Strengths of Michigan's

Public Mental Health System

The performance of Michigan's public mental health system surpasses other states and systems, as measured by dimensions of health care quality and innovation.

CHI2 drew from national and Michigan-based sources to demonstrate services available to support residents seeking mental health services.

Michigan's public mental health system is nationally recognized as one of the most comprehensive, innovative, person-centered and community-driven systems in the country.

Through the use of community-based rather than institution-based care, Michigan's public mental health system returns a 37-fold investment on the state dollars that fund that system, according to a report released by the Center for Healthcare Integration and Innovation (CHI2).

The report, entitled "A Tradition of Excellence and Innovation: Measuring the Performance of Michigan's Public Mental Health System," examines the performance of Michigan's public mental health system against several state-established and national standards.

Strong, longstanding performance against state established and nationally recognized performance standards: Michigan's public mental health system has exceeded the state established standards for 37 of the 38 standards measured. For the one standard not exceeded, the system was below the state standard by only 1.63% from the 95% standard.

High rankings against national standards of behavioral health prevalence and services accessibility: Michigan ranks sixth nationally in serving adults, as cited by Mental Health in America in 2020.

A national leader in de-institutionalization and community-based care: Michigan's use of state psychiatric hospitals compared to the rest of the country is significantly less, with other states using state psychiatric hospitals 17 times more, per-capita, than Michigan—a testament to the state's strong movement to a de-institutionalized and community-based system of care. In fact, if the $3.469 billion that is currently used to serve over 350,000 Michiganders per year was spent solely on the provision of long-term care at state psychiatric hospitals and developmental disability centers, then those dollars would only serve 9,500 people per year.

Proven ability to control costs over decades, resulting in major cost savings: When compared to Medicaid cost increases seen across the country, from 1998 to 2015, Michigan's public mental health system has saved the state of Michigan $5.27 billion. If extrapolated through 2024, Michigan could save over $12 billion. The report found the approaches that the public system uses to control costs contrast sharply with the approach of private systems.

Pursuit of healthcare integration and evidence-based practices: More than 620 integration efforts led by the public mental health system—weaving mental health care with primary care—take place throughout the state to lower costs of services, increase access to care, improve preventative intervention and serve the whole person.

CMHA
Community Mental Health Association of Michigan

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www. CMHAM.org
@CMHAMich

Evidence-Based Practices

Michigan's public mental health system has been a national leader in the Evidence-Based Practice movement, pioneering evidence-based and promising practices for decades, including:

- Assertive Community Treatment
- Assisted Outpatient Treatment
- Psycho-Social Rehabilitation/Clubhouse
- Cognitive Enhancement Therapy
- Dialectical Behavior Therapy
- Family Psychoeducation
- Motivational Interviewing
- Person Centered Planning, Training, and Evaluation
- Self Determination
- Independent Person-Centered Planning Facilitation
- First Episode Psychosis Services
- Eye Movement Desensitization and Reprocessing
- Peer Services
- Consumer-Driven Services
- Homebased Treatment Services for Children, Adolescents, and their Families
- Competitive Integrated Employment practices
- Trauma-Informed Care
- Treatment Courts
- Sequential Intercept Model of Jail Diversion/Decarceration

Efficient – Low Overhead Means More Dollars Spent on Care

94% **Medical loss ratio**

(i.e. the percentage of dollars spent on actual care)

Michigan's public PIHP system has a statewide average spent on administrative costs of 6%

Results-Oriented

Thanks to CMHA's work to make the state's behavioral mental health system value-based, innovative and evidence-based, Michigan ranked 15th in the 2019 State of Mental Health in America report. This puts Michigan among the top 30% for awareness and access to mental health.

MICHIGAN RANKS

6th **in the nation**
for services & outcomes for adult services

20th **in the nation**
for services & outcomes for children's services

15th **in the nation**
for access to care for both adult & children's services

Serving Thousands of Michiganders

10
public regional entities

46
public community mental health systems

100+
provider organizations

100,000+
persons providing services in Michigan's public mental health system

300,000+
Michiganders served annually

The Community Mental Health Association of Michigan is the state association representing Michigan's public Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans (PIHP – public health plans formed and governed by CMH centers) and the private providers within the CMH and PIHP provider networks. For more information, please visit CMHA.org or call 517-374-6848.

CMHA
Community Mental Health Association of Michigan

June 17, 2021

RE: HB 4925-4929

Chairperson Kahle & Members of the House Health Policy Committee,

I am Bob Sheehan, the CEO of the Community Mental Health Association of Michigan. CMHA is a trade association, representing the 46 CMH boards, 10 Prepaid Inpatient Health Plans (PIHP) and over 100 provider organizations. Annually, our members provide mental health, intellectual and developmental disability and substance use disorder services to over 300,000 of the most resilient Michiganders in all 83 counties in Michigan.

As you consider the package of bills before you and the dramatic changes called for by these bills, our association and our members think that it is key to start with an accurate picture of the current public system.

Ensuring an accurate picture of Michigan's public mental health system as starting point for system change

Michigan's system is nationally recognized as one of the most innovative, comprehensive, and community-based systems in the country. So, while we all must work to advance Michigan's mental health system – both its public and private sectors – we need to begin that work with a clear eyed view of the performance of the public system.

1. Since 1997, Michigan's public system has operated the nation's only publicly managed capitated mental health system serving all Medicaid populations. Over those 24 years, the system has met or exceeded nearly every performance standard established by the State of Michigan. Those standards measure: access to care, timeliness of response, follow-up after psychiatric inpatient stay and substance use detox, and readmission rates.

2. Michigan's system leads the nation in providing community based mental health care - to Michiganders in their homes, schools, and communities rather than in institutions. If Michigan's current public health budget, which now serves over 300,000 Michiganders, were used for hospital-based care, we would serve only 9,500 persons. Thus, the use of sound community based mental health approaches allows Michigan's public system to meet the mental health needs of 32 times more Michiganders, than would be served if those same dollars were used to provide long term inpatient care in the state's psychiatric hospitals and developmental disability centers.

3. While we know that improving access to mental health care is needed, it is important to know that Michigan ranks 15th in the country for access to mental health care and 6th in the nation for access for adults. Many of the access barriers exist outside of the control of the public system – and are related to access to inpatient psychiatric beds, the psychotherapy and psychiatric benefit managed by the private Medicaid and commercial health plans, and the nationwide mental health workforce shortage.

4. Michigan's public system has been able to achieve remarkable cost control during the 24 years over which the public system has managed Michigan's Medicaid benefit. During that time, the system saved the State of Michigan nearly $10 billion dollars when compared to the per enrollee cost increases experienced by Medicaid programs across the country.

And those cost savings are the result of innovative health care work including very low managed care overhead of 6% - resulting in 94% of the Medicaid payments to the system going to care, in what is called the Medical Loss Ratio. Additionally, the system employs very active clinical care management approach, a comprehensive and

closely coordinated network of providers, a whole person orientation, that concretely addresses the social determinants of health, uses thousands of persons with lived experience to come alongside clients to aid in their recovery and quality of life, and employs, at its core, a person-centered planning approach.

5. The system is ahead of nearly every other healthcare sector in the design and implementation of the clinical integration of mental health and physical healthcare. Every year, the Center for Healthcare Integration and Innovation (CHI2) conducts a study of the healthcare integration initiatives led by Michigan's public mental health system. The most recent study in this series found that Michigan's public mental health system was operating more than six-hundred healthcare integration efforts – from co-location of mental health practitioners in primary care practices and emergency departments to the co-location of primary care providers in mental health centers, from the linking of electronic health records to intensive case management and care coordination of super-utilizers and others with complex and often expensive health and human service needs.

6. Finally, Michigan's system leads the country in its use of mental health evidence based and promising practices – with over two-dozen being used by clinicians across the state with a training, fidelity assurance, and new practice identification and replication system that is the envy of the country.

So, with this concrete and fact-based picture of Michigan's public mental health system as the starting point, we want to thank Representative Whiteford for her aim in continuing to advance Michigan's public mental health system.

CMHA supportive of some components of the bills

We are very supportive of the movement, as outlined in Representative Whiteford's bills of the mild to moderate mental health system to the public mental health system. This change will close the gap that currently exists between the segment of the Medicaid benefit current managed by the state's private Medicaid managed care plans and the state's CMHs and PIHPs.

Additionally, we are heartened to see that these bills recognize the need to retain a specialized Medicaid behavioral health care benefit and that the full set of populations currently receiving mental health services through this public system remain covered by this comprehensive network.

The creation of the Behavioral Health Oversight Council is also a good step forward, in that its deliberation and decisions will be transparent, subject to the Open Meetings Act, FOIA, and will ensure that the consumer voice is loud and diverse.

CMHA has concerns surrounding other components of the bills

We are, however, concerned with several of the sections of these bills.

The bills eliminate the state's public managed care system, the state's PIHPs – one of the most cost effective and low-overhead managed care systems in the country. While the aim of reducing administrative overhead is one that we strongly support, the reduction in or elimination of many of the current non-value-added regulations and requirements currently loaded on the system would more directly and immediately reduce that administrative burden on both the managed care entity and clinicians.

The bills call for the creation of a single statewide, Administrative Services Organization. While such an ASO may be useful in fostering statewide uniformity, if an ASO is created, it should be a public body, with the transparency that Michiganders have come to expect in their public mental health system. If the ASO was created as a public body, The Behavioral Health Oversight Council should then be given a role that is more directly involved in governance of that ASO, rather than more advisory role called for currently in this package.

These bills eliminate the definition of the Department-designated community mental health entity and replaces it with a new organizational type "public behavioral health provider". This change dramatically alters one of the core aims of the Michigan Mental Health Code – the creation of the strong, longstanding, and proven partnership between the state and the counties through the county-based community mental health entities. The elimination of that distinction and the creation of a new type of organizational class "public behavioral healthcare provider" causes Michigan's public mental health system to no longer be a public system linked to both state and county government.

