State Notes
TOPICS OF LEGISLATIVE INTEREST
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Senate Fiscal Agency

Background Information on Mental Health Issues
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In recent months, a fair amount of attention has been paid to issues involving Michigan's mental health system. Three issues of particular interest are: 1) Community Mental Health (CMH) and other mental health-related program expenditures, 2) closures of State mental health facilities, and 3) CMH administrative costs.

Community Mental Health and Related Program Expenditures

One of the key questions asked by many interested parties is, "How much does the State spend on mental health services?" Table 1 provides a history of mental health expenditures since fiscal year (FY) 1989-90.

The most simplistic approach is to look at the amount spent on Community Mental Health services. These services are paid out of two line items in the Department of Community Health budget: the Medicaid Mental Health Services line item, which pays for CMH services to Medicaid-eligible clients, and the CMH non-Medicaid line, commonly known as "the Formula", which pays for mental health services to those not eligible for Medicaid. As some have noted in their testimony before Senate committees (and as Table 1 shows), Medicaid has increased from 25% of the CMH budget in FY 1989-90 to almost 80% of the CMH budget in FY 2003-04.

It also may appear from Table 1 that CMH expenditures have increased by a factor of four from FY 1989-90 to FY 2003-04. This is a highly misleading interpretation, however.

Ever since deinstitutionalization began in the 1960s, mental health responsibilities and funding have been transferred from State institutions and State-funded group homes to the CMH system. Thus, much of the increase in CMH expenditures over the years has not been an actual funding increase, but rather has been a shift in funding from State-run programs to locally run programs.

The fairest and most informative way to look at mental health expenditures is to examine combined mental health expenditures on locally run *and* State-run programs. This is the picture provided in Table 1.

State-run mental health services are funded in an unusual manner: Money is appropriated to the CMH boards (CMHs) for Purchase of State Services (POSS). The CMHs then spend that funding to pay for services for their clients in State facilities (institutional POSS) and State-run group homes (Community Residential Services or CRS POSS). Additionally, State facilities and group homes receive funding from Medicaid (mostly for services to the developmentally disabled), third-party collections (for those with insurance), and other sources.

Table 1 provides data on spending on CMH, spending on State institutions, and CMH boards', Medicaid, and third-party spending on State-paid Community Residential Services (CRS, commonly known as "group homes"). Much of the spending on State institutions has been transferred to CMHs as State facilities have closed and State facility population has decreased.

In fact, spending on facilities through POSS and other funding has declined from $315 million in FY 1989-90 to an appropriated $117 million in FY 2003-04. This reduction in funding actually has been a transfer of funding to the CMH system.

An even more dramatic reduction in State-directed programming has occurred with CRS. Spending on State-run group homes through POSS and other funding has declined from $350 million in FY 1989-90 to a mere $300,000 in FY 2003-04. Community Mental Health boards have taken over almost all of the formerly State-paid CRS group home leases and funding. There is about $3.8 million remaining in State CRS services and that funding will eventually be transferred to CMHs as State-paid leases expire.

There are also other, smaller line items aside from the Medicaid Mental Health Services and CMH non-Medicaid lines that provide funding to CMH; these smaller line items have been included in Table 1 as well. These lines include CMH Multicultural Services, the Federal Mental Health Block Grant, and CMH Respite Services, as well as other programs that have since been rolled up into the main CMH line items.

One other notable change occurred in FY 1998-99, upon the establishment of the managed care model for CMH services: The funding formerly spent in the physical health Medicaid unit on psychiatric hospitalization was transferred to the CMH Medicaid line. This funding, if included in the columns in Table 1 for years from FY 1998-99 onward, would make for an unfair comparison of funding between the years before FY 1998-99 and subsequent years, with funding available for mental health services being overstated. Thus, the expenditures and appropriations for FY 1998-99 and onward were adjusted in the table to remove the about $97 million that was transferred into the Medicaid Mental Health Services line.

Making all of these adjustments provides the basis for a reasonably fair comparison of mental health expenditures from FY 1989-90 to the present day.

Table 1 shows the results of this comparison. Adjusted expenditures on mental health services have grown from $1.05 billion in FY 1989-90 to an appropriated $1.77 billion in FY 2003-04, an annual growth rate of 3.8%, which is about 1% above the average annual growth in the Detroit Consumer Price Index (CPI), 2.7%.

