



# Center for Healthcare Integration & Innovation

---

Community Mental Health Association of Michigan

A Tradition of Excellence and Innovation:  
Measuring the Performance of Michigan's  
Public Mental Health System  
May 2020

## A Tradition of Excellence and Innovation: Measuring the Performance of Michigan's Public Mental Health System <sup>1</sup>

May 2020

### Abstract

This white paper examines the performance of Michigan's public mental health system against a number of state-established and national standards.

Michigan's public mental health system, for this paper, is made up of the public Community Mental Health centers (CMHs) linked to county governments, the public Regional Entities/Medicaid Prepaid Inpatient Health Plans (PIHPs) formed and governed by the CMHs, and the private non-profit and for-profit organizations in the CMH and PIHP networks.

This paper draws on a range of national and Michigan studies and data sources in constructing this picture of performance.

**This paper underscores the very high levels of performance that Michigan's public mental health system, in partnership with the Michigan Department of Health and Human Services (MDHHS), has demonstrated, over decades, on a number of dimensions of healthcare quality and innovation.**

This high level of performance was found in an examination of a number of components of the system's operations:

- Longstanding strong performance against the state-established and nationally recognized performance standards
- Nation-leading de-institutionalization
- High rankings against national standards of behavioral health prevalence and access to services
- Proven ability to control costs over decades
- Pursuit of healthcare integration
- Use of evidence-based and promising practices and the infrastructure to support their use

---

<sup>1</sup> When the terms public mental health system and public behavioral health system are used in this report, they refer to the system that serves adults with mental illness, children and adolescents with emotional disturbance, persons with intellectual and developmental disabilities, and persons with substance use disorders.

## **Impetus behind this report**

Michigan's public mental health system is made up of three distinct and interwoven components:

- Public Community Mental Health (CMH) systems, each linked to Michigan's county governments, serving all of Michigan's counties through their roles as providers, network organizers, conveners of a wide range of human service collaborative efforts, advocates for those with mental health needs and the services and supports needed by them, and sources of expertise on a wide range of mental health issues
- Public Medicaid behavioral health plans, formed and governed by the CMHs (known as Prepaid Inpatient Health Plans or Regional Entities) that manage the Medicaid behavioral health benefit through a capitated shared-risk arrangement with the State of Michigan
- Private non-profit and for-profit organizations making up, along with the CMHs themselves, the provider networks of the CMHs and Regional Entities

Throughout its history, Michigan's public mental health system has been an innovator in system design and processes. This system continues to develop a wide range of design and process refinements that are goal- and outcome-oriented, implemented with sound redesign principles and approaches, and based on a clear picture of the current performance of the system.

Over the last several decades, policy makers and elected officials have debated and implemented a range of plans for redesigning Michigan's public mental health system. Unfortunately, some these system redesign proposals have been based on a lack of accurate information on the performance of that system.

**This report has been developed to provide that accurate picture of the system's performance, as a basis for the development of policy, practice, and design changes.**

## Findings and Analysis

The performance of Michigan’s public mental health system is examined, in this report, by drawing together performance data from a variety of existing sources along the following dimensions:

- Performance against state-established performance standards
- Assessing Michigan’s progress on de-institutionalization against national norms
- Performance when compared with national standards of prevalence and access
- Cost control performance – bending the cost curve
- Pursuit of healthcare integration
- Use of evidence-based practices

### A. Performance against state-established performance standards

For the past several decades, Michigan has used a set of performance metrics for its public mental health system, built around standard measures of mental health system performance. This system, the Michigan Mission Based Performance Indicator System (MMBPIS), provides regular quarterly reports, issued by the Michigan Department of Health and Human Services, on a range of key performance measures across all of the populations served by Michigan’s public mental health system: persons with mental illness, intellectual/developmental disabilities, emotional disturbances, and/or substance use disorders.

**Findings:** Below is the performance of the Michigan’s system, for two quarters, one year apart, as samples of the systems performance against the MDHHS-established performance standards.<sup>i</sup>

Table 1: Performance of Michigan’s CMHs and PIHPs against standards of the Michigan Mission Based Performance Indicator System (MMBPIS) July – September 2018 and 2019.

|   |           |      | Standard established by MDHHS | Average of CMH/PIHP performance across the state | Met or exceeded state standard |
|---|-----------|------|-------------------------------|--|--------------------------------|
| Inpatient pre-admission screening timeliness  |           |      | At least                      |  |                                |
| Percentage of Children Receiving a Pre-Admission Screening for Psychiatric Inpatient Care for Whom the Disposition Was Completed Within Three Hours | July-Sept | 2019 | 95%                           | 98.10%   | <b>Yes</b>                     |
|   |           | 2018 | 95%                           | 97.67%   | <b>Yes</b>                     |
| Percentage of Adults Receiving a Pre-Admission Screening for Psychiatric Inpatient Care for Whom the Disposition Was Completed Within Three Hours   | July-Sept | 2019 | 95%                           | 98.01%   | <b>Yes</b>                     |
|   |           | 2018 | 95%                           | 97.99%   | <b>Yes</b>                     |

Face-to-face assessment timeliness

---

|   |           |      |     |        |            |
|---|-----------|------|-----|--------|------------|
| Percentage of New Persons Receiving a Face-to-Face Assessment with a Professional Within 14 Days of a Non-Emergent Request for Service  | July-Sept | 2019 | 95% | 97.45% | <b>Yes</b> |
|   |           | 2018 | 95% | 97.73% | <b>Yes</b> |
| Percentage of New Children with Serious Emotional Disturbance Receiving a Face-to-Face Assessment with a Professional Within 14 Days of a Non-Emergent Request for Service              | July-Sept | 2019 | 95% | 96.73% | <b>Yes</b> |
|   |           | 2018 | 95% | 98.13% | <b>Yes</b> |
| Percentage of New Adults with Mental Illness Receiving a Face-to-Face Assessment with a Professional Within 14 Days of a Non-Emergent Request for Service                               | July-Sept | 2019 | 95% | 98.64% | <b>Yes</b> |
|   |           | 2018 | 95% | 98.37% | <b>Yes</b> |
| Percentage of New Children with Intellectual or Developmental Disabilities Receiving a Face-to-Face Assessment with a Professional Within 14 Days of a Non-Emergent Request for Service | July-Sept | 2019 | 95% | 93.37% | No         |
|   |           | 2018 | 95% | 98.89% | <b>Yes</b> |
| Percentage of New Adults with Intellectual or Developmental Disabilities Receiving a Face-to-Face Assessment with a Professional Within 14 Days of a Non-Emergent Request for Service   | July-Sept | 2019 | 95% | 98.21% | <b>Yes</b> |
|   |           | 2018 | 95% | 96.46% | <b>Yes</b> |
| Percentage of New Persons with Substance Use Disorders Receiving a Face-to-Face Assessment with a Professional Within 14 Days of a Non-Emergent Request for Service                     | July-Sept | 2019 | 95% | 96.21% | <b>Yes</b> |
|   |           | 2018 | 95% | 96.47% | <b>Yes</b> |

