Michigan Mental Health Commission

Part II: Appendices

October 15, 2004

Prepared for

Governor Jennifer M. Granholm

Contents

Appendix A:
Commission Charge and Process

EXECUTIVE ORDER NO. 2003–24

Michigan Mental Health Commission

EXECUTIVE OFFICE OF THE GOVERNOR

WHEREAS, Section 1 of Article V of the Michigan Constitution of 1963 vests the executive power of the State of Michigan in the Governor;

WHEREAS, Section 1 of 1931 PA 195, MCL 10.51, authorizes and empowers the Governor, at such times and for such purposes as the Governor deems necessary or advisable, to create special advisory bodies consisting of as many members as the Governor deems appropriate;

WHEREAS, Michigan's publicly-supported mental health system must be committed to providing adequate and appropriate mental health care, treatment, and support in an efficient, effective, and fiscally accountable manner;

WHEREAS, the consumers and families involved with, and most affected by, publicly supported mental health programs and services must be included in the decision-making process;

WHEREAS, Michigan must move toward a more user-friendly mental health system that ensures timely access to care, fosters quality and excellence in service delivery, and promotes innovative and effective strategies to best serve adults and children with serious mental illness or emotional disturbances;

WHEREAS, the services provided by the publicly supported mental health system should be culturally competent and responsive to consumer needs and preferences;

WHEREAS, the publicly supported mental health system is currently at a crossroads, requiring the input of interested parties working together to address the challenges confronting the system;

NOW, THEREFORE, I, Jennifer M. Granholm, Governor of the State of Michigan, pursuant to the powers vested in me by the Michigan Constitution of 1963 and Michigan law, order the following:

I. DEFINITIONS

1. "Commission" means the Michigan Mental Health Commission created under this Order.

2. "Department of Community Health" means the principal department of state government created as the Department of Mental Health under Section 400 of the Executive Organization Act of 1965, 1965 PA 380, MCL 16.500, and renamed the "Department of Community Health" under Executive Order 1996-1, MCL 330.3101.

II. MICHIGAN MENTAL HEALTH COMMISSION

A. The Michigan Mental Health Commission ("Commission") is created as an advisory body within the Executive Office of the Governor.

B. The Governor shall appoint 29 members to the Commission to serve as members of the Commission at the pleasure of the Governor.

C. In addition to the 29 members appointed under Section II.B, the Directors of the Department of Community Health, the Family Independence Agency and the Department of Corrections, or their designated representatives, shall serve as ex officio, non-voting members of the Commission. The Governor may appoint additional persons as non-voting members.

D. A vacancy on the Commission shall be filled in the same manner as the original appointment.

E. The Governor shall designate one of the members of the Commission to serve as its Chairperson at the pleasure of the Governor.

III. CHARGE TO THE COMMISSION

A. The Commission is advisory in nature and shall:

1. Identify and prioritize pressing issues and significant challenges that must be addressed to preserve and improve services for adults and children with serious mental illness or emotional disturbances.

2. Recommend options to improve the organization, delivery, quality, and effectiveness of publicly supported mental health services.

3. Identify methods to enhance current state and county partnerships for planning, management, and delivery of mental health services

4. Assess opportunities for collaborative interagency and intergovernmental approaches to the provision of mental health care.

5. Identify methods designed to simplify access to care, promote effective service and support practices, improve care outcomes, and enhance consumer and family satisfaction.

6. Recommend approaches to improve federal, state, county, and community collaboration while increasing the efficiency and fiscal accountability of the publicly supported mental health system.

7. Identify strategies and financing options for expanding prevention and early intervention efforts within the publicly supported mental health system.

8. Provide recommendations on the best strategies to enhance public awareness and understanding of mental illness.

9. Identify strategies that will increase collaboration and communication between law enforcement, courts, corrections, community mental health programs, and public and private hospitals in most effectively meeting the needs of adults and children with serious mental illness or emotional disturbances.

10. Formulate policy and program recommendations to improve and promote community-based services and integration for adults and children with serious mental illness or emotional disturbances.

11. Develop a Michigan-specific plan to determine the most appropriate strategy for achieving mental health parity in this state.

B. In exercising its duties the Commission may:

1. Assess the most appropriate organizational framework for the delivery of publicly supported mental health services in Michigan.

2. Review model legislation and studies on the effective delivery of publicly-supported mental health services and collect information on states that have developed innovative solutions and best practices for similar challenges.

3. Identify training and technological assistance needs related to the efficient management and delivery of services provided through the publicly supported mental health system.

C. The Commission shall provide other information or advice as directed by the Governor or the Chairperson of the Commission.

D. The Commission shall complete its work and issue a final report and recommendations, including any proposed legislation, to the Governor not later than September 30, 2004.

