**Why we OPPOSE SBs 597 & 598**

* We MUST broaden the conversation beyond Medicaid – mental illness and addiction impact millions of individuals and families across the state of Michigan regardless of their insurance.
* Solutions MUST get at the root cause and address the areas of greatest need – access to care, increasing providers and workforce, and the lack of sufficient inpatient care.

**CCGP – CARE, COST, GOVERANCE, PERFORMANCE**

**1. CARE – Bills do not address care, only focused on funding.** SBs 597 & 598 **do nothing to ACTUALLY integrate care**. Real health care integration occurs on the ground at the point of service delivery. SBs 597 & 598 only integrates the funding.

* Financial integration – this proposal does nothing to actually integrate care other than giving the managed care functions and funding to health insurance companies. (New Dartmouth Study Shows That Greater Financial Integration Generally not Associated with Better Healthcare Quality**)**

<https://geiselmed.dartmouth.edu/news/2020/new-dartmouth-study-shows-that-greater-financial-integration-generally-not-association-with-better-healthcare-quality/>

* + This is not a 1 door solution – physical and behavioral health will still be siloed.
  + Health Plans do NOT provide services – they simply authorize care and pay the bills.
  + CCBHC & Health Homes are patient-centered on the ground integration efforts.

2. **COST** – **Our fear is this proposal will dramatically increase costs WITHOUT an increase in services delivered or quality and will ultimately lead to an overall reduction in services – NOT an increase**

Recent national study by Milliman, Michigan Medicaid Health Plans have the 2nd WORST Medical Loss Ratio (MLR) in the country: how much money they spend on actual care is 79%, which means they have an overhead or administrative rate of 21%, which includes a 3% profit margin. Page 26: <https://www.milliman.com/-/media/milliman/pdfs/2021-articles/7-7-21-medicaid_managed_care_financial_results.ashx>

* MI PIHP system has an average of 6% overhead / admin rate.
* 21% - 6% = 15% difference, doing simple math on $3 billion = **$450 million COST difference**
* Costs have gone up in other states that have done this – IOWA: [Iowa Medicaid cost increases nearly triple under managed care (desmoinesregister.com)](https://www.desmoinesregister.com/story/news/health/2018/09/19/iowa-medicaid-cost-increases-nearly-triple-under-privatized-managed-care-legislature-kim-reynolds/1293372002/?utm_source=dashboard&utm_campaign=loyalty%20action)
* The average cost of insuring an Iowan on Medicaid has climbed nearly three times as fast since the state hired private companies to manage the program, when compared to the previous six years, new state figures show.
* Since fiscal 2017, the first full year of privatization, the per-member cost of Iowa's Medicaid program has risen an average of 4.4 percent per year, according to the non-partisan Legislative Services Agency. In the previous six years, the per-member cost rose an average of 1.5  percent per year, the agency said.

**3. GOVERANCE – Eliminates local control and local decision making by the CMH and give it to for-profit insurance companies who are only accountable to non-elected bureaucrats in Lansing via contracts.** Bills wipe out the public accountability of the dollars, health plans are not accountable to boards of county commissioners, do not hold open board meetings or subject to FOIA. The bills would also destroy local community partnerships / collaborations (law enforcement, schools, courts, housing, homeless, hospitals etc) while making CMHs just another provider (eliminating their unique safety net role).

* Public oversight and accountability is needed
* Michigan Medicaid Health Plans show record profits in 2020; <https://www.crainsdetroit.com/health-care/michigan-health-plans-post-rosy-profits-first-half-2020-blues-cross-income-lower-2019>
  + For the Michigan health plans, net income increased 54 percent to $551.3 million from $353.8 million, said Baumgarten, who used data from the state Department of Insurance and Financial Services. Average profit margins increased to 6.2 percent from 4.2 percent.

1. **PERFORMANCE – Health plans do not have a good track record on behavioral health.** Currently they are responsible for the Medicaid mild/moderate benefit for mental health services – before this change is made there MUST be more data and proof they can do the job.

* Health plans are funded to provide Medicaid beneficiaries with mild/moderate behavioral health conditions. According to MDHHS, the average number of mental health visits authorized for qualifying MHP enrollees in 2014 was 4. In 2015, only 10% of all contacts for Medicaid recipients seeking behavioral health services were with a behavioral health professional.
* [Altarum\_Behavioral-Health-Access\_Final-Report.pdf](https://altarum.org/sites/default/files/uploaded-publication-files/Altarum_Behavioral-Health-Access_Final-Report.pdf) – July 2019, Health Endowment Fund Commissioned a report – Access to Mental Health Care in MI, below is from page 8:
  + **Unmet need for AMI (Adults with mental illness) in Michigan is greatest for the more prevalent, mild-to-moderate conditions.** Figure 11 shows the variation in estimated prevalence and unmet need for some of the most common mental health condition diagnostic categories. The conditions with the largest shares going untreated are anxiety disorders and depressive episode. More serious conditions such as bipolar disorder, recurrent depression, and post-traumatic stress disorder (PTSD) and other stress disorders are less prevalent among Michiganders and show lower shares going untreated

**If we really WANT to improve care and people’s lives**

**Do THIS not THAT**

* Address & expand access to mental health and addiction services
  + Access to services is a HUGE problem for those individuals who are not in the current Medicaid CMH system, they are on the outside looking in – Medicaid health plan mild/moderate benefit and those with commercial insurance services are very limited.
  + **Let’s not try to make Medicaid behavioral services look like commercial insurance, we should try to figure out how to expand commercial insurance for behavioral health so it looks more like the current Medicaid coverage.**
* Address the desperate need for more inpatient care settings for those most in need
  + We need more crisis and residential services.
* Find ways to dramatically expand and increase the mental health and addiction workforce shortage
  + From front line DCWs to psychiatrists

Improving these areas would have an immediate impact on people’s lives across the state.

* CCBHC & BHH/OHH must be part of the solution – patient-centered initiatives (true models of integration)