The bill package moves the system to a fee-for-service system with the state holding all of the financial risk for the system. CMHA recommends that the highly developed managed care system that employs a capitated payment system be retained, allowing for the greatest clinical and person-centered flexibility that such payment systems make possible. CMHA also recommends that the ASO, if created, continues the current highly cost effective and clinically responsive delegation of managed care functions to the state's CMHs. The delegation of these functions is key to the use of the advanced alternative payment methods that are the future of healthcare.

Finally, the size and complexity of the changes outlined in these bills calls for much greater and more in-depth planning, dialogue, and development. The impact of the changes outlined in these bills, if not done with a deep understanding of the current system and the impact of the changes proposed here, put a great many vulnerable Michiganders and Michigan communities at risk of losing access to some of the nation's best mental health resources.

So, again, we look forward to the continued advancement of our state's public mental health system through this and other venues.

Thank you for your time and attention to these concerns.

Robert Sheehan
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CHI²

Center for Healthcare Integration & Innovation

Community Mental Health Association of Michigan

A Tradition of Excellence and Innovation: Measuring the Performance of Michigan's Public Mental Health System

May 2020

Center for Healthcare Integration and Innovation
Community Mental Health Association of Michigan

A Tradition of Excellence and Innovation: Measuring the Performance of Michigan's Public Mental Health System [1]

May 2020

Abstract

This white paper examines the performance of Michigan's public mental health system against a number of state-established and national standards.

Michigan's public mental health system, for this paper, is made up of the public Community Mental Health centers (CMHs) linked to county governments, the public Regional Entities/Medicaid Prepaid Inpatient Health Plans (PIHPs) formed and governed by the CMHs, and the private non-profit and for-profit organizations in the CMH and PIHP networks.

This paper draws on a range of national and Michigan studies and data sources in constructing this picture of performance.

This paper underscores the very high levels of performance that Michigan's public mental health system, in partnership with the Michigan Department of Health and Human Services (MDHHS), has demonstrated, over decades, on a number of dimensions of healthcare quality and innovation.

This high level of performance was found in an examination of a number of components of the system's operations:

- Longstanding strong performance against the state-established and nationally recognized performance standards
- Nation-leading de-institutionalization
- High rankings against national standards of behavioral health prevalence and access to services
- Proven ability to control costs over decades
- Pursuit of healthcare integration
- Use of evidence-based and promising practices and the infrastructure to support their use

[1] When the terms public mental health system and public behavioral health system are used in this report, they refer to the system that serves adults with mental illness, children and adolescents with emotional disturbance, persons with intellectual and developmental disabilities, and persons with substance use disorders.

Impetus behind this report

Michigan's public mental health system is made up of three distinct and interwoven components:

- Public Community Mental Health (CMH) systems, each linked to Michigan's county governments, serving all of Michigan's counties through their roles as providers, network organizers, conveners of a wide range of human service collaborative efforts, advocates for those with mental health needs and the services and supports needed by them, and sources of expertise on a wide range of mental health issues
- Public Medicaid behavioral health plans, formed and governed by the CMHs (known as Prepaid Inpatient Health Plans or Regional Entities) that manage the Medicaid behavioral health benefit through a capitated shared-risk arrangement with the State of Michigan
- Private non-profit and for-profit organizations making up, along with the CMHs themselves, the provider networks of the CMHs and Regional Entities

Throughout its history, Michigan's public mental health system has been an innovator in system design and processes. This system continues to develop a wide range of design and process refinements that are goal- and outcome-oriented, implemented with sound redesign principles and approaches, and based on a clear picture of the current performance of the system.

Over the last several decades, policy makers and elected officials have debated and implemented a range of plans for redesigning Michigan's public mental health system. Unfortunately, some these system redesign proposals have been based on a lack of accurate information on the performance of that system.

This report has been developed to provide that accurate picture of the system's performance, as a basis for the development of policy, practice, and design changes.

Findings and Analysis

The performance of Michigan's public mental health system is examined, in this report, by drawing together performance data from a variety of existing sources along the following dimensions:

- Performance against state-established performance standards
- Assessing Michigan's progress on de-institutionalization against national norms
- Performance when compared with national standards of prevalence and access
- Cost control performance – bending the cost curve
- Pursuit of healthcare integration
- Use of evidence-based practices

A. Performance against state-established performance standards

For the past several decades, Michigan has used a set of performance metrics for its public mental health system, built around standard measures of mental health system performance. This system, the Michigan Mission Based Performance Indicator System (MMBPIS), provides regular quarterly reports, issued by the Michigan Department of Health and Human Services, on a range of key performance measures across all of the populations served by Michigan's public mental health system: persons with mental illness, intellectual/developmental disabilities, emotional disturbances, and/or substance use disorders.

Findings: Below is the performance of the Michigan's system, for two quarters, one year apart, as samples of the systems performance against the MDHHS-established performance standards.[i]

Table 1: Performance of Michigan's CMHs and PIHPs against standards of the Michigan Mission Based Performance Indicator System (MMBPIS) July – September 2018 and 2019.

			Standard established by MDHHS	Average of CMH/PIHP performance across the state	Met or exceeded state standard
Inpatient pre-admission screening timeliness			At least		
Percentage of Children Receiving a Pre-Admission Screening for Psychiatric Inpatient Care for Whom the Disposition Was Completed Within Three Hours	July-Sept	2019	95%	98.10%	**Yes**
		2018	95%	97.67%	**Yes**
Percentage of Adults Receiving a Pre-Admission Screening for Psychiatric Inpatient Care for Whom the Disposition Was Completed Within Three Hours	July-Sept	2019	95%	98.01%	**Yes**
		2018	95%	97.99%	**Yes**

Face-to-face assessment timeliness

Percentage of New Persons Receiving a Face-to-Face Assessment with a Professional Within 14 Days of a Non-Emergent Request for Service	July-Sept	2019	95%	97.45%	**Yes**
		2018	95%	97.73%	**Yes**
Percentage of New Children with Serious Emotional Disturbance Receiving a Face-to-Face Assessment with a Professional Within 14 Days of a Non-Emergent Request for Service	July-Sept	2019	95%	96.73%	**Yes**
		2018	95%	98.13%	**Yes**
Percentage of New Adults with Mental Illness Receiving a Face-to-Face Assessment with a Professional Within 14 Days of a Non-Emergent Request for Service	July-Sept	2019	95%	98.64%	**Yes**
		2018	95%	98.37%	**Yes**
Percentage of New Children with Intellectual or Developmental Disabilities Receiving a Face-to-Face Assessment with a Professional Within 14 Days of a Non-Emergent Request for Service	July-Sept	2019	95%	93.37%	No
		2018	95%	98.89%	**Yes**
Percentage of New Adults with Intellectual or Developmental Disabilities Receiving a Face-to-Face Assessment with a Professional Within 14 Days of a Non-Emergent Request for Service	July-Sept	2019	95%	98.21%	**Yes**
		2018	95%	96.46%	**Yes**
Percentage of New Persons with Substance Use Disorders Receiving a Face-to-Face Assessment with a Professional Within 14 Days of a Non-Emergent Request for Service	July-Sept	2019	95%	96.21%	**Yes**
		2018	95%	96.47%	**Yes**

On-going services start timeliness

Percentage of New Persons Starting any Needed On-going Service Within 14 Days of a Non-Emergent Assessment with a Professional	July-Sept	2019	95%	97.47%	**Yes**
		2018	95%	96.91%	**Yes**
Percentage of New Children with Serious Emotional Disturbance Starting any Needed On-going Service Within 14 Days of Non-Emergent Assessment with a Professional	July-Sept	2019	95%	95.76%	**Yes**
		2018	95%	96.35%	**Yes**
Percentage of New Adults with Mental Illness Starting any Needed On-going Service Within 14 Days of Non-Emergent Assessment with a Professional	July-Sept	2019	95%	97.14%	**Yes**
		2018	95%	97.41%	**Yes**
Percentage of New Children with Intellectual or Developmental Disabilities Starting any Needed On-going Service Within 14 Days of Non-Emergent Assessment with a Professional	July-Sept	2019	95%	97.75%	**Yes**
		2018	95%	98.10%	**Yes**
Percentage of New Adults with Intellectual or Developmental Disabilities Starting any Needed On-going Service Within 14 Days of Non-Emergent Assessment with a Professional	July-Sept	2019	95%	95.27%	**Yes**
		2018	95%	97.36%	**Yes**
Percentage of New Persons with Substance Use Disorder Starting any Needed On-going Service Within 14 Days of Non-Emergent Assessment with a Professional	July-Sept	2019	95%	96.88%	**Yes**
		2018	95%	97.88%	**Yes**

Follow-up after psychiatric inpatient care or substance use disorder detoxification unit					
Percentage of Children Discharged from a Psychiatric Inpatient Unit Who are Seen for Follow-up Care Within 7 Days	July-Sept	2019	95%	96.41%	**Yes**
		2018	95%	98.74%	**Yes**
Percentage of Adults Discharged from a Psychiatric Inpatient Unit Who are Seen for Follow-up Care Within 7 Days	July-Sept	2019	95%	96.00%	**Yes**
		2018	95%	97.57%	**Yes**
Percentage of Persons Discharged from a Substance Use Disorder Detox Unit Who are B12Seen for Follow-up Care Within 7 Days	July-Sept	2019	95%	97.77%	**Yes**
		2018	95%	97.79%	**Yes**
Psychiatric inpatient readmission rate			No greater than		
Percentage of Children Readmitted to Inpatient Psychiatric Units Within 30 Calendar Days of Discharge From a Psychiatric Inpatient Unit	July-Sept	2019	15%	11.71%	**Yes**
		2018	15%	8.64%	**Yes**
Percentage of Adults Readmitted to Inpatient Psychiatric Units Within 30 Calendar Days of Discharge From a Psychiatric Inpatient Unit	July-Sept	2019	15%	11.34%	**Yes**
		2018	15%	10.54%	**Yes**

Sources:
Michigan Mission Based Performance Indicator System: Medicaid Population: For Persons with Mental Illness, Developmental Disabilities, Emotional Disturbances, and Substance Use Disorders; Performance Indicator Final Report; July 1, 2019 - September 30, 2019;
https://www.michigan.gov/documents/mdhhs/FY19_Q4_PIHP_FinalReport_683534_7.pdf

Michigan Mission Based Performance Indicator System: Medicaid Population: For Persons with Mental Illness, Developmental Disabilities, Emotional Disturbances, and Substance Use Disorders; Performance Indicator Final Report; July 1, 2018 - September 30, 2018:
https://www.michigan.gov/documents/mdhhs/PIHP_FinalReport_Q4_FY18_648501_7.pdf

Analysis: A review of the thirty-eight (38) data points, across the quarter examined during the two most recent fiscal years, indicated that **Michigan's public mental health system met or exceeded the state-established standards for thirty-seven (37) of the thirty-eight (38) standards measured.** For the one standard not met or exceeded, the system was below the state standard by 1.63% from the 95% standard. This high level of performance, as outlined above, has been consistent across these measures for years.