IV. OPERATIONS OF THE COMMISSION

A. The Commission may promulgate bylaws, not inconsistent with Michigan law and this Order, governing its organization, operation, and procedures. The Commission may establish subcommittees as it deems advisable.

B. The Commission shall be staffed by personnel from and assisted by the Department of Community Health, as directed by the Governor or the Chairperson of the Commission.

C. The Chairperson of the Commission shall select from among the members of the Commission a Vice-Chairperson and a Secretary. Commission staff shall assist the Secretary with record-keeping responsibilities.

D. The Commission shall meet at the call of the Chairperson and as may be provided in procedures adopted by the Commission.

E. The Commission may establish committees and request public participation on advisory panels as it deems necessary. The Commission may adopt, reject, or modify recommendations made by committees or advisory panels.

F. The Commission shall act by majority vote of its serving members. A majority of the members of the Commission constitutes a quorum for the transaction business.

G. The Commission may, as appropriate, make inquiries, studies, investigations, hold hearings, and receive comments from the public. The Commission may consult with outside experts, consumers, and their families in order to perform its duties.

H. Members of the Commission shall serve without compensation. Members of the Commission may receive reimbursement for necessary travel and expenses according to relevant statutes and the rules and procedures of the Department of Management and Budget and the Civil Service Commission, subject to available appropriations.

I. The Commission may hire or retain contractors, sub-contractors, advisors, consultants and agents, and may make and enter into contracts necessary or incidental to the exercise of the powers of the Commission and the performance of its duties, as the Director of the Department of Community Health deems advisable and necessary in accordance with the relevant statutes, rules, and procedures of the Civil Service Commission and the Department of Management and Budget.

J. The Commission may accept donations of labor, services, or other things of value from any public or private agency or person.

K. Members of the Commission shall refer all legal, legislative, and media contacts to the Department of Community Health.

V. MISCELLANEOUS

A. All departments, committees, commissioners, or officers of this state or of any political subdivision of this state shall give to the Commission, or to any member or representative of the Commission, any necessary assistance required by the Commission, or any member or representative of the Commission, in the performance of the duties of the Commission so far as is compatible with its, his, or her duties. Free access shall also be given to any books, records, or documents in its, his, or her custody, relating to matters within the scope of inquiry, study, or investigation of the Commission.

B. The invalidity of any portion of this Order shall not affect the validity of the remainder the order.

This Order is effective upon filing.

Given under my hand and the Great Seal of the State of Michigan this 10th day of December, 2003.

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JENNIFER M. GRANHOLM
GOVERNOR

BY THE GOVERNOR:

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SECRETARY OF STATE

VOTING COMMISSION MEMBERS

C. Patrick Babcock, *Co-chair*	Director of Public Policy, W. K. Kellogg Foundation
Waltraud Prechter, *Co chair*	President, World Heritage Foundation
William Allen	Director, Oakland County Community Mental Health Authority
Fran Amos	State Representative, Waterford
Elizabeth Bauer	Michigan State Board of Education
Beverly Blaney, MD	Executive Physician for Healthcare Management, Ford Motor Company
Tom Carli, MD	Medical Director, U-M Medical Management Center
Nick Ciaramitaro	Director of Legislation & Public Policy, Michigan AFSCME Council 25
Bill Gill	Vice Chair, County Commission, Muskegon County
Beverly Hammerstrom	State Senator, Temperance
Rick Haverkate	Health Services Director, Inter Tribal Council of Michigan
Gilda Jacobs	State Senator, Huntington Woods
Joan Jackson Johnson	Director, East Lansing Center for the Family
Alexis Kaczynski	Director, North Country Michigan Community Mental Health
Guadalupe Lara	Manager, Conflict Management and Diversity Initiatives, Children's Hospital of Michigan
Kathryn Lynnes	President, Brainstorm
Milton Mack Jr.	Chief Judge, Wayne County Probate Court
Samir Mashni	Chair, Wayne County Community Mental Health Board
Andy Meisner	State Representative, Ferndale
Donna Orrin	Director, Creative Connections
Jeff Patton, MSW	Executive Director, Kalamazoo Community Mental Health and Substance Abuse Services
Brian Peppler	Prosecuting Attorney, Chippewa County
Michele Reid, MD	Medical Director, Detroit-Wayne County Community Mental Health Agency
Mark Reinstein	President and CEO, Mental Health Association in Michigan
Roberta Sanders	CEO, New Center CMHS
David Sprey	Consumer Advocate
Sara Stech, ACSW	
Rajiv Tandon, MD	Chief of Psychiatry, Florida Department of Children and Families
Maxine Thome	Executive Director, National Association of Social Workers, Michigan Chapter

NONVOTING COMMISSION MEMBERS

Patricia Caruso	Director, Michigan Department of Corrections
Sander Levin	U.S. Congressman, 12th District
Janet Olszewski	Director, Michigan Department of Community Health
Marianne Udow	Director, Michigan Family Independence Agency
Tom Watkins	Superintendent of Public Instruction, Michigan Department of Education