What also stands out is that the rate of growth since FY 1998-99 has been far lower than the earlier growth. Once capitation rates were set in FY 1998-99, resulting in a significant increase in funding for CMH, there were no Medicaid rate increases until the “local match” program went into effect during FY 2002-03. The “local match” program provided a 2% increase in Medicaid rates, and a further rate increase of 1.6% is to be implemented in FY 2003-04. This 3.6% Medicaid increase has been the only rate increase over that five-year period.

One may notice a 2% annual growth rate since FY 1998-99 and wonder how 2% over five years equates to a one-time 3.6% rate increase. The simple answer is that it does not. More than just CMH Medicaid funding is being considered. Furthermore, the Medicaid caseload has grown, so some of that 2% average annual growth actually reflects the increase in the Medicaid caseload. The overall Medicaid caseload has grown nearly 20%. Fortunately for State finances,

almost all of that growth has been in the far less expensive eligibility groups, so the weighted cost increase due to caseload has been just over 5%, or around 1% per year.

The end result is that there was significant growth in mental health funding until the first year of managed care, in FY 1998-99 (4.8% average annual growth from FY 1989-90 to FY 1998-99 vs. a 2.8% average annual increase in the Detroit CPI). Since FY 1998-99, however, the increases in funding are almost half due to an increased Medicaid caseload and the real increase has been in the range of 1% per year, well below the change in the Detroit CPI or any other inflation measure.

Also included in Table 1 is a comparison of mental health expenditures as a percentage of State Adjusted Gross Appropriations for all budgets. Data for FY 1989-90 were not included due to the large increase in State Adjusted Gross Appropriations following the March 1994 passage of Proposal A (the school finance reform proposal). One can see that State spending on the mental health programs delineated in this table has fluctuated between 4.44% and 4.86% of overall State Adjusted Gross expenditures. The current percentage of 4.59% is below the high point of 4.86% seen in FY 1998-99, which is not unexpected given the failure to increase CMH funding at a level equivalent to inflation since FY 1998-99.

Table 1 provides a reasonably clear and fair picture of changes in funding for the mental health system. There were above-inflation increases in funding until the first year of the Medicaid Managed Care Program, but since FY 1998-99 funding increases have been under the inflation level and the CMHs have been feeling financial pressures.

Mental Health Facility Closures

In the mid-1960s in Michigan, there were over 17,000 individuals in State facilities for the mentally ill and over 12,000 in State facilities for the developmentally disabled. Due to deinstitutionalization and the resultant facility closures, the combined total is now under 1,000 for the five remaining State facilities for the mentally ill and developmentally disabled, a 97% decline from the number of people in State institutions nearly 40 years ago.

Due to concern over the quality of life in institutions, the development of psychotropic drugs, and the growth of the CMH system, the vast majority of clients who would have been institutionalized in the mid-1960s are believed to be able to live in more independent community settings. Most of the actual facility population downsizing took place between 1965 and 1980 (when the total census went from 29,000 to 9,000). That period of deinstitutionalization was not particularly contentious; there was a strong consensus that these clients would be better served in the community. Since 1980, facility downsizing and closures have been more controversial.

Table 2 shows the change in census at State facilities since FY 1979-80. As one may see from Table 2, the State operated 10 facilities for mentally ill adults in FY 1979-80, treating over 3,800 residents. At present, the State operates three institutions for mentally ill adults, housing a little over 600 clients. (See Figure 1 for a map of current and former State of Michigan facilities for mentally ill adults.)

The State has gone from operating six facilities for mentally ill children in FY 1979-80, treating over 400 residents, to one facility housing about 60 residents (Figure 2).

The State has gone from operating 12 facilities for the developmentally disabled in FY 1979-80, treating almost 4,400 residents, to one facility housing under 200 residents (Figure 3).

Finally, the State has closed its two more general mental health centers, the EPIC Center and the Lafayette Clinic, which in FY 1979-80 housed nearly 130 residents combined.

The decline in State facility census has occurred in several waves. The closures in the early 1980s and early 1990s appear to have been mostly budget-driven, as the State was in a budget crisis in both those periods and was seeking savings. The closure waves in the late 1980s and in FY 1997-98 appear to have been census-driven, as facilities had low populations and consolidation of facilities made economic sense.