B. Assessing Michigan's progress on de-institutionalization against national norms

Since the 1970s, states and advanced community-based mental health systems, akin to Michigan's system, have moved in bold ways, as part of the deinstitutionalization movement, by applying a wide range of evidence-based practices to serving persons with serious mental illness in their home communities. As a result, the use of state psychiatric hospitals as the central approach to treating mental illness has declined dramatically.

However, states differ significantly in their approach to mental illness and the de-institutionalization movement. The depth and breadth of their community-based mental health resources to serve persons with serious mental illness vary as well. The use of state psychiatric hospitals, on a per capita basis, is a sound measure of the success of a state and its local and regional mental health provider community to use community-based approaches to serve their citizens with mental illness as an alternative to inpatient psychiatric care.

Findings: Michigan's progress in the deinstitutionalization movement can be best determined by examining the number of persons served in the state's psychiatric hospitals per every 100,000 persons in the population. That comparison is provided in the table below.

Table 2: The comparison of Michigan's use of state psychiatric facilities compared with the use of psychiatric hospitals by the rest of the United States, 2018

	Michigan	United States other than Michigan
Number of persons in state psychiatric hospitals	235	129,065
Population	9,906,857	319,528,722
Number of persons in state psychiatric hospitals per 100,000 persons in census	2.37	40.39

Source: National Outcome Measures System, a part of the Uniform Reporting System, Substance Abuse and Mental Health Services Administration (SAMHSA) https://wwwdasis.samhsa.gov/dasis2/urs.htm [ii]

Analysis: The contrast between Michigan's use of state psychiatric hospitals (2.37 persons served in state psychiatric hospitals per 100,000 Michigan residents) to the average use of state psychiatric hospitals by the rest of the country (40.39 persons served in state psychiatric hospitals per 100,000 residents in the rest of the country) is stark. **The use of state psychiatric beds, by the rest of the country is 17 times higher per capita than that of Michigan.** Michigan's use of state psychiatric hospitals - far less than the average of the rest of the country – is **a testimony to its continual commitment to deinstitutionalization and the development of a comprehensive community-based system of care, the state's public mental health system.**

Supplementary economic analysis: The economic impact of Michigan's success in using community-based services in supports rather than state psychiatric hospitals is significant.

If the dollars currently spent by Michigan's community-based public mental system $,3.469 billion, were spent solely on the provision of traditionally long-term inpatient care at the state's psychiatric hospital and developmental disability centers, those dollars would serve 9,500 persons per year. In contrast, those dollars, used to fund community-based services and supports, as they are now used, allows the public system to serve over 350,000 persons per year. (Source: Michigan Department of Health and Human FY 2020 Appropriations; http://legislature.mi.gov/documents/publications/AppropriationBillsPassed/2019/2019-mpla-0139-Health%20and%20Human%20Services.pdf) [iii]

The impact of this transition is impressive. Michigan's use of sound community based mental health approaches allows Michigan's public system to meet the mental health needs of **37 times more Michiganders,** than would be served if those same dollars were used to provide long term inpatient care in the state's psychiatric hospitals and developmental disability centers.

C. Performance when compared to national standards of prevalence and access

The national advocacy and research group, Mental Health America regularly ranks the nation's states relative to the prevalence and access to mental health services. These rankings are seen, by many observers, as **one of the best measures of each state's efforts to prevent and treat the mental health needs of their residents**. The most recent report from Mental Health America is The State of Mental Health in America 2020.

The Mental Health America study provides a picture of the performance of each state's public mental health system, its coverage of its residents by Medicaid and other insurance coverages, and its enforcement of insurance parity laws. The measures used by Mental Health America, for its 2020 study, include:

- Adults with Any Mental Illness (AMI)
- Adults with Substance Use Disorder in the Past Year
- Adults with Serious Thoughts of Suicide
- Youth with At Least One Major Depressive Episode (MDE) in the Past Year
- Youth with Substance Use Disorder in the Past Year
- Youth with Severe MDE, Adults with AMI who Did Not Receive Treatment
- Adults with AMI Reporting Unmet Need
- Adults with AMI who are Uninsured
- Adults with Disability who Could Not See a Doctor Due to Costs
- Youth with MDE who Did Not Receive Mental Health Services
- Youth with Severe MDE who Received Some Consistent Treatment
- Children with Private Insurance that Did Not Cover Mental or Emotional Problems
- Students Identified with Emotional Disturbance for an Individualized Education Program
- Mental Health Workforce Availability [iv]

Findings: Michigan's rankings in The State of Mental Health in America 2020 are provided below:

Table 3: National ranking of Michigan's mental health prevalence and access to mental health care relative to all 50 states and District of Columbia, Mental Health America, 2020

Ranking category	Michigan's rank relative to 50 states and District of Columbia
Overall ranking (all ages)	17
Adults	6
Children and Youth	20
Access to care (all ages)	15

Source: The State of Mental Health in America 2020; Mental Health America; https://mhanational.org/issues/state-mental-health-america

Analysis: The rankings of Mental Health America – with Michigan in the top third in the country across all of the rankings and underscore the strength of Michigan's mental health prevention and treatment delivery system.

D. Cost control performance – bending the cost curve

Since 1997, Michigan's public specialty managed care system managed the Medicaid mental health and intellectual disability benefit, and eventually the substance use disorder benefit, for four distinct groups: adults with mental illness; children and adolescents with emotional disturbance; children, adolescents, and adults with intellectual and developmental disabilities; and children, adolescents, and adults with substance use disorders.

In 1997, Michigan's Community Mental Health centers (CMH) became the risk-based managed care organizations for the state's Medicaid behavioral health benefit. Under two concurrent federal Medicaid waivers (1915(b) and (c)) the state of Michigan developed shared risk contracts with the state's CMHs. Those managed care contracts were held, for the first seventeen (17) years, from 1997 through 2014, by CMHs. In 2014, continuing through the present, the contracts are held by public Regional Entities formed and governed by the CMHs. These Regional Entities are known in federal parlance as the state's Prepaid Inpatient Health Plans (PIHPs).

Two factors underscore the wisdom of using the public county-based CMH system as the managed care and provider system backbone for the state's specialty Medicaid program:

- By linking the managed care responsibilities for state's Medicaid behavioral health dollars to the state's public mental health system, the chief financing source for the public mental health system was linked to the public system that holds the statutory responsibility to serve as the state's behavioral health and intellectual/developmental disability services and supports safety net.

  To have severed this connection would have left the statutorily defined safety net without control over nor unhindered access to the funds needed to fulfill this safety net role. Given that Medicaid makes up over 90% of the revenues that support the public mental health system in Michigan, such a severing of the connection between these funds and the safety net role would have left the 325,000 vulnerable persons and communities across the state, served by this system, without the resources needed to assure access to those services.

- The expertise of Michigan's public mental health system in serving persons with complex needs that spanned a wide range of health and human sectors (from psychiatry to housing supports, from peer-delivered services to inpatient psychiatry, from respite care to assertive community treatment, from homebased care to employment supports), far outside of the expertise of traditional managed care arrangements, was seen as a vital asset in the ability to manage the Medicaid benefit.

In 2017, the Community Mental Health Association of Michigan's Center for Healthcare Integration and Innovation (CHI2), carried out a study of the performance of Michigan's public mental health system relative to controlling Medicaid behavioral health costs, "Bending the Cost Curve Bending the Healthcare Cost Curve: The success of Michigan's public mental health system in achieving sustainable healthcare cost control".[v]

Source: "Bending the Cost Curve Bending the Healthcare Cost Curve: The success of Michigan's public mental health system in achieving sustainable healthcare cost control"; Center for Healthcare Integration

and Innovation (CHI2); March 2017 https://cmham.org/wp-content/uploads/2019/03/CHI2-bending-the-cost-curve-final.pdf

This study was built upon the emergence, over the past decade, of the triple aim [2] as a core set of concepts for driving healthcare reform and transformation, providing the impetus for this study.[vi] Nearly all of the leaders, observers, and critics of this country's health care system use the triple aim's constructs of improving population health, enhancing the patient's/consumer's experience of care, and controlling the per capita cost of care to measure the performance of the system, as a whole, and any segment of that system.

Given this centrality of the triple aim to measuring the success of any healthcare design or transformation effort and with nearly two decades of experience, by Michigan's public behavioral health and intellectual/developmental disability system operating a public specialty managed care system, CMHA's CHI2 identified the need to examine the performance of the state's public mental health system along the third dimension of the triple aim – the control of per member costs.