On-going services start timeliness

---

|   |           |      |     |        |            |
|---|-----------|------|-----|--------|------------|
| Percentage of New Persons Starting any Needed On-going Service Within 14 Days of a Non-Emergent Assessment with a Professional  | July-Sept | 2019 | 95% | 97.47% | <b>Yes</b> |
|   |           | 2018 | 95% | 96.91% | <b>Yes</b> |
| Percentage of New Children with Serious Emotional Disturbance Starting any Needed On-going Service Within 14 Days of Non-Emergent Assessment with a Professional              | July-Sept | 2019 | 95% | 95.76% | <b>Yes</b> |
|   |           | 2018 | 95% | 96.35% | <b>Yes</b> |
| Percentage of New Adults with Mental Illness Starting any Needed On-going Service Within 14 Days of Non-Emergent Assessment with a Professional                               | July-Sept | 2019 | 95% | 97.14% | <b>Yes</b> |
|   |           | 2018 | 95% | 97.41% | <b>Yes</b> |
| Percentage of New Children with Intellectual or Developmental Disabilities Starting any Needed On-going Service Within 14 Days of Non-Emergent Assessment with a Professional | July-Sept | 2019 | 95% | 97.75% | <b>Yes</b> |
|   |           | 2018 | 95% | 98.10% | <b>Yes</b> |
| Percentage of New Adults with Intellectual or Developmental Disabilities Starting any Needed On-going Service Within 14 Days of Non-Emergent Assessment with a Professional   | July-Sept | 2019 | 95% | 95.27% | <b>Yes</b> |
|   |           | 2018 | 95% | 97.36% | <b>Yes</b> |
| Percentage of New Persons with Substance Use Disorder Starting any Needed On-going Service Within 14 Days of Non-Emergent Assessment with a Professional                      | July-Sept | 2019 | 95% | 96.88% | <b>Yes</b> |
|   |           | 2018 | 95% | 97.88% | <b>Yes</b> |

Follow-up after psychiatric inpatient care or substance use disorder detoxification unit

| Percentage of Children Discharged from a Psychiatric Inpatient Unit Who are Seen for Follow-up Care Within 7 Days                       | July-Sept | 2019 | 95%             | 96.41% | <b>Yes</b> |
|---|-----------|------|-----------------|--------|------------|
|   |           | 2018 | 95%             | 98.74% | <b>Yes</b> |
| Percentage of Adults Discharged from a Psychiatric Inpatient Unit Who are Seen for Follow-up Care Within 7 Days                         | July-Sept | 2019 | 95%             | 96.00% | <b>Yes</b> |
|   |           | 2018 | 95%             | 97.57% | <b>Yes</b> |
| Percentage of Persons Discharged from a Substance Use Disorder Detox Unit Who are B12Seen for Follow-up Care Within 7 Days              | July-Sept | 2019 | 95%             | 97.77% | <b>Yes</b> |
|   |           | 2018 | 95%             | 97.79% | <b>Yes</b> |
| Psychiatric inpatient readmission rate  |           |      | No greater than |        |            |
| Percentage of Children Readmitted to Inpatient Psychiatric Units Within 30 Calendar Days of Discharge From a Psychiatric Inpatient Unit | July-Sept | 2019 | 15%             | 11.71% | <b>Yes</b> |
|   |           | 2018 | 15%             | 8.64%  | <b>Yes</b> |
| Percentage of Adults Readmitted to Inpatient Psychiatric Units Within 30 Calendar Days of Discharge From a Psychiatric Inpatient Unit   | July-Sept | 2019 | 15%             | 11.34% | <b>Yes</b> |
|   |           | 2018 | 15%             | 10.54% | <b>Yes</b> |

Sources:

Michigan Mission Based Performance Indicator System: Medicaid Population: For Persons with Mental Illness, Developmental Disabilities, Emotional Disturbances, and Substance Use Disorders; Performance Indicator Final Report; July 1, 2019 - September 30, 2019;

[https://www.michigan.gov/documents/mdhhs/FY19\\_Q4\\_PIHP\\_FinalReport\\_683534\\_7.pdf](https://www.michigan.gov/documents/mdhhs/FY19_Q4_PIHP_FinalReport_683534_7.pdf)

Michigan Mission Based Performance Indicator System: Medicaid Population: For Persons with Mental Illness, Developmental Disabilities, Emotional Disturbances, and Substance Use Disorders; Performance Indicator Final Report; July 1, 2018 - September 30, 2018:

[https://www.michigan.gov/documents/mdhhs/PIHP\\_FinalReport\\_Q4\\_FY18\\_648501\\_7.pdf](https://www.michigan.gov/documents/mdhhs/PIHP_FinalReport_Q4_FY18_648501_7.pdf)

**Analysis:** A review of the thirty-eight (38) data points, across the quarter examined during the two most recent fiscal years, indicated that **Michigan’s public mental health system met or exceeded the state-established standards for thirty-seven (37) of the thirty-eight (38) standards measured.** For the one standard not met or exceeded, the system was below the state standard by 1.63% from the 95% standard. This high level of performance, as outlined above, has been consistent across these measures for years.

## B. Assessing Michigan’s progress on de-institutionalization against national norms

---

Since the 1970s, states and advanced community-based mental health systems, akin to Michigan’s system, have moved in bold ways, as part of the deinstitutionalization movement, by applying a wide range of evidence-based practices to serving persons with serious mental illness in their home communities. As a result, the use of state psychiatric hospitals as the central approach to treating mental illness has declined dramatically.

However, states differ significantly in their approach to mental illness and the de-institutionalization movement. The depth and breadth of their community-based mental health resources to serve persons with serious mental illness vary as well. The use of state psychiatric hospitals, on a per capita basis, is a sound measure of the success of a state and its local and regional mental health provider community to use community-based approaches to serve their citizens with mental illness as an alternative to inpatient psychiatric care.

**Findings:** Michigan’s progress in the deinstitutionalization movement can be best determined by examining the number of persons served in the state’s psychiatric hospitals per every 100,000 persons in the population. That comparison is provided in the table below.

Table 2: The comparison of Michigan’s use of state psychiatric facilities compared with the use of psychiatric hospitals by the rest of the United States, 2018

|  | Michigan  | United States other than Michigan |
|--|-----------|-----------------------------------|
| Number of persons in state psychiatric hospitals                               | 235       | 129,065                           |
| Population   | 9,906,857 | 319,528,722                       |
| Number of persons in state psychiatric hospitals per 100,000 persons in census | 2.37      | 40.39                             |

Source: National Outcome Measures System, a part of the Uniform Reporting System, Substance Abuse and Mental Health Services Administration (SAMHSA)  
<https://www.dasis.samhsa.gov/dasis2/urs.htm> <sup>ii</sup>

**Analysis:** The contrast between Michigan’s use of state psychiatric hospitals (2.37 persons served in state psychiatric hospitals per 100,000 Michigan residents) to the average use of state psychiatric hospitals by the rest of the country (40.39 persons served in state psychiatric hospitals per 100,000 residents in the rest of the country) is stark. **The use of state psychiatric beds, by the rest of the country is 17 times higher per capita than that of Michigan.** Michigan’s use of state psychiatric hospitals - far less than the average of the rest of the country – is **a testimony to its continual commitment to deinstitutionalization and the development of a comprehensive community-based system of care, the state’s public mental health system.**

**Supplementary economic analysis:** The economic impact of Michigan’s success in using community-based services in supports rather than state psychiatric hospitals is significant.

