Kaeley Hux

From: Kathleen Gallagher
Sent: Tuesday, December 10, 2019 4:50 PM
To: Kaeley Hux
Subject: FW: [EXTERNAL]CMHA analysis of MDHHS proposal on system design
Attachments: CMHA analysis of MDHHS system structure proposal - December 2019.pdf

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

Could I get this email and attachment as part of the Advisory Board Packet (I will still be needing a paper copy) thanks

From: Lori Gauthier <LGauthier@scccmh.org>
Sent: Tuesday, December 10, 2019 4:39 PM
To: Management Team <ManagementTeam@scccmh.org>
Subject: FW: [EXTERNAL]CMHA analysis of MDHHS proposal on system design
Importance: High

FYI...

From: Monique Francis <MFrancis@cmham.org>
Sent: Tuesday, December 10, 2019 4:22 PM
To: Monique Francis <MFrancis@cmham.org>
Cc: Robert Sheehan <rsheehan@cmham.org>; Alan Bolter <ABolter@cmham.org>
Subject: [EXTERNAL]CMHA analysis of MDHHS proposal on system design
Importance: High

To: Members of the Executive Board and Steering Committee, Board Chairpersons, CEOs of CMHs, PIHPs, and Provider Alliance members
From: Robert Sheehan, CEO, CMH Association of Michigan
Re: CMHA analysis of MDHHS proposal on system design

Background: Last week, as you know, Robert Gordon, MDHHS Director, discussed the MDHHS proposal for the design of Michigan's public mental health system at a joint Senate-House appropriations subcommittee. As we indicated in an earlier e-mail, we noted that the MDHHS proposal is a combination of the views of a diverse set of stakeholders. As we noted in that e-mail and the recent CMHA Executive Board, Mr. Gordon and his staff talked, over the last several weeks, about potential system refinement with a large number of parties with interests in Michigan's public mental health system. Given the diversity of those views, the proposal that Mr. Gordon outlined reflected a similar diversity – reflecting the views of: many of you – PIHPs, CMHs, providers – who met with Mr. Gordon; members of the advocacy community; the health plan association; the hospital association; staff within MDHHS; state legislators; and our association. It seems clear that no party sees all they recommended in the MDHHS proposal.

Some of the principles and design elements put forth by our association are reflected in the MDHHS proposal: the foundation of person-centered planning, self-determination, recovery orientation, cultural competence; the centrality of

public mental health system; the recognition that integrated care, at the client/patient/clinical level, is where integration starts with financial integration done only to foster clinical integration; the public nature of any structure involved in managing Medicaid mental health care; the common good/safety net role of the public system as in addition to the care provision and care management roles of that system.

However, while we wish otherwise, a number of our association's other views are not reflected in the proposal. In fact, a number of the components of the proposals are diametrically opposed to the principles and views of our association and our members. Our sense is that the same reaction is being felt by all of the other parties with an interest in the system – no party sees all of their views and desires in MDHHS's proposal.

Analysis of proposal: Attached is the **analysis**, developed by the Community Mental Health Association of Michigan (CMHA), of the proposal, recently made by the Michigan Department of Health and Human Services (MDHHS) related to the structure of Michigan's public mental health system. Additionally, this paper outlines the **principles** behind that analysis and behind the association's advocacy around this proposal, as well as **the steps that CMHA will take** to support the segments of this proposal that benefit Michigan's public mental health system and those served by that system and to oppose and change those proposal segments that harm the public system and those served by that system.

Note that this analysis does not cover all of the bases relative to statutory, fiscal, regulatory (waiver), nor other dimensions related to this proposal.

As the dialogue at the state, regional, and local levels moves along, we will keep you informed. The initial set of public forums on the MDHHS proposal is being scheduled for the next few weeks.

Robert Sheehan
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Community Mental Health Association of Michigan

Analysis of MDHHS proposal for the structure and operation of Michigan's public mental health system

December 2019

Purpose of this paper

This document provides an analysis, of the Community Mental Health Association of Michigan (CMHA), of the proposal, recently made by the Michigan Department of Health and Human Services (MDHHS) related to the structure of Michigan's public mental health system. Additionally, this paper outlines the principles behind that analysis and behind the association's advocacy around this proposal, as well as the steps that CMHA will take to support the segments of this proposal that benefit Michigan's public mental health system and those served by that system and to oppose and change those proposal segments that harm the public system and those served by that system.

