Michigan House Appropriations Subcommittee on Health and Human Services
Behavioral Health Hearings
November 6, 2019

Public Input by Christine Gebhard, Chief Executive Officer
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Good Morning. Thank you, Madame Chair and Committee members, for the opportunity to provide public input during these hearings on improving Michigan's behavioral health system. As background, I serve as Chief Executive Officer for North Country Community Mental Health Authority which serves six counties in northern Michigan—Antrim, Charlevoix, Cheboygan, Emmet, Kalkaska, and Otsego. We provide a comprehensive array of specialty behavioral health and intellectual/developmental disability services to more than 4000 individuals each year, the majority of whom receive comprehensive long-term services and supports. We directly employ 240 staff and another 700 workers under contract. North Country is one of five Community Mental Health Service Programs (CMHSPs) that constitute the Northern Michigan Regional Entity (NMRE), the Pre-Paid Inpatient Health Plan (PIHP) for 21 counties in northern Michigan.

I wish to begin by thanking this Committee and the House for supporting the removal of Section 928, the Local Match Drawdown, which will return $25.2M in local unrestricted funds to Community Mental Health Boards over a five-year period. This action will allow CMHSPs to meet the unique local needs in their communities, such as services in the jails and schools that cannot be funded through Medicaid or State General Funds, in addition to meeting the required 10% local fund match for state provided services, such as state psychiatric hospital admissions.

I also want to thank this Committee and the Legislature for appropriating actuarial rate increases for Medicaid behavioral health, Healthy Michigan Plan, and Medicaid Autism services for FY20. This transfusion of funding will stop the bleeding of the past several years and stabilize our system.

If the behavioral health system is broken, it's not in the area of access to specialty behavioral health services and supports. The Michigan Health Endowment Fund recently contracted with Altarum to study access to behavioral health care in Michigan. Among their key

findings, it was noted that of the 1.76 million Michiganders experiencing a mental illness, about 62% receive treatment leaving more than 666,000 people with unmet need. The report goes on to say that "Medicaid enrollees have the largest share of untreated mental illness at 49%, [while] the uninsured population experience the highest prevalence of substance use disorders, followed closely by the Medicaid population." [1] Further, and more importantly, the "unmet need for [mental illness] in Michigan is greatest for the more prevalent, mild-to-moderate conditions...more serious conditions such as bipolar disorder, recurrent depression, and...stress disorders are less prevalent among Michiganders and show lower shares going untreated."[2] **Michigan's Community Mental Health system is meeting the needs of people with more serious conditions while those with mild to moderate mental health needs—those served by commercial payors including the Medicaid Health Plans—have the highest prevalence of unmet need.** And, as reported in Crain's Business just last week, at the same time that Health Plan profits topped half a billion dollars while enrollment declined.

I bring this to your attention not to disparage the Medicaid Health Plans; but rather to acknowledge the success of the public behavioral health system—which encompasses both CMHSPs and PIHPs—in meeting the needs of Michigan's most vulnerable citizens as stipulated by the Michigan Constitution and the Michigan Mental Health Code.

Care coordination isn't new; CMHSPs have been doing care coordination for the past fifty years by advocating, linking, and coordinating services and supports for the people we serve. It's what we do best. In the past decade, more than 600 models of behavioral health and physical health integration have been initiated and implemented by CMHSPs. It's who we are. We initiate, coordinate, collaborate, partner, and co-locate with community stakeholders, such as federally qualified health centers, schools, jails, hospitals, and health plans. You need only look at the efficacy of the eight Certified Community Behavioral Health Centers (CCBHC) being piloted across the state today; you'll find increased access to services for those with mild and moderate behavioral health needs, substance use disorders, veterans, and children and families. These care integration models work because we bring COMMUNITY to behavioral health services.

Two of the five CMHSPs in the Northern Michigan Regional Entity (Northern Lakes CMH and Centra Wellness Network) have participated in a behavioral health home pilot the past two years. The behavioral health home model serves people with co-occurring psychiatric and chronic health conditions by coordinating care and wrapping services around people regardless of where they receive their primary care. As reported by the Michigan Department of Health and Human Services, the pilot demonstrated improvement in health outcomes and a reduction of $366 per member per month in healthcare costs. Plans are underway to expand this model to our 21 counties on October 1, 2020. The NMRE is also piloting the first Opioid Health Home in the state. Our experience, along with the experience of the CCBHCs, will provide a pathway to improving Michigan's behavioral health system.

I don't believe Michigan's behavioral health system is broken, although I'm sure there are areas where we can do better. Michigan has a long and admired history in mental health system transformation. Let us continue to build on our strengths, as we do with the people we serve.

Thank you.

Endnotes

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(1) Corwin Rhyan, Ani Turner, Emily Ehrlich, and Christine Stanik. "Access to Behavioral Health Care in Michigan", Altarum, July 2019, p. 7.

(2) Ibid., p. 8.