Figure 4 shows the decline in State facility census for the three client groups, with the FY 1979-80 final census being equated to 100. As one can see, the most dramatic drop has been in the developmentally disabled institutional population, which has declined by over 95% since FY 1979-80. The decline in institutional population for the mentally ill adult and mentally ill children population also has been steep, well over 80% in each case.

These census declines reflect a shift from treatment for the more serious cases in a regional system of State-operated hospitals and centers to treatment in community-based settings. The most severe cases have continued to be treated in the remaining open State institutions.

It must be noted that nobody enters a State institution without going through the CMH system first. It is generally true that closures and consolidations have been made only when the census numbers dictated that there were sufficient vacant beds to make the closure of some facilities sensible from a budgetary perspective. Thus, the frequent focus on whether or not to close an institution often misses the point: Closure decisions are usually dictated by census numbers and the census numbers are dictated by case-by-case admissions decisions made by the local CMH boards.

Community Mental Health Administrative Costs

Each year, under Section 404 of the Department of Community Health (DCH) budget bill, the State's CMH boards must report data to the Department and the Legislature on their operations in the previous fiscal year.

One of the pieces of information reported by the CMHs is administrative expenditures. Table 3 shows the FY 2001-02 administrative expenditures by CMH board. Overall CMH administrative costs are 8.48% of total expenditures.

The table does snow some outlying CMH boards with much higher administrative costs. It should be noted that just about every one of those boards is in a small county and thus fixed costs and the lack of economies of scale are a concern. This concern about efficiency is one

reason that the new Federal mental health waiver (regarding the delivery of Medicaid speciality services) limited contracting to affiliations of CMHs with at least 20,000 covered Medicaid lives. This provision will result in reduced administrative costs.

In fact, looking at the FY 2001-02 data, if CMHs are grouped by their FY 2002-03 affiliations, there is only one affiliation with administrative costs over 15% and most affiliations have administrative costs under 10%. These numbers should decline in the future as affiliated CMHs merge their services and administrative functions.

One may quite correctly note that some CMHs contract out many of their services and the administrative costs reported do not include the administrative costs of subcontractors. To see the overall administrative cost of the mental health system, it is necessary to look at more than just the direct administrative costs.

There are no data on subcontractor administrative costs reported to the Legislature. Most CMH functions are run directly by CMHs, however, and the administrative cut for subcontractors, apart from various anecdotal situations, is relatively minor. It is highly unlikely that the combined administrative "take" for CMHs and their subcontractors is over 15%.

A figure around 15% would put CMHs in line with Michigan health maintenance organizations (HMOs), which cover physical health services through a managed care model. The HMOs' administrative costs generally range from 10% to 15% of total costs.

It should be expected, of course, that due to the affiliations and improvements in efficiency, CMH administrative expenses should decline as a percentage of total costs in the future.