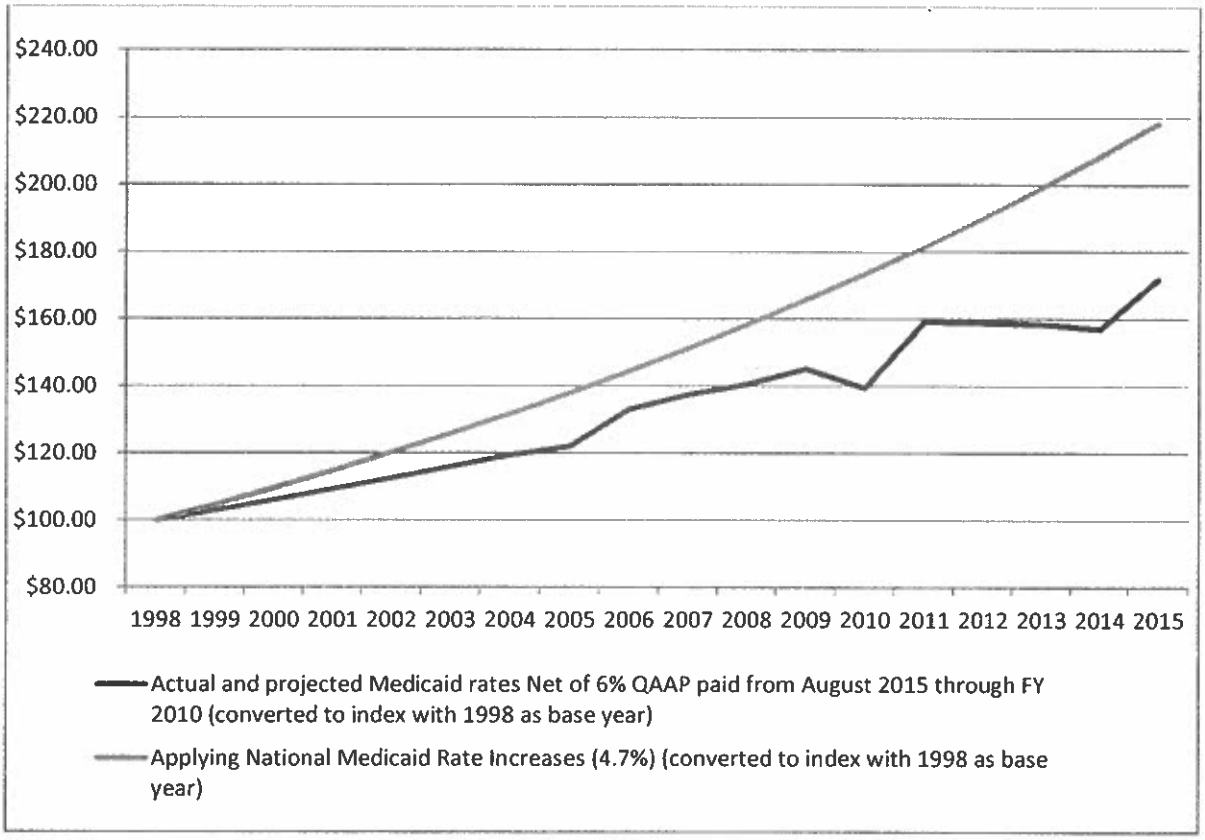
Findings: This study, "Bending the Cost Curve Bending the Healthcare Cost Curve: The success of Michigan's public mental health system in achieving sustainable healthcare cost control" examined the increases seen in the per enrollee per month (PEPM) costs of the state's Medicaid mental health system under the management of the public system, over a twenty-year span, and compared those increases to:

- National Medicaid per enrollee per month increases
- National commercial insurance per enrollee per month increases

[2] The triple aim, in many circles, has expanded to the quintuple aim, with the addition of healthcare workforce satisfaction/health and health equity as the fourth and fifth aims.

Against national Medicaid per enrollee rate increases: The cost control performance of Michigan's public behavioral health and intellectual and developmental disability services system, as the state's Medicaid Specialty Managed Care System, against national Medicaid rate increases, as determined via comparison of those two growth rates over the period of 1998 through 2015. These comparative growth rates are outlined in the graph and tabular analysis below.

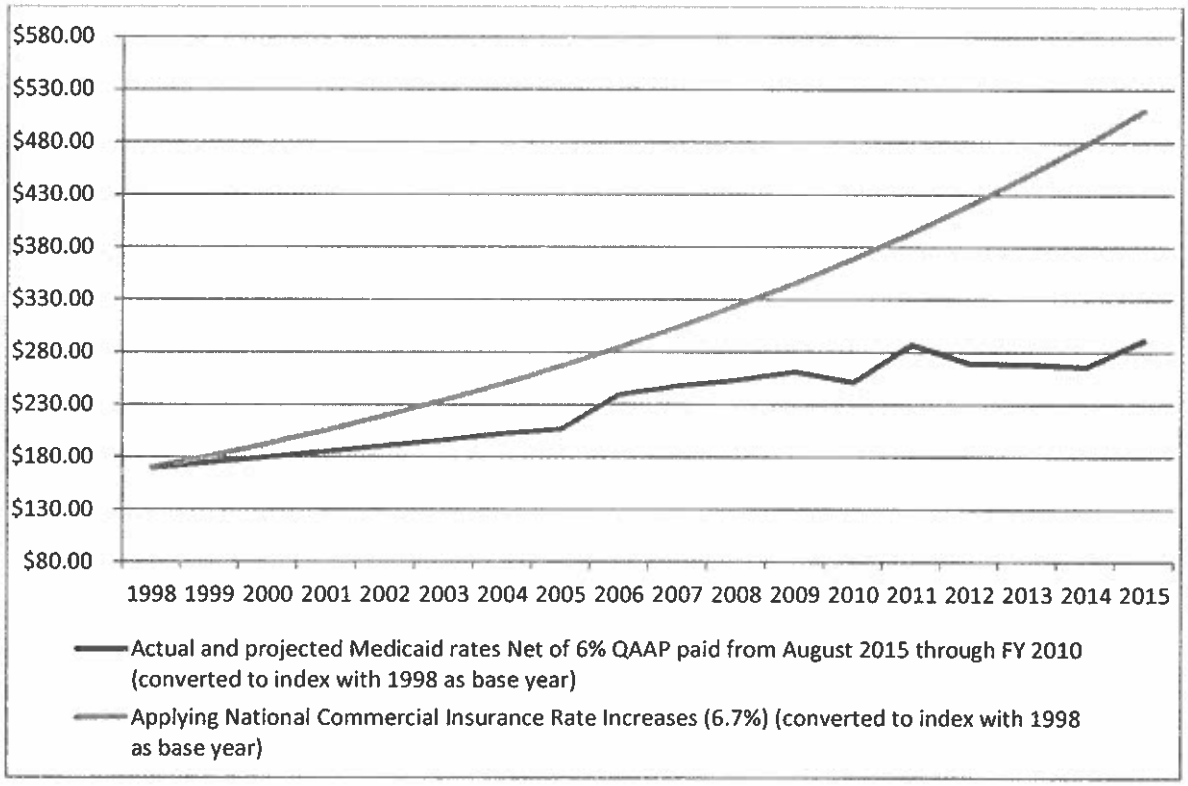
Graph 1: Comparison of Michigan Specialty (behavioral health and intellectual and developmental disability services) Medicaid rate increase (per enrollee per month) with those of average national Medicaid rate increases – as index with 1998 as base year at 100.



		Michigan public mental health system per enrollee rates	National Medicaid per enrollee rates
Cumulative increase from 1998 through 2015:		71.88%	118.32%
Cumulative savings from 1998 through 2015:	$	5,273,089,686	
If this eighteen-year trend continued through 2024:	$	12,737,764,999	

Against national commercial insurance rate increases: The cost control performance of Michigan's public behavioral health and intellectual and developmental disability services system, as the state's Medicaid Specialty Managed Care System, against national Medicaid rate increases, as determined via comparison of those two growth rates over the period of 1998 through 2015. These comparative growth rates are outlined in the graph and tabular analysis below.

Graph 2: Comparison of Michigan Specialty (behavioral health and intellectual and developmental disability services) Medicaid rate increase (per enrollee per month) with those of average commercial health insurance rate increases – as index with 1998 as base year at 100.



		Michigan public mental health system per enrollee rates	National Commercial Insurance per enrollee rates
Cumulative increase from 1998 through 2015:		71.88%	201.16%
Cumulative savings from 1998 through 2015:	$	13,992,156,174	
If this eighteen-year trend continued through 2024:	$	35,949,101,168	

Analysis: This study was designed to measure the cost control performance of Michigan's public mental health. This study found very significant cost savings when compared with the per enrollee cost increases seen in both the Medicaid program and commercial across the country.

> **Comparison with Medicaid rate increases across the country**: Over the years of the study, the per enrollee cost/rate increases of the behavioral healthcare benefit managed by Michigan's public mental health system (71.88%) was significantly below the cost/rate increases seen in Medicaid per enrollee costs/rates across the country (118.32%). **This difference represents a savings of over $5 billion dollars during those years and a savings of over $12 billion when extrapolated through 2024.**
>
> **Comparison with commercial insurance rate increases across the country**: Over the years of the study, the per enrollee cost/rate increases of the behavioral healthcare benefit managed by Michigan's public mental health system (71.88%) was significantly below the cost/rate increases seen in the commercial insurance per enrollee costs/rates across the country (201.16%). **This difference represents a savings of over $13 billion dollars during those years and a savings of over $35 billion when extrapolated through 2024.**

The success of the public system's ability to manage the state's Medicaid behavioral healthcare benefit and to bend the cost curve is clearly underscored through this comparative analysis.

Discussion of methods used to control costs: While no attempt was made to determine the variables that led to this success, **some variables, not typically seen in other managed care systems, appear to be related to the system's ability to sustain cost control over nearly two decades.** These factors include:

> **1. Active management of comprehensive and closely aligned service and support provider networks and central community convener role:** The public mental health system has a very long history, since the 1960s in nearly all of Michigan communities, of operating a comprehensive, tightly managed and interwoven provider network. In communities across the state, whether the CMH serves as a core provider, purchaser of services, or both, the county-based public CMH designs, organizes, pays, evaluates, and refines the services and supports network while also holding the role of convener of community efforts to address a range of health and human services needs. Both of these traits – active management of the service network and close ties to the community – allow Michigan's public mental health system to align the work of its provider network and that of other community partners to addressing mental health and related needs.
>
> **2. Guided by whole person orientation, impact of social determinants of health, and a person-centered planning approach.** A whole person orientation, with person-centered planning at its core (as required by Michigan statute), the public mental health system develops its services around cost effective methods that are community-based, non-traditional and focus on a wide range of social determinants of health. These approaches, long utilized in Michigan's public mental health system, are being applied, in ever greater frequency, by healthcare providers and care managers in other sectors of health care.

