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INTEGRATED HEALTHCARE THAT PRIORITIZES PEOPLE AND THE PUBLIC MENTAL HEALTH SYSTEM

Community Behavioral Healthcare services were put into existence nearly six decades ago by President John F. Kennedy and the Community Mental Health Act of 1963. To date community-based behavioral healthcare continues to be the most effective, inclusive way for persons receiving care in the setting of their choosing. The Detroit Wayne Integrated Health Network (DWIHN) believes that in order to serve individuals in the behavioral healthcare community; true integrated healthcare needs must be centered around people, excellent service, efficiency and provide consistent and efficient quality care. Community Mental Health was established to be the safety net for society's most vulnerable citizens. We are guided by this and the Mental Health Code to ensure the social determinants of health are met for the people we serve.

CORE PRINCIPLES

1) Behavioral health redesigned inclusive of integration must remain within the public mental health system.
2) Services must remain consistent and uninterrupted for the individuals we serve no matter where they reside.
3) Ultimate control of the finances must remain in the public sphere.
4) If a system redesign is contemplated, each entity must retain its own risk.
5) Shared savings must be reinvested in services to improve the lives of the individuals we serve.

Eliminating the 10 PIHPs by Creating an Administrative Service Organization will Lead to Chaos and not Efficiency

1) House Bill 4925 would eliminate the PIHPs which are the entities that oversee the finances.
2) The creation of an Administrative Service Organization (ASO) would be a 3rd party that control the finances, little or no understanding of the delivery of behavioral health services, and the population served.
3) It is unrealistic to believe that one ASO will carry out the job and functions of the ten PIHPs, managing everything, including customer service, utilization management, recipient rights, compliance, care management, provider network management/development, quality, just to name a few, for the entire state.
4) There is no integration of physical health services in this system redesign. The ASO bears zero risk.
5) The administrative layer that the ASO seeks to eliminate is simply substituted for another layer comprised of several oversight committees all doing the job of a single PIHP.
6) It is unreasonable to believe that a single ASO would carry out all of the functions of the PIHPs at an administrative cost of 3%.
7) The ASO structure does not solve issues of accessibility and efficiency. In fact, it does the opposite, creating instability and a so-called one size fits all approach that ignores geographical regions and issues of social determinants.
8) If the idea is to eliminate the PIHPs and replace them with the Medicaid Health Plans, (MPHs), the results are costly and highly inefficient.

Medicaid Health Plans (MHPs) Unrealistic and False Economic Benefits Coupled with Lack of Accountability:

1) MHPs' administrative cost is 16 – 17%. Administrative cost under the PIHPs is 6 – 9%.
2) MHPs must adhere to corporate structure that must account for profits, low risk individuals and dividends to be paid to shareholders. PIHPs are risk seekers simply by definition and operationally set up where there aren't board members, shareholders seeking certain return vs the PIHP board is more consumer, provider and has public officers which provides ability to stay connected with feedback and solving real problems.
3) There is no economic or business case that supports a conclusion that MHPs which consume nearly 7 to 10% more in operations cost and require profits, will be able to provide the same level of care as the PIHPs given the same level of funding.
4) MHPs do not have the structure to support Recipient Rights issues. PIHPs are responsible for establishing and maintaining a Recipient Rights structure inclusive of investigations and reporting.
5) MHPs do not have the infrastructure to support individuals, especially some of our most vulnerable populations, in residential settings throughout the community.
6) MHPs do not have to account for social determinant factors that many times create barriers to equity in health care.
7) MHPs do not provide services; they authorize services. Authorizations are limited ultimately by reducing critical services and consistency in care.
8) MHPs have demonstrated through MIHealthLink, they are aware that PIHPs/CMHs do a better job in providing efficient and quality mental health services for individuals we serve.
9) No MHP in Michigan has any experience or certification regarding the provision of services to the behavioral health population. Further, the MHPs engaged in the MIHealthlink program in Wayne County have very little experience in providing behavioral health services.
10) The primary tool available to any managed care organization as a result of being risk adverse, is to reduce cost by a reduction in services.

Specialty Integrated Plans (SIPs), Must Meet the Following Requirements that Currently Put the PIHPs and/or Public Mental Health at a Significant Disadvantage.