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Table 1

HISTORY OF COMMUNITY MENTAL HEALTH AND RELATED PROGRAM EXPENDITURES

	Appropriated FY 1989-90	Actual Expenditures FY 1994-95	Actual Expenditures FY 1996-97	Adjusted Expend. (1) FY 1998-99	Adjusted Expend. (1) FY 2000-01	Estimated Expend. (1) FY 2002-03	Adjusted Appropriations (1) FY 2003-04
Community Mental Health Expenditures	**$381,408,700**	**$740,471,281**	**$936,236,798**	**$1,379,662,400**	**$1,400,397,400**	**$1,538,242,900**	**$1,604,262,900**
CMH Medicaid client spending	93,655,849	433,738,424	572,549,708	1,079,567,600	1,091,254,200	1,228,242,900	1,275,868,800
CMH "Formula" (non-Medicaid) spending	287,752,851	306,732,857	363,687,090	300,094,800	309,143,200	310,000,000	328,394,100
Sum of "Other" CMH Lines (2)	4,500,000	43,808,414	16,610,699	9,536,800	16,556,700	19,299,800	19,981,200
Sum of Institutional POSS (3)	194,762,000	207,833,950	175,922,867	149,987,200	166,918,500	110,000,000	97,115,800
Sum of Institutional Other (4), (5)	120,000,000	78,696,011	67,751,595	56,998,500	69,765,100	58,168,800	48,025,200
Sum of CRS POSS	225,421,200	126,346,667	101,289,089	0	0	0	0
Sum of CRS Other Funding (4), (5)	125,000,000	104,375,313	93,047,961	6,720,900	300,000	300,000	300,000
Total of Other Related Expenditures	**$669,683,200**	**$561,060,355**	**$454,622,211**	**$223,243,400**	**$253,540,300**	**$187,768,600**	**$165,422,200**
Grand Total Expenditures	**$1,051,091,900**	**$1,301,531,636**	**$1,390,859,009**	**$1,602,905,800**	**$1,653,937,700**	**$1,726,011,500**	**$1,769,685,100**
Average Cumulative Annual Change since FY 1989-90		**4.4%**	**4.1%**	**4.8%**	**4.2%**	**3.9%**	**3.8%**
Average Cumulative Annual Change since FY 1998-99					**1.6%**	**1.9%**	**2.0%**
Average Cumulative % Change in Det. CPI since FY 1989-90		**3.1%**	**3.0%**	**2.8%**	**2.9%**	**2.8%**	**2.7%**
State Adjusted Gross Appropriations (all budgets)		**$27,351,901,100**	**$29,594,523,700**	**$32,968,977,300**	**$36,972,014,800**	**$38,868,573,300**	**$38,563,666,300**
Mental Health Expenditures as % of State Adjusted Gross		**4.76%**	**4.70%**	**4.86%**	**4.47%**	**4.44%**	**4.59%**

General Note: The greatest challenge in comparing CMH-related spending from year to year is accounting for transfers in funding from institutions and Community Residential Services (CRS) to CMH. The best approach is to take a global look at spending on CMH, institutions, and CRS (while adjusting for all transfers, such as Medicaid Psychiatric Hospitalization, that were not part of that universe). This approach guarantees an "apples to apples" comparison of expenditures and eliminates the need to debate the estimated value of each transfer from an institution or CRS into CMH.

(1) The CMH expenditure level was reduced by approximately $97 million in order to adjust out the transfer in of Medicaid Psychiatric Hospitalization and the Medicaid CMH Special Financing. The funding associated with these transfers was removed from the total CMH expenditure number as those transfers came from outside the universe of CMH, institutions, and CRS.

(2) These are other CMH-related lines that have appeared in past budgets, including Community Demand, Respite Services, Expanded CMH Services, Prior Year Settlements, CMH Multicultural, CMH Act 423, CMH Critical Needs Services, and the Federal Mental Health Block Grant.

(3) These are actual expenditures from Purchase of State Services (POSS) used to support the institutional line items.

(4) These rows represent the actual expenditures from fund sources other than POSS to support CRS and institutions for the mentally ill and developmentally disabled.

(5) Approximate values used for FY 1989-90 "other" funding as the budget structure was reflected differently then and only approximate values are available.