If the dollars currently spent by Michigan’s community-based public mental system \$3.469 billion, were spent solely on the provision of traditionally long-term inpatient care at the state’s psychiatric hospital and developmental disability centers, those dollars would serve 9,500 persons per year. In contrast, those dollars, used to fund community-based services and supports, as they are now used, allows the public system to serve over 350,000 persons per year. (Source: Michigan Department of Health and Human FY 2020 Appropriations;

<http://legislature.mi.gov/documents/publications/AppropriationBillsPassed/2019/2019-mpla-0139-Health%20and%20Human%20Services.pdf> )<sup>iii</sup>

The impact of this transition is impressive. Michigan’s use of sound community based mental health approaches allows Michigan’s public system to meet the mental health needs of **37 times more Michiganders**, than would be served if those same dollars were used to provide long term inpatient care in the state’s psychiatric hospitals and developmental disability centers.

### C. Performance when compared to national standards of prevalence and access

---

The national advocacy and research group, Mental Health America regularly ranks the nation’s states relative to the prevalence and access to mental health services. These rankings are seen, by many observers, as **one of the best measures of each state’s efforts to prevent and treat the mental health needs of their residents**. The most recent report from Mental Health America is The State of Mental Health in America 2020.

The Mental Health America study provides a picture of the performance of each state’s public mental health system, its coverage of its residents by Medicaid and other insurance coverages, and its enforcement of insurance parity laws. The measures used by Mental Health America, for its 2020 study, include:

- Adults with Any Mental Illness (AMI)
- Adults with Substance Use Disorder in the Past Year
- Adults with Serious Thoughts of Suicide
- Youth with At Least One Major Depressive Episode (MDE) in the Past Year
- Youth with Substance Use Disorder in the Past Year
- Youth with Severe MDE, Adults with AMI who Did Not Receive Treatment
- Adults with AMI Reporting Unmet Need
- Adults with AMI who are Uninsured
- Adults with Disability who Could Not See a Doctor Due to Costs
- Youth with MDE who Did Not Receive Mental Health Services
- Youth with Severe MDE who Received Some Consistent Treatment
- Children with Private Insurance that Did Not Cover Mental or Emotional Problems
- Students Identified with Emotional Disturbance for an Individualized Education Program
- Mental Health Workforce Availability <sup>iv</sup>

**Findings:** Michigan’s rankings in The State of Mental Health in America 2020 are provided below:

Table 3: National ranking of Michigan’s mental health prevalence and access to mental health care relative to all 50 states and District of Columbia, Mental Health America, 2020

| Ranking category           | Michigan’s rank relative to 50 states and District of Columbia |
|----------------------------|--|
| Overall ranking (all ages) | 17   |
| Adults                     | 6  |
| Children and Youth         | 20   |
| Access to care (all ages)  | 15   |

Source: The State of Mental Health in America 2020; Mental Health America;  
<https://mhanational.org/issues/state-mental-health-america>

**Analysis:** The rankings of Mental Health America – with Michigan in the top third in the country across all of the rankings and underscore the strength of Michigan’s mental health prevention and treatment delivery system.

## **D. Cost control performance – bending the cost curve**

---

Since 1997, Michigan’s public specialty managed care system managed the Medicaid mental health and intellectual disability benefit, and eventually the substance use disorder benefit, for four distinct groups: adults with mental illness; children and adolescents with emotional disturbance; children, adolescents, and adults with intellectual and developmental disabilities; and children, adolescents, and adults with substance use disorders.

In 1997, Michigan’s Community Mental Health centers (CMH) became the risk-based managed care organizations for the state’s Medicaid behavioral health benefit. Under two concurrent federal Medicaid waivers (1915( b ) and ( c )) the state of Michigan developed shared risk contracts with the state’s CMHs. Those managed care contracts were held, for the first seventeen (17) years, from 1997 through 2014, by CMHs. In 2014, continuing through the present, the contracts are held by public Regional Entities formed and governed by the CMHs. These Regional Entities are known in federal parlance as the state’s Prepaid Inpatient Health Plans (PIHPs).

Two factors underscore the wisdom of using the public county-based CMH system as the managed care and provider system backbone for the state’s specialty Medicaid program:

- By linking the managed care responsibilities for state’s Medicaid behavioral health dollars to the state’s public mental health system, the chief financing source for the public mental health system was linked to the public system that holds the statutory responsibility to serve as the state’s behavioral health and intellectual/developmental disability services and supports safety net.

To have severed this connection would have left the statutorily defined safety net without control over nor unhindered access to the funds needed to fulfill this safety net role. Given that Medicaid makes up over 90% of the revenues that support the public mental health system in Michigan, such a severing of the connection between these funds and the safety net role would have left the 325,000 vulnerable persons and communities across the state, served by this system, without the resources needed to assure access to those services.

- The expertise of Michigan’s public mental health system in serving persons with complex needs that spanned a wide range of health and human sectors (from psychiatry to housing supports, from peer-delivered services to inpatient psychiatry, from respite care to assertive community treatment, from homebased care to employment supports), far outside of the expertise of traditional managed care arrangements, was seen as a vital asset in the ability to manage the Medicaid benefit.

In 2017, the Community Mental Health Association of Michigan’s Center for Healthcare Integration and Innovation (CHI2), carried out a study of the performance of Michigan’s public mental health system relative to controlling Medicaid behavioral health costs, “Bending the Cost Curve Bending the Healthcare Cost Curve: The success of Michigan’s public mental health system in achieving sustainable healthcare cost control”.

Source: “Bending the Cost Curve Bending the Healthcare Cost Curve: The success of Michigan’s public mental health system in achieving sustainable healthcare cost control”; Center for Healthcare Integration

and Innovation (CHI2); March 2017 <https://cmham.org/wp-content/uploads/2019/03/CHI2-bending-the-cost-curve-final.pdf>

This study was built upon the emergence, over the past decade, of the triple aim <sup>2</sup> as a core set of concepts for driving healthcare reform and transformation, providing the impetus for this study.<sup>vi</sup> Nearly all of the leaders, observers, and critics of this country's health care system use the triple aim's constructs of improving population health, enhancing the patient's/consumer's experience of care, and controlling the per capita cost of care to measure the performance of the system, as a whole, and any segment of that system.

Given this centrality of the triple aim to measuring the success of any healthcare design or transformation effort and with nearly two decades of experience, by Michigan's public behavioral health and intellectual/developmental disability system operating a public specialty managed care system, CMHA's CHI2 identified the need to examine the performance of the state's public mental health system along the third dimension of the triple aim – the control of per member costs.

