Mental Health Funding and Services

BACKGROUND

The public responsibility for caring for people with developmental disabilities and mental illness was set out in Michigan more than 150 years ago, in the 1850 state constitution. The state's first mental institution, the Kalamazoo Asylum for the Insane, began receiving patients in 1859. The most recent state constitution (1963) also stipulates that care for this population is an explicit responsibility of the state. Article VIII, section 8, says,

> Institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously disabled shall always be fostered and supported.

In practice, the state system for mental health care that has evolved over the years was designed to meet the needs of two very different client populations:

- the *developmentally disabled*—people with mental retardation, autism, cerebral palsy, or epilepsy, and
- the *mentally ill*—adults and children afflicted by such conditions as schizophrenia, manic-depressive disorder, and serious depression.

Delivery System

State hospitals and centers originally were the main means of treating and caring for the mentally ill and developmentally disabled. In the first half of the 1900s, the capacity of state institutions grew dramatically. However, by the 1960s there evolved a general consensus among mental health professionals and the public that the needs of most mental health patients best can be met in community programs located as close to a patient's family as possible. In 1974 the Michigan Mental Health Code (Public Act 258) transferred the authority and funding for the care and treatment of adults and children with mental illness and developmental disabilities from the state to community mental health services programs (CMHSPs), agencies sponsored by Michigan's 83 counties and overseen by the Michigan Department of Community Health (MDCH).

Today there are 48 CMHSPs; some are single-county, some are multi-county, and one is city-county. Each CMHSP offers a variety of services that may include

- psychosocial rehabilitation,
- assertive community treatment,
- supported employment,
- inpatient and outpatient services,
- day programs,
- special services for children and adolescents, and
- emergency and telephone crisis services.

GLOSSARY

Assertive community treatment
Team treatment that provides comprehensive, community-based psychiatric treatment, rehabilitation, and support to people who have serious and persistent mental illness.

Case management
Coordination of a person's health care needs through a plan overseen by a case manager.

Developmental disability
A mental or physical incapacity, such as mental retardation, autism, cerebral palsy, or epilepsy, that arises before adulthood and usually lasts through life.

Managed care
The effort to "manage," or control, utilization and costs through alternative care-delivery systems and specific management techniques. Health maintenance organizations (HMOs) are a well-known managed-care delivery system; individual case management and utilization review are typical managed-care techniques.

Medicaid
The federal/state program that pays for many health care services for low-income people who qualify.

Mental illness
Any mental or emotional disorder that substantially impairs normal life activity. Examples are schizophrenia, manic-depressive disorder, and serious depression.

For the past three years, the MDCH has operated a managed-care specialty-services program for the mentally ill and developmentally disabled Medicaid population. The department sees managed care as a way to

- facilitate freedom for people with mental health needs,
- retain state-county-community partnerships,
- ensure accountability and integrity, and
- promote efficiency.

Under the program, the MDCH has contracted with each CMHSP to operate as a specialty prepaid health plan (SPHP) responsible for providing Medicaid-covered mental health and developmental disability services in its area.

Parity
The proposition that limitations or restrictions on mental health insurance benefits should be no greater than those on other medical services.

Psychosocial rehabilitation
Combined psychological and social services to help people develop and improve the skills needed to live and participate in the community.

Psychotropic drug
Medication that modifies mood, cognition (e.g., awareness, perception, reasoning, judgment), or behavior.

Specialty prepaid health plan (SPHP)
A plan whereby for a fixed amount of funding per person, services are provided to a special population; in this case, the state provides the funding for Medicaid recipients needing mental health services.

Supported employment
Programs that help clients get and keep long-term employment.

Utilization review
Examining the delivery of health care services for their appropriateness and medical necessity.

In 2002 the MDCH will begin to select SPHPs differently, no longer automatically contracting with the 48 CMHSPs. To continue to serve as a SPHP, a CMHSP must meet certain requirements and have specified capabilities, among them having

- at least 20,000 Medicaid beneficiaries living in its service area,
- the ability to serve the mental health population in its geographic area,
- adequate administrative capability,
- established cost limits on mental health services,
- the capacity to ensure client access to services,
- established practices that ensure consumers equal treatment and inclusion in their care decisions, and
- a focus on consumer-directed services and consumer participation in planning and governing.

A CMHSP that does not have the required number of Medicaid recipients in its service area is permitted to join another for SPHP purposes. Initially, only CMHSPs may apply, but if a CMHSP application is found wanting, a competitive process will be used to find an organization qualified to act as the SPHP in that geographic area. Although it may be possible for private, mental-health management companies to act as SPHPs, all existing CMHSPs probably will be successful in receiving a SPHP designation—either individually or as part of a group—because they have the first opportunity to bid and have acted as SPHPs for the past three years. If a CMHSP were not to receive the SPHP designation, it would lose state Medicaid dollars and thus the vast majority of its business. It could continue to function, albeit at a greatly reduced level, relying on the non-Medicaid dollars it receives from the state and clients' private-insurance and out-of-pocket payments.

