

WORKGROUP PLAN TO ACHIEVE FUNDING EQUITY FOR ALL CMHSPs

(FY2006 Appropriation Bill - Public Act 154 of 2005)

May 31, 2006

Section 462: The department shall establish a work group comprised of representatives of the department, CMHSPs, legislature, and any other persons considered appropriate to develop a plan to achieve funding equity for all CMHSPs that receive funds appropriated under the community mental health non-Medicaid services line. The funding equity plan shall establish, at a minimum, a payment schedule or scale to ensure that each CMHSP is paid or reimbursed equally based on the recipient's diagnosis or individual plan of service sufficient to meet his or her needs, or both. The department shall submit the written plan to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director by May 31, 2006.

*Michigan Department
of Community Health*



**Jennifer M. Granholm, Governor
Janet Olszewski, Director**



STATE OF MICHIGAN

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GOVERNOR

DEPARTMENT OF COMMUNITY HEALTH

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A REPORT TO COMPLY WITH THE REQUIREMENTS OF SECTION 462 OF PUBLIC ACT 154 FUNDING EQUITY FOR COMMUNITY MENTAL HEALTH SERVICES PROGRAMS

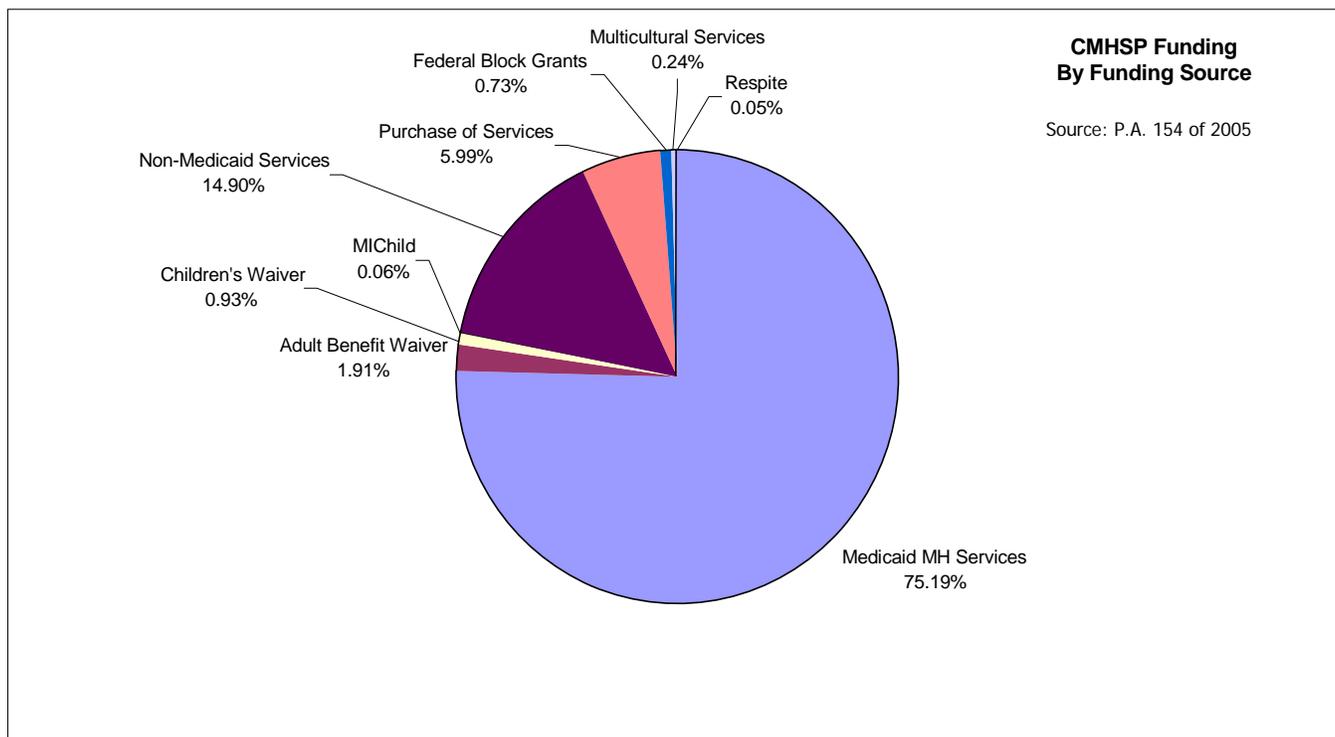
BACKGROUND

To address this boilerplate requirement, MDCH established (in late December 2005) a “two-layer” project team to examine current public mental health funding arrangements and make suggestions for achieving funding equity for all Community Mental Health Services Programs (CMHSPs) “...that receive funding appropriated under the community mental health non-Medicaid services line.” The *core workgroup* of the two-layer project team was composed of a small number of participants who were charged with examining technical issues related to current funding arrangements and proposed changes. The second “layer” of the project team was a larger *review workgroup* that met periodically to inspect the work of the core group, and to provide reaction and feedback regarding various changes or proposals under consideration.

The core workgroup convened for an initial meeting in early February 2006, and has continued to meet regularly over the last four months. The core group also established several time-limited sub-committees to research particular items pertinent to the charge of the workgroup. The review workgroup first met in late February 2006, and there have been two subsequent meetings of this larger body.

A BRIEF OVERVIEW OF CMHSP FUNDING ARRANGEMENTS

