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MICHIGAN DEBATES INTEGRATING PHYSICAL, MENTAL HEALTH SYSTEMS

By Jay Greene

Photo by iStock The state of Michigan is debating whether to integrate two separate systems that generally get good marks for quality — Medicaid's physical and behavioral health services.

Michigan is at a crossroads for how it delivers physical and behavioral health services under Medicaid.

During the past 19 years, Medicaid health plans have managed the state's now $8 billion-plus physical health Medicaid budget for a growing number of beneficiaries. With Healthy Michigan Medicaid expansion, HMOs now manage medical care for 1.7 million people.

In 1998, Michigan also embarked on a separate system of regional public authorities to manage its now $2.4 billion-plus Medicaid behavioral health budget for 230,000 patients.

The 10 prepaid inpatient health plans, or PIHPs — three in Wayne, Oakland and Macomb counties — coordinate behavioral and social-service care for serious mental conditions, developmental disabilities and substance abuse.

Now the state is debating whether to integrate the systems — and if so, how.

Much money is at stake, and so are two separate systems that generally get high marks for quality.

Last year, 14 Medicaid HMOs earned $298 million on revenue of $7.67 billion for a 3.9 percent margin. Now down to 12 because of acquisitions, many of those plans have received good ratings for quality and customer service that in some cases exceeded commercial HMOs, according to the **National Committee on Quality Assurance**, an HMO accrediting body.

While no national quality accreditation body exists for managed behavioral health providers, Michigan has created a national model based on its breadth of care, according to the **National Council of Behavioral Health** and the **National Association of County Behavioral Health and Developmental Disability Directors**.

In February, Gov. Rick Snyder proposed in his fiscal 2017 budget to unify the two parallel systems by allowing the Medicaid HMOs to manage the $10.4 billion-plus managed Medicaid system for physical and behavioral health.

Public outcry led the Michigan House and Senate to put a temporary hold on Snyder's proposal. Lt. Gov. Brian Calley already had slowed the process in February by creating a 122-member stakeholder work group to study the issue. The state Legislature wants an initial report by December.

But the question remains: How best can Michigan improve delivery of physical and behavioral health care?

Experts on both sides of the issue say care coordination is the best way to improve health, reduce costs and increase quality. It is well known that people with chronic diseases who also are suffering from mental illness are more likely to have higher medical bills.

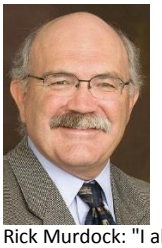
The question is how best to coordinate their care. Through a single delivery system managed by multiple Medicaid HMOs? By retaining the current system and using enhanced electronic medical records and a state mandate for HMOs and PIHPs to coordinate case management?

Or possibly, as some state legislators and providers have suggested, by allowing Medicaid health plans to include coverage for serious mental illness and substance abuse, a so-called carve-in of those services.

In that scenario, PIHPs, or a single statewide managed care entity, would retain responsibility for patients with developmental disabilities and other related services, experts said.

Doing nothing doesn't seem part of the agenda. All sides want improvement.

Lansing searches for solution



Rick Murdock: "I absolutely believe we can" integrate behavioral health care with physical health care.

Medicaid health plan officials say they are prepared to compete for contracts to manage physical health and behavioral health Medicaid services. They say they can help the state save money, improve quality and care coordination and extend more services to patients.

The **National Conference of State Legislatures** says more than 30 states have embarked on a variety of approaches the past five years to incorporate some behavioral health with physical health into health plan-type management systems.

Rick Murdock, executive director of the **Michigan Association of Health Plans**, said health plans have the experience to manage both systems.

"We have always tried to position our industry as part of the solution, not part of the problem," Murdock said. "With proper planning and all the systems in place, I absolutely believe we can" integrate behavioral and physical care.

Murdock noted that health plans have incorporated many populations into managed care over the years. They include dual-eligible Medicaid and Medicare patients, physically disabled patients, pregnant women and special-needs high-risk children.

Behavioral health officials, providers and families of clients want the state to help them improve the current system of care that they acknowledge isn't perfect and needs streamlining. They say this is because care is delivered and funded unevenly across regions and doesn't always address patient and family needs.

Contrary to some mental health providers who argue they have been shortchanged by the state with funding, Elmer Cerano, executive director of the nonprofit advocacy group **Michigan Protection and Advocacy Service Inc.**, said cutting regulations and bureaucracy — not more money — is needed to improve the system.

"I don't care who operates the program. I want to see better service," Cerano said. "If profits are to be made, it should go to additional services."

There is widespread fear among mental health advocates that Medicaid HMOs, the majority of which are for-profit health plans, will siphon off profits, cut services and increase administrative costs for the state, leaving patients and families frustrated — or worse.