State Facilities

The state has closed 24 state mental health institutions since 1981, 16 of them since 1990. Currently, six state-operated hospitals and centers serve mentally ill adults and children and people with developmental disabilities. They are

- the Caro Center, Kalamazoo Psychiatric Hospital, Northville Psychiatric Hospital, and Walter Reuther Psychiatric Hospital, which serve mentally ill adults;
- the Hawthorn Center, which serves mentally ill children; and
- the Mt. Pleasant Center, which serves developmentally disabled clients.

January 2002 saw the most recent closure—the Southgate Center for the developmentally disabled. The Northville Psychiatric Hospital is slated to close within three years. Hospital and center closures mean a decrease in the patient census at state mental health institutions: in FY 1992–93 the institutionalized population was 2,707; by FY 2000–01 the population had dropped to 1,328.

There also is a system of private hospital care, providing short-term care for the mentally ill, that people access through private health insurance or out-of-pocket payment. According to the MDCH, in 2001 there were 61 private psychiatric hospitals/units in Michigan, with the capacity to serve 2,038 adults and 394 minors. The number of private units is down, due mainly to financial considerations, from 72 in 1999, when there was capacity to serve 2,526 adults and 523 minors.

Funding

Exhibit 1 shows spending for community mental health, institutional care, and community residential services for the past five fiscal years plus the current year (FY 2001–02) appropriation. The data show that mental health expenditures increased the most in FY 1998–99—up 11.7 percent from the previous year. The current year appropriation is down slightly (0.3 percent) from last year's expenditures. Although the executive order of November 2001 reduced the MDCH budget by several million dollars, the majority of the cuts affected hospitals and nursing homes. Mental health funding did receive some cuts, but due to an increase in mental health services in FY 2001–02, the net effect was a freeze in funding.

DISCUSSION

Mental health advocates are concerned that (1) mental health resources in Michigan are insufficient, (2) the closure of so many state institutions means that some people with mental health needs are being deprived of a continuum of care, and (3) Michigan's new Medicaid prescription drug formulary (effective in February 2002) will deny Medicaid recipients access to certain mental-health drugs.

Hospital Closures

As stated, the state has closed 24 mental health institutions in the last two decades. Several reasons are cited: the belief that the mental health and developmentally disabled population should not be locked up but allowed to live freely and receive care in their community; growth of the community mental health system; development of psychotropic drugs that help manage mental illness; and last but not least, budget constraints.

Opponents of such extensive closures argue that the institutional beds being lost are not being replaced by enough beds in private general and psychiatric hospitals in the state. They contend that people in psychiatric hospitals are there because they cannot be properly treated in a community setting or in a regular hospital, where stays usually are short-term and unsuited for people with long-term mental illness. They further maintain that many patients who are displaced from institutions—for example, the Northville Psychiatric Hospital, where the beds are full and closure is expected by 2004—will end up in a homeless shelter or jail instead of in a community program or general hospital.

Parity

Observers generally argue that private insurance coverage for mental health services is inadequate. As may be seen in Exhibit 2, in recent years a large percentage of the state's mental health spending has gone to Medicaid recipients. But only about half of Michiganians with men-

EXHIBIT 1. Mental Health Spending, FY 1996–97 through FY 2001–02 ($ millions)

Expenditure Category	*Actual Expenditures FY 1996–97*	*Actual Expenditures FY 1997–98*	*Adjusted Expenditures FY 1998–99*	*Adjusted Expenditures FY 1999–2000*	*Estimated Expenditures FY 2000–01*	*Appropriations FY 2001–02*
Community mental health	$936.2	$1,173.4	$1,380.7	$1,380.2	$1,426.7	$1,417.0
Other CMH-related budget lines	7.2	0.0	0.0	6.9	7.2	7.2
Institutions, purchase of state services (POSS)	176.0	138.1	150.0	158.0	166.9	166.8
Institutions, other financing sources	67.8	54.1	57.0	61.0	63.1	67.4
Community residential services, POSS	101.3	32.8	0.0	0.0	0.0	0.0
Community residential services, other	93.0	28.7	6.7	0.6	1.0	0.9
TOTAL	$1,381.4	$1,427.0	$1,593.4	$1,606.6	$1,664.8	$1,659.3
Percentage change over previous year	–0.23%	3.30%	11.66%	0.83%	3.62%	–0.33%

SOURCE: Senate Fiscal Agency.

tal health needs are eligible for Medicaid. Therefore, there is need for private insurers to cover mental health services for the non-Medicaid population.

