LETTER FROM LANSING

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Section 298 Pilot Sites Selected by State

The Michigan Department of Health & Human Services (MDHHS) has selected three areas to be state budget section 298 pilot sites. They are: Genesee Health System (Genesee CMH); Saginaw County Community Mental Health Authority; and a combined project in the contiguous Muskegon and West Michigan CMH service regions. A demonstartion project on behavioral and other health integration, with different parameters, is also being established for Kent County.

In the three pilot areas, all state Medicaid appropriations for behavioral and other health care will go to Medicaid Health Plans (MHPs), which will then have to contract with the MHPs for specialty behavioral services. Despite MHP control of the funds, MDHHS insisted that CMHSPs be the lead entities on Request For Information proposals.

The State Administrative Board says that a proposal was also received from Kalamazoo County CMH & Substance Abuse Services, but it "did not meet the requirements of being responsive as they failed to meet (certain) mandatory minimum requirements." It is our understanding that the Kalamazoo proposal called for an integrated service approach between the CMHSP and at least one MHP, but without sending all related initial Medicaid appropriations to the MHP.

MDHHS says, "It is anticipated the pilots will be implemented by Oct. 1, 2018."

Medicaid Drug Access Bill Introduced

Senator Margaret O'Brien (R-Portage) has introduced SB 823, which would place all existing protections for Medicaid access to psychotropic and certain other drugs in one state statute.

To make a long story short, a combination of state statute (2004), MDHHS policy, and budget boilerplate language (Fiscal Years '17 & '18) protects from bureaucratic prior authorization (and step therapy) drugs for the follwing in all of Medicaid: mental health (including substance use disorder); epilepsy; HIV-AIDS; and organ replacement therapy. Additionally, those under Medicaid Fee For Service arrangements enjoy the same protection regarding cancer drugs.

Many health advocates believe the current protections need to be contained in one place, and that best would be state statute. Senator O'Brien's bill would accomplish this objective, which was endorsed last year by the state's Section 298 Workgroup, with the support of three MDHHS Deputy Directors who had voting privileges.

This is a critical bill because budget boilerplate is only good for one year at a time, and Department polcy can be changed anytime. The bill has been referred to the Senate Committee on Health Policy. We will let you know when it's time for you to start making contact with your Senators.

New Report on Psych Hospital Bed Access Falls Short

MDHHS has released a final report from its Michigan Inpatient Psychiatric Admissions Discussion (MIPAD) workgroup. This body was established the second half of 2017 to look at the growing problem of non-access to psychiatric hospitalization for those who clinically need it.
The effort began without recognition of two huge related problems:

(1) The average length of stay in private psychiatric hospitals and psych units of community hospitals is very short – less than a week. This is not enough time to stabilize many people. New standards and lessening of insurance pressures would be needed so that people can truly be stabilized during a hospital stay.

(2) Michigan has a critical shortage of state-operated (longer-term) psych hospital beds; the Treatment Advocacy Center (Virginia) says we're one of the five worst per capita states in the U.S. when it comes to this category.

The new report is divided into sections on physical plant, staffing & team-based care, continuum of care, interoperability (clinical and administrative processes across health care providers), and financing/reimbursement. There is also discussion of the state having a psychiatric bed registry, without any attention to how consumers and their families/advocates would be able to access it (or would have any access at all).

The report's 42 recommendations are also divided into short-term (2018), medium-term (2019), and long-term (by the end of 2022). Much of the report concentrates on how to connect consumers to community hospitals. Yet there is acknowledgment that we have 33% fewer such beds than 25 years ago, and that community hospitals don't always feel equipped to deal with publicly referred patients and won't, in fact, always accept them. Add in that, when there is acceptance, the stay will likely be very short.

Some 35 years ago, there was tremendous Michigan interest in public sector contracting with the private sector for psych hospital beds. Meanwhile, most of the state-operated psych hospitals were closed. Today we have four for adults and one for children. There is also the Forensic Center for criminally-related cases, but the criminalization of mental illness extends far beyond the Forensic Center's capacity; thus, our remaining state hospitals have many forensic cases, and the report says there is a 200-person wait list most days for state hospital admission. In sum, the state's policies since the early 1980s have proven a failure.

The report notes that the Legislature has already approved a rebuilt Caro Center that would have 50 additional beds. The report also has one long-term recommendation calling for a state "50-bed psychiatric inpatient hospital in the northern-most area of Michigan's Lower Peninsula." The report does not project a cost, but goes on to say, "While the new facility is being planned and constructed, the state should partner with a community hospital to provide state psychiatric care in this currently underserved community." This begs the question of how a "community hospital" provides "state psychiatric care."

Even if Michigan has another 100 state-operated beds by 2023 (and there is no guarantee it will), this is not nearly enough. No one wants most people with mental illness to be in hospitals. And no one is calling for the re-opening of 15 state psychiatric hospitals. But several advocacy groups and professional associations recommended over 15 years ago that the state needed an

additional 400 such beds (200 adult and 200 children). At that time, Michigan had over 950 state-operated beds (excluding the Forensic Center). Today that number is approximately 200 less. Without extra state beds, we will continue to chase our tails with short-term-only stays in community hospitals for those consumers that these hospitals don't reject. Why? Because we won't see significant improvements with the community hospital situation unless we can somehow change standards for length-of-stay and drive down the pressure that insurers (including Medicaid) put on those hospitals to get people out ASAP.

Medicaid Work Requirement Follow-Up

As we projected last issue, bills have now been introduced in the state Legislature to require Michigan to seek a Medicaid waiver so that some beneficiaries would have to be working in order to receive their health coverage. There is no question that these bills will have a fair amount of support in the Legislature. As of mid-March, Governor Snyder's position and whether he would veto any such bills are unknown.

Save the Dates

MHAM Annual Membership Meeting, May 17, 3:00 p.m., Hyatt Place Detroit/Livonia (19300 Haggerty Rd., Livonia 48152). To be immediately followed by an educational presentation on one or more public policy topics.

MHAM Tribute Dinner, honoring Tom Watkins, who has led state departments (including Mental Health) and most recently the Detroit-Wayne Community Mental Health Authority. June 21, Burton Manor, Livonia (27777 Schoolcraft Rd., Livonia 48150). Reception at 6:00, dinner at 7:00, program at 8:00.

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