1) Fully licensed and meets insurance regulatory requirements.
2) Adequately capitalized and risk-bearing.
3) Strong networks for health and specialty care.
4) Typical health plan administrative infrastructure.
5) Specialized care planning and management.

*The ASO structure doesn't even allow for the PIHPs.

Reserve and Risk: Uneven Playing Field for Public Entity to Compete

1) The new Specialty Integrated Plans (SIP) must be a Managed Care Organization (MCO) and will be required to maintain a substantial risk reserve, 20-30% of annual spending.
2) There is no mention of start-up costs associated with the proposal.
3) SIPs must establish a statewide network and infrastructure at their own expense and risk.
4) This new proposal can open the door for out of state organizations to bid and potentially profit in the system by reducing services to increase profits.

- *This gives undue advantage to Medicaid Health Plans.*
- *These changes will have to be more than administrative.*
- *Legislators must pass specific legislations to change the structure of mental health service delivery.*
- *These requirements are a significant challenge to the current structure of PIHP/CMHs.*
- *Current structure would have to change in order for CMHs to compete in the new structure.*
- *The current public system does not allow for significant levels of reserves.*
- *There would need to be special administrative rules, other considerations and even legislation in order to allow the accumulation of reserves.*
- *Three of the PIHPs are also CMHs, DWIHN is one of the three; PIHPs are the legal entities that control Medicaid dollars and reserves.*

Facts First

- ✓ DWIHN currently operates with the same level of certification as the MHPs.
- ✓ DWIHN has already begun working with the Association, stakeholders, the provider network, the individuals we serve in opposition to this plan.
- ✓ DWIHN maintains National Committee on Quality Assurance (NCQA) standards while providing services to individuals with the most severe behavioral health diagnosis and conditions.
- ✓ MHPs currently engaged in MIHealthlink, which is a contractual delegation of service management and delivery by several MHPs to DWIHN for individuals with mild to moderate behavioral health diagnosis, MHPs rely upon the NCQA certification of DWIHN to support their respective certifications by NCQA in the area of managed behavioral health services.
- ✓ This new integration plan will eliminate the current PIHP/CMHSP structure and control the allocation of funds.
- ✓ The SIPs would require the use of managed care entities to administer a Medicaid health care benefit package.
- ✓ There would be a bid/procurement process that would require the applicants to have managed care experience.
- ✓ There would be a statewide implementation contingent upon number of qualified applicants.
- ✓ Under this proposal, the existing flow of funds that are currently appropriated to the PIHPs, would be diverted to the participating SIPs.

Detroit Wayne Integrated Health Network 's Preparation

1) DWIHN has proven that we can compete with the MHPs, obtaining a NCQA 3-year accreditation.
2) DWIHN shored up best practices from implementation across clinical, financial, oversight as well as technology through the network.
3) DWIHN has implemented benefit plans across all lines of services which are in turn tied to clinical assessments and standardized plans of service provide best practices of how delivery of services can be optimized with minimum delay and disruption.
4) DWIHN continues to work with stakeholders and legislators in expressing our concerns and offering potential alternatives to the proposal.
5) DWIHN is strengthening reserves to prepare for our future role in the delivering of integrated health services.
6) DWIHN is collaborating and establishing partnerships with health plans to deliver physical health services to our members. This is a one component of integration; care coordination.
7) DWIHN intends to better integrate behavioral and physical health in order to improve the person's overall health by using a Holistic Care approach.
8) DWIHN has taken steps to maximize efficiency and elimination or minimization of unnecessary costs.
9) DWIHN like its PIHP partners, deploys the leading evidence-based models for the treatment of the severely mental ill, intellectually and developmentally disabled, and those who have substance use disorder.

DWIHN as a PIHP is Recognized as a Behavioral Healthcare Leader with Outstanding Quality and Clinical Programs that Brings Change

1) **National Committee on Quality Assurance (NCQA) Accreditation** A key assumption in the current integration proposal is that private MHPs will operate at a more efficient level than the PIHPs, resulting in a more efficient use of resources and better behavioral health services. This is simply not true.

