Perspectives of the Advocacy Community on the Lakeshore Regional Entity & the Public Mental Health System in Michigan

Part Two: Steps to Be Taken Statewide
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The Arc-Michigan
Association for Children's Mental Health
Mental Health Association in Michigan
Michigan Developmental Disabilities Council
Michigan Disability Rights Coalition
Michigan Protection & Advocacy Service
National Alliance on Mental Illness - Michigan

Introduction

Michigan's publicly funded mental health system is in crisis. Among the reasons are the system's poor structure and organization, an overly complicated bureaucracy, and lack of funding.

The recent announcement from MDHHS that it intends to terminate the PIHP contract for the Lakeshore Regional Entity (LRE) PIHP has sparked a new controversy in the mental health arena. This comes on top of the very controversial decision by a majority in the Legislature that Michigan should test certain new models of integrating behavioral and other health care appropriations ("Section 298").

In the first installment of our report, dated August 5, we discussed immediate steps that should be taken in the Lakeshore region if LRE is indeed terminated. (LRE has asked for the state administrative appeal it is allowed, and also filed a lawsuit, but then withdrew the suit, perhaps only temporarily, August 19.)

This Part Two installment discusses the huge problems the state has created with its PIHPs; how to move forward with PIHPs statewide; the need to improve system funding; and the danger of using Lakeshore as a back-door for further system privatization. We also recommend a thorough evaluation of whether the state can and should reduce its number of CMHSPs.

Our overarching goal is to improve service availability, accessibility, and involvement for consumers in need, irrespective of current spheres of influence, profit margins, or protecting anyone's place within the bureaucracy.

Prepaid Inpatient Health Plans (PIHPs)

Michigan has used capitated managed care funding for 20 years with respect to Medicaid specialty behavioral care. As long as this continues, the federal government requires that we have at least one PIHP to be a Medicaid intermediary between MDHHS and the CMHSPs that handle local care delivery. For several years, Michigan has had 10 PIHPs. These PIHPs require money that could go directly to service provision, and they add another administrative layer to a confounding bureaucracy. Among the players that consumers and families have to deal with are MDHHS, PIHPs, CMHSPs, contracted CMHSP network providers, and – in some communities – middle managers positioned between CMHSPs and their contracted providers. This was a concern for the MDHHS Section 298 Workgroup and its precursor – Lt. Governor Calley's task force on Section 298.

Michigan does not need and should not have 10 PIHPs. **For purposes of efficiency, practice uniformity, and reduced duplication of resources, the state should narrow the number of PIHPs to one for the entire state.**

{NOTE: We refer to PIHPs in the plural form from hereon in the event the state continues to have more than one.}

The number of PIHPs is far from our only problem here. A review of the legal administrative underpinnings for Michigan PIHPs shows that the state has set up an unsustainable model for their establishment and governance.

The Social Welfare Act says "specialty prepaid health plans (are) chosen by the department" (excepting Section 298 pilots). But the state's Mental Health Code has more specificity. It requires PIHPs to be formed by the CMHSPs themselves. The CMHSPs are to come up with bylaws, including how PIHP Board members are appointed, for their catchment areas. Further, the MDHHS-PIHP contract states that PIHPs "must be representatively governed by all CMHSPs in the region."

We have created an incredible conflict-of-interest situation when it comes to PIHPs and CMHSPs. The former are supposed to manage the CMHSPs regarding Medicaid specialty behavioral health, yet the CMHSPs establish and govern the PIHPs. It is no wonder, given this conflict-of-interest, that matters have failed badly in the Lakeshore region, and this may be one contributing factor to several of the PIHPs now experiencing financial difficulty. **State law must be changed so that PIHPs (both multi-county and single-county) are organized and governed by counties and/or MDHHS, with counties and/or MDHHS establishing their bylaws and making appointments of the local individuals who will sit on PIHP Boards. No one connected to a CMHSP should be allowed to sit on a PIHP Board in anything but an ex-officio capacity.**

With further regard to state law and PIHPs:

***Uniform statewide roles and responsibilities for PIHPs should be specified.**

***MDHHS and PIHPs should continue to share Medicaid risk.**

***There should be a process instituted for assuring potential Board members do not bring a conflict-of-interest situation to their service.**

***PIHP Boards should be required to produce an annual public report on PIHP finances and administrative actions.**

***PIHP Boards should be subject to Open Meetings and FOIA laws that apply to governmental bodies.**

***PIHP Boards should be required to have at least 33% representation from primary consumers and their families, with at least half of this bloc being primary consumers.**

The latter two recommendations are consistent with state law for CMHSPs and with recommendations made by the MDHHS Section 298 Facilitation Workgroup in 2017. They also help guard against something that can't happen here – i.e., to use the Lakeshore situation as a back-door way to try implementing the Legislature's Section 298 concept.

