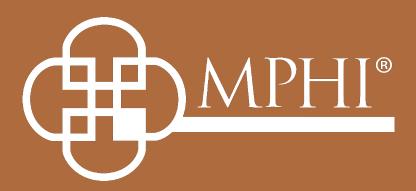


Michigan's Journey Toward Equity in Medicaid

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Michigan Medicaid Background

Separate Physical and Behavioral Health Payers, Programs, State Staff

- Implemented managed care in 1996 with behavioral health (BH) carve out for anything beyond mild to moderate needs
- Expanded Medicaid eligibility in 2014, known as Healthy
 Michigan Plan (HMP)
- 3 million enrollees in Medicaid including 1 million HMP enrollees

- Currently over 2 million beneficiaries in 9 Managed
 Care Organizations
- MCO 1% capitation withhold for performance bonus/incentives
- MCOs pay for ALL emergency visits, even for MH, SUD diagnoses

Michigan Public Mental Health System

Separate Physical and Behavioral Health Payers, Programs, State Staff

- Community Mental Health Service Providers (CMHSPs) are public entities responsible for behavioral health/SUD services
- CMHSPs serve as the governing boards for regional pre-paid inpatient health plans (PIHPs) covering behavioral health/SUD costs and administration
- PIHPs operate as MBHOs and manage services for people with:
 - severe mental illness (SMI) intellectual disabilities (ID)
 - serious emotion disturbance (SED) -substance use disorder SUD-Developmental disabilities (DD)

- PIHPs cover behavioral health inpatient/outpatient, hospital, and HCBS services for eligible populations
- There are 10 PIHPs operating regionally, one PIHP per region
- PIHPs 0.75% capitation withhold for bonus/incentives

Michigan's Equity Journey

2015

Health Equity, SDOH, CHWs included in the MCO rebid



2018

2010

Medicaid Health Equity
Project begins

2012

First Medicaid Health
Equity Report published
online, every year since

MCOs first incentivized for reductions in disparities in key quality measures...

Innovations in Behavioral/Physical Health Care

Joint Metrics began in 2015

Identical metrics, benchmarks, and expectations in both MCO and PIHP contracts – known as 'joint metrics'

Services for shared members tied to capitation withhold – designed to incentivize collaboration

FY 21 criteria include joint care management and performance on specific measures.

Follow-up After Hospitalization for Mental Illness (FUH) – meet overall benchmark *and* reduce racial/ethnic disparities

Follow-up After ED Visit for Alcohol and
Other Drugs (FUA) –
reduce racial/ethnic disparities

Innovations in Behavioral Health Care

BHDDA is now looking new measures disaggregated by race/ethnicity

IET

Initiation, Engagement and
Treatment (IET) of Alcohol
and Other Drug
Dependence rates by PIHP

AOD Initiation

Initiation of AOD Treatment:
The percentage of
beneficiaries who initiate
treatment within 14 calendar
days of the diagnosis

AOD Engagement

Engagement of AOD

Treatment: The percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or Medication

The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the necessary service

Michigan Foundations Support Equity in MH/SUD

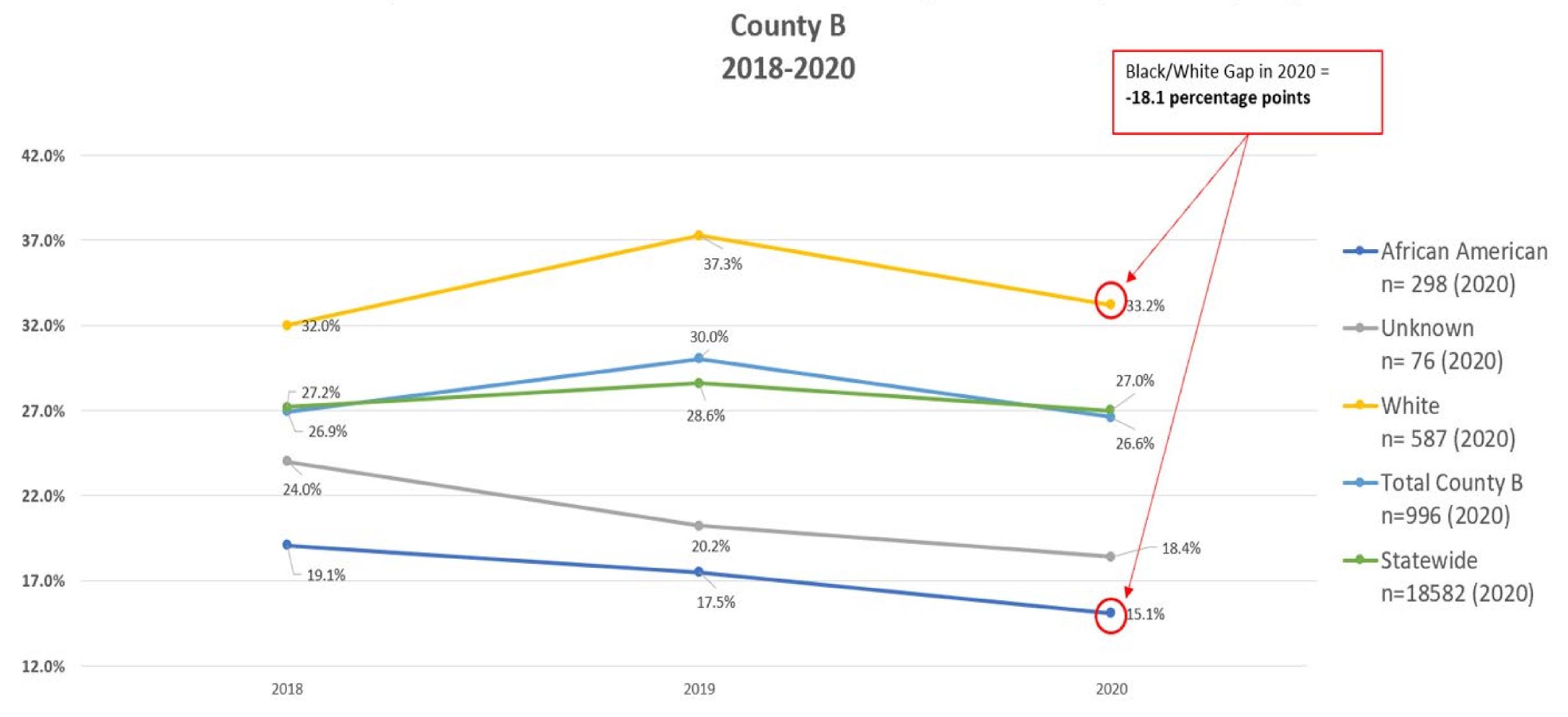
BHDDA partnered with MPHI and the Michigan
Health Endowment Fund to identify inequity in
MH/SUD services at the *county level (plan agnostic)*. Focused on quality measures also in Joint Metrics (including FUA and IET)

