

Comments on Mental Health Commission Work Group Reports

Michigan Association of Community Mental Health Boards — August 4, 2004

The Michigan Association of CMH Boards offers the following comments on the issues raised in the July 26, 2004 Mental Health Commission work group reports.

I. Education, Rights, Outreach and Advocacy.

Stigma. We commend the work group for addressing the issue of stigma which prevents individuals from seeking treatment and which results in fear, discrimination and mistreatment of persons with mental illnesses. We support the formation of an independent organization to address the issue of stigma and provide ongoing public information regarding mental illnesses.

Parity. We congratulate the Commission for the attention it has paid to the issue of mental health parity, for including both mental health and addictive disorders and for its support of pending state legislation which requires all insurers to offer coverage for the treatment of mental illnesses and addictive disorders that is equivalent to the coverage for other illnesses. We urge that the Mental Health Commission report make the strongest statement possible in support of mental health parity and the legislation which is pending.

Rights Protection. Consumers of public mental health services are entitled to the rights and privileges extended in federal, state and local statutes and rules. In addition, consumers and their families are guaranteed additional rights and protections by Michigan's Mental Health Code. CMHSPs strongly support the rights protection provision of the MH Code and are committed to rights protection and advocacy for all consumers. The MH Code places responsibility with local rights offices to ensure the protection of rights of consumers through advocacy, prevention, education and training, monitoring and complaint resolution. The current mandate for local rights programs was established in statute when the Code was enacted in 1974. They were designed as internal rights protection systems which would enable each program to more easily identify and address problems within their organizations. Local rights officers were protected from pressure from clinical and administrative systems within the CMHSP organization by requirements that they report directly to the CMH executive director. An internal rights protection capacity is also a requirement of national accreditation agencies and mandated by the Balanced Budget Act. We do not support the suggestion that these local rights offices be turned into local or regional offices staffed by and responsible to the state rights office.

Instead, we suggest an outcomes-based approach to rights protection in which the CMHSP rights offices engender an agency-wide vision and consciousness for consumer rights, empowerment and advocacy. Rights protection activities would be delivered in the four essential areas identified in the Mental Health Code – prevention, education, monitoring, and complaint resolution. Specific outcomes would be required of the local rights office including:

- A. Establish a minimum standard for ongoing prevention consultation contacts per quarter.
- B. Establish a minimum standard for rights related education and training activities.
- C. Ongoing, timely monitoring including the review of incident reports, sentinel events, agency policy reviews, review of reports from accrediting organizations, rights protection in contract language, site visits made and other data report reviews, and input on clinical committees where rights matters are an issue.
- D. Complaint resolution with an established high and low threshold, along with the identification and communication to the CMHSP of problem areas and trends.
- E. Regular input, involvement and inclusion of the CMHSP's senior administrative and clinical management team.
- F. In compliance with local CMHSP ethics policies, the ORR shall openly identify any conflict of interest issues related to rights protection activities. These conflicts would be resolved so that the ability to provide rights protection is not compromised. Documentation of identified conflict of interest issues would become a routine expectation in all matters of rights protection.
- G. If within a prescribed time period, a CMHSP ORR fails to meet established outcomes, the state would be empowered to take corrective action and, in extreme cases of system failure, direct DCH operation of the local rights program.

This outcomes-based approach to improving the state and local rights protection would create more specific performance objectives for local rights programs while retaining the benefits of the internal rights protection system. The state would establish performance standards for CMHSP rights programs in consultation with consumers, advocacy groups, families and providers. Corrective action plans would be required for any CMHSP ORR programs that do not achieve desired outcomes with additional sanctions for failure to correct deficiencies identified. Technical assistance would be made available to CMHSP rights programs to assist in achieving performance outcomes. We do not support the state rights office becoming an agency independent of DCH. The state Office of Recipient Rights should continue to report to the DCH director. We request that the Commission consider this outcome-based approach as an alternative to the work group suggestions.

Evidence-Based Practices. We support the emphasis on evidence-based practices and the work group suggestion that the state develop uniform methodologies and programs for monitoring the use of evidence-based practices. Much work has already been done by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and

others to identify and encourage approaches to treatment which have been tested and determined to be effective. DCH has developed a group — the Quality Improvement Council — comprised of consumers, advocates, providers and departmental staff which is reviewing ways of evaluating program outcomes and service quality. We object to these functions being transferred to the state rights office as the work group suggests. There are other, more appropriate locations within the department already working on these areas and doing so effectively.

