

Michigan House of Representatives
Appropriations Subcommittee on Health and Human Services
Representative Mary Whiteford, Chairperson

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Chairperson Whiteford and members of the committee:

Thank you for the privilege of addressing this committee regarding the important topic of caring for people living with mental illness and/or developmental disabilities. My previous experience as chief deputy director of MDHHS and my current role as Chief Operating Officer of Hope Network afford me the blessing of seeking solutions to help people overcome life's challenges through innovative and integrated supports.

Hope Network is a non-profit healthcare and life services organization caring for more than 30,000 people annually in programs ranging from Applied Behavioral Analysis for autistic children, tutoring for young readers, a full array of behavioral health supports, neuro rehabilitation, career and job training, transportation, housing, and more.

With the recent announcement by MDHHS Director Gordon canceling the Section 298 pilots, we have an opportunity to re-evaluate how we should move forward in our ongoing efforts to seek the best possible care for the most vulnerable in our great state. I believe Section 298 pilots never got started because we started with the wrong premise. I regret that we started the conversation with financing. We should have started the conversation, and I urge that we do so now, by asking first: what is the optimal system to ensure best possible outcomes for those experiencing serious and persistent mentally illness (SPMI) and those living with an intellectual or developmental disability (IDD)?

A person with a persistent mental illness or a person with an intellectual or developmental disability may need a lifetime of supports. It is important this be recognized and that care not be rationed arbitrarily or for the sake of saving dollars at the expense of our moral obligation to provide needed care.

I suggest the SPMI and IDD populations be empowered with the same rights and privileges the general population has when it comes to receiving care: choice and portability. Our current system was developed to ensure these rights through person-centered planning and the principle of self-determination. Person-centered planning is prescribed in law in section 712 of the Michigan Mental Health Code:

"The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individualized plan of services in partnership with the recipient." (emphasis mine)

Self-determination is prescribed by MDHHS through *Michigan's Self-Determination Policy and Practice Guideline* which "requires that Prepaid Inpatient Health Plans/Community Mental Health Service Programs (PIHPs/CMHSPs) offer arrangements that support self-determination, assure methods for people to exert direct control over how, by whom, and to what ends they are served and supported."

The department provides four principles upon which self-determination is based:

“FREEDOM: The ability for individuals, with assistance from significant others (e.g., chosen family and/or friends), to plan a life based on acquiring necessary supports in desirable ways, rather than purchasing a program. This includes the freedom to choose where and with whom one lives, who and how to connect to in one’s community, the opportunity to contribute in one’s own ways, and the development of a personal lifestyle.

AUTHORITY: The assurance for a person with a disability to control a certain sum of dollars in order to purchase these supports, with the backing of their significant others, as needed. It is the authority to control resources.

SUPPORT: The arranging of resources and personnel, both formal and informal, to assist the person in living his/her desired life in the community, rich in community associations and contributions. It is the support to develop a life dream and reach toward that dream.

RESPONSIBILITY: The acceptance of a valued role by the person in the community through employment, affiliations, spiritual development, and caring for others, as well as accountability for spending public dollars in ways that are life-enhancing. This includes the responsibility to use public funds efficiently and to contribute to the community through the expression of responsible citizenship.”

Given what we already have in statute and in guidelines it would be reasonable to surmise choice and portability already exist. With 10 PIHPs and 46 CMHSPs tasked with these responsibilities we see variation and some inherent challenges. In my estimation, the current system deserves credit for some regions adhering strongly to self-determination. However, it is also fair to say we see fractures in self-determination in regions where the budgets are in deficit as evidenced by spikes in Medicaid Fair Hearing requests. These hearings are generally requested when individuals feel their access to care is limited or reduced in a manner incompatible with their person-centered plan.

Experience has taught me there are many very well-meaning people in Michigan’s system doing great work providing compassionate care. I do feel the ability for this work to continue may be enhanced with some prudent improvements. I recommend the following:

- 1) Distinguish service payers from service providers: much of the state is served by quality providers, and where providers are scarce some rural CMHSPs provide needed quality services directly. It can be confusing to an individual as to what their service options are and there is an inherent conflict when the paying CMHSP is also providing the same services as its contracted provider network.
- 2) Standardize administrative requirements: CMHSPs should rely on audits of their peers and accrediting bodies rather than duplicating audits, trainings, credentialing, and other administrative overlaps that take money away from direct care. We also need to begin allowing for system interfaces. It is illogical in 2019 that any organization is still required to direct enter data for persons served into a CMHSP system while also maintaining the integrity of the organization’s own medical record. This forces dual entry, increases the administrative burden, increases chances for data entry errors, and exposes organizations to risks of non-compliance with the Federal Health Insurance Portability and Accountability Act (HIPAA). The standard contract between the State and the PIHPs requires the regions to have systems that accept data from provider systems and yet many providers are still required in certain regions to enter data directly into the region’s system.

- 3) Get people to the appropriate level of care. In some cases, inpatient psychiatric placements are appropriate and necessary. In other cases, emergency departments and others default to inpatient psychiatric as a perceived safe placement, when it may not be the appropriate level of care. Relieve the pressure on the limited inpatient psychiatric beds through greater utilization of crisis residential units, mobile crisis, and peer supports.
- 4) Make the benefits for SPMI and IDD portable. Michigan's system is geographically-dependent with 10 PIHP regions and 46 different CMHSPs. This means a program offering for a particular diagnosis in Wayne County may look far different than the program offering for the same diagnosis in Marquette. Access to services should not be dictated by geography. A person in a rural community should have access to the same types of programs as a person living in a larger city. This can be realized if we ensure capitated rates are equalized and allow people utilizing services to have a statewide uniform benefit.
- 5) Ensure recipient rights are consistent and uniform. While there is an Office of Recipient Rights at the State level housed within MDHHS, each region also has a recipient rights officer. The protection of a recipient's rights should not vary by the vigilance and competency of the rights officer in the recipient's region. This right should be uniformly applied and uniformly administered.
- 6) Resist the temptation to assume the only options before us are a full carve in of the behavioral health benefit or the status quo. Other options are being explored and tested elsewhere and are at the very least instructional and possibly even applicable in Michigan. I encourage serious consideration of the Provider-Led Arkansas Shared Savings Entity (PASSE). I believe the concepts of the Arkansas model can be applied in Michigan building upon the existing system infrastructure to offer a statewide uniform benefit and enhanced self-determination through annual open enrollments.

The Legislature and the Administration will continue to receive advice both solicited and unsolicited from payers, providers, advocates, and other interested parties on this important subject of Michigan's behavioral health system. These are important voices and should be heard. However, I implore you not to lose sight of the most important voice of all: that of the people receiving these services. Ensure these voices and those of their families are heard and seriously considered in any major decisions regarding the system.

I thank you for your continued interest in ensuring the people of Michigan receive the best possible care. I pray we will all commit to placing the needs of those we serve above all else and remember we are called to this work for their benefit and not our own.