**Findings:** This study, "Bending the Cost Curve Bending the Healthcare Cost Curve: The success of Michigan's public mental health system in achieving sustainable healthcare cost control" examined the increases seen in the per enrollee per month (PEPM) costs of the state's Medicaid mental health system under the management of the public system, over a twenty-year span, and compared those increases to:

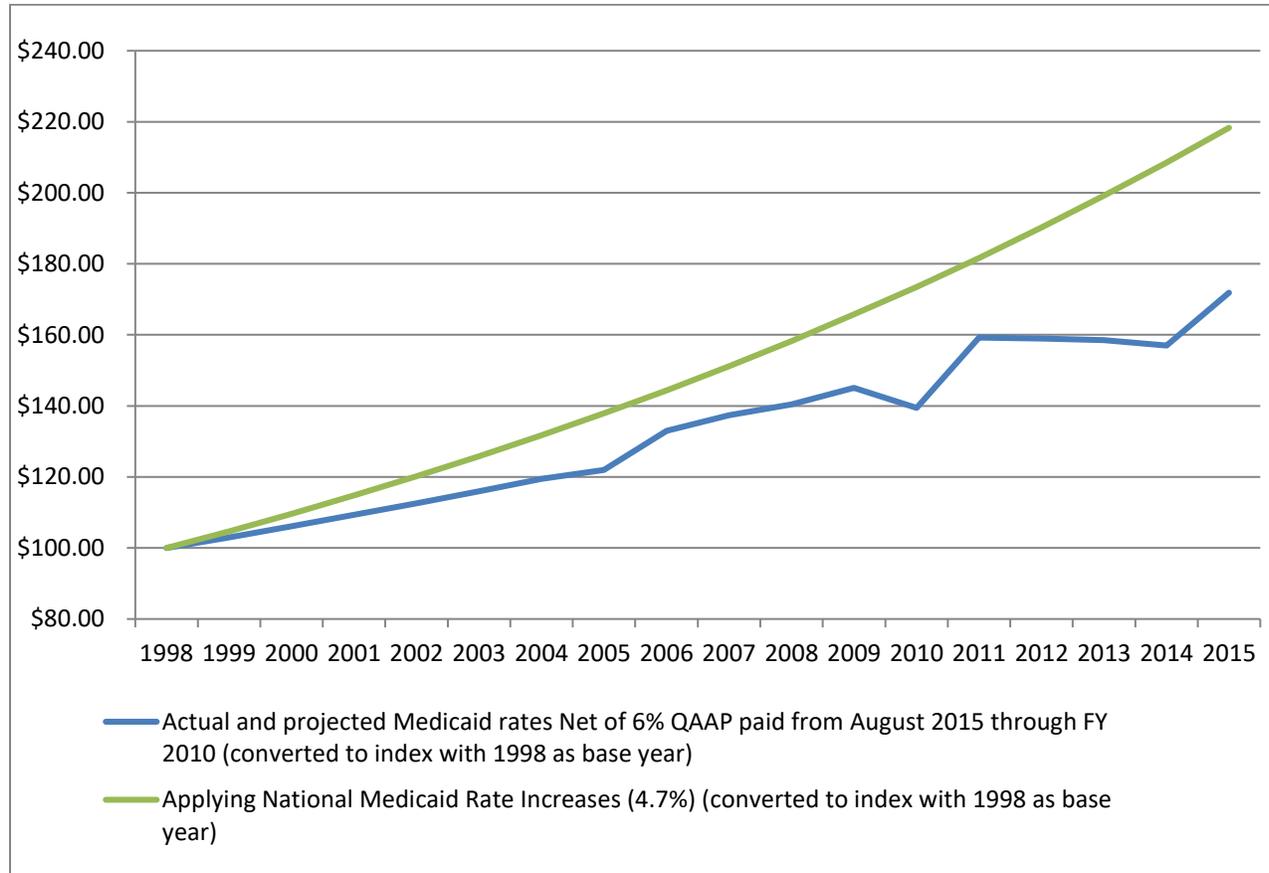
- National Medicaid per enrollee per month increases
- National commercial insurance per enrollee per month increases

---

<sup>2</sup> The triple aim, in many circles, has expanded to the quintuple aim, with the addition of healthcare workforce satisfaction/health and health equity as the fourth and fifth aims.

**Against national Medicaid per enrollee rate increases:** The cost control performance of Michigan’s public behavioral health and intellectual and developmental disability services system, as the state’s Medicaid Specialty Managed Care System, against national Medicaid rate increases, as determined via comparison of those two growth rates over the period of 1998 through 2015. These comparative growth rates are outlined in the graph and tabular analysis below.

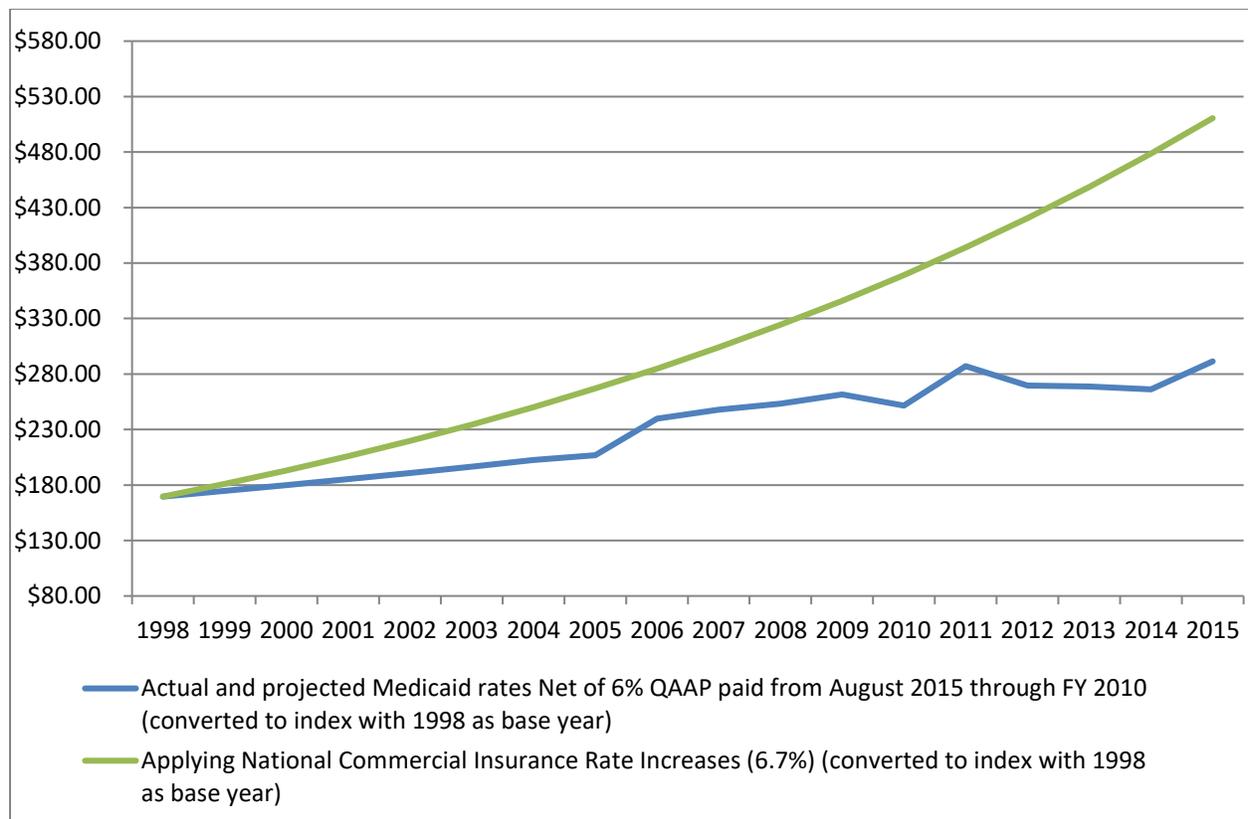
Graph 1: Comparison of Michigan Specialty (behavioral health and intellectual and developmental disability services) Medicaid rate increase (per enrollee per month) with those of average national Medicaid rate increases – as index with 1998 as base year at 100.



