TO: The Hon. Rick Snyder, Governor, State of Michigan

FROM: The Arc Michigan; Assn. for Children's Mental Health; Epilepsy Foundation of Michigan; Mental Health Assn. in Mich.; Michigan Partners in Crisis; Michigan Protection & Advocacy Service; Michigan Psychiatric Society; NAMI Michigan; NASW Michigan; UCP Metro Detroit; UCPMichigan

DATE: June 12, 2017

We respectfully request that you veto section 298 of the House-Senate June 8 conference report on the DHHS budget (HB 4238), should that section ultimately be presented to you by the two chambers.

We make this request for several reasons:

*Requiring 1-3 pilots where Medicaid Health Plans (MHPs) control behavioral health Medicaid money is in direct contradiction to all three major state-initiated reviews of this issue since February 2016. The reviews were: Lt. Governor Calley's Workgroup; the affinity groups (public meetings) MDHHS convened last fall, where consumers and family members constituted 69% of 1,100 participants; and the MDHHS Section 298 Facilitation Workgroup, where service providers and payers were 65% of voting members (with advocates representing the other 35%). Attached are numerous reasons why MHP control of Medicaid behavioral health services and supports should not be undertaken.

*The legislative language is totally unclear on the intent of a pilot program in Kent County, involving both Community Mental Health and MHPs. Are the involved parties to be equal and funded partners in a shared program, or will one side control the funding and the pilot authority? The Legislature's failure to specify its desire here provides inadequate direction to MDHHS.

*The legislative language on the number of Prepaid Inpatient Health Plans (PIHPs) does not require that these entities must remain public (governmental) bodies. One might presume that the current PIHPs for Wayne, Oakland and Macomb, respectively, would remain in place. But what would be expected of the 4th (rest-of-state) is unclear. There should be specific guidance that PIHPs are to remain public (governmental) bodies.

*There is no requirement for a pre-pilot feasibility study. The required "project facilitator" could possibly undertake some feasibility action, but there is no specific call for it in the language. If there is not a pre-pilot feasibility study, any and all pilots will wind up suffering. Additionally, it is questionable as to whether the "project facilitator" (not required to have health care expertise) will produce value beyond what the state will have to pay to it.

*The Legislature failed to tie the pilots to the public mental health system reporting requirements of budget section 904. Once again, this provides inadequate direction to MDHHS.

*The timeframe for the initiation of pilot evaluation by a university is too late (6 months prior to pilot completion). For evaluation to be effective, the evaluator must be involved sooner than that. Also, where does actuarial expertise fit into evaluation; will universities automatically have

that expertise? Finally re evaluation, the legislative language does not call for a comparison of how the pilots have done compared to the rest of Michigan. Instead, it calls for comparison with similar models in other states.

*The legislative language, taken by itself, is illegal on two fronts. First, a given Legislature cannot in a budget bill bind future Legislatures to actions beyond the budget year in question. Section 298 in the June 8 conference report clearly attempts to do that. Secondly, there are numerous state laws that would have to be revised for the pilots to proceed. (The question of whether federal approval would be needed is also open.) The legislative language directs the pilots to start between this October and next March. Irrespective of the federal government, pilots cannot start without statutory change in Michigan. If the Legislature wants the new pilots, it would be much better advised to do all the base work from a statutory, not budgetary, standpoint (and to check with the federal government on any possible waivers needed).

A champion is needed to protect the desires and interest of service beneficiaries and their families, as well the continued viability of a public safety net for persons experiencing mental illness, emotional disorder, intellectual or developmental disability, and substance use disorder. We sincerely hope you are willing to play that role.

Thank you for your thoughtful consideration of our request. We would be pleased to discuss it further.

Attachment

cc: Lt. Governor Calley; Nick Lyon, Farah Hanley, Lynda Zeller, Matt Lori, Erin Emerson

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Reasons That MHPs Should Not Manage Specialty Behavioral Health

1. MDHHS has continually pointed out that Medicaid beneficiaries with behavioral disorders have more negative “physical” health outcomes than the rest of the population. How well have the MHPs performed in this regard? They have controlled “physical” health benefits for 20 years.

2. The MHPs administer a limited benefit (up to 20 annual outpatient visits) for mental health-related cases considered “moderate or mild.” According to MDHHS, the average number of mental health visits authorized for qualifying MHP enrollees in 2014 was four. This is extremely troubling. Are MHPs being given money for a mental health benefit they’re choosing to not provide?

3. CMH programs, although using managed care techniques for Medicaid, are not profit-driven. Will behavioral care managed by MHPs be further rationed than it is today?

4. MHPs are connected to government primarily through contracts. CMH programs are connected to government through law. Their board members are appointed by elected officials, and they must comply with FOIA and Open Meetings laws. Will the public be able to attend and make comment at MHP Board meetings in their entirety? Will MHPs be able to withhold from public inspection material they consider to be of business propriety?

5. MHPs don't appear to have extensive experience dealing with severe behavioral disorders or the unique needs of children, youth and families touched by serious emotional disorder. The CMH programs have over 40 years experience with severe behavioral disabilities as well as the special needs of children and youth.

6. Many of the services available through CMH programs today recognize and rely on the importance of non-medical social supports to foster recovery and the capacity to deal with one's circumstances and life situations. This includes legal requirement for person-centered planning and self-determination choices regarding beneficiary preferences and needs. It further includes matters like housing, transport, employment and education. And, for children and youth, family-driven/youth-guided planning, early identification/intervention, peer supports for parents and minors, and emphasis on home- and community-based initiatives. The MHPs don't appear to have this experience.

7. Would MHP control of Medicaid behavioral health require tens of thousands of state residents to leave their current doctors and providers for new ones that are imposed on them?

8. Michigan has been running a demonstration project on financial integration in four regions for persons enrolled in both Medicaid and Medicare. Eligible individuals are automatically enrolled in an MHP-like entity, with the option to subsequently dis-enroll. So far, after two years, over 60% of people that the state automatically placed with MHP-like managed care entities have chosen to dis-enroll from the program.

9. Service coordination is best achieved at the local provider level. How does statewide macro-level funding of one type of entity (be it MHP or CMHSP/PIHP) enhance service coordination at the provider level, especially if some providers still have respectively separate contracts with MHPs and CMHSPs/PIHPs?

10. What happens next MHP contract cycle if an MHP that is managing behavioral health doesn't bid or isn't selected?