MDHHS proposal

In December 2019, Robert Gordon, the Director of the Michigan Department of Health and Human Services (MDHHS), proposed the restructuring of Michigan's public mental health system. That restructuring proposal is captured in the press release, Director Gordon's editorial, slides, and Frequently Asked Questions (FAQ) found at the following links:

Link to website on the MDHHS Future of Behavioral Health (which includes Director Gordon's editorial, MDHHS press release):
https://www.michigan.gov/mdhhs/0,5885,7-339-73970_5093_96724---,00.html

Link to Director Gordon's PowerPoint slides:
https://www.michigan.gov/documents/mdhhs/Future_of_Behavioral_Health_Presentation_to_Joint_HHS_Committee_672948_7.pdf

Link to FAQ sheet:
https://www.michigan.gov/documents/mdhhs/Future_of_Behavioral_Health_Fact_Sheet_and_FAQs_672946_7.pdf

Political context

Since early in 2016, the private health plans (health insurance companies) have applied considerable political pressure to assume the management of the $2.5 billion in Michigan's Medicaid mental health benefit. This trend, often known as a Medicaid "carve-in" of the mental health benefit into the physical health benefit, both of which would be managed by private health plans, is occurring nationally, as private health plans view long-term care and mental health care as the last remaining Medicaid markets into which they can move. That early 2016 threat appeared as Section 298 of the FY 2017 MDHHS budget, as proposed by Governor Snyder. The highly intense political advocacy effort of CMHA, its members, and allies turned back the initial privatization threat, in early 2016, with the removal of Section 298 from the budget bill.

The privatization threat emerged again in 2017, when Senate leadership proposed the carve-in via the reintroduction of the original Section 298. The result of another strong advocacy effort was a compromise/negotiated agreement in which up to three privatization pilot programs would be developed. The inability to reach agreement, by the CMHs and private health plans, on fundamental design elements caused the development of these pilots to be halted in 2019.

With the end of the Section 298 pilots, three facts become clear:

1. With the end of the Section 298 pilot development, **the private health plans, their association, and their legislative supporters are again calling for a carve-in of the state's Medicaid mental health benefit**, now managed by the state's PIHPs, into the benefit managed by the state's private health plans. [1]

2. It is key to see the **MDHHS proposal as a counter proposal to the carve-in proposal advocated by the private health plans, their association, and their legislative supporters.**

3. **While the MDHHS proposal has weaknesses, in the absence of a bold redesign proposal, such as that put forth by MDHHS, most observers see the political forces at work moving toward a carve-in,** under the management of private health plans, of Michigan's Medicaid public mental health benefit.

[1] While CMHA, its members, and allies have significant political power, the financial campaign contribution power of the private health plans and their association are underscored by the investigative reporting conducted by the Campaign Financing Network and Michigan Radio. That story is available at this link.

Analysis of design elements of MDHHS proposal

Below is an analysis of each of the major design elements of the MDHHS proposal highlighting the benefits and detriments of each component.

Design element contained in MDHHS proposal	Positives/Benefits	Negatives/Detriments
Statewide public Specialty Integrated Plan (SIP) (formed as joint venture between Michigan CMHs and one private physical health plan)	Ensures that the management of the Medicaid mental health benefit remains with the public sector, linked to local CMH system	Threatens current role of the state's PIHPs
	Savings generated on physical health side of system is available for use in the behavioral healthcare side	Health plan could dominate public/CMH partners of Specialty Integrated Plan
	Fosters statewide uniformity of benefit, provider contracts and standards	Requires meshing of cultures, defining of roles, determination of power balance
	Ensures sufficient number of enrollees to make risk management possible	Statewide purview could limit local voice
	Brings best of public sector (sophisticated and proven local provider network; focus on social determinants, person-centered planning; deep roots in community and health and human services networks) together with best of private sector (insurance license, access to capital, access to range of technical and practice resources)	
	Requires and fosters dialogue across public and private and the physical health and behavioral health spheres	