|   | Michigan public mental health system per enrollee rates | National Medicaid per enrollee rates |
|---|---|--------------------------------------|
| Cumulative increase from 1998 through 2015:         | 71.88%  | 118.32%                              |
| Cumulative savings from 1998 through 2015:          | \$ 5,273,089,686  |                                      |
| If this eighteen-year trend continued through 2024: | \$ 12,737,764,999                                       |                                      |

**Against national commercial insurance rate increases:** The cost control performance of Michigan’s public behavioral health and intellectual and developmental disability services system, as the state’s Medicaid Specialty Managed Care System, against national Medicaid rate increases, as determined via comparison of those two growth rates over the period of 1998 through 2015. These comparative growth rates are outlined in the graph and tabular analysis below.

Graph 2: Comparison of Michigan Specialty (behavioral health and intellectual and developmental disability services) Medicaid rate increase (per enrollee per month) with those of average commercial health insurance rate increases – as index with 1998 as base year at 100.



|   | Michigan public mental health system per enrollee rates | National Commercial Insurance per enrollee rates |
|---|---|--|
| Cumulative increase from 1998 through 2015:         | 71.88%  | 201.16%  |
| Cumulative savings from 1998 through 2015:          | \$ 13,992,156,174                                       |  |
| If this eighteen-year trend continued through 2024: | \$ 35,949,101,168                                       |  |

**Analysis:** This study was designed to measure the cost control performance of Michigan’s public mental health. This study found very significant cost savings when compared with the per enrollee cost increases seen in both the Medicaid program and commercial across the country.

**Comparison with Medicaid rate increases across the country:** Over the years of the study, the per enrollee cost/rate increases of the behavioral healthcare benefit managed by Michigan’s public mental health system (71.88%) was significantly below the cost/rate increases seen in Medicaid per enrollee costs/rates across the country (118.32%). **This difference represents a savings of over \$5 billion dollars during those years and a savings of over \$12 billion when extrapolated through 2024.**

**Comparison with commercial insurance rate increases across the country:** Over the years of the study, the per enrollee cost/rate increases of the behavioral healthcare benefit managed by Michigan’s public mental health system (71.88%) was significantly below the cost/rate increases seen in the commercial insurance per enrollee costs/rates across the country (201.16%). **This difference represents a savings of over \$13 billion dollars during those years and a savings of over \$35 billion when extrapolated through 2024.**

The success of the public system’s ability to manage the state’s Medicaid behavioral healthcare benefit and to bend the cost curve is clearly underscored through this comparative analysis.

**Discussion of methods used to control costs:** While no attempt was made to determine the variables that led to this success, **some variables, not typically seen in other managed care systems, appear to be related to the system’s ability to sustain cost control over nearly two decades.** These factors include:

**1. Active management of comprehensive and closely aligned service and support provider networks and central community convener role:** The public mental health system has a very long history, since the 1960s in nearly all of Michigan communities, of operating a comprehensive, tightly managed and interwoven provider network. In communities across the state, whether the CMH serves as a core provider, purchaser of services, or both, the county-based public CMH designs, organizes, pays, evaluates, and refines the services and supports network while also holding the role of convener of community efforts to address a range of health and human services needs. Both of these traits – active management of the service network and close ties to the community – allow Michigan’s public mental health system to align the work of its provider network and that of other community partners to addressing mental health and related needs.

**2. Guided by whole person orientation, impact of social determinants of health, and a person-centered planning approach.** A whole person orientation, with person-centered planning at its core (as required by Michigan statute), the public mental health system develops its services around cost effective methods that are community-based, non-traditional and focus on a wide range of social determinants of health. These approaches, long utilized in Michigan’s public mental health system, are being applied, in ever greater frequency, by healthcare providers and care managers in other sectors of health care.

**3. High medical loss ratios (high level of funds spent on services - low overhead/administrative costs):** Low administrative costs and no profits drawn out of the system allow for 94% of the funds received by the public mental health system to be used to provide services in the year in which the funds were received or in future years. **This 94%, the system's medical loss ratio, is far below that of traditional private health plans – ratios that hover around 85% - underscoring the commitment by the public system to ensure that as many of the Medicaid dollars that it manages, as possible, are used for services and supports to the Medicaid beneficiaries who rely upon this system.**

**4. Impact of whole person orientation and healthcare integration efforts:** The recent work of the public mental health system to pursue a wide range of healthcare integration efforts is in keeping with these factors and holds great promise for continued cost control.

These methods include:

- Addressing a range of social determinants of health through a whole-person orientation by working closely with a range of healthcare and human services in the consumer's home community
- Weaving the services offered by the CMH and provider network with the care that families and friends provide
- Using other consumers as peer supports and advocates on behalf of the persons served
- Using an array of both traditional (psychiatric care, psychotherapy, inpatient psychiatric care) and nontraditional services (housing supports, employment supports, homebased services).

Additionally, over the last several years, the CMHs, PIHPs, and their provider networks have been at the forefront of designing and implementing healthcare integration efforts that result not only in improved care but in healthcare cost control. These efforts include: shared and linked electronic health records, walk-in centers, the co-location of mental health practitioners in primary clinics and the provision of primary care providers on CMH campuses, and efforts to identify and work closely with super-utilizers of health care. These healthcare innovation efforts are annually catalogued by CHI2 in its study, "Healthcare Integration and Coordination: Hundreds of innovative initiatives identified in a survey of Michigan's CMHs, PIHPs and Providers", which is discussed below.

## E. Pursuit of healthcare integration

---

**Findings:** The value of integrated care – weaving mental health care with primary care – is well recognized by the healthcare community, policy makers, and the public-at-large. Michigan healthcare leaders and policy makers have discussed the value of whole health integration and have pursued a number of efforts to promote such integration.

To foster an understanding of healthcare integration, from the perspective of the client/patient receiving services (what most would call “real” healthcare integration, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) developed the Standard Framework for Levels of Integrated Healthcare (<https://www.integration.samhsa.gov/resource/standard-framework-for-levels-of-integrated-healthcare>)

vii

Based on the SAMHSA/HRSA framework, every year, the Community Mental Health Association of Michigan’s (CMHA) Center for Healthcare Integration and Innovation (CHI2) conducts a study of the healthcare integration initiatives led by Michigan’s Community Mental Health Services Programs (CMH), the state’s public Regional Entities/Prepaid Inpatient Health Plans (PIHP), and providers within the CMH system. This annual study examines the range of efforts aimed at integrating behavioral health and intellectual/developmental disability services with physical healthcare services, in which the members of the state’s public mental health system are leading or deeply involved.

