SENATE FISCAL AGENCY

PUBLIC MENTAL HEALTH MANAGED CARE
by Steve Angelotti, Fiscal Analyst

Since the advent of mental health deinstitutionalization several decades ago, the public mental health services system has greatly evolved. Prior to this evolution, the system focused on only the most acute cases, in the two major categories of the mentally ill and the developmentally disabled, and treated those cases in large state-run facilities.

Presently, treatment in state-run facilities is only one of many treatment options. The public mental health services system now covers far more people and, thanks to new treatment options and advances in psychotropic medication, the system treats far fewer people in state-run institutions.

Evaluation of Michigan's Mental Health Services System

In Michigan, this process began with the first wave of deinstitutionalization and the rise of the Community Mental Health (CMH) system. Individual counties or several counties working together for greater efficiency began to take over public mental health services. The CMH boards were appointed by (and responsible to) the county commissions and were funded through a 90%/10% State/county match.

This evolution continued over two decades and through several waves of deinstitutionalization until the early 1990s, when the final two CMH boards became "full management". This meant that all CMH boards in the State (now numbering 49) took on full responsibility for all levels of treatment. Most of the treatment and expenditures were now in the community, but the CMH boards did contract with the State for the provision of services in State facilities to the segment of their clientele that required the most direct care.

In 1995 a second major change occurred with the revision of the Mental Health Code. Language added to the revised Code permits CMH boards to become "authorities", with greater autonomy. These changes helped prepare the CMH boards for the eventual transition to managed mental health care, as they could now more closely resemble other managed care organizations.

Since 1995 there has been much discussion about converting public coverage for both the mentally ill and developmentally disabled populations to a managed care model. After much input from the CMH system, clients, client families, interest groups, the Executive office, and the Legislature, plus approval by the Federal Department of Health and Human Services of a needed Medicaid waiver, public mental health managed care was implemented on October 1, 1998.

Funding Managed Care

Perhaps the most difficult issue to deal with in shifting to managed care was the question of funding. The funding levels provided to CMH boards have reflected government by inertia rather than a global approach: Boards received initial levels of funding, then were granted increases due to inflation as well as due to program expansion. As these changes occurred at different times for different boards, the per capita expenditure by any measure of total population or population at risk has differed significantly from one CMH to another. Some of the smaller (and a few larger) CMH boards receive over $200 per capita while other CMH boards operate with less than $100 per capita.

Any new funding formula could create problems. A sudden shift to a new system would create "winners and losers" and cause severe dislocations in services. As the new funding formula would represent a capitation system (in which there would no longer be fee-for-service reimbursement), the CMHs could be at severe financial risk if there were a sudden shift in funding.

On the other hand, a CMH that was underfunded under the current system also would be at financial risk unless its funding were increased to reflect more accurately the actual underlying need for mental health services.

Furthermore, as noted before, there are two distinct populations (mentally ill and developmentally disabled) covered. Making matters more complicated is payment eligibility–some clients are covered by Medicaid and others are not. The Medicaid population at risk for mental health problems may be estimated through one set of data, since Medicaid data are collected fairly thoroughly, while the non-Medicaid population is more difficult to estimate.

With the help of the Citizens' Research Council, the Department of Community Health (DCH) developed a formula that attempted to strike a balance between these two concerns.

For the non-Medicaid population the Department developed a weighted formula to spread approximately $430 million in funding to the CMHs. This formula used total population (weighted at 10%), population under age 18 at or below the poverty level (15%), population 18 and over at or below the poverty level (35%), and population with serious mental disorders (40%). Furthermore, to prevent severe dislocations, the total redistribution is limited to 10% of the difference between the current distribution and the new formula distribution.

For example, for the Detroit/Wayne CMH, the new formula without this limitation would result in a distribution of approximately $134 million, compared with the current-year estimated distribution of $149 million, for a reduction of $15 million. Because of the 10% limitation, however, the redistribution is limited to $1.5 million, or 10% of the $15 million, for a total distribution of approximately $147.5 million under the new formula.

For the Medicaid component the process is more complicated, as there are separate calculations for the developmentally disabled and the mentally ill populations. In this case the per month capitation rate was based on actuarially adjusted fiscal year (FY) 1995-96 historical rates with varying rates applied for categories of age and Medicaid eligibility. Adjustments were to be made up or down depending on the number of eligible clients served. For the mentally ill population this represents an attempt to redistribute funding toward a Statewide average. As with the non-Medicaid portion, the redistribution is limited to 10%; however, CMHs whose costs are within 10% of the average are not adjusted.