2) DWIHN's efficiency and quality measures have been certified to be consistent with the most rigorous standards in the managed health care industry. The universally recognized standard of excellence within managed health care is NCQA. NCQA is a private, nonprofit organization dedicated to improving health care quality and promulgates the Healthcare Effectiveness Data and Information Set (HEDIS), the most widely used and comprehensive performance measurement tool in health care. NCQA acts as the accrediting body for a wide range of health care organizations, including Managed Behavioral Health Organizations (MBHO) such as PIHPs.

3) DWIHN, the largest PIHP in the public behavioral health system in Michigan has just been recognized for another 3 years and receiving another NCQA certification.

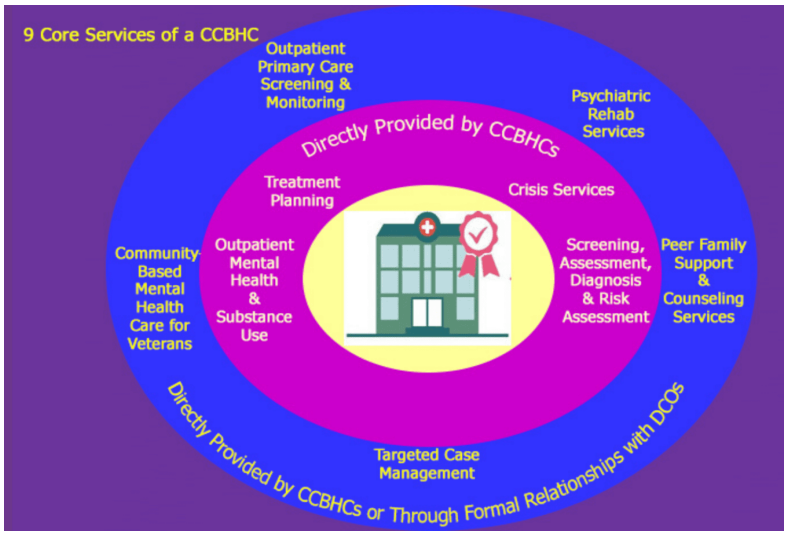
4) NCQA has reviewed DWIHN's operations in utilization management, denials of service and appeals, quality improvement, credentialing and aspects of network sufficiency and determined that DWIHN is exemplary. In fact, DWIHN received a score of 100% on nearly all submission standards.

5) DWIHN rolled out a Certified Care Coordination platform coupled with HEDIS quality measures to the provider network working with a health plan partner that enabled true care coordination and interoperability.

6) DWIHN partnered with the **Network for Regional Healthcare Improvement (NRHI)**, which enabled it to be positioned as a national leader working to improve the behavioral and physical health status of individuals served. This was accomplished through partnerships that provide programs promoting integrative holistic health and wellness**.** With DWIHN's expertise and commitment to the community mental health field, we are working with NRHI to collaborate on several future healthcare endeavors by utilizing NRHI's network.

Collaborations and Innovation in Service Delivery - In 2020, DWIHN announced a groundbreaking partnership that brought behavioral health support services to police officers, 911 dispatchers and homeless outreach workers. This partnership provides support to individuals when they encounter citizens experiencing mental health challenges in the field. The partnership affords individuals with mental health challenges the opportunity to be directly connected to the appropriate behavioral healthcare agencies so they can receive the care and support services they need.

CLINICAL SERVICES and DELIVERY MODELS



DWIHN is continuing to work aggressively on enabling the Behavioral Health Homes model across the population who can benefit most in terms of better health outcomes as well as evidence-based treatment.

DWIHN is working to enable meaningful implementation of Certified Community Behavioral Health Clinics (herein CCBHCs) across the network to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals. Presently there are five (5) CCBHCs operating within the DWIHN provider network.

Certified Community Behavioral Health (CCBHC) model is an integrated care model that ensures access to fully integrated, evidence-based behavioral health services. CCBHCs have an integrated approach to healthcare which focuses on recovery, wellness, and physical-behavioral health integration. CCBHCs have increased access to treatment, increased collaboration with law enforcement, schools and hospitals to improve care while simultaneously decreasing hospitalizations, and recidivism. DWIHN meets much of the CCBHC criteria and is aligning itself toward this model of care. DWIHN directly provides access to services for persons seeking behavioral health treatment in Wayne County, crisis intervention services, and complex case management. DWIHN has multiple partnerships including the Detroit Police Department, a School Success Initiative providing behavioral health screening and services in over 300 schools, and hospital partners. CCBHCs are a proven care model that promotes overall member wellness while decreasing costs to the behavioral and physical systems of care.

