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Together, We Can Fix Michigan's Mental Health System
By Dan Cherrin

Every Michigander deserves access to quality behavioral health and addiction care when and where they need it. But today, the system designed to deliver these services is burdened with inefficiencies that limit access, create unnecessary administrative hurdles, and place bureaucratic interests ahead of patient outcomes.

Michigan is evaluating how it procures behavioral health and addiction treatment services. This moment offers a chance to address long-standing issues, eliminate conflicts in decision-making, and build a system that ensures every dollar reaches the people who need care the most. If we get it right, we can create a model that expands access, improves quality, and optimizes resources.

Community safety net providers, who are committed to delivering care to individuals with serious mental illness, substance use disorders, and developmental disabilities, face relentless administrative barriers. Funding is tangled in bureaucracy, crisis services are inconsistent throughout the state, and the entities that control funding also provide services—creating a system where conflicts of interest take priority over patient care. The result? Delays, confusion, and an uneven system that varies by region, limiting access for those who need it most.

But we have a chance to fix it. The Michigan Department of Health and Human Services (MDHHS) wants to improve the state's behavioral health system. This is a rare opportunity to make bold changes that put people over process, access over inefficiency, and quality over bureaucracy.

We should start first by eliminating the conflicts of interest in the system. The same organizations that allocate funding should not also provide services. We should consolidate the number of agencies that distribute funding, and they should limit their role to managing the provider network and managing provider contracts. This creates a more accountable system where decisions are made based on community needs rather than financial incentives.

At the same time, Community Mental Health Service Providers (CMHSPs) should take full responsibility for funding crisis services delivered by contracted providers, ensuring every region has a reliable and responsive system for people in immediate distress. This shift would remove barriers to urgent care, reduce unnecessary hospitalizations, and ensure that crisis services are coordinated, accessible, and adequately funded.

Our system must also meet people where they are. Creating regional Accountable Care Organizations (ACOs) will improve access and coordination across the state. The ACOs would replace the Prepaid Inpatient Health Plans (PHIP) and each ACO would manage provider networks, use standardized needs and acuity assessments, and ensure services are available based on need rather than administrative boundaries. This would prevent disparities in care and ensure every region has a functional, sustainable system.

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As overdose deaths rise, we must integrate SUD care into the behavioral health system to ensure timely, effective treatment. Funding should be equitable, and care should be seamless—regardless of whether someone seeks help for addiction or a mental health condition. Too many individuals seeking addiction treatment face unnecessary administrative burdens because the system was built for mental health care first, with addiction services as an afterthought. While we must recognize SUD serves as a separate discipline from mental health, we should also integrate SUD care into the behavioral health system, ensuring that providers either offer these services directly or have formal partnerships with SUD specialists. Funding must also be equitable so that persons receive the same quality care regardless of which part of the behavioral healthcare spectrum their needs fall.

We must also rethink how Michigan funds and selects Certified Community Behavioral Health Clinics (CCBHCs). Codifying CCBHC into law and expanding opportunities for all qualified providers will transform the current reliance on short-term grants, making long-term planning nearly impossible for providers. Transitioning to a CCBHC cost-based payment model would provide financial stability, allowing clinics to expand services and better meet community needs. A statewide CCBHC model would establish clear eligibility standards and a fair, statewide reimbursement system, ensuring consistency in funding and service quality.

Finally, we must ensure that individuals with intellectual and developmental disabilities (IDD) receive the care they deserve. These services should be managed separately from behavioral health but in a way that guarantees seamless coordination. Funding must follow the individual rather than being tied to specific provider networks, allowing people with IDD the flexibility to access services that best fit their needs.

Delivering mental health services is complex, yet MDHHS's initiative to strengthen behavioral health access is a pivotal moment for Michigan. If we fail to act boldly, we risk maintaining a system that prioritizes administrative convenience over the people it serves. But if we take this opportunity, we can build a system that expands consumer choice, increases accountability, operate from a consistent set of administrative and contracting standards, policies, and procedures, and ensures that every person in need has access to quality care when and where they need it. Now is the time to act. Now is the time to listen. Now is the time to start the conversation.

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