Design element contained in MDHHS proposal	Positives/Benefits	Negatives/Detriments
Specialty Integrated Plan (SIP) governance with greatest number of board seats provided to CMH and public partners	Ensures public governance of system	Health plan board members could dominate decision making by public board members
	Savings generated on physical health side of system is available for use in the behavioral healthcare side	Health plan could dominate public/CMH partners of Specialty Integrated Plan
Medicaid payments to Specialty Integrated Plan are based on enrollment of specialty population with Specialty Plan not full Medicaid enrollment	Medicaid revenues will be more stable, avoiding the variability of the overall Medicaid enrollment	Current risk that actuarial assumptions will be inaccurate, causing revenue gaps, remain
Public SIP's private sector partner allows for the Infusion of private capital	Provides access to capital markets - useful in ensuring sufficient risk reserves	Investment of private capital comes with the expectation, by investors, of profits to be drawn from the public SIP The private plan partner, as the source of capital could become the final decision maker, overwhelming the safety net obligations of the SIP

Design element contained in MDHHS proposal	Positives/Benefits	Negatives/Detriments
Private SIPs competing with the public SIP	Fosters, in theory, high performance	Competition among Medicaid Health Plans, in Michigan and across the country, has not led to high performance
	Provides the image of choice for persons served	Leads to cherry picking of low need and low cost enrollees, by private plans, leaving high need and high cost persons as enrollees in public SIP Competition among health plans does not represent choice for persons served (most Michigan Medicaid enrollees do not select their health plans based on discernible differences in service and supports offerings nor quality) Ensuring a level playing field is difficult and would require similar set of safety net requirements and standards (person centered planning, recipient rights, self determination), similar MLR floor, marketing limitations, and rapid in-year rate adjustment to reflect differences in chronicity/acuity of enrollees
Many of the components of the system design are built around the locally/county-based CMH system	Underscores the centrality of the locally/county-based CMH system to the service delivery, provider network organizing, safety net, community benefit, and managed care functions of the system	

Design element contained in MDHHS proposal	Positives/Benefits	Negatives/Detriments
Establishment of defined functions with earmarked funding, to CMHs, for fulfilling the functions of crisis safety net and community benefit services role for CMHs	Recognizes the safety net role played by the CMH system that services individuals, regardless of Medicaid coverage, and the communities in which they live	Set of crisis safety net and community benefit services may be defined too narrowly Funding for these services, given that they do not have the federal entitlement protections provided to Medicaid services, may not be sufficient to adequately fund them.
Mild to moderate mental health benefit remains managed by current Medicaid Health Plans		Causes an artificial divide in the provision and risk management of the mental health benefit
Timeframe resulting in system change implemented in fall 2020	Allows for in-depth discussion and planning without the loss of direction caused by prolonged planning and discussion	May not provide sufficient time for working out conceptual and technical details and mechanics and identifying design or implementation flaws

Next steps

Over the next few months, with intense activity in the next few weeks, CMHA will be working, as it has for the past several years, to impact the MDHHS design proposal to more closely mirror the views of our association, its members, and its allies. That advocacy will apply the advocacy tools that have been so effective over the past several years: grass-roots advocacy, direct legislative and executive branch advocacy, media relations, alliances with advocates and other stakeholders, and policy analysis - using pro-active and responsive approaches.

The association's efforts have been and will continue to be based on a set of principles documents adopted by the Association's Executive Board over the past several years: the set of principles adopted by the Executive Board in August 2016, the association-adopted vision for a world class public mental health system and the association's recommendations around addressing the underfunding our system.

The synthesis of the principles contained in these documents, Attachment A, was adopted unanimously by the CMHA Executive Board on Friday, December 6, 2019.

Community Mental Health Association of Michigan

Core system integrity principles and design elements

Passed unanimously by the CMHA Executive Board, December 6, 2019

The following principles and design elements – proposed by the Community Mental Health Association of Michigan for any system refinement effort pursued by Michigan's policy makers and elected officials - have, as their foundation, the set of values that are so fundamental to Michigan's public mental health system, that they do not need explanation beyond their listing:

- **an individual's right to self-determination, person-centered planning, full community inclusion, cultural competence in the services and supports provided them**

- **system design should always start with what is best for those served by the system**

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1. **Recognize and build on the current system's strengths:** Build on the nationally-recognized strengths and accomplishments of the state's leading edge public mental health system

2. **Foster real primary and mental healthcare integration and coordination via clinical integration (where the client/patient receives services and supports)and build structural and financial supports from there:** : Foster real health care integration, via clinical integration (where the client/patient receives services and supports) and not simply the consolidation of funding. Support the current and emerging clinical integration models in local communities, often led by the CMH/provider system. Once these clinical integration efforts are designed, structural and financing arrangements would then be designed to foster clinical integration.

