

MARO

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We've Come a Long Way Baby...and
What's Next for Michigan's Public
Mental Health System?

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Looking Back at the Decades

- Sixties : Community
- Seventies: Deinstitutionalization
- Eighties: Inclusion
- Nineties: Person- Centered
- Naughtyies:
 - Lost decade ?
 - Accountability and Best Practices
- Teens: Dissolution? Integration?

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Before 1960s

- DMH created 1945
- Psycho-pharmacy developments provide opportunities for persons with mental illness to leave state hospitals

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1960's

- 41 state hospitals and centers, over 40,000 residents
- GF/GP almost all in state hospitals
- State had created some local clinics
- Medicaid is created (1965)
- Federal Community Mental Health Act (1963)
- Federal staffing and building grants
- State Constitution articles
- PA54 : CMH Services Act (1963)
- 12 CMHB's created by 1965; grows to 55 (now 46)
- Use of state psychiatric hospitals drops from 20,000 to 11,000

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1970s

- SSI program started
- 1974 Mental Health Code
- MHC section 116 – objective to shift delivery from state to CMHBs
- 1978 service integration strategies (boundary between community and state)
- Group home development escalates (all GF, except for ICF/MR-AIS)
- 1979 Michigan's first clubhouse

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1980s

- Huge developments in this decade – lots of room for being creative
- Pilot CMHBs followed by Full Management (1981) to meet intent of MHC sec 116
- Medicaid Clinic Services Waiver (1983)
- Medicaid State Plan Clinic Services (1985)
- Medicaid case management (1987)
- Ongoing challenges as to how to cover clubhouses and day programs as Medicaid

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1980s continued

- Vocational seen as “not Medicaid” as covered by other federal program
- 5 year supported employment grants
- Michigan cannot match federal vocational funds – other states thank us!
- Creates CMH cash match (second version)
- Mainstreaming value
- Rising the bar for Expectations of persons with disabilities
- People First – the voice of persons we serve
- CLSA – expands supports for living arrangements (DD only)
- Home and Community Based 1915c waiver – includes supported employment (DD only)

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1990s

- Federal Rehab option – expands the Medicaid covered services
- Significant downsizing of state facilities
- People First language
- 1996 Mental Health Code revisions: Person centered planning and CMHSPs/Authorities
- Department of Community Mental Health created
- DCH unloads the last of state residential
- Medicaid managed care initiatives

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1990s continued

- CMHSPs maximize federal funding as getting no increase in GF; CMH GF continues to grow – all due to state services transfers
- CMH Lost funding opportunities 1981 to 1998
 - No/limited COLA on GF – loss of \$155m
 - GF reductions \$90m
 - No COLA on Medicaid – lost FFP \$166m
- CMH GF base in FY98 \$748m
- CMH Medicaid FFP \$430m (gross \$790m, uses \$360m of CMH GF)
- State Facilities POSS \$202m (beds: MIA 1319, MIC 131, DD 431; total 1881. Start of full management was at 8051)

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2000's

- Promise of CMH managed care
 - Alternative services to support PCP/choices
 - No managed care savings
 - Rate increases
 - Merges the Medicaid hospital funds (about 1/3 of MH \$\$)
 - Eliminates ICF/MR-AIS
 - Shared risk with DCH
 - Provides a seamless system
 - Provides a unique solution for spend-down
 - One of a kind waiver
 - Coordination of benefit with health care (MHPs)

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2000s continued

- Managed care funding base for Fy98
 - DD \$735m
 - MIA/SED \$346m
 - SA \$23m
- Medicaid monthly eligibility base : 317k DABs (of which 244k are disabled) and 757k TANF. Total about 1.1m
- Alternative services (1915a)
 - Anything that is “medically needy”
 - Removes obstacles on much of the pre-voc and voc services

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2000s continued

- Balanced Budget Act – effective 2004
 - Intended to provide beneficiaries from “bad” managed care
 - Intended to protect providers from state shortchanging rates
- What we got: Lots more rules, more reviews, more reports, more oversight requirements
- We also got B3 as basis for alternative services – DCH gets to decide (with CMS approval) what is on list. Eliminates specialized residential as bundled service. Eliminates “day program” as a service
 - Skill-building
 - Supported employment
 - Clubhouses
 - Peer operated drop-ins

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Naughties continued

- 2002 DCH consolidates Medicaid on 18 PIHPs (8 stand-alones, 10 regional affiliations)
- Medicaid eligibility increases – rapidly in 2003-2005 and again 2008 to present
- 2010 : CMS/OMB concern about growth of B3 in Michigan's PIHPs
- Federal threat of a number of rules changes to constrain spending on Medicaid
- DMB discovery of “optional” eligibility and “optional” services