COMMISSION WORK PROCESS

February Meeting 1	**GROUNDING/SETTING GUIDING PRINCIPLES** ▪ Receive charge from the governor ▪ Review and approve work plan, calendar, roles/responsibilities for commission and project management team, and protocol ▪ Hear presentations on the history and description of the mental health system ▪ Consider guiding principles for recommendations and framework for deliberation ▪ Receive public comment
March Meetings 2–3	**DEVELOPING VALUES AND WORK GROUPS** ▪ Develop values for the commission's recommendations and final report ▪ Determine work group structure and composition ▪ Seek outside expert counsel and research as necessary ▪ Receive public comment
April Meeting 4 Seminar 1	**DEVELOPING ISSUES AND OPTIONS AS THE BASIS FOR RECOMMENDATIONS** ▪ Prepare issue statements and options in work groups ▪ Hear presentations on the structure and financing of the mental health system; legal mandates of the system; the population served by the system; and the rights of those served ▪ Conduct public hearings (4)
May Meeting 5 Seminar 2	**REFINING ISSUE STATEMENTS AND OPTIONS** ▪ Refine issues and options in work groups based on continued deliberation and public input ▪ Hear presentations on financing and evidence-based practices as they relate to mental health ▪ Receive public comment
June–August Meetings 6–8	**PREPARING PRELIMINARY RECOMMENDATIONS AND GOALS** ▪ State facility visits ▪ Review issues and work group options ▪ Prepare preliminary recommendations ▪ Obtain public commentary on preliminary recommendations ▪ Consider and adopt goals for commission report ▪ Receive public comment
September–October Meetings 9–11	**FINALIZING RECOMMENDATIONS AND REPORT** ▪ Review draft report and finalize ▪ Adopt final report ▪ Deliver final report to the governor

PROJECT MANAGEMENT TEAM

Commission Members
C. Patrick Babcock, Co-chair
Waltraud Prechter, Co-chair
Kathryn Lynnes, Commission Secretary
Guadalupe Lara, Work group I Chair
Joan Jackson-Johnson, Work group II Chair
Michele Reid, MD, Work group III Chair
Nick Ciaramitaro, Work group IV Chair
Milton Mack, Work group V Chair

Ethel & James Flinn Foundation
Leonard Smith

Office of the Governor
Pamela Paul-Shaheen
Kimberly Brosky

Michigan Department of Community Health
Michael Ezzo
Patrick Barrie
Irene Kazieczko
Judy Webb
Geralyn Lasher
T. J. Bucholz

Project Staff

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Suzanne Miel-Uken, Project Manager
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Harriett Posner
Peter Pratt
Craig Ruff
Donna Van Natter
Elisabeth Weston

Michigan Department of Corrections
R. Cole Bouck

Michigan State University College of Nursing
Jeanette Klemczak

WORK GROUP MEMBERS

Work Group I

Education, Rights, Outreach, and Advocacy

Commission members

Guadalupe Lara, Chair
Kathryn Lynnes
Wally Prechter
Mark Reinstein

Appointed Work Group Members

Dave Burtch, Assistant Director, T.O.P., UAW
Lesley Crowell, Director of Consumer Relations, Kalamazoo CMH
Henry Erb, investigative reporter for WOOD-TV 8
Bill Feiser, Vice-president, NAMI-Michigan
Rev. George Heartwell, Mayor of Grand Rapids
Anthony Spaniola, Ufer and Spaniola, P.C.
Faith Freeman

Staff team

Elisabeth Weston, Lead Staff
Michael Jennings, MDCH
John T. Sanford, MDCH

Work Group II

The Array of Services and Supports for Children

Commission members

Joan Jackson Johnson, Chair
Gilda Jacobs
Alexis Kaczynski
Sara Stech
Maxine Thome
Marianne Udow
Thomas Watkins

Appointed Work Group Members

Judy Coucouvanis
Judge Richard Garcia, 30th Judicial Circuit Court, Family Division
Sherry Solomon Jozwiak, President and CEO of Catholic Social Services / St. Vincent's
Barb MacKenzie, Family Independence Agency
Susan McParland, Executive Director, MACED
Cindy Miller, parent of a consumer
Mary Roberts, MD, child psychiatrist
Betty Tableman, Editor, Best Practice Briefs, Michigan State University
Doug Williams, Ingham County FIA Director
Meredith Campbell, Lansing Catholic Central
Bob Sheehan, Clinton-Eaton-Ingham Community Mental Health
Jeanette Scheid, Michigan State University

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Tom Renwick, MDCH
Jim Wotring, MDCH