Murdock said because health plans would be at risk for total care, HMOs will not skimp on behavioral, medical or social services.

But mental health advocates question how Medicaid HMOs can increase benefits and services while at the same time save the state an estimated $200 million — a number that was floated last year — and retain 2 percent to 5 percent profit margins for HMO owners.

Tom Watkins, CEO of **Detroit Wayne Mental Health Authority**, asked the $2.4 billion question about the state's effort to change the behavioral health system: "What are we trying to fix?" Administrative costs? Care coordination?

Watkins said several PIHPs have already restructured to cut administrative costs. For example, the Detroit Wayne authority has used efficiency savings the past two years to increase services by $30 million and spend $21 million to give $1-per-hour pay raises to direct-care workers, who are paid slightly above minimum wage.

"We all need to be more efficient," Watkins said. "If we go looking for savings, but we let HMOs take profits and not invest savings in services, I just don't think we have done anything except give money to the health plans. I just believe public money should be reinvested in public good."

But to accomplish change without disruption of services, Murdock said, the health plans have to work with community mental health providers to maintain continuity of care for patients.

"There already are access issues" with the current system, Murdock said. "We need to find additional providers and find more resources."

Medicaid plans already have difficulty finding enough psychiatrists to conduct mild to moderate counseling for which they are currently responsible, said Robert Sheehan, CEO of the **Michigan Association of Community Mental Health Boards**.

"If they can't get an appointment, they call us and we see them," Sheehan said. "If we don't treat the person now, it is inhumane."

While Sheehan believes funding needs to remain separate, he said reforms can improve the current Medicaid mental health system.

"Decisions we make on how dollars are spent have to be based on taking care of the most vulnerable population in Medicaid" — those with behavioral health and developmental disability problems, Sheehan said.

But Sheehan said he is not tied to the current management structure of using prepaid inpatient health plans as the vehicle to manage state funds at the regional level.

"We could have a single PIHP — the state could be it. There could be (fewer) public PIHPs (than the current 10 now)," he said. "The key is not letting go of public" mental health oversight.

Sheehan also said he wouldn't tamper with the behavioral health provider network. "It is very robust and comprehensive," he said. "They do so much more than what they are paid for."

But Jon Cotton, president and COO of **Meridian Health Plan of Michigan**, said PIHPs have had enough time to prove they can be effective and coordinate care.

Jon Cotton: PIHPs' "time has passed."

"Their time has passed. Medicaid health plans should take over that role," he said. "It's like comparing a bicycle to a Ferrari. You both go from A to B, but the ride is different."

Cotton said health plans have the capital to invest in more services and the infrastructure to coordinate care but in a much more cost-effective manner. He also said he looks forward to working with mental health providers.

"They are incredibly valuable assets for managing behavioral health," he said. "We could work with them in a number of ways."

For example, Meridian would contract with mental health networks the same way it does with its existing hospitals, medical groups and pharmacies, he said.

"We need everything done under one roof: medical, behavioral, social," he said.

The timetable question

Despite Snyder's original proposal to start integrating funds and services in 2017, Murdock said he supports a slower rollout over two to five years.

"We need to identify a plan, identify first steps, use existing systems, work collaboratively, and through the process bring things together," he said.

However, Willie Brooks, executive director of the **Oakland County Mental Health Authority**, said he favors a reform plan that puts people — not HMOs and profits — first. PIHPs are required to redistribute excess dollars within their operations, he said, not to owners or shareholders.

"It also is important that the system we have is driven by outcomes and not profitability," said Brooks, who believes for-profit health plans, many of which are based out of state, have different goals than public mental health providers.

Cotton disagrees. He said one of the weaknesses of the PIHPs is that they are public organizations.

"They don't want to hear that. When you put someone (HMO) at (financial) risk, you have someone saying they are willing to invest in information technology and hiring people to get the job done," he said. "We were at their level maybe 15 years ago. We have much higher standards (than PIHPs) and where we were before."

But combining physical and behavioral health under one delivery system is inherently dangerous, Brooks said.

"It is imperative we have a separate funding system for people we serve," Brooks said. "They are already devalued, unnoticed by society. If you commingle dollars, the majority of dollars will go to other areas — to physical health care and profits itself. We want to make sure all the dollars remain in the system."

A careful approach, said Kevin Fischer, CEO of the **National Alliance on Mental Illness of Michigan**, is to first work to improve the current public mental health system.

"There is room for improvement and efficiencies, but the implication that the mental health system is broken in Michigan is not true," Fischer said. "We can build something better. HMOs talk about integration, but the physical health system is not even ready for it."