3. High medical loss ratios (high level of funds spent on services - low overhead/ administrative costs): Low administrative costs and no profits drawn out of the system allow for 94% of the funds received by the public mental health system to be used to provide services in the year in which the funds were received or in future years. **This 94%, the system's medical loss ratio, is far below that of traditional private health plans – ratios that hover around 85% - underscoring the commitment by the public system to ensure that as many of the Medicaid dollars that it manages, as possible, are used for services and supports to the Medicaid beneficiaries who rely upon this system.**

4. Impact of whole person orientation and healthcare integration efforts: The recent work of the public mental health system to pursue a wide range of healthcare integration efforts is in keeping with these factors and holds great promise for continued cost control.

These methods include:

- Addressing a range of social determinants of health through a whole-person orientation by working closely with a range of healthcare and human services in the consumer's home community
- Weaving the services offered by the CMH and provider network with the care that families and friends provide
- Using other consumers as peer supports and advocates on behalf of the persons served
- Using an array of both traditional (psychiatric care, psychotherapy, inpatient psychiatric care) and nontraditional services (housing supports, employment supports, homebased services).

Additionally, over the last several years, the CMHs, PIHPs, and their provider networks have been at the forefront of designing and implementing healthcare integration efforts that result not only in improved care but in healthcare cost control. These efforts include: shared and linked electronic health records, walk-in centers, the co-location of mental health practitioners in primary clinics and the provision of primary care providers on CMH campuses, and efforts to identify and work closely with super-utilizers of health care. These healthcare innovation efforts are annually catalogued by CHI2 in its study, "Healthcare Integration and Coordination: Hundreds of innovative initiatives identified in a survey of Michigan's CMHs, PIHPs and Providers", which is discussed below.

E. Pursuit of healthcare integration

Findings: The value of integrated care – weaving mental health care with primary care – is well recognized by the healthcare community, policy makers, and the public-at-large. Michigan healthcare leaders and policy makers have discussed the value of whole health integration and have pursued a number of efforts to promote such integration.

To foster an understanding of healthcare integration, from the perspective of the client/patient receiving services (what most would call "real" healthcare integration, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) developed the Standard Framework for Levels of Integrated Healthcare (https://www.integration.samhsa.gov/resource/standard-framework-for-levels-of-integrated-healthcare) [vii]

Based on the SAMHSA/HRSA framework, every year, the Community Mental Health Association of Michigan's (CMHA) Center for Healthcare Integration and Innovation (CHI2) conducts a study of the healthcare integration initiatives led by Michigan's Community Mental Health Services Programs (CMH), the state's public Regional Entities/Prepaid Inpatient Health Plans (PIHP), and providers within the CMH system. This annual study examines the range of efforts aimed at integrating behavioral health and intellectual/developmental disability services with physical healthcare services, in which the members of the state's public mental health system are leading or deeply involved.

The most recent study, published in early 2020, found that more than six-hundred-twenty-six (626) healthcare integration efforts, led by these public sector parties, were in operation throughout Michigan. The CMHs, PIHP, and providers involved in healthcare integration, often pursue a number of efforts simultaneously, with each organization that responded to the survey reporting an average of over 20 healthcare integration initiatives. Of this number, work around physical health-informed mental health services, co-location, and identification of super-utilizers underscored the variety and maturity of these efforts. [viii]

While the public system is involved in a wide range of healthcare integration initiatives, three types of integration, with considerable complexity, stood out. This 2019 study identified 626 healthcare integration efforts occurring across the state, with the potential for more to come. While there were many different methods of integration implemented by the public system, three of those efforts stood out, given their organizational, clinical, technical, and relational complexity. Those efforts were physical health informed mental health services, co-location, and identification of super-utilizers.

1. **Physical health informed mental health services:** Integrating physical health needs and goals into mental health services improves outcomes and proves the most effective approach to caring for people with multiple healthcare needs. The CMHA Center for Healthcare Integration and Innovation study found two primary approaches to physical health informed mental health services in the state of Michigan. The first entails identification of patients without a primary care provider. The second involves health screenings. The study found that there are 100 current efforts surrounding increased health information in place, while recording 126 total initiatives regarding physical health informed mental health services.

   - Health Screening: Twenty-nine locations utilize health screenings. These screenings consist of items designed to identify risk factors for undiagnosed acute or chronic care issues

integrated throughout traditional behavioral health assessments. Untreated chronic disease is a major factor in the increased cost of care for people with behavioral health issues or substance use disorders. The implementation of health screening processes allows providers in primary care and other healthcare settings to assess the severity of health issues and identify the appropriate level of treatment.

- Identification of Patients Without a Primary Care Provider: Twenty-eight locations throughout the state have processes in place to identify patients without a primary care provider and/or patients who have not engaged a primary care provider in the past year. Having a regular primary care provider (i.e., family physician or nurse practitioner) is crucial for obtaining compressive, continuous, accessible, and timely healthcare. A primary care provider allows for coordination among other parts of the healthcare system. Research suggests patients who have a primary care provider benefit from improved care coordination and chronic disease management. They receive more preventative care, are less likely to use emergency services, and have better health outcomes overall.

- Facilitating Communication between mental health provider and primary care providers (Fostering Integration): Twenty-nine out of thirty locations aimed at fostering communication efforts between mental health sites and primary care providers. These efforts included communication via case manager, supports coordinators, care managers and similar intensive coordination. Coordinating with primary care providers increases the likelihood of positive outcomes for patients, strengthens coordination and improves quality of care

2. Co-location initiatives: This study identified 89 efforts to co-locate physical and mental health services within the same physical space.

The most common method of co-location was housing mental health staff in hospital emergency departments or creating regular protocol that mental health staff provide crisis screening in emergency departments, with 18 sites reporting this method of integration.

Thirteen organizations have mental health staff co-located within a primary care practice.

Fourteen co-location efforts across the state involve a federally recognized Community Health Center/Federally Qualified Health Center (FQHC).

Research indicates that colocation of physical and behavioral healthcare is linked to reductions in no-shows, increased primary care utilization, and improved physical health goals among adults with serious mental illness. Co-location may also improve practitioners' understanding and skills in relation to the other professionals with whom they co-locate. The growing number of co-location initiatives across the state represents the CMH system's appreciation for the importance of integration efforts, and the impact they may have on access to care, care coordination, and the overall client experience.

3. High/super-utilizer initiatives: A significant segment of the integration initiatives identified in this study are those efforts that address the needs of the high/super-utilizer population. High/super-utilizers are individuals with very high healthcare service utilization patterns, often

across disciplines and sectors. These same people often demonstrate high levels of utilization of human services outside of traditional healthcare domains, such as: public safety, housing supports, judiciary, and child welfare. The study found eight-six (86) joint efforts between CMHs, PIHP, providers, and primary care practices, hospitals, and Medicaid Health Plans to address the needs among this population in order to effectively utilize healthcare resources.

Twenty-one (21) sites reported the active use of Medicaid claims databases that included both physical and behavioral health services, using the data available through the State of Michigan's Care Connect 360 (CC360) database, portal, and/or other data analytics, to identify high/super utilizers at the point of access and throughout the course of services, supports, and treatment.

Fifteen (15) sites reported joint efforts with primary care practices to address additional needs of increased use of healthcare resources.

Nine (9) sites reported active use of data (primarily through CC360) to provide outreach to high/super-utilizers who have not accessed the public mental health system of care. These initiatives significantly impacted the effectiveness of healthcare resources through the use of the targeting, assertive outreach, and case-management approaches, as well as the provision of adjunct supports including transportation, housing supports, vocational services, and advocacy, to this population.

The full version of the most recent study can be found at: https://cmham.org/wp-content/uploads/2020/01/2019-2020-CHI2-Healthcare-Integration-Survey.pdf

Analysis: Michigan's public mental health system has a proven track record of developing and implementing a wide range of healthcare integration initiatives in communities across Michigan. These integration efforts are built on the well-recognized federal (SAMHSA/HRSA) integrated care constructs and use integrated care approaches designed to most directly impact clients and patients.

F. Use of evidence-based and promising practices and the infrastructure to support their use

Findings: Michigan's public mental health system has a long history, with the strong support of MDHHS, of using evidence based and promising practices. What is rare, across the nation, is the well-developed and sophisticated infrastructure that Michigan has built to support the use of EBPs and promising practices.

