).

3. Provider-Led Option – An association of a hospital system and providers.

4. Public-Private Partnership – In the department's Dec. 4 presentation to legislators, this was described as "a partnership among MHPs, CMHs, Federally Qualified Health Centers, and regional providers." In the departments Q-&-A document on this, CMHs were replaced by PIHPs.

NOTE: The department has recently said there could be "3-5" SIPs. If there are 3, we don't know which of the above would be out. If there are 5, we don't know what the addition would be.

The department has begun holding related public forums (total of five planned). We have attended the first two, and they were poorly done and not designed to get consistently meaningful input. Most importantly, they don't focus on other ways (beyond the MDHHS proposal) to move ahead in a post-298 world. The affinity groups that were held across the state about three years ago re Section 298, utilizing focused questions, were much better organized and implemented.

There are literally over a hundred questions and concerns that can be raised about the MDHHS plan. Space doesn't permit all of them, so here are 16:

1. Why has MDHHS stated a desired endpoint without *first* getting broad-based

stakeholder input?

2. Why is financial integration necessary to improve coordination between behavioral and other medical care? There are many other ways service coordination can be fostered.

3. If it's believed financial integration is a "must," why not develop a service integration model first?

4. How will the MDHHS proposal *improve public mental health outcomes*? It's not nearly enough to say there may be non-behavioral savings, and these might be invested in mental health.

5. Why are MDHHS and legislators saying they'll look at Arizona, Arkansas, and North Carolina for guidance when Mental Health America's 2020 rankings of all states show Michigan significantly ahead of those three – for overall mental health care and the sub-rankings of adult service, youth service, and access to care?

6. For an improved non-Medicaid mental health safety net, what appropriation level is the department prepared to seek?

7. How is the department going to find overall service managers (single payers) that have demonstrated experience and positive performance with both behavioral and non-behavioral health care? What happens if no such entities can be found?

8. Why does MDHHS want mild-to-moderate mental health conditions to remain with MHPs, when the department's own data indicate this isn't working out well?

9. What minimum requirements are envisioned for SIP boards in terms of who makes appointments, consumer-family representation, contractor representation (if any), and compliance with FOIA & Open Meetings laws?

10. In a mental health system that already has major deficiencies in statewide uniformity, how do we achieve better uniformity moving forward, so that if consumers can choose their SIP, the options they can pick from are equal?

11. How can the "public option" realistically compete with the private sector in development and implementation of SIPs? And are we really better served if the "public option" has to operate like a private insurer?

12. What happens to rights protections and appeal-&-grievance mechanisms in the disparate new system envisioned?

13. If some consumers and families don't fully understand existing public health care systems and how to navigate them, what makes anyone think the department's newly envisioned systems won't make matters less understandable and navigable?

14. What, if any, is the role of PIHPs moving forward?

15. Will the department's plans need federal approval? (We presume the answer is Yes.)

16. MDHHS director Robert Gordon in a recent speech to the Community Mental Health Association acknowledged the department has difficulty monitoring PIHPs, and PIHPs have difficulty monitoring CMHSPs. In the department's new convoluted proposal, how does the state effectively monitor and enforce all this?

In sum, instead of focusing on better service coordination and fixing a broken mental

health system, our bureaucrats have come up with a complex, unvetted plan for drastically re-arranging public mental health care, without any assurance it can improve outcomes, and without any specific details on how we move from A to Z. It is overkill, it is misguided, and it would create a mess that will take years to clean up.

MDHHS Hosts Public Forums

In anticipation of its plan to reinvent the community mental health system yet again, the MDHHS has been holding public meetings across the state since mid-January. The first three forums were held in Detroit (January 8); Grand Rapids (January 9); and in Marquette (January 22). There is a fourth forum being held in Saginaw on January 30 and a virtual forum being held on February 6. For more information, here is a link to the web page on the MDHHS web site: https://www.michigan.gov/mdhhs/0,5885,7-339-73970_5093_96724_96727---,00.html

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Final Thoughts about the MDHHS' Proposal to Redesign the Public Mental Health System in Michigan

As long as I have been in and around the community mental health system in Michigan (my first experience began in 1991 with a family member who needed mental health treatment), which spans almost 30 years of both professional and personal involvement, the "CMH system" has experienced varying degrees of pressure and threats from diverse sectors of society. Pressure and threats have arrived in the form of forced policy changes originating at the state and/or federal level. At other times, the threats have been due to changes in the healthcare environment such as the emphasis upon "integrated care" that was part of the Affordable Care Act.

Over the years that I have been an observer of and, at times, a participant in the "system", I have watched as CMH has become under-funded and changed in myriad ways in order to "serve the people" better—which often did not mean that the people were "served better." I have witnessed numerous attempts to "integrate" the system; "improve" the system; and rearrange its funding so that there can be increased administrative efficiencies. And yet, in spite of much talk about improving public mental health and despite various mental health commission reports, such as the Mental Health Commission report in 2004 and the Mental Health and Wellness Commission report in 2014 and the recommendations of the Section 298 Work Group in 2016, little has been done to actually improve access to and the quality of behavioral health services at the service delivery level. And yet, here we are again, with another administration that is seeking to make

monumental “changes” to a “system” that is currently under-funded; unable to keep up with the demands that are imposed upon it; and has, for a variety of reasons, over-promised and under-delivered. Albert Einstein said it best: “Insanity: Doing the same thing over and over again and expecting different results.”

There are no easy answers about “what to do” and “how to do it”. At the same time, since Michigan’s public mental health system is based in government, the political environment has been a major factor in shaping the structure and form of community mental health and this will continue. In some respects, one could argue that there would be no “CMH” system without the will of state and local government to fund it. This argument is correct. At the same time, one could also argue that the over-involvement of politics in a “system” that is supposed to be serving the most vulnerable citizens in Michigan has been, at times, beneficial and, at others detrimental. It is hoped that there will be meaningful and positive changes created in the “CMH system” that will, ultimately, be for the benefit of those who need to have access to quality behavioral health care. One thing that has become clear to me over these past almost 30 years is this: if there is going to be meaningful redesign of the “system”, then it needs to be done from the “bottom up” and not from the “top down”. And all changes most certainly need to be conceived and birthed with an ear to the voices of those who matter most: The persons served by CMH; their families and those who love them.

MHAM will provide you regular updates as the redesign effort moves forward. Also, MHAM will be hosting at least four (4) community forums over the next eleven months to elicit feedback from all of you! Thank you for your support over the years! We look forward to hearing from you.

Sincerely,

Marianne Huff, LMSW, President & CEO

Letter from Lansing is published monthly by MHAM. The primary mode of distributing the newsletter is electronic mail, but we will postal-mail copies to persons lacking internet access. If you’ve come across this issue through a friend or colleague and wish to subscribe (there is no charge), kindly let us know. If at any point you wish to unsubscribe, simply contact mhamiweb@gmail.com.

Mental Health Association in Michigan
Mark Reinstein, Ph.D., President & CEO | Oliver Cameron, M.D., Ph.D., Board Chair
NEW ADDRESS
1100 West Saginaw, Suite 1-B | Lansing, MI 48864-5956
P: 517.898.3907 | F: 517.913.5941
mhamich@aol.com | mha-mi.com (membership available on-line)
A United Way-Supported Agency, affiliated with Mental Health America

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