3. **Ensure strong local public governance**: Ensure that the governance of the managed care, provider, and collaborative convener roles of the state's public mental health system remain local and public; embedded and linked to the counties served by the system. This recognizes the statutory basis of the county role in Michigan's public mental health system. (This would mean that if a new structure (Integrated Specialty Plan, Special Needs Plan, etc.) was formed, the counties or CMHs would need to be **owners (co-owners), where ownership is required, governing body members, and creators (or co-creators) of that new structure.**

4. **Persons served in key governing roles**: Ensure that the persons served are mandated members of the local governance bodies (not advisory).

5. **Direct contract with the state:** The governance role includes the fiscal control of the system via a direct contract, of the county, CMH, or county- or CMH-created body (such as a PIHP) with the State of Michigan and not through a private entity, unless the counties/CMHs are owners (or co-owners), governing body members, and creators (or co-creators) of that private entity.

6. **Protect and strengthen the full set of safety net roles played by Michigan's the public mental health system:** The community mental health system's role as the population-based and place-based resource and public safety net committed to the common good, population-health, social determinants, and community collaboration.

   The safety net role played by the state's CMHs is made up of several components:

   - **Organizers of care** - Providers, purchasers, and managers of a well-organized comprehensive array of services and supports across a **network of proven providers** in fulfillment of statutory role to serve the individuals, families, and communities regardless of the ability to pay.

     For this statutorily-defined safety net role to be retained and strengthened, the CMH in each community and, through the CMH, the provider network organized by the CMH, must serve as the **exclusive provider network** of any system redesign. **Additional providers can be added to the network** as needed and as requested by persons served through the joint work of the risk-bearing care manager and the CMH in each community.

   - **Community conveners and collaborators** – initiating and participating, often in key roles, collaborative efforts designed to address a broad range of social determinant-related needs of individuals and communities

   - **Advocates** for vulnerable populations and a whole-person, social determinant orientation

   - **Sources of guidance and expertise**, drawn upon by the public, to address a range of health and human services needs

7. **Adequate financing:** Ensure adequate and sustainable funding to the public system to ensure that it is sufficiently strong to meet the growing demand and expectations for access to mental health services by all Michiganders.

   This growing demand centers around the full range of mental health needs including: ready access to crisis services for all the Michiganders, fostering the ability of those with a range of mental health needs to live a full and productive life, treatment of substance use disorder (with opioid treatment being the highest profile SUD treatment currently), prevention of incarceration, prevention of homelessness, and the provision of services to children with mental health needs and their families.

8. **State retaining central risk-sharing role in public mental health system**: The State of Michigan should retain its longstanding risk-sharing involvement in the state's public mental health system.

9. **Competition only when it fosters common good**: If competition is considered for a potential design element in any restructuring of Michigan's public mental health system, the competitive structure must ensure that cost, risk, regulation, marketing, enrollee and/or client assignment, and other factors be controlled to ensure that the competition takes place on a "level playing field" and that the individuals and persons served by the system benefit from competition. Where the system cannot be designed to control such factors, competition should not be included as a design element.

10. **Risk management:** Provide for foundational risk management tools:

    Financing of risk reserves: The Medicaid capitation rates must include an annual and sufficient contribution to the risk reserves of any CMH-centered risk bearing organizations. Federal regulations required that the payments to risk-bearing entities, such as PIHPs, in a capitated/risk-based financing model, include a component for contribution to risk reserves.

    Sub-capitation payments to the CMHs: with incentive and shared saving structures and the ability to retain savings parallel to risk reserve component of rates to care management entity: Parallel to the changes needed to allow for the development of risk reserves by the care management entity, the payments to the CMHs should be in the form of subcapitation payments, allowing CMHs to retain savings from their Medicaid line of business, as is allowed for all other Medicaid providers, all of which will be retained in the public system for use in meeting unmet community need and invest in system improvements.

    Sharing of savings across the physical-mental health care line: Require shared savings agreements across mental health and physical health systems to foster the development of cost controlling, quality of life enhancing practices.

11. **Retain and expand the groups served by the public mental health system:** Retain and expand the populations served by the system (to meet the expectations of the community):

    Current groups served by the system:
    - adults with serious mental illness
    - children and adolescents with serious emotional disturbance
    - children, adolescents, and adults with intellectual/developmental disabilities
    - children, adolescents, and adults with substance use disorders

    Group to be added to responsibility of the public mental health system
    - children, adolescents, and adults with mild to moderate mental health needs