The EBP and promising practices used throughout the state's public mental health system - some for over 30 years, ahead of most states - include:

- Assertive Community Treatment
- Assisted Outpatient Treatment
- Use of nationally recognized children, adolescent and family assessment: CAFAS/PECFAS
- Clubhouse (Psycho-Social Rehabilitation)
- Cognitive Enhancement Therapy
- Community Living Supports
- Co-Occurring Disorders
- Services to Persons who are Deaf & Hard of Hearing
- Dialectical Behavior Therapy
- Family Psycho-Education
- Behavioral Health Home
- Opioid Health Home
- Medication Assisted Treatment
- LOCUS
- Motivational Interviewing
- Person Centered Planning Training & Evaluation
- Screening, Brief Intervention & Referral to Treatment (SBIRT)
- Self Determination
- Supported Employment (Integrated Competitive Employment and Employment First)
- Trauma Informed Practice
- Trauma focused Cognitive Behavioral Therapy
- Value Based Purchasing
- Veteran Navigator
- Wrap Around
- Parent Management Training - Oregon

The infrastructure for the use of EBPs and promising practices – a partnership of the Michigan Department of Health and Human Services (MDHHS), the state's CMHs, Regional Entities/PIHPs, providers, and the Community Mental Health Association of Michigan (CMHA) includes the following components:

1. Face-to-face education and training EBP offerings to thousands of practitioners: The provision, annually, of clinical education and training to over 8,000 mental health providers and clinical supervisors, and administrators via over 200 face-to-face workshops and conferences. Many of these offerings are made possible through an innovative joint effort of the Michigan Department of Health and Human Services and the Community Mental Health Association of Michigan (CMHA). This partnership allows for many of these educational offerings to be provided at no- or low-cost to Association members, as a result of the MDHHS use of federal mental health and substance abuse block grant dollars. The vision of MDHHS and this partnership allows CMHA

to provide, every year, over $7 million in education and training to the members of the Association, via a comprehensive education and training contract with MDHHS, without these costs being borne by the Association members. A sample of these offerings can be found at the CMHA link: https://cmham.org/education-events/conferences-training/

2. EBP fidelity review and guidance teams – MIFAST teams: As part of the MDHHS-CMHA partnership, skilled clinicians, from across the state, who have demonstrated mastery of a given EBP, are recruited by MDHHS to form fidelity review and guidance teams, known as Michigan Fidelity Assistance Support Teams (MIFAST).

Overall Purpose of MIFAST: The overall purpose of the Michigan Fidelity Assistance Support Team (MIFAST) is to provide technical assistance in moving the publicly funded behavioral health system forward in ascertaining the degree to which an evidence-based program has been implemented and is functioning for both fidelity and efficacy. The focus is on providing peer-lead technical assistance as opposed to a formal site visit or audit. Generally, Michigan Department of Health and Human Services (MDHHS) staff are not members of the MIFAST visit.

As the result of a MIFAST visit, agencies/teams will be provided an outside perspective of how their evidence-based program is being implemented, and where internal focus can be prioritized for moving forward. In addition, cumulative information from visits provide a way for the state to see where needs may be in terms of support for improving practices and providing technical assistance across the system. Post-visit technical assistance, materials, training or further development, consultation, or coaching depending on needs identified during the visit itself will be offered and provided by either the MIFAST lead or MDHHS staff.

MIFAST visits are conducted every one-to-three years depending on available capacity, number of projects within each evidence-based program, and number of MIFAST teams available. Prioritization may occur where exemplary reviews may result in a re-visit in three years and poor reviews may result in a re-visit in one year.

Recent and current MIFAST teams: To date, the MIFAST process has been predominately implemented as part of adult mental health block grant providers although there have been recent efforts to expand this process to substance abuse funded efforts as well. There are currently MIFAST teams available for the following evidence-based programs:

- Supported Employment/Individual Placement and Supports (IPS)
- Dialectical Behavior Therapy (DBT)
- Integrated Dual Disorder Treatment (IDDT)
- Assertive Community Treatment (ACT)
- Dual ACT/IDDT Teams
- Dual Diagnosis Capability (DDCAT/DDCMHT)
- Motivational Interviewing
- Cognitive Enhancement Therapy (CET)
- Behavior Supports (Adult focus)
- Family Psycho-Education (FPE)
- Trauma

3. Michigan's EBP website – Improving MI Practices: The design and operation of the Improving MI Practices website, led by MDHHS and coordinated n partnership with CMHA and an Advisory Group led by MDHHS, provides access to a broad set of resources around a wide range of EBP and promising practices. This website is unique, across the nation, and is regularly updated with the latest clinical intervention developments.
The EBP and promising practices for which resources can be found on this website include: Applied Behavior Analysis, Assertive Community Treatment, Clubhouse – Psycho-Social Rehabilitation, Cognitive Behavior Therapy, Co-Occurring Disorder Treatment, Family Psychoeducation, Individual Placement And Support, Motivational Enhancement / Motivational Interviewing, Parent Management Training - Oregon Model, Substance Use Disorders, Supported Housing Trauma Focused Cognitive Behavioral Therapy, Trauma-Informed Services, Trauma-Specific Treatment, Wraparound

The Improving MI Practices site can be found at: https://www.improvingmipractices.org/

4. Statewide training guidelines group standardizes clinical training: The State Training Guidelines Workgroup (STGW) is a committee of the Community Mental Health Association of Michigan (CMHA).

The purpose of the workgroup is to review and recommend training guidelines for support staff working in all types of support and service settings including, but not limited to, residential direct support staff. The workgroup is comprised of representatives from the Mental Health Association of Training (MHAT), the Provider Alliance, Provider agencies representing Developmental Disability and Mental Health/Illness services, Community Mental Health (CMH) agencies, parents and guardians, the Michigan Department of Health and Human Services (MDHHS), and other stakeholders.

The intended use of these statewide training guidelines is for the development and presentation of training content. The documents developed by this group include a training grid for people providing direct support; curriculum guides which identify training topics, competencies, content, trainer qualifications, suggested length and format; and vetting tools.

The training grid below illustrates training requirements and options based on work setting and the needs of persons served. The guidelines were designed to address concerns related to reciprocity, uniformity, and the flexibility to stay current in an ever-changing environment. The legal requirements of the various oversight agencies were cross-referenced and included within the guidelines. These include licensing requirements for Adult Foster Care (AFC). Curricula based on these guidelines will contribute to statewide uniformity, reciprocity, and portability. These resources are intended as training tools for the benefit of persons who work with people receiving services through the Community Mental Health system. They are intended to be considered best practices.

State Training Guidelines Workgroup (STGW) resources:

1. Training Reciprocity: Implementation Guide
2. Direct Support Staff Training Requirements Grid
3. Areas around which the State Training Guidelines Group has established guidelines and a vetting tool, the latter to foster reciprocity of training certification and staff

credentialing across the state's public mental health system include: Assisting People with Eating or Swallowing Difficulties, Autism Spectrum Disorder, Behavior Crisis Intervention, Best Practice Guidelines for Online Learning, Building Natural Supports, CPR, Crisis Planning, Critical Thinking and Creative Problem Solving, Cultural Competence, Documentation Skills, Client Appeal and Grievance Due Process, Emergency Preparedness, First Aid, Food Safety, Health and Wellness, HIPAA And Confidentiality, Human Relationships, Immobility Positioning, Infection Control and Standard Precautions, Intro to Human Services, LEP, Lifts & Transfers, Medications, Medication Refresher, Nutrition, Person Centered Planning, Philosophy and Current Trends, Recipient Rights, Suicide Risk Assessment and Intervention, Teaching New Skills, Train the Trainer, Trauma Informed Services

More about this group and its resources can be found at:
https://www.improvingmipractices.org/about-site/state-training-guidelines-workgroup

Analysis: The longstanding partnership between the Michigan Department of Health and Human Services (MDHHS) and the state's public mental health system have fostered a culture that embraces the adoption of evidence based and promising practices. The large number of these practices, their wide spread use, the adherence to the fidelity of the approaches, and the well-developed infrastructure supporting the use of these practices is core to the clinical strength of Michigan's public mental health system.

Conclusion

Michigan's public mental health system is made up of the public Community Mental Health centers (CMHs) linked to county governments, the public Regional Entities/Medicaid Prepaid Inpatient Health Plans (PIHPs) formed and governed by the CMHs, and the private non-profit and for-profit organizations in the CMH and PIHP networks. This system, in partnership with the Michigan Department of Health and Human Services (MDHHS), has demonstrated, over decades, strong performance on a number of dimensions of healthcare quality and innovation. This high level of performance is demonstrated in an examination of a number of components of the system's operations:

Longstanding strong performance against the state-established and nationally-recognized performance standards measuring: access, timeliness of response, follow-up to inpatient and detoxification services, and psychiatric readmission rates. This study found that Michigan's public system met or exceeded the state's performance in 37 of the 38 state established standards. These standards make up Michigan's Mission Based Performance Indicator System (MMBPIS). For the one standard not met or exceeded, the system was below the state standard by 1.63% from the 95% standard.

Nation-leading de-institutionalization allowing persons with mental health needs to live, work, attend school, worship, and socialize in their home communities. The federal National Outcome Measures system found that the use of state psychiatric beds, by the rest of the country is 17 times higher per capita than that of Michigan. Michigan's use of state psychiatric hospitals - far less than the average of the rest of the country – is a testimony to its continual commitment to deinstitutionalization and the development of a comprehensive community-based system of care, the state's public mental health system. This investment in community-based services and supports, rather than in state institutional care, allows for the dollars that would have paid for services in state institutions to serve thirty-seven (37) times more people, through Michigan's community-based system.

High rankings against national standards of behavioral health prevalence and access to services: When Mental Health America compared to all fifty (50) states and District of Columbia, Michigan ranks among the top 1/3 of all of the states and the District of Columbia, relative to prevalence of behavioral healthcare need (a function of many variables including prevention and early intervention mental health services) and access to care. Michigan's ranking of 17th, nationally, for the entire state population, 6th relative to services to adults, and 20th relative to services to children and youth. When access, as a lone measure, was examined, Michigan ranked 15th out of the fifty (50) states and the District of Columbia.

Proven ability to control costs over decades: As the state's managed care organizations for the Michigan's Medicaid behavioral healthcare system, Michigan's public mental health system was able to bend the cost curve far below that of the nation's Medicaid and commercial insurance systems.

A study of national healthcare rate data found that while Michigan's public mental health system saw cost/rate increases totaling 72% from 1998 through 2015, the Medicaid programs across the country saw rate increases of 118%. This difference represents a savings of over $5 billion dollars, from the per enrollee rate increases seen in Medicaid across the country, during the first 18 years of the system's managed care work years and a savings of over $12 billion when extrapolated through 2024.

Similarly, while the per enrollee cost/rate increases of the behavioral healthcare benefit managed by Michigan's public mental health system saw per enrollee rates increases totaling 72% during this same eighteen (18) year period, the cost/rate increases seen in the commercial insurance per enrollee

costs/rates across the country totaled 201%. This difference represents a savings of over $13 billion dollars during those years and a savings of over $35 billion when extrapolated through 2024.