The most recent study, published in early 2020, found that more than six-hundred-twenty-six (626) healthcare integration efforts, led by these public sector parties, were in operation throughout Michigan. The CMHs, PIHP, and providers involved in healthcare integration, often pursue a number of efforts simultaneously, with each organization that responded to the survey reporting an average of over 20 healthcare integration initiatives. Of this number, work around physical health-informed mental health services, co-location, and identification of super-utilizers underscored the variety and maturity of these efforts. <sup>viii</sup>

While the public system is involved in a wide range of healthcare integration initiatives, three types of integration, with considerable complexity, stood out. This 2019 study identified 626 healthcare integration efforts occurring across the state, with the potential for more to come. While there were many different methods of integration implemented by the public system, three of those efforts stood out, given their organizational, clinical, technical, and relational complexity. Those efforts were physical health informed mental health services, co-location, and identification of super-utilizers.

**1. Physical health informed mental health services:** Integrating physical health needs and goals into mental health services improves outcomes and proves the most effective approach to caring for people with multiple healthcare needs. The CMHA Center for Healthcare Integration and Innovation study found two primary approaches to physical health informed mental health services in the state of Michigan. The first entails identification of patients without a primary care provider. The second involves health screenings. The study found that there are 100 current efforts surrounding increased health information in place, while recording 126 total initiatives regarding physical health informed mental health services.

- Health Screening: Twenty-nine locations utilize health screenings. These screenings consist of items designed to identify risk factors for undiagnosed acute or chronic care issues

integrated throughout traditional behavioral health assessments. Untreated chronic disease is a major factor in the increased cost of care for people with behavioral health issues or substance use disorders. The implementation of health screening processes allows providers in primary care and other healthcare settings to assess the severity of health issues and identify the appropriate level of treatment.

- **Identification of Patients Without a Primary Care Provider:** Twenty-eight locations throughout the state have processes in place to identify patients without a primary care provider and/or patients who have not engaged a primary care provider in the past year. Having a regular primary care provider (i.e., family physician or nurse practitioner) is crucial for obtaining compressive, continuous, accessible, and timely healthcare. A primary care provider allows for coordination among other parts of the healthcare system. Research suggests patients who have a primary care provider benefit from improved care coordination and chronic disease management. They receive more preventative care, are less likely to use emergency services, and have better health outcomes overall.
- **Facilitating Communication between mental health provider and primary care providers (Fostering Integration):** Twenty-nine out of thirty locations aimed at fostering communication efforts between mental health sites and primary care providers. These efforts included communication via case manager, supports coordinators, care managers and similar intensive coordination. Coordinating with primary care providers increases the likelihood of positive outcomes for patients, strengthens coordination and improves quality of care

**2. Co-location initiatives:** This study identified 89 efforts to co-locate physical and mental health services within the same physical space.

The most common method of co-location was housing mental health staff in hospital emergency departments or creating regular protocol that mental health staff provide crisis screening in emergency departments, with 18 sites reporting this method of integration.

Thirteen organizations have mental health staff co-located within a primary care practice.

Fourteen co-location efforts across the state involve a federally recognized Community Health Center/Federally Qualified Health Center (FQHC).

Research indicates that colocation of physical and behavioral healthcare is linked to reductions in no-shows, increased primary care utilization, and improved physical health goals among adults with serious mental illness. Co-location may also improve practitioners' understanding and skills in relation to the other professionals with whom they co-locate. The growing number of co-location initiatives across the state represents the CMH system's appreciation for the importance of integration efforts, and the impact they may have on access to care, care coordination, and the overall client experience.

**3. High/super-utilizer initiatives:** A significant segment of the integration initiatives identified in this study are those efforts that address the needs of the high/super-utilizer population. High/super-utilizers are individuals with very high healthcare service utilization patterns, often

across disciplines and sectors. These same people often demonstrate high levels of utilization of human services outside of traditional healthcare domains, such as: public safety, housing supports, judiciary, and child welfare. The study found eight-six (86) joint efforts between CMHs, PIHP, providers, and primary care practices, hospitals, and Medicaid Health Plans to address the needs among this population in order to effectively utilize healthcare resources.

Twenty-one (21) sites reported the active use of Medicaid claims databases that included both physical and behavioral health services, using the data available through the State of Michigan's Care Connect 360 (CC360) database, portal, and/or other data analytics, to identify high/super utilizers at the point of access and throughout the course of services, supports, and treatment.

Fifteen (15) sites reported joint efforts with primary care practices to address additional needs of increased use of healthcare resources.

Nine (9) sites reported active use of data (primarily through CC360) to provide outreach to high/super-utilizers who have not accessed the public mental health system of care. These initiatives significantly impacted the effectiveness of healthcare resources through the use of the targeting, assertive outreach, and case-management approaches, as well as the provision of adjunct supports including transportation, housing supports, vocational services, and advocacy, to this population.

The full version of the most recent study can be found at: <https://cmham.org/wp-content/uploads/2020/01/2019-2020-CHI2-Healthcare-Integration-Survey.pdf>

**Analysis:** Michigan's public mental health system has a proven track record of developing and implementing a wide range of healthcare integration initiatives in communities across Michigan. These integration efforts are built on the well-recognized federal (SAMHSA/HRSA) integrated care constructs and use integrated care approaches designed to most directly impact clients and patients.

## **F. Use of evidence-based and promising practices and the infrastructure to support their use**

---

**Findings:** Michigan’s public mental health system has a long history, with the strong support of MDHHS, of using evidence based and promising practices. What is rare, across the nation, is the well-developed and sophisticated infrastructure that Michigan has built to support the use of EBPs and promising practices.

The EBP and promising practices used throughout the state’s public mental health system - some for over 30 years, ahead of most states - include:

- Assertive Community Treatment
- Assisted Outpatient Treatment
- Use of nationally recognized children, adolescent and family assessment: CAFAS/PECFAS
- Clubhouse (Psycho-Social Rehabilitation)
- Cognitive Enhancement Therapy
- Community Living Supports
- Co-Occurring Disorders
- Services to Persons who are Deaf & Hard of Hearing
- Dialectical Behavior Therapy
- Family Psycho-Education
- Behavioral Health Home
- Opioid Health Home
- Medication Assisted Treatment
- LOCUS
- Motivational Interviewing
- Person Centered Planning Training & Evaluation
- Screening, Brief Intervention & Referral to Treatment (SBIRT)
- Self Determination
- Supported Employment (Integrated Competitive Employment and Employment First)
- Trauma Informed Practice
- Trauma focused Cognitive Behavioral Therapy
- Value Based Purchasing
- Veteran Navigator
- Wrap Around
- Parent Management Training - Oregon

The infrastructure for the use of EBPs and promising practices – a partnership of the Michigan Department of Health and Human Services (MDHHS), the state’s CMHs, Regional Entities/PIHPs, providers, and the Community Mental Health Association of Michigan (CMHA) includes the following components:

**1. Face-to-face education and training EBP offerings to thousands of practitioners:** The provision, annually, of clinical education and training to over 8,000 mental health providers and clinical supervisors, and administrators via over 200 face-to-face workshops and conferences. Many of these offerings are made possible through an innovative joint effort of the Michigan Department of Health and Human Services and the Community Mental Health Association of Michigan (CMHA). This partnership allows for many of these educational offerings to be provided at no- or low-cost to Association members, as a result of the MDHHS use of federal mental health and substance abuse block grant dollars. The vision of MDHHS and this partnership allows CMHA

to provide, every year, over \$7 million in education and training to the members of the Association, via a comprehensive education and training contract with MDHHS, without these costs being borne by the Association members. A sample of these offerings can be found at the CMHA link: <https://cmham.org/education-events/conferences-training/>

**2. EBP fidelity review and guidance teams – MIFAST teams:** As part of the MDHHS-CMHA partnership, skilled clinicians, from across the state, who have demonstrated mastery of a given EBP, are recruited by MDHHS to form fidelity review and guidance teams, known as Michigan Fidelity Assistance Support Teams (MIFAST).