Opioid Health Homes As the largest behavioral health organization in Michigan, DWIHN has all the elements to better serve its residents in Opioid Health Homes. We have Community Mental Health Services Programs (CMHSPs) • Federally Qualified Health Centers (FQHCs) • Tribal Health Centers (THCs) • Clinical Practices and Clinical Group Practices • Community/Behavioral Health Agencies

- Coordinates and provides access to individual and family supports, including referral to community social supports.
- Meets regularly with the care team to plan care, discuss cases and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
- Identifies community resources (i.e., social services, workshops, etc.) for patient to utilize to maximize wellness; and conducts referral tracking.
- Coordinate and provide access to chronic disease management, including self-management support.
- Implements wellness and prevention initiatives and facilitate health education groups.
- Provides education on health conditions and strategies to implement care plan.

- Provides access to Medical Consultant (e.g., primary care physician, physician assistant, or nurse practitioners).
- Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.
- Psychiatric Consultant Care team must have access to a licensed mental health service professional (i.e., psychologist, psychiatrist, psychiatric nurse practitioner) providing psychotherapy consult and treatment.
- Plans development services. This provider will be responsible for communicating treatment methods and expert advice to the Behavioral Health Provider (incorporated into care team). It will be the responsibility of the Behavioral Health Provider (and/or other members of care team as assigned) to develop a licensed mental health provider's treatment into a beneficiary's care plan.

Behavioral Health Homes - DWIHN currently coordinates care for Medicaid beneficiaries with serious and complex chronic conditions by serving the "whole-person" through integrating and coordinating physical, behavioral, and social services for persons all ages. We currently have thousands of persons meeting criteria with high hospitalization costs that through appropriate collaboration, these individuals could receive more appropriate treatment in a Behavioral Health Home (BHH) environment. In a BHH Model as the Lead Entity, DWIHN would ensure a high-level care coordination as well as payment and enrollment by identifying potential enrollees through Waiver Support Application. Our already identified Health Home Partners exist through our relationships with our: Federally Qualified Health Centers, Tribal Health Centers, Clinical Practices or Clinical Group Practices and Community/Behavioral Health Agencies.

- Increased 7-day follow-up appointments after hospitalization
- Decreased inpatient hospitalization
- Decreased inpatient hospital length of stay
- Decreased hospital readmissions
- Increased screenings: BMI, Depression, Readmission Rate, Follow-up after Hospitalization, Controlling High Blood Pressure, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Prevention Quality Indicator: Chronic Conditions Composite, Use of Pharmacotherapy for Opioid Use Disorder, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse.

Improvements Must be Reflected in Deliverables, Measures, and Outcomes

Several initiatives, outcomes and technology/platforms developed to further the cause of providing the best possible services to the individuals we serve including:

- Universal credentialing with our NCQA certified Credentialing Solution: DWIHN in partnering with Medversant Technologies has implemented a Universal credentialing platform across the entire provider network. This is a one stop-shop for credentialing.
- Universal training across the region for clinicians, including recipient rights training.
- Universal compliance program throughout the region.
- Collaborating across the region for crisis services, including building additional crisis centers.
- Collaborating across the region for children's services.
- Collaborating across the region for Substance Use Disorder services.
- Eliminating the requirements for County of Financial Responsibility (COFRs) across the region.
- Streamlined provider outreach and support to minimize non-responders.
- Patented verification technology automates data capture from primary sources.
- Transparent client interface which allows heath plans to track providers credentialing file status
- Highly trained audit team to reduce errors and improve compliance.
- NCQA certified and URAC accredited CVO.
- Virtual Review Committee Solution that facilitates medical peer review meetings remotely, providing the tools and the information necessary to render and document committee decisions.
- Paperless access to providers' profiles including full supporting documentation.
- Annotate, exchange information, vote and record the entire process.