The financing of Community Mental Health Services Programs has become more complex and heterogeneous over the last decade. Currently, most funds for CMHSPs are linked to certain federal-state entitlement programs and/or waivers (e.g., Medicaid, Child Health Insurance Program, Adult Benefit Waiver, etc.) and are distributed through capitated payment arrangements. The “community mental health non-Medicaid services line” in P.A. 154 is approximately \$312 million or roughly 15% of the total funding appropriated for community mental health services.



The department's last systematic examination of allocation and distribution methods for non-Medicaid General Funds (GF) was completed in 1997, prior to the implementation of the Medicaid specialty managed care waiver program. The study and subsequent report was completed by the Citizens Research Council (CRC)¹. The allocation model recommended by CRC involved synthetic prevalence estimates of the distribution of seriously mentally ill individuals throughout the state, combined with other variables (e.g., poverty) assumed to be appropriate proxies for service need.

The department implemented some general fund redistribution based on a modified version of the CRC allocation model, but programmatic changes (Medicaid specialty managed care), funding reductions (2002 Executive Order) and the redirection of general funds for other purposes (e.g., to support the Adult Benefit Waiver and to finance Medicaid capitation increases, etc.) have both altered the applicability of the model and constrained further implementation.

Another factor that has influenced general fund distribution in recent years is the change in Medicaid capitation arrangements. Federal regulations and waiver conditions related to source data, capitation development methodology, permissible adjustments and actuarial soundness have produced significant shifts in the distribution of Medicaid funds across the state. In this volatile environment, general fund allocations have been periodically adjusted to compensate for Medicaid funding swings and to assure some measure of financial stability for affected organizations.

The cumulative effect of changes in the availability and use of the non-Medicaid general fund appropriation has been to reduce the viability and applicability of any simple formula to distribute

¹ Funding Community Mental Health in Michigan - Available at: <http://www.crcmich.org/PUBLICAT/1990s/1997/rpt318.pdf>

or allocate these funds among the 46 CMHSPs. Additional factors that complicate an equitable distribution of general funds are the carry-forward provision in the Mental Health Code (permitting CMHSPs to carry forward up to 5% of their annual general fund allocation into the subsequent fiscal year) and the ability of CMHSPs to retain (as unrestricted local funds) unexpended Adult Benefit Waiver capitation payments.

In short, the linkages, conditions and connections between the various funding sources for CMHSPs confound any simple approach to achieving “funding equity” for the non-Medicaid GF portion of CMHSP funding.