**Overall Purpose of MIFAST:** The overall purpose of the Michigan Fidelity Assistance Support Team (MIFAST) is to provide technical assistance in moving the publicly funded behavioral health system forward in ascertaining the degree to which an evidence-based program has been implemented and is functioning for both fidelity and efficacy. The focus is on providing peer-lead technical assistance as opposed to a formal site visit or audit. Generally, Michigan Department of Health and Human Services (MDHHS) staff are not members of the MIFAST visit.

As the result of a MIFAST visit, agencies/teams will be provided an outside perspective of how their evidence-based program is being implemented, and where internal focus can be prioritized for moving forward. In addition, cumulative information from visits provide a way for the state to see where needs may be in terms of support for improving practices and providing technical assistance across the system. Post-visit technical assistance, materials, training or further development, consultation, or coaching depending on needs identified during the visit itself will be offered and provided by either the MIFAST lead or MDHHS staff.

MIFAST visits are conducted every one-to-three years depending on available capacity, number of projects within each evidence-based program, and number of MIFAST teams available. Prioritization may occur where exemplary reviews may result in a re-visit in three years and poor reviews may result in a re-visit in one year.

**Recent and current MIFAST teams:** To date, the MIFAST process has been predominately implemented as part of adult mental health block grant providers although there have been recent efforts to expand this process to substance abuse funded efforts as well. There are currently MIFAST teams available for the following evidence-based programs:

- Supported Employment/Individual Placement and Supports (IPS)
- Dialectical Behavior Therapy (DBT)
- Integrated Dual Disorder Treatment (IDDT)
- Assertive Community Treatment (ACT)
- Dual ACT/IDDT Teams
- Dual Diagnosis Capability (DDCAT/DDCMHT)
- Motivational Interviewing
- Cognitive Enhancement Therapy (CET)
- Behavior Supports (Adult focus)
- Family Psycho-Education (FPE)
- Trauma

**3. Michigan’s EBP website – Improving MI Practices:** The design and operation of the Improving MI Practices website, led by MDHHS and coordinated in partnership with CMHA and an Advisory Group led by MDHHS, provides access to a broad set of resources around a wide range of EBP and promising practices. This website is unique, across the nation, and is regularly updated with the latest clinical intervention developments.

The EBP and promising practices for which resources can be found on this website include: Applied Behavior Analysis, Assertive Community Treatment, Clubhouse – Psycho-Social Rehabilitation, Cognitive Behavior Therapy, Co-Occurring Disorder Treatment, Family Psychoeducation, Individual Placement And Support, Motivational Enhancement / Motivational Interviewing, Parent Management Training - Oregon Model, Substance Use Disorders, Supported Housing Trauma Focused Cognitive Behavioral Therapy, Trauma-Informed Services, Trauma-Specific Treatment, Wraparound

The Improving MI Practices site can be found at: <https://www.improvingmipractices.org/>

**4. Statewide training guidelines group standardizes clinical training:** The State Training Guidelines Workgroup (STGW) is a committee of the Community Mental Health Association of Michigan (CMHA).

The purpose of the workgroup is to review and recommend training guidelines for support staff working in all types of support and service settings including, but not limited to, residential direct support staff. The workgroup is comprised of representatives from the Mental Health Association of Training (MHAT), the Provider Alliance, Provider agencies representing Developmental Disability and Mental Health/Illness services, Community Mental Health (CMH) agencies, parents and guardians, the Michigan Department of Health and Human Services (MDHHS), and other stakeholders.

The intended use of these statewide training guidelines is for the development and presentation of training content. The documents developed by this group include a training grid for people providing direct support; curriculum guides which identify training topics, competencies, content, trainer qualifications, suggested length and format; and vetting tools.

The training grid below illustrates training requirements and options based on work setting and the needs of persons served. The guidelines were designed to address concerns related to reciprocity, uniformity, and the flexibility to stay current in an ever-changing environment. The legal requirements of the various oversight agencies were cross-referenced and included within the guidelines. These include licensing requirements for Adult Foster Care (AFC). Curricula based on these guidelines will contribute to statewide uniformity, reciprocity, and portability. These resources are intended as training tools for the benefit of persons who work with people receiving services through the Community Mental Health system. They are intended to be considered best practices.

State Training Guidelines Workgroup (STGW) resources:

1. Training Reciprocity: Implementation Guide
2. Direct Support Staff Training Requirements Grid
3. Areas around which the State Training Guidelines Group has established guidelines and a vetting tool, the latter to foster reciprocity of training certification and staff

credentialing across the state's public mental health system include: Assisting People with Eating or Swallowing Difficulties, Autism Spectrum Disorder, Behavior Crisis Intervention, Best Practice Guidelines for Online Learning, Building Natural Supports, CPR, Crisis Planning, Critical Thinking and Creative Problem Solving, Cultural Competence, Documentation Skills, Client Appeal and Grievance Due Process, Emergency Preparedness, First Aid, Food Safety, Health and Wellness, HIPAA And Confidentiality, Human Relationships, Immobility Positioning, Infection Control and Standard Precautions, Intro to Human Services, LEP, Lifts & Transfers, Medications, Medication Refresher, Nutrition, Person Centered Planning, Philosophy and Current Trends, Recipient Rights, Suicide Risk Assessment and Intervention, Teaching New Skills, Train the Trainer, Trauma Informed Services

More about this group and its resources can be found at:

<https://www.improvingmipractices.org/about-site/state-training-guidelines-workgroup>

**Analysis:** The longstanding partnership between the Michigan Department of Health and Human Services (MDHHS) and the state's public mental health system have fostered a culture that embraces the adoption of evidence based and promising practices. The large number of these practices, their wide spread use, the adherence to the fidelity of the approaches, and the well-developed infrastructure supporting the use of these practices is core to the clinical strength of Michigan's public mental health system.

## Conclusion

Michigan's public mental health system is made up of the public Community Mental Health centers (CMHs) linked to county governments, the public Regional Entities/Medicaid Prepaid Inpatient Health Plans (PIHPs) formed and governed by the CMHs, and the private non-profit and for-profit organizations in the CMH and PIHP networks. This system, in partnership with the Michigan Department of Health and Human Services (MDHHS), has demonstrated, over decades, strong performance on a number of dimensions of healthcare quality and innovation. This high level of performance is demonstrated in an examination of a number of components of the system's operations:

**Longstanding strong performance against the state-established and nationally-recognized performance standards** measuring: access, timeliness of response, follow-up to inpatient and detoxification services, and psychiatric readmission rates. This study found that Michigan's public system met or exceeded the state's performance in 37 of the 38 state established standards. These standards make up Michigan's Mission Based Performance Indicator System (MMBPIS). For the one standard not met or exceeded, the system was below the state standard by 1.63% from the 95% standard.