Third Party Contractual Beneficiaries. We object to the work group suggestion that all DCH/CMHSP/provider contracts designate both Medicaid and non Medicaid applicants and recipients of services to be third party contractual beneficiaries. The unprecedented action of adding third party beneficiaries would complicate the ability of CMHSPs to carry out their contractual responsibilities. It would encourage costly and time consuming litigation and settlements and not improve system performance or quality of care. The Medicaid fair hearings process ensures the rights of Medicaid beneficiaries and we support improvements in the grievance and appeals process for non Medicaid consumers. Ensuring that existing rights systems are effective is the preferable approach.

Fair Hearings for non-Medicaid Population. We support a grievance and appeals process for consumers who are not Medicaid eligible and served by CMHSPs out of their GF budgets. CMHSPs have been working with DCH on such a process as part of contract negotiations. We have no objection to improving information collected or standardization of current forms, handouts, brochures, booklets and other materials made available to consumers and families regarding their rights and available programs.

Advance Psychiatric Directives. We support the work group suggestion that the use of advance psychiatric directives be promoted consistent with primary health care precedents.

II. Services and Supports for Children and Families.

We support the observations and conclusions of this work group regarding the issues affecting services to children and families. Their report identifies a significant under funding of children's services, lack of a comprehensive system of care for children's mental health services, and inconsistent use of best practices and standards of care as the major problem areas affecting the organization and delivery of services to children and families. We agree.

MACMHB has a standing committee which focuses on children's mental health issues. Many of our committee observations support the recommendations of the MHC work group on services and supports for children and families. We know that the needs of multi system involved children cannot be adequately addressed by agencies or organizations acting independently or by systems of care which are fragmented. We know that collaboration and blended/braided funding at the local level is the best

approach to serving multi system children. Our current funding streams and mechanisms, however, are far too fragmented and categorical. The state must partner with communities to enhance flexibility in ways which allow local systems of care to bring their dollars to the table as well as to increase the financing available.

CMH capitation rates were developed based on historical utilization patterns. Because, historically, many children served in foster care, child welfare and juvenile justice systems with specialty mental health needs were served outside the public mental health system, funding to support their care is not included in CMH capitation rates. This under funding further highlights the need for flexibility so that all local systems of care serving children can bring their dollars to the table to address the needs of multi system kids.

Our committee has also noted that with the emphasis on specialty care for multi system children, there is a severe shortage of basic mental health services for some children. We note that the work group suggestion that alternatives to the current 20 visit outpatient benefit for children enrolled in qualified health plans (QHPs) be explored. While we support this suggestion, it does not address the basic care needs of a group of children who are not enrolled in QHPs, primarily foster care/adopted children. They are not covered by the 20 outpatient benefit and they frequently have multiple needs. These children must get their basic (mild/moderate) mental health needs met by community psychiatrists who will accept Medicaid fee for service payments. Problems with unrealistically low fees and too few child psychiatrists make basic care for this group non-existent. Payment for basic care for foster care/adoption children often falls to FIA, the courts, or CMHSPs even though these children technically have Medicaid coverage. This is a huge gap in the continuum of care and must be addressed for children in foster care or adoption placements.

Another issue not addressed is the under funding of the MI Child program. CMHSPs receive approximately \$3.80 per child per month to provide mental health needs. Of this amount, 30% is state match to draw down the federal payment and is already in the CMH GF budget. CMHSPs are serving children enrolled in the MI Child program with GF or local dollars at an alarmingly high rate. One CMHSP is projecting that over 60% of the cost of serving MI Child consumers in their county is coming out of their general fund budget. Additional federal SCHIP funding is needed to support mental health services for these children.

Our Association strongly supports a long term commitment to prevention as essential to improving our system of care for children and families. We support retaining local responsibility and accountability in delivering public mental health services to children. Local systems of care hold the best hope for achieving the local collaboration which is essential for effective treatment. We look forward to continuing to work with the department and MHC to address barriers to services for children and families.

III. **Services and Supports for Adults.**

Quality Oversight. We seek clarification of the work group suggestion that there is a need for oversight in the area of quality. There is already a state organized Quality Improvement Council. Quality improvement standards are an integral piece of the accreditation process. Most CMHSPs and many contract agencies are accredited by external accrediting organizations; the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF) being the most widely used. In addition to accreditation requirements, DCH has its own standards for quality improvement programs which are required of all CMHSPs. The Balanced Budget Act also contains quality improvement program standards. As such, we are not convinced that the additional group (MH Committee) suggested in the work group discussion will add a great deal in this area.

Eligibility for Safety Net Services. At least one CMHSP has developed and aired a local message regarding the availability of safety net services in their community. It has been useful in clarifying what consumers should expect in the way of access to safety net services. This becomes complicated as a state-wide strategy as the availability of safety net services will vary from community to community based on available resources and local need. In general, we support such a communication plan and are willing to work with DCH in planning these activities.

Medication Guidelines. There seem to be existing mechanisms including existing medication protocols which would assist in meeting the suggestions of the work group in this area.