Again, for the Detroit/Wayne CMH, if one simply considers the estimated Medicaid capitation for the developmentally disabled and the mentally ill, the CMH appears to face a possible $6 million reduction in revenue. When funding related to Medicaid estimated payments for institutional care is added, however, the Detroit/Wayne CMH could realize an increase in funding of approximately $50 million for its Medicaid population. This increase would be limited due to the 10% redistribution rule, which helps prevent major changes up or down to allow a slow change to a more rational funding basis. The model is somewhat similar to the changes made in the School Aid formula after the passage of Proposal A in 1994: The major redistribution is not due to a huge reduction in funding for the CMHs that have the highest per capita reimbursements, but rather due to the increases given to the CMHs that have the lowest reimbursements, which allows the less well-funded boards to "catch up" to the better-funded boards.

Mental Health Managed Care Issues

The State is now five months into the first year of managed mental health care. One of the major concerns is how the public mental health care system in Michigan will evolve under managed care. Managed care has, in the past, mostly covered general health care to populations that, by and large, do not have pre-existing conditions, thus risk is well-spread. The clientele for the mental health managed care system generally does have pre-existing conditions, so the advent of managed mental health care is one that could produce some unique problems.

In the November/December 1998 issue of Health Affairs, Dr. David Mechanic of Rutgers University explores these issues in a thorough paper (David Mechanic, "Emerging Trends in Mental Health Policy and Practice", Health Affairs, November/December 1998, pages 82-98). Dr. Mechanic notes that mental health managed care offers the promise of cost control as well as mental health and physical health insurance parity, to whit, managed care "enables greater parity of mental health insurance benefits with general medical care, because by constraining benefits and utilization, it makes the parity concept more economically and politically acceptable" (Mechanic, page 84). He predicts that the effects of the limited Federal mental health parity law that went into effect in 1998 will be minimal but should lead to some minor shifting in health care expenditures toward mental health.

The major concern raised by Dr. Mechanic, and the concern that should be most on the minds of decision-makers, is the integration of a complete, cohesive array of mental health services under a managed care format. The proper coordination of acute services with ongoing but less intensive chronic care services is something that should inevitably emerge due to cost pressures and the enforcement of quality measures, but such shifts in health care markets do not happen immediately.

Dr. Mechanic's own study of New York State hospitals with specialized psychiatric institutions indicated that there was a wide variance in treatment concept: Some used an acute care model while others took a long-term approach with a significant emphasis on outpatient services. It is likely that managed care's emphasis on containing long-term costs and avoiding repeated expensive acute episodes will lead to fuller implementation of the latter approach. This shift, however, will take time. Dr. Mechanic also expects that the shift from acute services to a more preventive approach would include greater family involvement and "may increase families' caretaking burdens" (Mechanic, page 93).

It should be noted, however, that Dr. Mechanic argues that mental health managed care is likely to lead, over time, to a more integrated system that should serve clients better. As he notes, "...inpatient care has often been poorly coordinated with aftercare, clients often fail to get needed services, and patients have unnecessary repeated rehospitalizations . . . [I]ncentives to provide a balanced system of mental health services have been absent . . . If managed care companies are at financial risk for repeated hospitalizations, they have an incentive to plan transitions and aftercare carefully and take measures that reduce the need for rehospitalization" (Mechanic, page 95).

In the end, Dr. Mechanic sees public mental health managed care as inevitable given the costs and coordination problems inherent in the current system. He strongly emphasizes the need for clearly defined expectations written into contracts with providers. He endorses strong state oversight, especially in the setting of standards, the collection of data, and the coordination of services. Finally, he urges state regulation guaranteeing confidentiality, access to specialists, and an impartial appeals process (Mechanic, pages 95-96).

Conclusion

The future of public managed mental health care will be dictated by decisions made by the Governor and the Legislature. The Governor has proposed new language for the FY 1999-2000 DCH budget that would permit a pilot project for the bidding out of mental health services. The language does not specifically mention who would be eligible to submit bids, but it is clear that the CMH system's current monopoly on provision of services would end if such a pilot project were expanded statewide.

Decision-makers in Lansing will have to decide whether to approve such pilots as well as whether, if the pilots prove successful, to move the state toward fully bidding out such services. They would also have to determine what role, if any, the CMHs would play in bidding for or providing such services. While a major step has been taken in moving to a capitated system, other decisions with even greater potential consequences lurk around the corner.