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Naughties continued

- Adult Benefit Waiver (2004, by removing \$40m CMH GF)
- QAAP tax generates \$100m+ from PIHPs
- FY06 was the first year the state funded rate increase

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2000s continued

- Escalation of alphabet-soup of best practices
- Downsizing of state facilities – slows down
 - Closure of Southgate DD Center (?2001)
 - Closure of Mt Pleasant 2010
 - Closure of Northville 2002
- FY11: 3 MIA state facilities (680), 1 SED (75)
- Over 50% of MIA use by persons with forensic status, with CMHSPs paying once no longer IST
- What next for state facilities

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FY11 and Fy12 CMH Current Reality

- CMHSPs serve about 250, 000 people; of whom 150,000 (60%) are Medicaid
- Medicaid eligibles September 2010 : DABs at 450k, TANF at 1,140k, plus at least 5% retros – totals at 1.7m+
- Fy11 CMH Medicaid at \$2b (and being overspent by \$120m due to eligibles; about 80% of CMH funding); Community GF at \$282m; Purchase of state facility \$127m (auth to CMH at \$63m); ABW/Medicaid “Lite” at \$41m (plus SA)

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Current Reality

- FY10 service use reports (all fund sources)
- MIA
 - * 158,000 persons; \$820m
 - * State facilities: \$65m (8%)
 - * Community inpatient: \$108m (13%)
 - * Licensed residential: \$150m (18%), (3900 daily census)
 - * Non-licensed residential: \$39m (5%)
 - * Case management/ACT: \$178m (22%) (est 61,000 persons)

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Current Reality

- MIA ctd: Daytime activities: Vocational and Prevocational (5.5%)
 - * Clubhouses: 4000 consumers, \$22m
 - * Drop-ins: \$5.8m
 - * Skill building: 4000 consumers, \$11m
 - * Supported employment (excludes MRS): 2600 consumers, \$6m

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Current Reality

- DD
 - 40,000 consumers, \$1,057m
 - Inpatient: \$7m
 - Licensed Residential: \$400m (38%), census 7,700
 - Non-licensed residential: \$285m (27%)
 - Respite: \$35m (3%)
 - Support Coordination/case management: \$91m (9%),

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Current Reality

- DD: Daytime Activities (16%)
 - Clubhouses \$1.7m
 - Skill building: \$128m (12%)
 - Supported employment: \$23m (2%)
 - Prevoc (HSW): \$13m

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What Next? FY12 Appropriation

- MH/DD Medicaid increases by \$250m over FY11 (adjusting for removal of 6% use tax) to \$2,150m. This is a 13% effective increase in appropriation. About \$120m needed to fill in FY11 “hole”; about \$20m for actuarial soundness; leaves \$110m for Fy12 eligible trend
- SA Medicaid increased 21%
- Claims tax at 1% expense with no revenues (effectively a reduction)
- Michigan’s Budget Director has said that Medicaid would be next in line for any additional state funding

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FY12 Appropriation

- ABW decreases effectively by 18%, to \$32m (with no use tax). This is due to shift from FY11 with enhanced FMAP to regular FMAP (at 66.14% in FY12)
- ABW enrollment will be frozen until drops to about 50,000 persons (was at 90,000 early 2011)
- This reduction in revenues will be a challenge as the more needy persons remain in ABW and CMH services, with fewer covered lives capitation payment

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FY12 Appropriation

- CMH Community GF: \$274m
 - Hit by another \$8.5m decrease (about 2.7%), on top of \$5.4m in FY11, and \$40m (12% decrease) in FY10
 - Decrease for FY12: \$3.4m in administration and \$5.1m in general decreases (with no CMHSP having more than 4% hit on this second cut)
 - CMHSPs already reported decreasing admin costs by \$12m in Fy10, with \$3-4m being GF

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FY12 Appropriation

- DD Child C-Waiver: Decreased by \$2m to \$19m. Not sure why DDCW keeps being hit and/or had no increases compared to the other child physical health care waiver. Fee screens not adequate (DCH applies a fee screen adjuster once a year). DCH will freeze new applications
- SEDW at \$8m – appropriation is just the FMAP; either local entities or DHS settlement provides GF
- Multi-cultural: 15% decrease to \$5.8m
- Special funding –onetime funding added at \$3m
- SA non-Medicaid cut 2%

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What Next?

MEDICAID:

- Medicaid eligibles will not keep increasing; PIHPs have had 3-5% added revenues due to eligible trend, this has offset low rate increases
- DCH has been redistributing Medicaid via rate setting adjustments. PIHPs with traditional high DD penetration and where most needy persons were placed have had rate reductions (FY10 at -2%, FY11 at -5%).
- DCH wants to collect better severity data on all populations to aid in rate setting risk adjustment
- Bottom line- PIHPs will have to work out how to ratchet back Medicaid spending, especially for persons with developmental disabilities
- At the same time there is more emphasis on certain values and outcomes: smaller living arrangements, less use of licensed settings (loss of economy of scale), employment, more use of peers

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What Next?