**Nation-leading de-institutionalization** allowing persons with mental health needs to live, work, attend school, worship, and socialize in their home communities. The federal National Outcome Measures system found that the use of state psychiatric beds, by the rest of the country is 17 times higher per capita than that of Michigan. Michigan's use of state psychiatric hospitals - far less than the average of the rest of the country - is a testimony to its continual commitment to deinstitutionalization and the development of a comprehensive community-based system of care, the state's public mental health system. This investment in community-based services and supports, rather than in state institutional care, allows for the dollars that would have paid for services in state institutions to serve thirty-seven (37) times more people, through Michigan's community-based system.

**High rankings against national standards of behavioral health prevalence and access to services:** When Mental Health America compared to all fifty (50) states and District of Columbia, Michigan ranks among the top 1/3 of all of the states and the District of Columbia, relative to prevalence of behavioral healthcare need (a function of many variables including prevention and early intervention mental health services) and access to care. Michigan's ranking of 17<sup>th</sup>, nationally, for the entire state population, 6<sup>th</sup> relative to services to adults, and 20<sup>th</sup> relative to services to children and youth. When access, as a lone measure, was examined, Michigan ranked 15<sup>th</sup> out of the fifty (50) states and the District of Columbia.

**Proven ability to control costs over decades:** As the state's managed care organizations for the Michigan's Medicaid behavioral healthcare system, Michigan's public mental health system was able to bend the cost curve far below that of the nation's Medicaid and commercial insurance systems.

A study of national healthcare rate data found that while Michigan's public mental health system saw cost/rate increases totaling 72% from 1998 through 2015, the Medicaid programs across the country saw rate increases of 118%. This difference represents a savings of over \$5 billion dollars, from the per enrollee rate increases seen in Medicaid across the country, during the first 18 years of the system's managed care work years and a savings of over \$12 billion when extrapolated through 2024.

Similarly, while the per enrollee cost/rate increases of the behavioral healthcare benefit managed by Michigan's public mental health system saw per enrollee rates increases totaling 72% during this same eighteen (18) year period, the cost/rate increases seen in the commercial insurance per enrollee

costs/rates across the country totaled 201%. This difference represents a savings of over \$13 billion dollars during those years and a savings of over \$35 billion when extrapolated through 2024.

Key to understanding the significance of this cost control performance is that the practices that underlie to this success are those not typically seen in other managed care systems. These factors include:

- Active management of comprehensive and closely aligned service and support provider networks and central community convener role:
- Managed care guided by whole person orientation, impact of social determinants of health, and a person-centered planning approach.
- High medical loss ratios (low overhead/ administrative costs) system to ensure that as many of the Medicaid dollars that it manages, as possible, are used for services and supports to the Medicaid beneficiaries who rely upon this system.
- Impact of whole person orientation and healthcare integration efforts

**Pursuit of healthcare integration:** Michigan’s public mental health system is at the forefront of healthcare integration, having designed, and implemented hundreds of healthcare integration efforts. These efforts, identified through an annual study of the public system, found that a wide range of healthcare integration initiatives led by the public mental health system in communities across Michigan. These integration efforts are built on the federal (SAMHSA/HRSA) integrated care constructs and use integrated care approaches designed to most directly impact clients and patients.

**Use of evidence-based and promising practices and the infrastructure to support their use:** The longstanding partnership between the Michigan Department of Health and Human Services (MDHHS) and the state’s public mental health system have fostered a culture that embraces the adoption of evidence based and promising practices. The large number of these practices, their wide spread use, the adherence to the fidelity of the approaches, and the well-developed infrastructure supporting the use of these practices is core to the clinical strength of Michigan’s public mental health system. This study found that Michigan’s public system is actively implementing over twenty (20) evidence based or promising practices and that their use is supported by a multi-component infrastructure. The components of that infrastructure include:

- Large number of face-to-face education and training EBP offerings to thousands of practitioners
- Evidence based practice fidelity review and guidance teams – MIFAST teams
- Michigan’s evidence based practices website – Improving MI Practices
- Statewide training guidelines group standardizes clinical training:

---

*The Center for Healthcare Integration and Innovation (CHI<sup>2</sup>) is the research and analysis office within the Community Mental Health Association of Michigan (CMHA). The Center, in partnership with the members of the CMH Association, leaders, researchers, consultants and advisors from across Michigan and the country, issues white papers and analyses on a range of healthcare issues with a focus on behavioral health and intellectual/developmental disability services.*

*The Community Mental Health Association of Michigan (CMHA) is the state association representing the state's public mental health system – the state's Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans ((PIHP) public health plans formed and governed by the CMH centers) and the providers within the CMH and PIHP provider networks. Every year, these members serve over 300,000 Michigan residents with mental health, intellectual/developmental disability, and substance use disorder needs. Information on CMHA can be found at [www.cmham.org](http://www.cmham.org) or by calling (517) 374-6848.*

---

## Appendices: Sources of data for this report and endnotes

<sup>i</sup> Source: Michigan Mission Based Performance Indicator System: Performance Indicator Final Reports, including the ones cited in this study can be found at :

[https://www.michigan.gov/mdhhs/0,5885,7-339-71550\\_2941\\_4868\\_4902-90608--,00.html](https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4902-90608--,00.html)

<sup>ii</sup> National Outcome Measures System, a part of the Uniform Reporting System, under the federal Substance Abuse and Mental Health Services Administration (SAMHSA) – 2018 Report;

<https://www.dasis.samhsa.gov/dasis2/urs.htm>

<sup>iii</sup> Michigan Department of Health and Human Services FY 2020 Appropriations;

<http://legislature.mi.gov/documents/publications/AppropriationBillsPassed/2019/2019-mpla-0139-Health%20and%20Human%20Services.pdf> )

<sup>iv</sup> The State of Mental Health in America 2020; Mental Health America;

<https://mhanational.org/issues/state-mental-health-america>;

<sup>v</sup> “Bending the Cost Curve Bending the Healthcare Cost Curve: The success of Michigan’s public mental health system in achieving sustainable healthcare cost control”; Center for Healthcare Integration and Innovation (CHI2); March 2017 <https://cmham.org/wp-content/uploads/2019/03/CHI2-bending-the-cost-curve-final.pdf>

<sup>vi</sup> Berwick DM, Nolan TW, Whittington J. The Triple Aim: care, health, and cost. Health Affairs; 2008; 27(3); p. 759-769

<sup>vii</sup> Standard Framework for Levels of Integrated Healthcare; Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA)

(<https://www.integration.samhsa.gov/resource/standard-framework-for-levels-of-integrated-healthcare> )

<sup>viii</sup> Healthcare Integration and Coordination – 2019/2020 Update: Survey of Initiatives of

Michigan’s Public Mental Health System; Center for Healthcare Integration and Innovation; January 2020 (<https://cmham.org/wp-content/uploads/2020/01/2019-2020-CHI2-Healthcare-Integration-Survey.pdf> )