Recovery. We support the work group emphasis on recovery. A state-wide definition of recovery along with information on models which have been adopted in other states would be helpful. Development of outcomes related to recovery and perhaps recovery related practice guidelines would be useful as well.

Information Technology. We support the work group suggestions regarding the use of information technology to gain service integration and improve continuity of care.

Housing. While safe, affordable housing is essential for consumers of mental health services, solutions to the housing shortage involve a broader community than just the mental health system. This set of suggestions should include collaboration with the federal Department of Housing and Urban Development, the Michigan State Housing Development Authority, local housing authorities, the homeless services network and others.

Supported Employment. We support the suggestions of the work group that supported employment and supported education are essential components of the recovery model.

Integration of MH and Primary Care. We support the integration of MH and primary care while preserving the current carve-out of Medicaid specialty services. We agree

with the work group link between this integration and early detection and intervention. We further agree that the federally qualified health center (FQHC) model should be expanded including co-location of FQHC and CMH staff in clinics of both systems. There are several pilot projects in Michigan which bring CMH and FQHC staff together in integrated treatment settings. These pilots should be encouraged and expanded. We also agree with the work group observation that communication between agencies and programs serving children and adults in the community is essential.

Education and Training. We agree with the work group that there is an overall lack of consistency in education and training among providers, consumers, family members and staff. The web-based training infrastructure suggestion is also a good one. This would standardize training curriculum and provide easy access locally. These efforts could be a project of the Mental Health Institute which is being supported by our Association. It should also be coordinated with other organizations which have made commitments to training and education such as the Michigan Association of CMH Boards.

Definition of Serious Mental Illness. We support uniform access to care for persons with serious mental illnesses. We don't think that merely defining serious mental illness will guarantee uniform access or promote a "no wrong door" approach state wide. Access to care for persons with serious mental illness is bound to vary somewhat because of different levels of state and local resources and the local need/demand for services. Therefore, we recommend a two part plan of action. As a goal we strongly support equal access to care either through a definition of serious mental illness or through the establishment of eligibility criteria. To get there, we recommend increases in state (GF) funding with the new resources distributed to move toward funding equity. We also need the ability to stretch our existing GF by extending Medicaid eligibility to populations now served by the CMH GF budget. MACMHB offered extensive input on this issue in previous written and oral testimony. While new GF may be hard to come by, we should not let GF currently in the mental health budget be removed when the Medicaid match percentage changes, when Medicaid eligibility declines, or for any other reason.

IV. **Criminal Justice and Human Services Interface.**

Prevention and Early Intervention. We support the suggestions of the work group to improve primary prevention and early intervention to address mental health issues before they result in an encounter with the criminal justice system. We also agree that identification of appropriate screening and assessment tools, the training of first responders and joint training efforts between CMH and other parties are important to improving the interface between the mental health and criminal justice systems.

Pre-Entry. We also support work group suggestions that real and measurable pre and post booking diversion programs, for adults and children, exist on a state wide basis. We further agree that these programs should identify potential decision points for diversion and contain formal evaluation mechanisms. We are unclear what is meant by "publicly

run secure facilities other than jails.” We are interested in more information regarding such facilities prior to finalizing our comments. While we strongly support the current Mental Health Code requirements for jail diversion programs and the further suggestions of the work group, we know that full implementation of the recommendations will require either new funding or incentives which will encourage the redirection of existing dollars to jail service and diversion activities. We want to work with the department and the MHC in implementing these recommendations so that individuals are served in the mental health system and not in prisons and jails.

Detention/Incarceration. While CMHSPs provide some level of services to individuals with mental health needs in county jails, we support work group observations that screening and assessment at the point of entry and treatment services be improved. We further support development and use of best practice models in collaboration with other federal, state and local partners and establishment of formal mechanisms for evaluation and monitoring of jail services and diversion programs.

Pre-Release Planning. We support work group recommendations that pre-release planning activities begin at intake. The work group observes, especially for children and adolescents, that pre-release and community reintegration planning should include not just mental health but other related needs and systems. We agree. We commend the work group for its observations and recommendations on these interface issues. We are committed to working with the department and MHC on implementing these suggestions.

V. **Governance, Structure, Finance and Accountability.**

Structure and Governance. The work group suggests consolidation of the current 46 CMHSPs into 18 regional authorities but it does not show how this consolidation addresses the major system problems it identifies — variation in funding levels, inefficiency, lack of accountability, and variation in access and quality of care. While we do not support this recommendation, we agree that the public mental health system could be improved by greater efficiency, improved mechanisms to ensure accountability, and more standardization of access and funding across the state. These should be achieved by continuing to refine the existing clinical and administrative performance standards which could include objectives for access, administrative cost, standardization of process/procedures and data collection. An outcomes-based approach such as this would maintain the beneficial aspects of local control while improving service delivery, reducing administrative costs and working toward other aspects of system change in the areas identified by the work group. DCH should continue the work of its Quality Improvement Council (made up of consumers, family members, MACMHB and other provider and advocacy groups) which has made progress in clarifying eligibility criteria, data collection and reporting responsibilities and mandated and optional safety net services. The development of uniform standards for determining administrative costs and establishment of PIHP, CMHSP and provider administrative cost targets would also improve system efficiency.