GF

- GF funding continues to erode – vulnerability as does not draw down federal funding
- Mental health parity in Michigan would help alleviate some of the GF pressure
- Much of CMH system at restricted benefit of crisis/hospitalization and limited supports
- At same time greater expectations on community collaboration and community benefit
- Early Adopter (Health Care Reform) could have been used to leverage CMH GF for an expansion of Medicaid “Lite” for very low income childless adults. Issue was where the state match for healthcare to come from. If wait until 2014 then expansion almost all covered by federal funding
- Health care reform takes Medicaid to 133% poverty: How much of CMH GF population will this cover? It will alleviate the \$22m GF spent on spend-downs as spend-down disappears.
- Some ball-park #s: 250,000 served by CMH, 150,000 Medicaid, 15,000 ABW, leaves **85,000 without insurance**, plus some of that 165,000 in Medicaid/ABW use GF sometime in the year

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What Next: Health Care Reform

- Medicaid is expanded to 133% poverty: Basically only adds childless adults and spend-down – so not a huge influx of new people. There will be the woodwork effect, ie persons currently eligible who are not in Medicaid
- Medicaid expansion allows states to configure different benefit packages, eg Medicaid “lite”
- Medicaid as a Block Grant – as a way to deal with federal spending on Medicaid

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What Next: Health Care Reform

Medicaid ctd

- Where it gets complicated is the structure of Medicaid, the issue of dual eligibles (and accountable care organization construct as a managed care concept for unfettered fee-for-service Medicare); the construct of comprehensive medical “homes”
- How do the current specialty waivers fit in with these new constructs?
- Will there be a specialty waiver (carve-out) after 2014 for persons with MH, DD, and SA specialty needs?
- Emphasis on integrated care – but various ways that could happen
- DCH gets to make some huge decisions

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Health Care Reform PURE SPECULATION

- Is the CMHSP system broken?
- Is the Medicaid carve-out the best way to meet needs of 150,000 persons with MH or DD needs?
- What are the implications of the shift to the term “behavioral health” ? The advocates dislike it – re-stigmatizes persons with serious illness and disabilities
- Is the CMHSP system to be dismantled with respect to its direct relationship with DCH. Perceived as “government”, and private is better (note 80% of CMH services are provided by private agencies; in addition CMH administration costs are less than 10% including admin for direct services, and at about 8% for benefit plan management)
- Do the Medicaid Health Plans want the CMH business?
- There is dissonance between the integrated/ACO construct and a MCO structure

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Health Care Reform PURE SPECULATION

- Health Plans likely have more interest in MH and SA
- Health Plans added as a layer would strip funding away from services (as much as 15%)
- Health Plans likely to carve it out – at 85c on the \$ - as psychosocial, residential, employment, skill-building, case management not their forte
- Role of FQHCs is interesting (they cannot be an ACO at this time) and a relationship that many CMHSPs are pursuing for collaboration/integration
- Many adults with serious mental illness are dual care/caid
- What happens to residual GF population above 133% FPL – they will be required to purchase insurance (hopefully with MH parity) but it will be a limited MH benefit (basically therapy, meds, physician, inpatient)

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Health Care Reform PURE SPECULATION

- What happens to the \$1b+ DD system? Unlikely to be placed under Medicaid Health Plans?
- What happens to persons with developmental disabilities under age 18 who are not Medicaid eligible
- Many adults in CMH DD system are dual care/caid – does that put them into ACO and “health” home (DD alone is not a qualifying condition for “health” home at this time) arena
- Integration for DD is likely more about their specialty services than about their health care
- Will DCH issue a RFP to procure at least 2 DD networks?
- Will DCH look to aligning DD with Long Term Care?

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Health Care Reform PURE SPECULATION

- How will all this be financed?
- What will be the payment mechanisms -- especially if have more than one entity in a region (“cherry picking”)
- Need for better data for risk adjustment
- Who gets to decide what a “need” is worth?
- Case rate methodologies - who gets to categorize, model tends towards enrollment of more persons and “underserving” them
- Capitation methodologies – what adjustment factors used as not all eligibles are same; model tends towards keeping beneficiaries away from access.

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Conclusions

- Rapid and significant changes on the horizon: funding, resources available, array of services, structure of health care system
- Who is advocating for the 250,000 persons with specialty needs served by the public system
- What happens to the constitutional commitment
- What happens to current values within a medical model: psychosocial rehab, self-determination, choice, employment, supported living, community inclusion
- What happens to “local” control
- Collective interest vs every-one for themselves
- Who has a place at decision-making table at DCH
- Voices of the people we serve need to be heard – it impacts their lives