Sources: Mental Health/Community Health bill histories and MAIN

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Table 2

STATE MENTAL HEALTH INSTITUTIONAL CENSUS: SELECTED YEARS 1980 - 2003

	9/30/80	9/30/83	9/30/86	9/30/89	9/30/92	9/30/95	9/30/98	9/30/01	8/31/03
TOTAL All Facilities	**8,779**	**6,610**	**5,675**	**4,532**	**2,743**	**1,805**	**1,247**	**1,198**	**864**
Adult									
Caro Regional	10	12	98	126	141	90	184	193	182
Clinton Valley Center	619	530	469	447	411	329	0	0	0
Coldwater	0	0	117	230	0	0	0	0	0
Detroit Psychiatric Institute	128	139	157	149	137	105	0	0	0
Kalamazoo Regional	736	617	561	478	313	181	135	125	183
Michigan Institute for Mental Health	61	0	0	0	0	0	0	0	0
Newberry Regional	156	79	68	82	0	0	0	0	0
Northville Regional	731	972	897	742	661	385	371	376	0
Walter Reuther	216	319	280	289	270	196	210	227	243
Traverse City Regional	360	189	132	0	0	0	0	0	0
Ypsilanti Regional	805	648	530	295	0	0	0	0	0
TOTAL Adult	**3,822**	**3,505**	**3,309**	**2,838**	**1,933**	**1,286**	**900**	**921**	**608**
Children									
Detroit Psychiatric Institute	10	11	13	12	10	13	0	0	0
Arnell Engstrom (Traverse City)	43	34	29	33	0	0	0	0	0
Fairlawn (Clinton Valley)	112	144	122	125	114	27	0	0	0
Hawthorn Center (Northville)	136	103	126	118	106	65	111	95	59
Mary Muff/Pheasant Ridge	44	44	34	43	22	12	0	0	0
York Woods	84	67	57	60	0	0	0	0	0
TOTAL Children	**429**	**403**	**381**	**391**	**252**	**117**	**111**	**95**	**59**
Developmentally Disabled									
Alpine Regional	133	0	0	0	0	0	0	0	0
Caro Regional	594	387	332	265	132	101	0	0	0
Coldwater Regional	588	427	113	17	0	0	0	0	0
Hillcrest Regional	331	0	0	0	0	0	0	0	0
Macomb-Oakland Regional	115	85	106	0	0	0	0	0	0
Mt. Pleasant	449	424	358	217	206	172	161	182	197
Muskegon	379	340	265	238	0	0	0	0	0
Newberry	233	149	98	55	0	0	0	0	0
Northville Residential	138	0	0	0	0	0	0	0	0
Oakdale Regional	819	534	427	210	0	0	0	0	0
Plymouth Center	468	93	0	0	0	0	0	0	0
Southgate Regional	152	161	168	174	184	129	75	0	0
TOTAL Developmentally Disabled	**4,399**	**2,600**	**1,867**	**1,176**	**522**	**402**	**236**	**182**	**197**
Other									
EPIC Center	14	0	0	0	0	0	0	0	0
Lafayette Clinic	115	102	118	127	36	0	0	0	0
TOTAL Other	**129**	**102**	**118**	**127**	**36**	**0**	**0**	**0**	**0**

Source: Department of Mental Health/Department of Community Health Census Reports

Table 3

FY 2001-02 COMMUNITY MENTAL HEALTH ADMINISTRATIVE EXPENDITURES

	CMH Administrative Expenditures	Total CMH Expenditures	Percent Administrative
Allegan	$1,555,600	$15,341,900	10.14%
Antrim/Kalkaska	970,400	10,044,300	9.66%
AuSable Valley	1,150,900	10,935,200	10.52%
Barry	738,800	4,138,600	17.85%
Bay/Arenac	5,831,000	29,389,000	19.84%
Berrien	5,100,600	26,882,000	18.97%
Central Michigan	4,130,200	56,123,600	7.36%
Clinton/Eaton/Ingham	5,027,200	59,605,400	8.43%
Copper Country	1,417,100	13,808,100	10.26%
Detroit/Wayne	26,801,300	524,213,800	5.11%
Genesee	8,881,900	91,986,800	9.66%
Gogebic	953,500	6,263,600	15.22%
Gratiot	113,500	7,734,500	1.47%
Great Lakes (G. Traverse/Leelanau)	1,510,700	18,260,100	8.27%
Hiawatha (Chip./Mack./Schoolcraft)	2,397,500	13,490,000	17.77%
Huron	1,186,600	7,330,400	16.19%
Ionia	1,554,200	9,413,700	16.51%
Kalamazoo	3,031,200	48,112,400	6.30%
Kent	4,017,400	78,568,700	5.11%
Lapeer	N/R	10,631,900	N/R
Lenawee	1,330,200	15,081,100	8.82%
Lifeways (Hillsdale/Jackson)	2,972,500	29,219,400	10.17%
Livingston	1,837,200	15,863,000	11.58%
Macomb	8,359,800	120,768,500	6.92%
Manistee/Benzie	2,000,200	13,969,000	14.32%
Monroe	2,209,900	24,472,600	9.03%
Montcalm	1,929,500	6,503,200	29.67%
Muskegon	3,975,800	35,093,100	11.33%
Newaygo	1,487,200	7,340,000	20.26%
North Central	1,234,800	15,633,200	7.90%
Northeast Michigan	1,238,300	18,289,500	6.77%
Northern Michigan	1,958,200	17,545,300	11.16%
Northpointe (Dickin./Iron/Menom.)	1,551,400	14,517,000	10.69%
Oakland	8,169,900	178,267,600	4.58%
Ottawa	2,909,300	24,547,000	11.85%
Pathways (Alger/Delta/Luce/Marq.)	5,685,000	30,160,300	18.85%
Pines (Branch)	555,700	8,415,400	6.60%
Saginaw	4,996,300	41,344,300	12.08%
Sanilac	1,847,400	15,148,900	12.19%
Shiawassee	2,807,500	12,706,600	22.09%
St. Clair	5,356,700	34,967,400	15.32%
St. Joseph	997,200	10,274,300	9.71%
Summit Pointe (Calhoun)	1,009,300	22,416,100	4.50%
Tuscola	2,890,700	12,464,600	23.19%
Van Buren	1,798,700	13,315,300	13.51%
Washtenaw	3,644,000	37,608,500	9.69%
West Michigan	2,920,300	13,245,600	22.05%
Woodlands (Cass)	991,800	8,386,800	11.83%
TOTAL	**$155,034,400**	**$1,829,205,700**	**8.48%**