Key to understanding the significance of this cost control performance is that the practices that underlie to this success are those not typically seen in other managed care systems. These factors include:

- Active management of comprehensive and closely aligned service and support provider networks and central community convener role:
- Managed care guided by whole person orientation, impact of social determinants of health, and a person-centered planning approach.
- High medical loss ratios (low overhead/ administrative costs) system to ensure that as many of the Medicaid dollars that it manages, as possible, are used for services and supports to the Medicaid beneficiaries who rely upon this system.
- Impact of whole person orientation and healthcare integration efforts

Pursuit of healthcare integration: Michigan's public mental health system is at the forefront of healthcare integration, having designed, and implemented hundreds of healthcare integration efforts. These efforts, identified through an annual study of the public system, found that a wide range of healthcare integration initiatives led by the public mental health system in communities across Michigan. These integration efforts are built on the federal (SAMHSA/HRSA) integrated care constructs and use integrated care approaches designed to most directly impact clients and patients.

Use of evidence-based and promising practices and the infrastructure to support their use: The longstanding partnership between the Michigan Department of Health and Human Services (MDHHS) and the state's public mental health system have fostered a culture that embraces the adoption of evidence based and promising practices. The large number of these practices, their wide spread use, the adherence to the fidelity of the approaches, and the well-developed infrastructure supporting the use of these practices is core to the clinical strength of Michigan's public mental health system. This study found that Michigan's public system is actively implementing over twenty (20) evidence based or promising practices and that their use is supported by a multi-component infrastructure. The components of that infrastructure include:

- Large number of face-to-face education and training EBP offerings to thousands of practitioners
- Evidence based practice fidelity review and guidance teams – MIFAST teams
- Michigan's evidence based practices website – Improving MI Practices
- Statewide training guidelines group standardizes clinical training:

The Center for Healthcare Integration and Innovation (CHI²) is the research and analysis office within the Community Mental Health Association of Michigan (CMHA). The Center, in partnership with the members of the CMH Association, leaders, researchers, consultants and advisors from across Michigan and the country, issues white papers and analyses on a range of healthcare issues with a focus on behavioral health and intellectual/developmental disability services.

The Community Mental Health Association of Michigan (CMHA) is the state association representing the state's public mental health system – the state's Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans ((PIHP) public health plans formed and governed by the CMH centers) and the providers within the CMH and PIHP provider networks. Every year, these members serve over 300,000 Michigan residents with mental health, intellectual/developmental disability, and substance use disorder needs. Information on CMHA can be found at www.cmham.org or by calling (517) 374-6848.

Appendices: Sources of data for this report and endnotes

[i] Source: Michigan Mission Based Performance Indicator System: Performance Indicator Final Reports, including the ones cited in this study can be found at : https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4902-90608--,00.html

[ii] National Outcome Measures System, a part of the Uniform Reporting System, under the federal Substance Abuse and Mental Health Services Administration (SAMHSA) – 2018 Report; https://wwwdasis.samhsa.gov/dasis2/urs.htm

[iii] Michigan Department of Health and Human FY 2020 Appropriations; http://legislature.mi.gov/documents/publications/AppropriationBillsPassed/2019/2019-mpla-0139-Health%20and%20Human%20Services.pdf)

[iv] The State of Mental Health in America 2020; Mental Health America; https://mhanational.org/issues/state-mental-health-america;

[v] "Bending the Cost Curve Bending the Healthcare Cost Curve: The success of Michigan's public mental health system in achieving sustainable healthcare cost control"; Center for Healthcare Integration and Innovation (CHI2); March 2017 https://cmham.org/wp-content/uploads/2019/03/CHI2-bending-the-cost-curve-final.pdf

[vi] Berwick DM, Nolan TW, Whittington J. The Triple Aim: care, health, and cost. Health Affairs; 2008; 27(3); p. 759-769

[vii] Standard Framework for Levels of Integrated Healthcare; Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) (https://www.integration.samhsa.gov/resource/standard-framework-for-levels-of-integrated-healthcare)

[viii] Healthcare Integration and Coordination – 2019/2020 Update: Survey of Initiatives of Michigan's Public Mental Health System; Center for Healthcare Integration and Innovation; January 2020 (https://cmham.org/wp-content/uploads/2020/01/2019-2020-CHI2-Healthcare-Integration-Survey.pdf)

Community Mental Health Association of Michigan

Within Our Reach:
Concrete approaches to building a world class public mental health system

Build upon the strengths of Michigan's nationally recognized county-based public mental health system

- Longstanding strong performance against the state-established and nationally recognized performance standards
- Nation-leading de-institutionalization success - moving care to the community
- High rankings against national standards of behavioral health prevalence and access to services
- Proven ability to control costs over decades
- Pursuit of healthcare integration
- Use of evidence-based and promising practices and the infrastructure

(See the Center for Healthcare Integration and Innovation study "A Tradition of Excellence and Innovation:Measuring the Performance of Michigan's Public Mental Health System" for detail on these strengths) https://cmham.org/wp-content/uploads/2020/05/CHI2-tradition-of-excellence-and-innovation-May-2020-updated.pdf

Focus on areas where continual advancement is needed and for which concrete solutions exist and can be readily strengthened and expanded

Area where system advancement is needed	Concrete approach to system advancement	Benefits of this approach
Improve access to comprehensive set of mental health services to all community members (including those with commercial insurance coverage and Medicaid enrollees with mild/moderate mental health needs)	Support the implementation of Michigan's **Certified Community Behavioral Health Centers (CCBHC)** in the initial pilot sites and then scale up statewide	Full access to CMH services for all Michiganders, 24/7 crisis teams, improved access to substance use disorder services, increased focus on services to veterans, linking to primary care, national quality standards - all with added federal funding
	Restore state General Fund dollars cut from the CMH funding reserved to serve persons not enrolled in Medicaid	Ensures ease of access to broad array of CMH services to all Michiganders
	Support and expand **first episode psychosis (FEP)** treatment approach - already piloted in Michigan communities	Ensures ease of access and early intervention to young adults experiencing their first episode of psychosis

Improve access to inpatient psychiatric care and residential alternatives to hospitalization	Support the creation and expansion of **Psychiatric Residential Treatment Facilities (PRTF)** - recently approved by CMS for use in Michigan	Provides safe therapeutic environments for children and youth with complex mental health needs
	Support inpatient psychiatric hospitals and wards in **physical plant and staffing changes** to better meet the needs of children, adolescents, and adults with complex mental health needs	Improves access to high quality inpatient psychiatric services
Improve access to and coordination of crisis services	Support creation and expansion of **Crisis Stabilizaton Units (CSU)** - recently contained in statute	Provides comprehensive and seamless crisis response system - statewide and local response capabilities
	Support and fully implement **Michigan Crisis and Access Line (MiCAL)**	
	Support implementation of **988** crisis line system - recently approved by FCC	
	Support funding for mental health **crisis response teams** - partnering with law enforcement and first responders at scene of crises	
Provide whole person care, especially to those with complex needs	Support expansion of Behavioral Health Homes **(BHH)** and Opioid Health Homes **(OHH)**	Strengthens links between mental health and physical health care; improves transitions in care between mental health, primary care, and inpatient settings
	Support full funding and expansion of hundreds of existing **health care integration efforts** led by public mental health system and primary care partners	
Address behavioral health workforce shortage	Increase capitation payment to public mental health system to allow for **competitive wages and benefits for direct support professionals**	Closes workforce gaps, improves access to high quality care and eliminates waiting time for care
	Expand federal (National Health Servicess Corps) and state **loan repayment programs** to attract **psychiatrists, social workers, psychologists, and other clinicians** to underserved Michigan communities	

Certified Community Behavioral Health Clinics
in Michigan

CMHA
Community Mental Health Association of Michigan

CCBHC's are nonprofit organizations or units of a local government behavioral health authority. They must directly provide (or contract with partner organizations to provide) nine types of services, with an emphasis on the provision of 24-hour crisis care, evidence-based practices, care coordination with local primary care and hospital partners, and integration with physical health care.

The future is now. The Governor and legislators have made financial investments that improve quality care. Let us continue the momentum. Any successful healthcare integration effort must first start with the person. Michigan's public mental health system is the leader in person-centered care, leading with Certified Community Behavioral Health Clinics (CCBHC).

CCBHC's dramatically increase access to mental health and substance use disorder treatment while expanding the state's capacity to address acute mental health crises. They also:

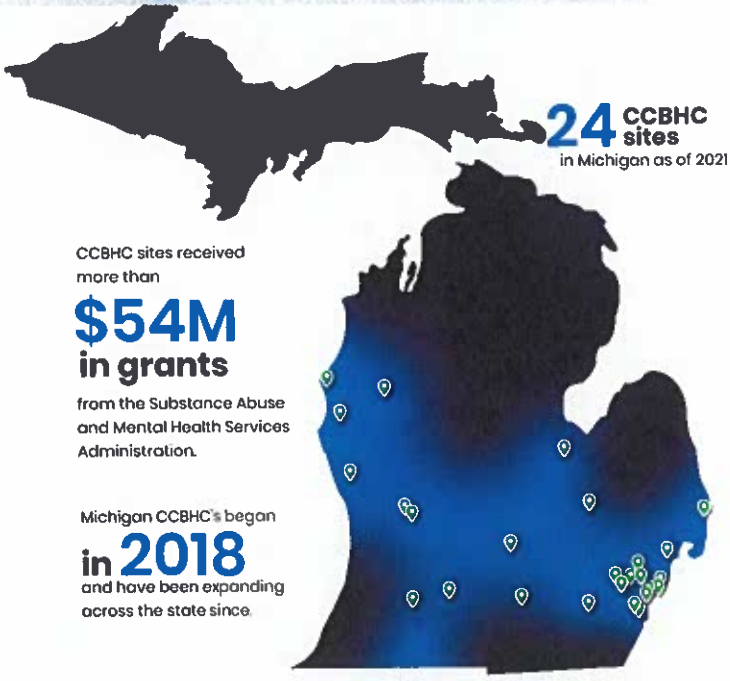
- **ADOPT** a standard model to improve the quality and availability of addiction and mental healthcare
- **PROVIDE** care to people regardless of insurance type, geography, or the ability to pay. Those typically include uninsured, underinsured, underserved, low income individuals on Medicaid, and active-duty military or veterans

CCBHC's directly...