The structure and governance of the public mental health system as defined in the Mental Health Code provides for local control primarily through county appointment of local CMHSP boards of directors, consumer and family representation on CMH boards and through the CMHSP's status as a governmental entity complying with open meetings and freedom of information requirements. Our state has selected this model as have numerous other states. CMS has three times approved Medicaid waivers which included CMHSP/PIHP management of the Medicaid specialty services benefit. Over the life of these waivers, CMS has raised some of the issues identified by the work group. This concern was directly responsible for CMS requiring regional affiliations in areas not having a minimum of 20,000 Medicaid enrollees and for the current 18 PIHP specialty services structure. These single and multiple county CMHSPs are producing economies of scale and consolidation of functions. The regional structure has been important in ensuring that PIHPs are able to meet the increasingly rigorous federal statutory and regulatory requirements and expanded risk management demands. This structure should be evaluated in depth prior to engaging in one more round of fundamental change with the accompanying disruption which would be inevitable. The outcome-based approach to system change described here would maintain the benefits of the locally accountable system of care while moving the system toward agreed upon objectives. We recommend this approach. Where there is local interest in mergers or other strategies to enhance efficiencies or system performance, DCH should support that interest with technical assistance.

Funding. We support the work group suggestion that the state investigate waiver options with the goal of providing the greatest flexibility in benefits and covered populations and the least risk of losing current and future state and federal funding. We suggest that the recommendation include specific mention of the 1115 waiver possibility as well as the Ticket to Work and Work Incentives Act and the medical improvement option as choices for consideration. We also support, as part of a long term strategy, to pursue additional state GF appropriations for mental health services and new dedicated funds through special fees and assessments. As DCH improves its ability to measure the quality of outcomes and compliance with applicable standards and policies, it should move toward financial incentives or greater flexibility for CMHSPs who are meeting DCH outcomes.

Prevention. We commend the work group for recognizing the essential nature of prevention and early intervention activities. The work group commentary notes that these have been underfunded in the past. We agree and urge support for making funding for prevention and early intervention a priority. We also support the work group suggestion that EPSDT be fully implemented.

Parity. We congratulate the work group for the attention it has paid to the issue of mental health parity and for its support of pending state legislation which requires all insurers to offer coverage for the treatment of mental illnesses that is equivalent to coverage for all other disorders. We encourage that the final MHC report include the strongest statement possible in support of mental health parity and the legislation which is pending.

Other Comments and Recommendations.

1. **Support for a stronger DCH.** Because of early retirement opportunities and countless reorganizations, the capacity of the department to perform essential functions has diminished. Additional resources for the Department of Community Health is essential if it is to be a more effective organization and meet the accountability expectations which are expressed in the report of each of the work groups.
2. **Mental Health Institute.** We support the creation of a Mental Health Institute which would foster best practices, disseminate research findings, identify trends in service delivery and administrative practices, and assist other organizations in their training programs.
3. **Consumer involvement.** If advisory groups are formed to follow up on recommendations of the Mental Health Commission, consumers and families should be represented at least at the percentages (1/3) required for consumer and family representation on CMHSP boards of directors in the Mental Health Code.
4. **Shrinking GF Budget.** The shrinking CMH general fund budget is the most serious problem facing the public mental health system. The state should ensure that no GF funding currently supporting mental health services leaves the budget. This includes excess GF which may occur in the future if the number of Medicaid beneficiaries declines or if the federal match percentage increases. This could also include the ability to de-categorize and retain GF serving as Medicaid match if a PIHP is going to lapse Medicaid funding. Expansion of GF funding for CMH services should be a high priority.

The state should ensure that we explore all avenues with CMS, including modification of our existing waivers or seeking new waivers, to gain additional flexibility to extend Medicaid coverage to populations such as MI Child and Adult Benefits Waiver and others populations served by the CMH network that are not currently covered. We should negotiate ways in which Medicaid savings can be appropriately utilized to expand both Medicaid and safety net services to persons with serious mental illnesses. DCH, CMHSPs and other stakeholders should work together to identify administrative costs related to state and federal mandates which can be reduced or eliminated.

Our Association commends the MH Commission for undertaking this difficult and complex task. We appreciate the many hours spent listening, studying and seeking ways to improve Michigan's public mental health system. Thank you for the opportunity to comment.

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