GENERAL FUND DISTRIBUTION AND ADJUSTMENTS

Under the Mental Health Code, the department is directed to allocate state (GF) funding in response to each CMHSP’s annual plan and budget submission, taking into account statewide mental health concerns as well as local needs for essential mental health services. Under the Code, a CMHSP must (*shall*) direct services and funding to those with the most severe forms of serious mental illness, serious emotional disturbance or developmental disability, and to those individuals with these conditions who are in urgent or emergency situations. The CMHSP *may* direct services and funding to other individuals with less severe conditions, and to prevention and mental health promotion activities if the CMHSP has sufficient funds available after providing services to the priority populations.

Hence, GF funding and service provision under the Code is a priority population/defined contribution arrangement. Within the constraints of general funds actually appropriated by the legislature, and consistent with the stipulations of the Mental Health Code, a CMHSP must prioritize admission, service provision and resource utilization for those served through its general fund allocation. Individuals may be denied admission or have services limited consistent with severity and funding constraint considerations. This is a different arrangement than the individual entitlement/defined benefit programs administered by CMHSPs (or by affiliations of CMHSPs), such as the Medicaid specialty services program, MiChild or the Adult Benefit Waiver.

Since the Code and GF allocations reflect this priority population/defined contribution framework, members of the project team concluded that **no** funding equity plan for state general funds could be legally structured “...to ensure that each CMHSP is paid or reimbursed equally based upon a recipient’s diagnosis or individual plan of service sufficient to meet his or her needs”. Modifying CMHSP general fund allocations to reflect individual recipient diagnosis, characteristics or severity-related needs implies an individual entitlement and a defined benefit program (an insurance like arrangement), rather than the priority designations, defined contribution, and permissible service constraints described in Chapter 2 of the Mental Health Code.

Although the project team concluded that there is currently no legal means to “severity-adjust” or “recipient-equalize” general fund allocations, the team did have some suggestions to promote more equitable distribution of GF at a “macro” level among CMHSPs, rather than at the boilerplate-referenced “micro” (recipient adjusted or equalized funding) level. These suggestions were directed at reducing disparities in the availability and provision of services between various areas and groups across the state.

In suggesting revised “proxy measures for need” to guide the allocation process for non-Medicaid general funds, the project team indicated that the proposed adjustments to the

distribution methodology represented an attempt to address “**relative need**” between different CMHSPs, and to achieve greater equity among areas and groups in the provision of essential services. However, the project team emphasized that every area of the state and all CMHSPs still needed more general fund dollars. The team concurred with the views expressed in a recent article on mental health funding changes, which concluded that the increasing dominance of Medicaid in financing public mental health care, combined with stagnant state non-Medicaid funding for mental health care, has “...constrained state mental health policymakers’ flexibility to allocate resources to serve the full range of mental health needs in poor and disadvantaged populations, in terms of both the populations that may be served and the services that may be reimbursed”.²

SUGGESTED REVISIONS TO GF ALLOCATION METHODS AND IMPLEMENTATION TIMELINES

As noted above, the core workgroup and the larger review group were unable to devise any method, under current state statute, for “fine-tuning” non-Medicaid general fund allocations at the micro (recipient-specific severity or need adjustments) level. The project team instead recommended macro level changes in the distribution methodology, suggesting that a “weighted index” of various proxy measures for need and cost (per capita considerations, social-economic indicators, and measures of area market conditions/input price differentials) be developed and utilized for general fund allocations.

The refinement and weighting of various items in the proposed index will take additional time and resources, and hence the project team recommended that adjustments to general fund distributions/allocations be postponed until FY 07-08. Beyond the time and energy necessary to refine and weight the proposed proxy indices for implementation, the project team also noted that the current distribution of general funds was predicated, in part, on changes in aggregate Medicaid capitation payments to various areas of the state, as a consequence of capitation rebasing in FY 05-06. Since Medicaid capitation rates for FY 06-07 will reflect only modest “trending forward” of prior year capitation calculations, it is important that existing general fund allocations (which were devised to compensate for large swings in Medicaid capitation revenue precipitated by the rebasing) be retained in FY 06-07.