- Increase access to telehealth and 24 hour mobile crisis services
- Decrease serious psychological distress
- Reduce suicide and overdoses by helping consumers feel healthier overall
- Address access to addiction treatment and mental health services
- Bring in more federal funding
- Provide better services for veterans
- Increase the use of Medically Assisted Treatments
- Reduce wait times for care

The 24 CCBHC sites include:

- Calhoun County Mental Health
- CNS Healthcare
- Community Mental Health Authority of Clinton, Eaton, Ingham Counties
- Detroit Recovery Project
- Development Centers, Inc.
- Easterseals Michigan
- Faith Hope and Love Outreach Center
- Genesee Health System
- HealthWest
- Hegira Programs Inc Psychotherapy
- Integrated Services of Kalamazoo
- Judson Center
- LifeWays Community Mental Health
- Macomb County Community Mental Health - Administration
- Neighborhood Service Organization
- Network180 Mental Health
- Northeast Guidance Center
- Saginaw County Community Mental Health Authority
- Southwest Counseling Solutions, Inc.
- St. Clair County Community Mental Health
- Team Wellness Center
- The Guidance Center
- Washtenaw County Community Mental Health
- West Michigan Community Mental Health



24 CCBHC sites in Michigan as of 2021

CCBHC sites received more than **$54M in grants** from the Substance Abuse and Mental Health Services Administration.

Michigan CCBHC's began **in 2018** and have been expanding across the state since.

The Process

Integration at the Person-Level

1 Intake

CCBHC's work together with partners to develop an integrated person-centered plan to support whole person care. This includes but is not limited to developing and understanding each consumer's psychosocial, physical health, behavioral health, substance use, and social determinant strengths and needs.

2 Prioritize health goals

Based upon prioritized needs and areas of risk, consumers enter services with prioritized goals including physical health screening, primary care coordination, and comprehensive supports coordination.

3 Full array of services

CCBHC consumers have access to a full array of evidence-based physical and behavioral health interventions that support health outcomes--from smoking cessation programs, to nutrition management to weight loss and exercise planning, to whole health action management strategies.

4 Integration of physical & behavioral health needs

All behavioral interventions are tied to the physical health needs of the individual consumer. These efforts are also supported by peers fully trained to implement evidence-based practices and connect with consumers based on their own physical and behavioral health recovery.

5 Producing real life outcomes

Based on national data and Michigan-based metrics, consumers receive better quality of care including these essential services of CCBHC's.

Crisis mental health services

Patient-centered treatment planning: Screening, assessment & diagnosis, including risk assessment

Outpatient mental health & substance use services

Primary care screening & monitoring of key health indicators/health risk

Intensive, community-based mental health care for members of the armed forces & veterans

Psychiatric rehabilitation services

Peer support & family supports

Targeted case management

Behavioral Health Homes & Opioid Health Homes

CMHA Community Mental Health Association of Michigan

The future is now. Any successful healthcare integration effort must first start with the person. Michigan's public mental health system is the leader in person-centered care.

The Behavioral Health Home (BHH) and Opioid Health Home (OHH) provides comprehensive care management and coordination of services to Medicaid beneficiaries with a serious mental illness, serious emotional disturbance or opioid use disorder.

For enrolled beneficiaries, the BHH or OHH will function as the central point of contact for directing percent-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care.

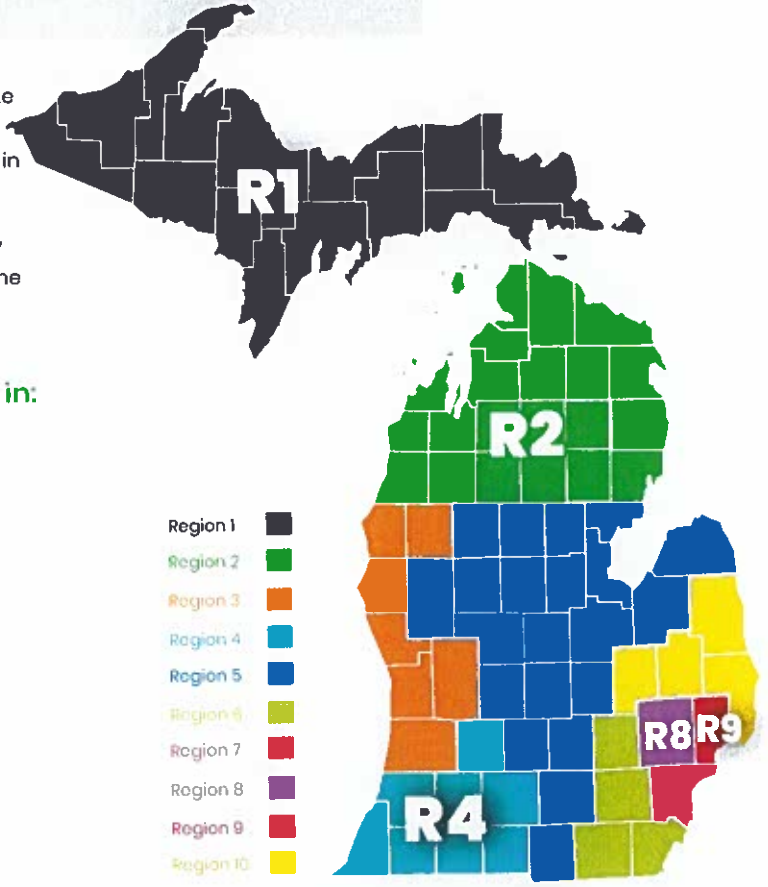
Goals for Behavioral and Opioid Health Homes

Michigan has three goals for the BHH and OHH programs:

1. Improve care management of beneficiaries with serious mental illness, serious emotional disturbance, or opioid use disorder
2. Improve care coordination between physical and behavioral health care services
3. Improve care transitions between primary, specialty and inpatient settings of care

BHH and OHH have demonstrated great cost savings for the state ($103-366 per member, per month savings), thus the Michigan Department of Health and Human Services expanded coverage in the fiscal year of 2021 budget.

It is conservatively projected that when these programs are fully implemented, the BHH will serve up to 20,000 beneficiaries and the OHH will serve up to 5,000 beneficiaries throughout the state.



Behavioral Health Homes operate in:

**PIHP stands for prepaid inpatient health plan*

- The upper peninsula (PIHP Region 1)
- The northern lower peninsula (PIHP Region 2)
- The east side of the state (PIHP Region 8)

Opioid Health Homes operate in:

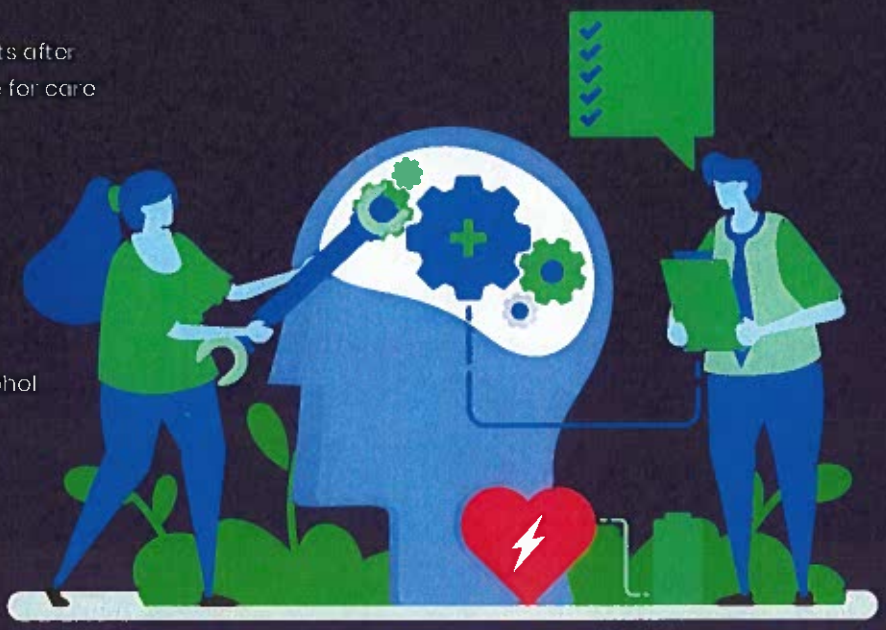
- The upper peninsula (PIHP Region 1)
- The northern lower peninsula (PIHP Region 2)
- The west side of the state (PIHP Region 4)
- The east side of the state (PIHP Region 9)

Real Life Outcomes – Federally Required Core Health Home Metrics

- BHH enrollees showed greater cost reductions

  19% decrease in costs per member/per month – around $103 per member/per month

- Increased seven-day follow-up appointments after hospitalization—leading to reduced wait time for care
- Decreased inpatient hospitalization
- Decreased inpatient hospital length of stay
- Decreased hospital re-admissions
- Increased screenings for adult body mass
- Increased initiation and engagement of alcohol or other drug dependence treatment
- Decreased healthcare expenditures overall
- Increased community education and preventative measures



Delivery System Transformation and Behavioral Health Integration

The future is here. There are steps lawmakers and providers can take to continue serving our most vulnerable citizens. These steps help existing programs that already demonstrate patient-centered care, cost savings, and are backed by the Michigan Department of Health and Human Services.

- **OVERCOME** traditional barriers of care by continuing integration of Michigan's physical and specialty behavioral health delivery systems
- **INCREASE** communication between systems of care to result in greater care coordination for people
- **UTILIZE** an innovative payment model including a bundled case rate and value-based payments to maximize savings