Shared with BHDDA and PIHP leadership for vetting/validation

Used to establish grantmaking to community-based organizations in counties where disparities were consistent

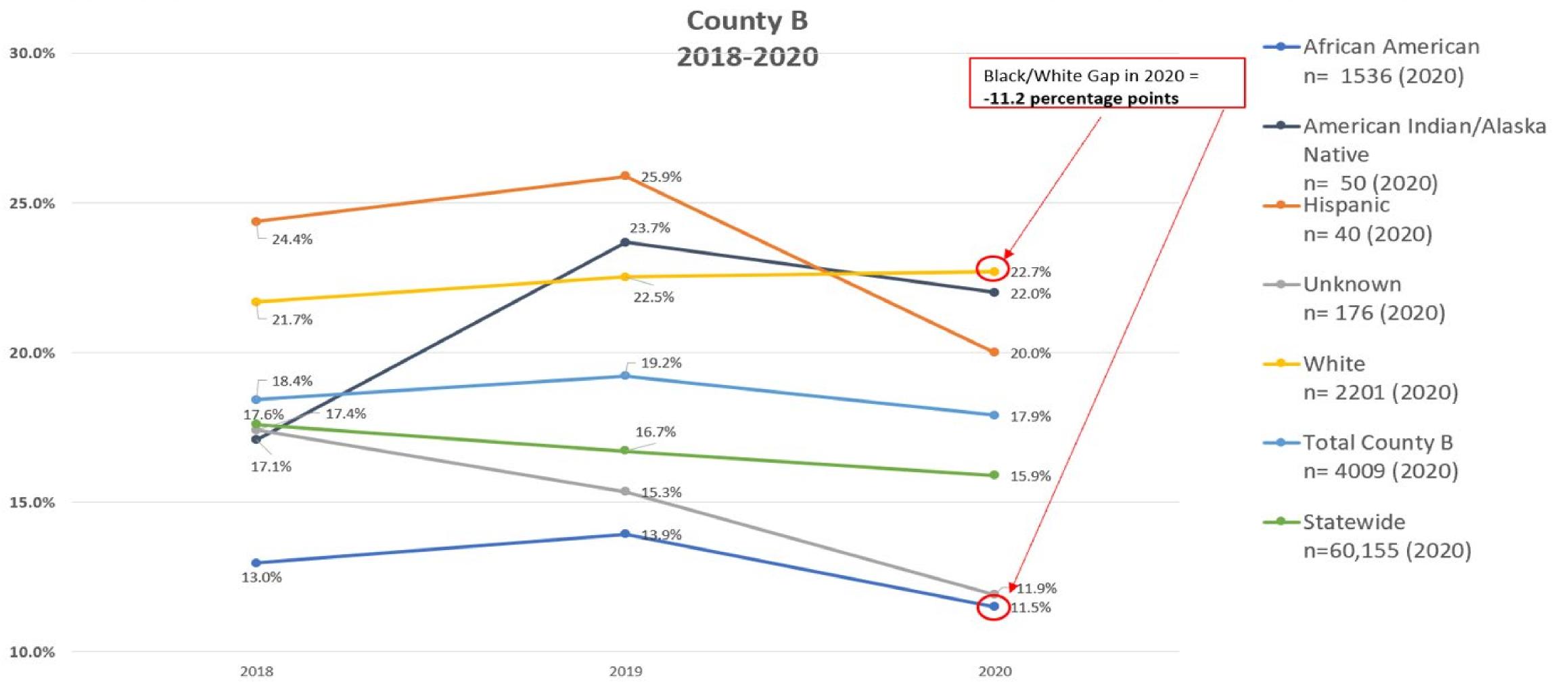
What Does Inequity in SUD Service Look Like?

Follow Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA)



What Does Inequity in SUD Services Look Like?

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment, 34 Days (IET)



Recap and Wrap Up

Racial disparities exist in access to treatment for substance use disorder in the Michigan Medicaid population.

The disparities differ by county, by year, and by measure.

We only know this because our foundation friends partnered with us and the Medicaid/BH agency to get answers to the question.

The foundation then funded four CBOs in key counties to work in their communities to address these disparities *in partnership with* health care service providers.

It is not difficult to establish a process to determine how equitably services are being delivered but it requires time, collaboration, patience, and grace.

And money (but not gobs).