Against unanimous advice from the mental health community, the Legislature has called for three pilots in which private Medicaid Health Plans (MHPs), some of which are for-profit, would be given all of the state's Medicaid specialty behavioral appropriations. This concept has been

written about numerous times; see https://www.mha-mi.com/section-298-update-august-2019/. **These pilots, now delayed for at least the second time since 2017, should be ceased**. (Since '17, the Legislature has also called for a demonstration project on integration in Kent County. It was recently announced that this project has failed to materialize.)

With further regard to MHPs, **It is time to shift to CMHSPs the "mild-to-moderate" mental health benefit that MHPs have been allowed to offer.** MDHHS data provided during the Section 298 process showed that, for 2014, the average number of "mild-to-moderate" mental health visits for qualifying MHP enrollees was four. And department data for 2015 indicated that the vast majority of MHP referrals for such service were NOT to psychiatrists, neurologists, psychologists, or social workers. These are alarming figures.

State Appropriations

While fewer PIHPs may save some money, and fewer CMHSPs surely would (see next section), such savings will not be enough to offset the way Michigan has underfunded mental health service.

Since the advent of Healthy Michigan, CMHSP non-Medicaid appropriations have been cut to virtually nothing, even though the CMHSPs under law are to be a safety net, regardless of reimbursement sources, for persons with nowhere else to turn.

For Medicaid, the state is required to have "actuarially sound" capitated rates for managed care. But there is no such thing as universal actuarial soundness; it is whatever a given actuary says, and different actuaries will not necessarily agree.

In Michigan, our system has been forced to take on more and more responsibility without concomitant increases in funding. Among the areas of increasing responsibility have been autism; opioids and other substance use disorder services; Healthy Michigan; federally mandated Home & Community Based Waiver requirements; and minimum wage increases. Additionally, recent years have seen movement of Medicaid enrollees from the category of Disabled/Aged/Blind (DAB) to the categories of Healthy Michigan or TANF, which have much lower per person reimbursement than DAB.

Michigan needs to dramatically increase the amount it appropriates for specialty mental health service to those not enrolled in Medicaid (presently a little over $100 million). This line should be restored to $300 million, essentially where it was before Healthy Michigan Medicaid expansion and its misguided assumption that Healthy Michigan would pick up all CMHSP non-Medicaid clients.

The state also needs to develop a fairer and higher-yield model for determining Medicaid specialty mental health care rates. The broad mental health community should be given a role to play in those deliberations. The Governor has proposed, and the legislative FY-20 budget bills to date (not finalized) have a 2.5% Medicaid mental health increase. That is a good first step.

The State's CMHSP Network

Michigan presently has 46 CMHSPs. That means 46 separate Executive Directors and administrations; 46 streams of policies and financial/technology procedures; 46 different recipient rights offices; and numerous other duplications of expenditure and efforts (some of which aren't uniform across the various CMHSPs). In today's technological world, is there a need to have 46 CMHSPs? Can we put more money into service availability and accessibility with a reduced number of CMHSPs, and can we foster more system-wide uniformity (an area of concern for the MDHHS Section 298 Facilitation Workgroup and the earlier Calley group on 298)? We need to minimize differences in how consumers are responded to based on where they happen to live.

The Whitmer administration and/or the Legislature should facilitate a comprehensive analysis of how many CMHSPs Michigan requires, taking into account factors such as geography; socio-economic demographics; Medicaid eligibility/enrollment; technological tools; availability of professional resources; prevalence rates of developmental/intellectual disability, serious mental illness, serious emotional disturbance, and substance use disorder; and disbursement of priority populations as specified in the Mental Health Code.

Closing Comments

Michigan can continue doing things the way it has been, with mental health services left to flounder further. The state could also continue trying to find a way to make unworkable Section 298 projects somehow happen. Or, we can recognize that it is time for dramatic practical change to the mental health landscape – change that puts the interest of consumers and families (and ultimately society) first. It is time to rescue the system from turf battles, conflicts-of-interest, inflated bureaucracy, lack of uniformity, underfunding, and MHP profit margins. Do we have the political will to do what is necessary?