Figure 1

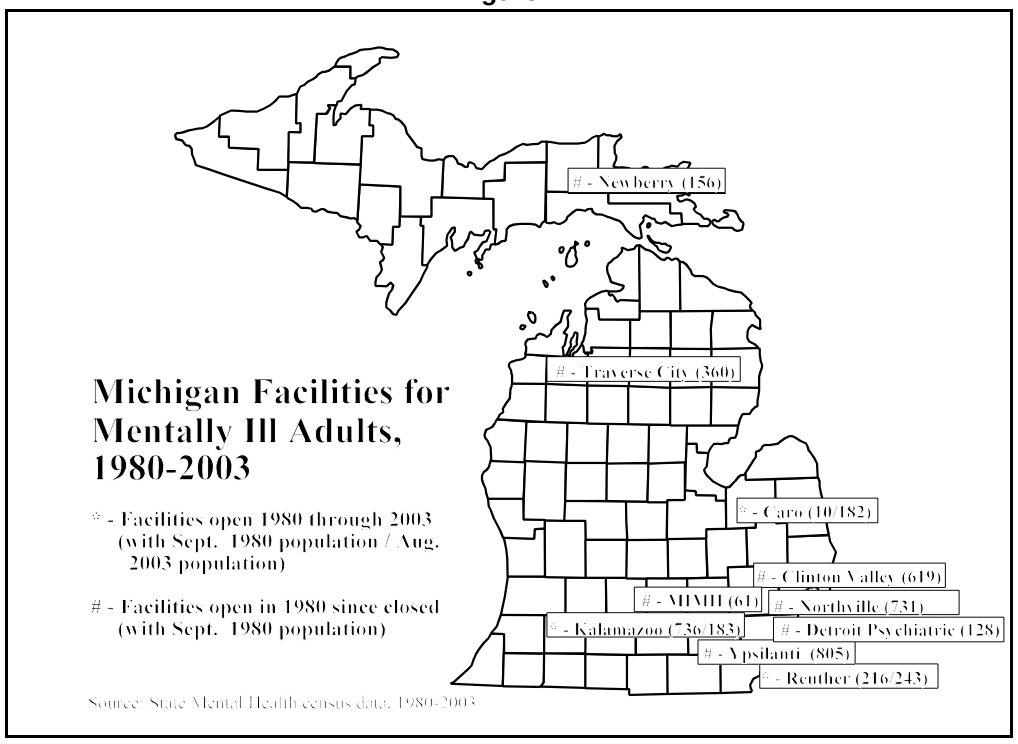

Figure 2

