Advocacy Priorities for Sec. 298 (Possible Behavioral Health Privatization)
September 2016

1. Carve in physical health services to the CMHSPs/PIHPs for persons with behavioral health and physical health care needs. This means the behavioral health needs of individuals aren't managed by MHPs, insurers, or private (non-public) entities. It also means that behavioral health services (mental illness, emotional disorder, developmental disability, intellectual disability and substance use disorder) must remain a public responsibility and in the public sector.

2. Offer individualized person-centered planning and coordinated supports for all consumers; assure person-centered planning is done with integrity; and educate professionals re people-first language, person-centered planning principles, and trauma-informed care.

A. The design and delivery of supports and services must be based on a person-centered plan (PCP) that is created and implemented with integrity, allowing individuals to live successfully in the community. PCP is inclusive of family-driven and youth-guided practices.
B. To have integrity, the PCP must be developed independent of control from service providers, managers and funders.
C. Integrity means that the arrangement of supports and services are reflective of individuals' needs and are sufficiently flexible to be altered as those needs change.
D. The state has the ultimate responsibility and authority to assure that supports and services for eligible populations comply with the values of PCP, self-determination and community inclusion. This includes provision of adequate funding for such compliance.
E. The PCP dictates the utilization and allocation of resources, not the other way around. Funding provided to the system must reflect this principle.

3. The state is responsible for overseeing the depth and breadth of the publicly funded behavioral health system. This can be accomplished through an existing state department or a newly established independent & public entity.

4. Have an independent, state-level entity for all grievances, appeals, and rights complaints (as well as mediation of those complaints) of CMHSP/PIHP and Medicaid Health Plan service recipients/applicants. This should kick in after one local attempt to promptly resolve the complaint. State Medicaid hearing officers would be housed in the new entity and would be required to use independent clinical consultation in their case reviews.

5. Retain state administration of *all* Medicaid mental health & epilepsy drugs, including products new to the marketplace (i.e., no carve-in of these drugs to Medicaid HMOs and no prior authorization or other administrative procedures

delaying receipt of the drug that was prescribed). This means one of two things: (a) the Snyder administration announces the current carve-out for mental health and epilepsy medications is extended through December 31, 2018; or (b) PA 248 of 2004 is revised.

6. Determine the efficacy of various administrative models in the CMH system (i.e., state, PIHPs, intermediate managers, local administrators) toward action that improves access, responses to consumer needs, and mitigation of costs.

7. Develop high-quality and uniform administrative, service and other policies, procedures and operational definitions for the entire public behavioral health system. Possible areas of focus = person-centered planning & self-determination integrity; criteria for priority client status; eligibility assessment; CMH pre-admission screening; available service array; utilization of peer supports and services; and financial obligations for service.

8. Any savings/efficiencies generated by improved integration, coordination and use of available community resources need to go right back into direct service for persons with behavioral disorders (mental illness, emotional disorder, developmental disability, intellectual disability or substance use disorder) and/or other health needs.

9. The Calley Workgroup was unable to devote sufficient time and attention to certain special populations. It is important that immediate planning be done to better meet the unique needs of (a) children, youth and families dealing with emotional disorder; (b) persons experiencing or at risk of substance use disorder; and (c) indigenous and tribal residents of Michigan.

10. The delivery of supports and services for eligible populations must comply with the word and aspirations of Home & Community-Based Services, Michigan Medicaid waiver applications (and federal waiver rules), the ADA, the Supreme Court's Olmstead Decision, guidelines for Certified Community Behavioral Health Clinics, the Work Innovation and Opportunities Act and all other applicable federal and state laws and policies.

The Arc Michigan
Association for Children's Mental Health
Epilepsy Foundation of Michigan
Mental Health Association in Michigan
Michigan Disability Rights Coalition
Michigan Protection & Advocacy Service
National Alliance on Mental Illness – Michigan
United Cerebral Palsy Michigan