ROBUST SERVICE DELIVERY SYSTEM

DWIHN has continued to seamlessly manage and coordinate consistent and uninterrupted service delivery to the population we serve throughout the COVID-19 pandemic.

Measure	FY19	FY20	%age compared to 2019
Total # of Services	6,078,054	5,300,294	-13%
Total # of Telehealth Services	843	633,307	
Total Members Served	74,917	71,672	-4%

Measure	FY19	FY20
Total # of Services		
00-17	918,947	886,133
18-25	456,857	402,799
26-39	1,320,488	1,157,564
40-49	831,555	721,982
50-64	1,885,101	1,584,220
65+	665,106	547,596
Total # of Telehealth Services		
00-17	596	211,785
18-25	78	51,253
26-39	95	116,246
40-49	34	82949
50-64	34	141,277
65+	6	29,797
Total Members Served		
00-17	17,379	16,411
18-25	8,353	7,820
26-39	17,463	17,061
40-49	11,097	10,596
50-64	18,126	17,038
65+	5,096	5,435

Demographics	FY19	FY20
Total # of Services		
Female	2,412,000	2,127,967
Male	3,665,934	3,172,289
Total # of Telehealth Services		
Female	332	301,420
Male	511	331,884
Total Members Served		
Female	34,341	33,136
Male	40,737	38,764

The numbers above show an expansive network of providers in the community working very closely to navigate and adjust methods of service delivery to ensure continuity as well as coverage through the pandemic.

Face Shields	6,000
Gowns	10,000
Hand Sanitizer	5,000 bottles
KN95 Mask	125,000
Gloves	150,000 pairs
Surgical Mask	90,000
Thermometer	2,000
Wipes	500

DWIHN has been actively involved in ensuring there is sufficient distribution of PPE to the people we serve and the staff that support them. Additionally, we have provided COVID-19 testing and vaccination efforts to protect provider staff as well as consumers.

House Bill 4925 – 4929 Summary and DWIHN Perspective

HOUSE BILL 4925 – Rep Whiteford (R)

SUMMARY

House Bill 4925 would amend the Mental Health Code to create the Behavioral Health Oversight Council within the Department of Health and Human Services (DHHS) to advise DHHS in developing and executing public behavioral health policies, programs, and services. It would also authorize DHHS to contract with an Administrative Services Organization (ASO), which would assume certain responsibilities from DHHS and DHHS-designated community mental health (CMH) entities. The other four bills are complementary and amend other acts to account for changes in HB 4925.

> ***Administrative services organization*** *would mean a contracted third-party organization with special expertise in behavioral health systems management that contracts with DHHS to provide certain specified administrative services necessary to manage the public behavioral health system, including Medicaid specialty supports and services on the state's behalf.*

Composition of the Proposed Behavioral Health Oversight Council

5 recipients of public behavioral health of service, their families or former recipients of recovery – at least 3 must be current recipients.

10 members, with one from each of the ten prosperity regions identified by the Department of Technology, Management, and Budget

Up to 4 non-voting members appointed by the DHHS director to represent DHHS and departmental agencies pertinent to delivering public behavioral health and intellectual or developmental disability services.

Function of the Council

The council would make specific recommendations on matters related to the planning and execution of public behavioral health services, including doing each of the following:

- Review of services under the chapters of the code that govern county CMH programs and SUD services and any other pertinent law or regulation for the provision of public behavioral health services.
- Review of periodic reports on the program activities, finances, and outcomes, including reports on achievement of service delivery system goals.
- Report annually to the legislature regarding the council's activities and the administrative services organization that includes service outcomes for individuals served.

Contracting with an ASO

DHHS could contract with a single administrative services organization to carry out the powers and duties described above by issuing a request for proposal. The single ASO would have to be organized as a nonprofit organization or a public or quasi-public entity. It could not be a CMHSP, a group of CMHSPs under the Urban Cooperation Act, or any other group or confederation of CMHSPs.