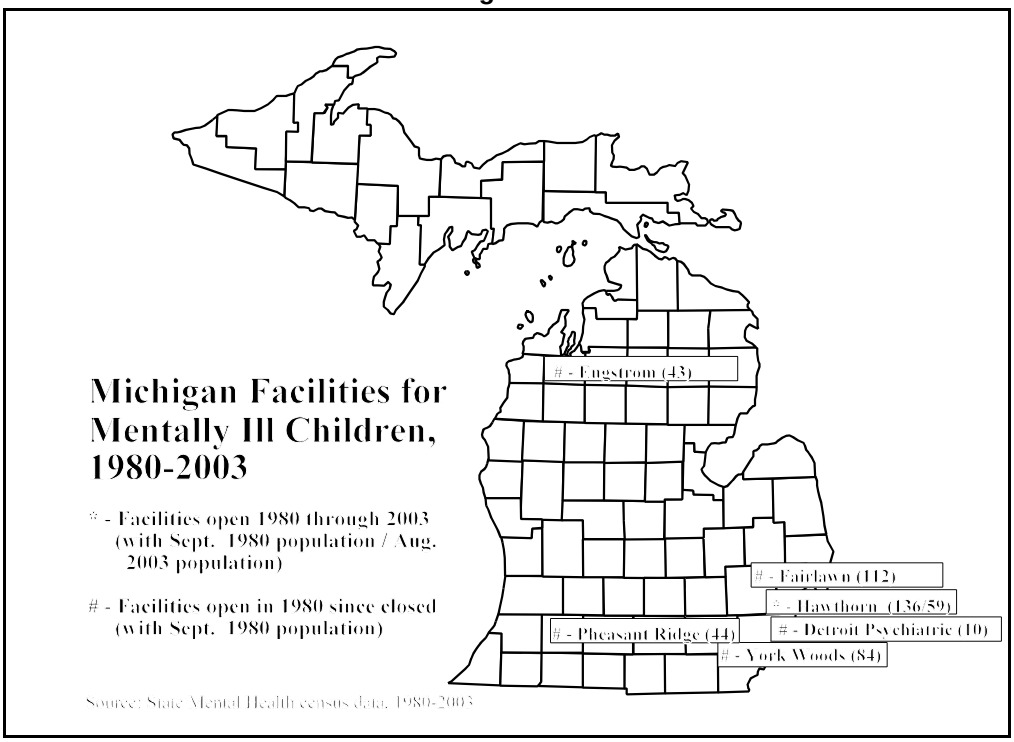

Figure 3

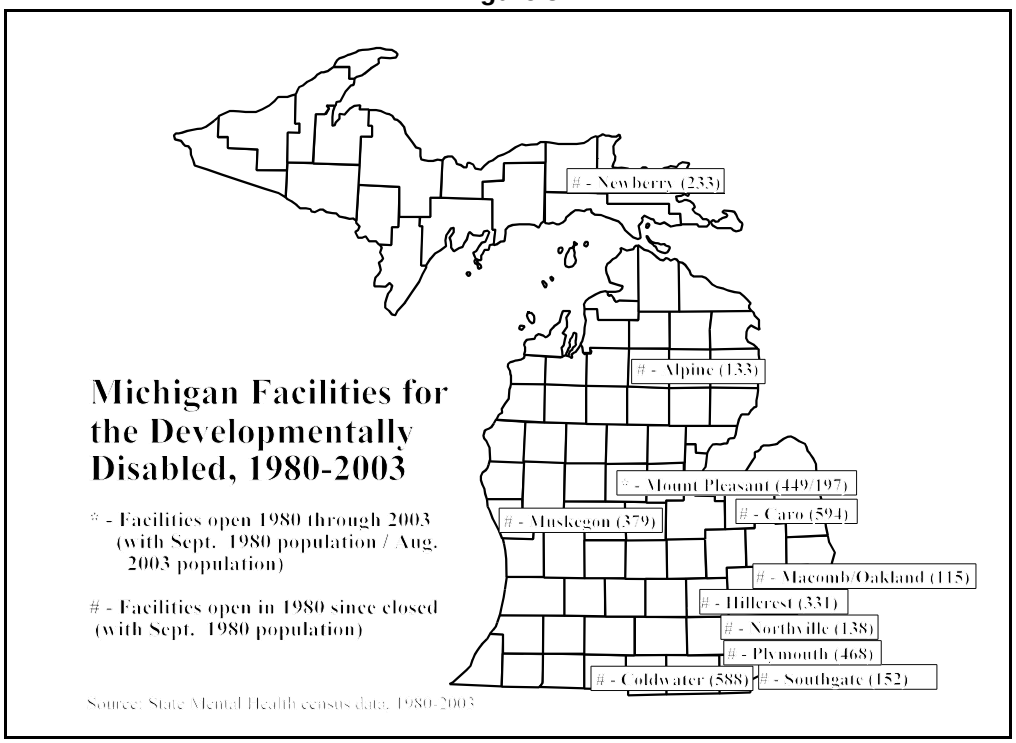

Figure 4