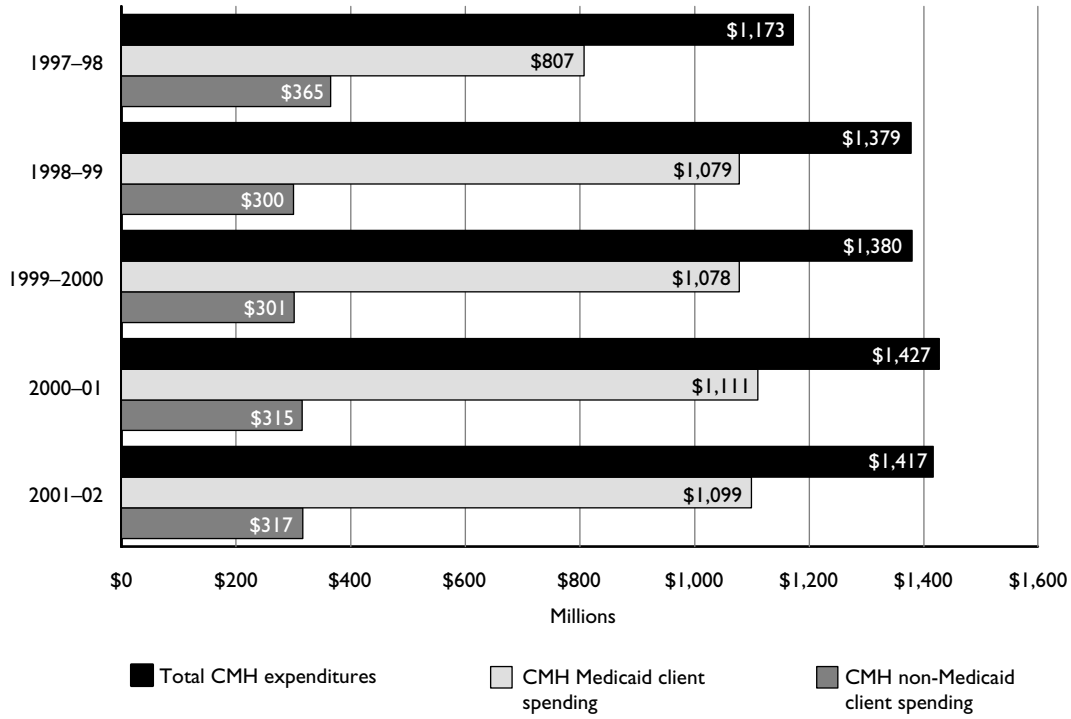
In 1996 the federal Mental Health Parity Act was enacted, requiring insurers to provide the same aggregate lifetime and annual limits for mental health coverage as they do for medical and surgical coverage. The law, which expired in 2001, applied to treatment for mental illness, but it did not *require* insurers to cover mental health services (it said only that if they *do*, there must be parity in coverage). The law also did not prohibit insurers from imposing copayments, deductibles, and treatment time limits for mental health services that were different from those imposed for medical services. This meant, for example, that an insurer could require its members to pay cost-sharing amounts that were so high that mental health treatment still was inaccessible because of the out-of-pocket expense. Or the insurer could agree to cover only a certain number of days of mental health treatment.

In 2001 the Michigan Legislature introduced bills that address the parity issue. House Bills 5123 and 5128 and Senate Bills 101–02 would require health insurers in Michigan to ensure that their cost-sharing requirements and benefit and service limitations for inpatient and outpatient mental health services are the same as those for inpatient and outpatient medical services. Like the expired federal law, these bills do not *mandate* mental health care coverage, but they differ from the federal law in that

- the Michigan bills would require commercial insurers, Blue Cross Blue Shield of Michigan, and HMOs to ensure that any cost-sharing amount or coverage limitation imposed on those requiring mental health services is no different from that imposed on those requiring medical services, and
- the bills do not exempt small businesses (those with 50 or fewer employees) from providing such coverage for their workers.

As of this writing, none of the bills has been reported out of committee. Parity opponents argue that it could be costly for health insurers and employers that provide insurance. Supporters counter that providing mental health coverage actually will lower the overall costs of treating mental illness because when it is treated early, the amount of care needed is far less than when it has become chronic due to a lack of care. Parity supporters also maintain that employers would receive a net benefit from paying the

EXHIBIT 2. Michigan Community Mental Health Expenditures, FY 1996–97 through FY 2001–02 ($ millions)



SOURCE: Senate Fiscal Agency.

additional costs of mental health coverage because absenteeism from mental illness would be greatly reduced and job productivity increased.

Medicaid Prescription Drug Formulary

Several mental health organizations have joined the national Pharmaceutical Research and Manufacturing Association in its lawsuit against the state's new Medicaid prescription drug formulary, which limits the drugs that may be covered without preauthorization. Opponents of the formulary say that the state's new plan will deny patients access to some necessary psychotropic drugs. The MDCH argues that if a drug requiring prior authorization is medically necessary, the patient will receive that drug, but if a less costly drug will serve as well, Michigan taxpayers should not have to pay for the more expensive medication. Opponents counter that by requiring prior authorization for certain drugs, mental health patients, and their physicians, are forced to jump through too many hoops to get necessary medication.

The issue was addressed by the Senate Appropriations Committee in SB 1101, the FY 2002–03 funding bill for the MDCH. The committee added language allowing the state to negotiate rebates with pharmaceutical manufacturers. If the pharmaceuticals provide quarterly rebates on all their products, the products will not be subject to prior authorization except in the case of (1) drugs that required prior authorization during FY 2000–01 and (2) drugs dispensed to Medicaid recipients enrolled in health plans. At this writing, the bill has passed the Senate and awaits action in the House.

See also Aging; Health Care Access, Medicaid, and Medicare; Special Education.

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