The contract would have to require the ASO to perform specific functions, including:

- Eligibility verification, Utilization management, Intensive care management, Quality management
- Coordination of medical and behavioral health services, Provider network development and management
- Recipient rights and provider services and reporting, Customer services
- Clinical management services not retained by DHHS
- Corporate compliance that includes adherence to all applicable state and federal civil rights statutes and regulations

Functions of a CMHSP:

The bill would add all of the following to the description of mental health services provided by a CMHSP:

- Coordination with MiCAL
- Providing mobile crisis teams staffed or contracted by CMHSPs that are dispatched at the direction of MiCAL.
- Providing crisis stabilization units that serve everyone in need from all referral sources

DWIHN/CMHSP POSITION - HOUSE BILL 4925
Observations and More Questions
A. The elimination of the PIHPs only to create a different administrative layer that will supposedly have the knowledge to oversee the entire state and its different regions is completely misleading and not true.
B. It is absolutely false to believe that these administrative services will be accomplished at 3%. Historically these operating costs run 16 – 17%. Administrative costs for PIHPs are 6 – 9%.
C. An ASO must adhere to corporate structure that must account for profits, low risk individuals and dividends to be paid to shareholders. PIHPs are risk seekers simply by definition and operational setup where there aren't board members, shareholders seeking certain return vs PIHP board is more consumer, provider and public officers which provides ability to stay connected with feedback and solving real problems.
D. An ASO does not have the structure to support Recipient Rights issues. PIHPs are responsible for establishing and maintaining a Recipient Rights structure inclusive of investigations and reporting.
E. ASOs do not provide services; they authorize services. Authorizations are limited ultimately by reducing critical services and consistency in care.
F. The voting members and the standing committees are again additional layers of pseudo administrative organizations that supposedly will understand behavioral health services in the entire state.
G. This plan actually reduces access to care by limiting the options to care so drastically. Geographically, where will this ASO be located to oversee the entire state and these services from UM to Recipient Rights to compliance, customer service, quality to managing the network just to name a few?
H. It is said that the ASO must be an expert in behavioral health system management. If this is true, how would they know how the system works in numerous regions throughout the state? The pain points are different in various regions around the state.
I. Eliminates Section (23) from the Mental Health Code – The definition of the Department-designated community mental health entity is at the heart of the intent of the Michigan Mental Health Code and distinguishes the public community mental health entities and their duties from all other provider organizations. 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.

HB 4926 – Rep Abdullah Hammoud
Summary: Would amend the Social Welfare Act to mirror the description of DHHS's provision of behavioral health services in HB 4925. It would retain the provision that, generally, Medicaid-covered specialty services and supports be managed and delivered by specialty prepaid health plans chosen by DHHS. However, it would provide that, within one year of the bill's effective date, DHHS would have to use a self-insured financing and delivery system structure to provide or arrange for the delivery and integration of those services for eligible Medicaid beneficiaries with the specified conditions. These specialty services and supports would have to be carved out from the basic Medicaid health care benefits package.

HB 4927 – Rep Green
Summary: Would amend the Public Health Code to remove a reference to a "DHHS designated CMH entity," which is an entity whose function would be assumed by the ASO proposed by HB 4925.
DWIHN - A Better Solution (HB 4927)
A. It is an issue to have folks pay for the cost of screenings and assessment services. This is considered treatment and should not be punitive.

HB 4928 – Rep Sue Allor
Summary: Would amend the Michigan Liquor Control Code to provide that a minor who purchases, consumes, or possesses alcohol, attempts to do so, or has any bodily alcohol content must undergo screening and assessment by a person or agency designated by the ASO (rather than a person or agency designated by a DHHS-designated CMH entity) to determine whether the minor would benefit from rehabilitative services.
DWIHN - A Better Solution (HB 4928)
A. We should not create criminal records for minors and juveniles. This will affect their prospects of employment now and in the future. These matters should be treated as treatment services. The imposition of jail and misdemeanor charges will lead to difficulties for these young persons. Moreover, this may very well disproportionally affect persons of color.

HB 4929 –Rep Shri Thanedar
Summary: Would amend the Social Welfare Act to require that certain functions, such as SUD treatment, be performed by an ASO rather than by a DHHS-designated CMH entity.
DWIHN - A Better Solution (HB 4929)
A. For costs to be deducted from an individual's family independence program assistance payment will affect person and family on other levels. If these are truly services, they should be provided without impunity.