PURCHASE OF STATE SERVICES

In examining possible methods for a more equitable distribution of CMHSP non-Medicaid general funds, the project team was inevitably drawn into a consideration of other funding issues. Besides the CMH non-Medicaid appropriation line in section 104 of P.A. 154, another large pool of general fund dollars appropriated to CMHSPs is the approximately \$126 million contained in the CMHSP purchase of state services (POSS) line in section 104. Initial discussions within the core workgroup of the project team focused on whether these POSS funds could be included as part of a more comprehensive general fund allocation formula or distribution methodology.

Under the Code (MCL 330.1302), a county is liable (with certain exceptions) for 10% of the “net cost” of any service provided by the department (e.g., state facility services) to a resident of the county. In the early 1980s, as an incentive to reduce state facility utilization, the state began to distribute to CMHSPs the state share - the 90% of net cost - for state facility services. Under this arrangement – referred to as full management - a CMHSP can use their “purchase of state

² “Changes in Mental Health Financing Since 1971: Implications for Policymakers and Patients”, by Richard G. Frank and Sherry Glied; *Health Affairs* - Volume 25, Number 3

service” (POSS) allocation to either “buy back” days of care from the state facility system, or they can use some of the funds to develop alternative services to divert facility admissions or reduced length of stay at these institutions. If a CMHSP is able to reduce its use of state facilities during the year (i.e., purchasing fewer “state services” by investing in community alternatives) the POSS dollars saved by the CMHSP as a result of reduced utilization become part of the CMHSP base funding (the dollars move to the CMHSP non-Medicaid line) in the subsequent fiscal year (these are referred to as “trade-off” dollars).

While it appears that there are statutory problems³ in trying to include POSS funds in a more comprehensive general fund allocation formula or model, the discussion regarding the POSS appropriation exposed significant limitations in the current full management model and revealed structural flaws in the funding framework for state facilities. A changing population at state facilities (i.e., increasing number of individuals with past forensic involvement) and shifts in case mix (increased acuity/severity) further exacerbate the problems associated with an obsolete funding framework. It appears that current funding arrangements may have perverse incentives for over-utilization by some CMHSPs, as well as obstacles to care and cost control (e.g., “not guilty by reason of insanity” patients) for other CMHSPs. The core workgroup of the project team concluded that the POSS appropriation, and the issue of state facility utilization and funding, required additional research, and the group established a special subcommittee to address this matter.

BROADER FINANCING CONSIDERATIONS

While the issue of equity in the distribution of the general fund appropriation was the principal focus of the project team, all members were cognizant of the need to refine another funding arrangement: the rate-setting methodology used in the Medicaid specialty concurrent waiver program. The specialty program involves the simultaneous administration of two different but interrelated waivers: a 1915(b) “freedom of choice” waiver and a 1915(c) “home and community based services” waiver (for the developmentally disabled). The concurrent waivers account for 75% of the total funding for community mental health services, and they have special operational conditions and constraints.

Payment rate development for the specialty program is governed by federal regulations and interpretive guidance (“Financial Review Documentation for At-Risk Capitated Contract Ratesetting”). The Centers for Medicare and Medicaid Services (CMS) require certification of the “actuarial soundness” of Medicaid managed care capitation rates.

CMS regulations and the rate-setting checklist emphasize the importance of accurate and complete service utilization (encounter) and cost reporting. However, this methodology also creates subtle organizational incentives related to cost, utilization and allocation decisions. To counter these subtle biases, certain permissible (albeit complex) adjustments need to be introduced into the rate-setting process for the Medicaid specialty program. These permissible modifications could include severity (case mix) adjustments, as well as price and utilization parameters.

While the project team and workgroups were formed to address the requirements of Section 462 (more equitable distribution of general funds), the participants indicated their belief that the project and the workgroups should continue beyond the report date (May 31, 2006) and that the scope of the team and groups should be expanded to address possible permissive adjustments

³ See MCL 330.1302 – Financial liability of county

to the Medicaid rate-setting methodology. The next major rate rebasing effort will occur next year (2007), to set capitation rates for FY 07-08. Given the interrelationship between GF allocations, capitation rates and aggregate Medicaid payments, the project team and groups will continue to meet, both to finish work on revised proxy measures for GF allocation, and to tackle possible modifications to the Medicaid rate-setting methodology.