April 17, 2017

Dear Legislators,

Michigan has been and continues to be a leader in behavioral health services. It continues to be one of the most forward thinking behavioral health systems in the nation for persons with serious mental illness, children with emotional disturbances, persons with intellectual and developmental disabilities and persons with substance use disorders. We are the only state in the nation that provides its behavioral health Medicaid services through a managed care approach while integrating the four main behavioral health disciplines – mental illness, children with emotional disturbances, intellectual and developmental disabilities and substance use disorders. The state does all of this through a publicly managed and operated CMH/PIHP system, which provides and manages a comprehensive set a benefits to the state's most vulnerable population.

Over a year ago, Section 298 of the original FY 2017 budget proposal shocked and dismayed those who serve, support and advocate for family members and friends with disabilities. Section 298 of the budget tossed over 50 years of one of the nation's most progressive **public** behavioral health systems and would turn it over to the private/for-profit insurance industry.

Specifically, the budget bill called for taking $2.6 billion from the public mental health system and turning that over to private insurance companies, the Medicaid Health Plans.

The reaction then was as swift and as visceral as it is now -- "No way!"

Parents, consumers, advocates and providers fear that the valued Michigan public mental health safety net will be ripped to shreds. The language and its interpretations sent shivers down our spines. Given the struggles to get what we now have, our worries are not ill-founded.

Lieutenant Governor Calley and Senator Marleau and Representative Verheulen, the MDHHS Appropriations Sub-Committee Chairs at the time calmed the waters by removing the original 298 language from the budget. Subsequently, Lieutenant Governor Calley and MDHHS brought together a massive cross-section of consumers, advocates, family members, providers, and insurance companies to study the issue of how to best structure our system of care, to improve and integrate services, and reduce unnecessary administrative levels and costs. Following the conclusion of the Calley Workgroup, at the request of the private health plans, MDHHS led a second 298 dialogue process that was inclusive of a wide range of stakeholders and was dialogue rich. This process, the 298 Workgroup Process, concluded its work a month ago.

After a yearlong, engaged, collaborative process, which included verbal and written comments from over 800 service recipients and their family members, as well as citizens who participated in the Affinity Groups, the "298 Workgroup" has submitted its recommendations to Lt. Gov. Calley and Department of Health and Human Service Director, Nick Lyon, who have forwarded them to the Legislature for consideration.

The Final Report of the 298 Facilitation Workgroup as submitted to the Michigan Legislature can be found here:

http://www.michigan.gov/documents/mdhhs/Final_Report_of_the_298_Facilitation_Workgroup_-_Version_for_Publication_554605_7.pdf

The 298 Workgroup was crystal clear on over 70 thoughtful recommendations put forth as a sensible way forward. O*ne unequivocal position was that we maintain public oversight of public dollars, not abandon our constitutional obligation or relinquish our moral charge to assist in supporting the dreams and aspirations of the most vulnerable persons to the private/for-profit health plans/insurance companies*. The essence of this recommendation was co-drafted and voted for by the Michigan Association of Health Plans.

A few of the 298 workgroup participants have complained that the process gave too much weight to the people served – that their voice was too loud in the process. Now we hear rumblings that potential pilot projects could be chosen that are in direct contradiction to the workgroup's policy recommendations.

This rumor, if true, seems to be driven, not by sensible public policy but by empty promises of budget savings and efficiencies. The only way budget savings could occur, if the management of this system was transferred to private insurance companies would be through reductions in services, the imposition of access barriers, or reductions in payments to providers.

Private health plans have had two opportunities to demonstrate their ability to manage the behavioral health and intellectual/developmental disability supports and services benefit. The first effort, running for nearly 20 years, is seen in the management, by the state's private health plans, of the psychiatric and psychotherapy benefit for the state's Medicaid enrollees who have 'mild-to-moderate' mental health conditions. **In communities across the state, Medicaid enrollees point to the inability to gain access to this benefit due to the fact the health plans have few, if any, psychiatrists and psychotherapists who will take new Medicaid patients**. Long waiting times exist for Medicaid enrollees who are seeking psychotherapy or psychiatry. In some communities, there are no psychiatrists accepting Medicaid patients, for whom the private health plans are managing the psychotherapy and psychiatric benefit for these Medicaid enrollees.

Additionally, while the private health plans have managed, for these two decades, the physical healthcare for the state's Medicaid enrollees with mental health and substance use disorder, the state's data show **these persons have some of the highest physical healthcare costs and die earlier than the rest of the state's residents, even while their physical healthcare is managed by the private health plans.**

In the second opportunity for health plans to manage the care of the vulnerable, as part of a multi-year demonstration project, private health plans manage the physical healthcare benefit for Michigan residents in four regions in the state, who are enrolled in Medicare and Medicaid (dual enrollees). These dual enrollees have significant health issues and/or disabilities. However, in spite of the fact that program automatically assigns these persons to a private health plan for their physical healthcare, when given a choice to stop these health plans from managing their care, **65% of these dual enrollees choose to leave these health plans.**

These two efforts provide us with a clear picture of the track record of the private health plans in managing the care for persons with behavioral health and intellectual/developmental disability needs. This is not the track record of a group that can adequately manage the care of some of the most vulnerable members of our communities. Please understand that we will vigorously oppose this money and power grab that is not good public policy, nor good for the people we love, represent, serve and support.

We agree changes can be and MUST be made to our current behavioral and physical health system, but greater uniformity, measurable outcomes, healthier consumers can all be accomplished within our public system. We look to the legislative and MDHHS leadership who have been empowered to study these important issues and make recommendations in the best interest of the people. We propose that Medicaid money funding public behavioral health services and supports be used where they are intended and most needed – to benefit the people and with organizations who have consistently put people before profits.

It is only prudent when amending Section 298 of the Governor's proposed Fiscal Year 2018 DHHS budget bill (consistent with Fiscal Year 2017) that there is a prohibition on the transfer of Medicaid money from the public PIHP and CMH system to the Medicaid Health Plans.

The process of the last year has advanced the best ways to structure and fund all Medicaid health services; improve the quality of supports and services for behavioral health beneficiaries; and improve shared programming for those enrolled in both Medicaid Health Plans and public behavioral care. It is now time for the legislative and executive branches to get to work on these, rather than throw public behavioral services into ill-advised legal, administrative and programmatic chaos.

We look forward to Section 298 language, from the House and Senate that supports the recommendations contained in the final 298 Report – recommendations made in the overwhelmingly loud and clear voice of consumers and stakeholders, as the state works to foster system transformation and improvement.

Sincerely,

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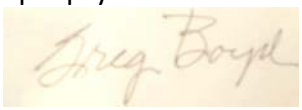

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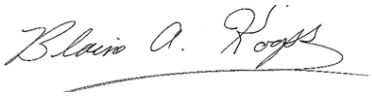

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