Work Group III

The Array of Services and Supports for Adults

Commission members
Michele Reid, MD, Chair
Rick Haverkate
Donna Orrin
Brian Peppler
Roberta Sanders

Appointed Work Group Members
Tom Bissonnette
James Borushko, Muskegon County
Andrea Bostrom
Mike Fauman, PhD, MD, Adjunct Clinical Associate Professor of Psychiatry, University of Michigan School of Medicine
John Freeman, Director, Michigan Home Care Campaign, SEIU, AFL-CIO
Sandy Herman, Michigan Public Health Institute
Hubert Huebl, President, NAMI-Michigan
Peter Lichtenberg, PhD, Director, Institute of Gerontology, Wayne State University
William Nowacki, Plymouth
Judith Seaborn, private practitioner, Bridges Counseling and Consulting, Okemos
Tim J. Uhlmann, PhD

Staff team
Jeanette Klemczak, MSU, Lead Staff
Cindy Kelly, MDCH
Mark Kielhorn, MDCH

Work Group IV

Criminal Justice and Human Service Interface

Commission members
Nick Ciaramitaro, Chair
William Allen
Patricia Caruso
Bill Gill
Andy Meisner
Rajiv Tandon, MD

Appointed Work Group Members
Anne Burns, MACED
John Davidson, Ann Arbor
Morris Goodman, former board member, Detroit-Wayne County CMH
Gary Goss, Michigan Sheriffs Association

Judith Kovach, Legislative Director, Michigan Psychological Association
Ted Lewis, Director, Children's Center of Detroit
Mac Miller, Director, Livingston CMH
Tony Rome, MD, Wayne County Jail
Don Williams, former chair, MSU Department of Psychiatry
Beth Yerrick, Otsego

Staff team

R. Cole Bouck, Lead Staff
Hugh Carbone, MD, MDCH
Doris Gellert, MDCH
Doug Nurenberg, MDCH
Jim Wotring, MDCH

Work Group V

Governance, Structure, and Accountability

Commission members

Milton Mack, Chair
Fran Amos
Elizabeth Bauer
Beverly Blaney, MD
Tom Carli, MD
Beverly Hammerstrom
Sander Levin (Karen Caird or Morna Miller, Sander Levin's Office)
Samir Mashni
Janet Olszewski
Jeff Patton
David Sprey

Appointed Work Group Members

Jamie Armstrong, Board Member, MHAM
Michael Breen, Vice President, Behavioral Medicine Services, St. John Health System
Bob Dillaber
Kyle Grazier, PhD, School of Public Health, University of Michigan
Kathy Madden
Steve Ruskin, Board Member, Oakland CMH
Lynda Zeller, Regional Director, Hope Network

Staff team

Peter Pratt, Lead Staff
Irene Kazieczko, MDCH
Judy Webb, MDCH

Appendix B:
Crosswalk: Commission Recommendations and the Governor's Executive Order

		Executive Order
Pressing Issues		A.1.
RECOMMENDATION		
GOAL 1: Public Awareness		
1.	Create a continuing public education campaign.	A.7., A.8.
2.	The partnership should also develop a single, Web-based repository of information for the media, mental health professionals, and the public on mental illness and emotional disturbance.	A.7., A.8.
3.	Enlist the support of the MEDC and local economic development groups to embellish the "life sciences corridor" by attracting to Michigan pharmaceutical and other related private industries that will capitalize on research into the causes and treatments of mental illness and attract mental health professionals and experts to the state.	A.5.
4.	Michigan's Surgeon General should lead the implementation of the draft Suicide Prevention Plan of the Michigan Suicide Prevention Coalition.	A.7., A.8.
GOAL 2: Priority Populations & Early Interventions		
5.	Case finding: Early identification and screening should be strengthened throughout all health care and service systems, consistent with other health conditions.	A.5., A.7.
6.	Hierarchy of choice: The legislature should amend the Michigan Mental Health Code and the Estates and Protected Individuals Code (EPIC), MCL 700.1, to simplify the assessment of persons who may need mental health services and assure care more quickly.	A.5., A.7.
7.	Clarify assessment for people needing treatment.	A.5.
8.	MDCH should (a) implement uniform screening and assessment for priority populations, as well as all other populations, and uniform operational definitions and service selection guidelines statewide for individuals eligible for public mental health treatment and support service and (b) expand the system's capability for serving individuals with previous mental illness and mild and moderate disorders.	A.5.
	a. "Enhanced access" status	A.5.
	b. Crisis stabilization	A.5.
	c. Coordination assistance	A.5.
	d. Parity legislation	A.5., A.11.
GOAL 3: Model Service Array		
9.	Enactment of parity legislation and convening an implementation task force.	A.11.

		Executive Order
10.	MDCH, in cooperation with other state departments, should establish a clear policy and timetable to have in place a comprehensive, high-quality statewide service array that will increase the volume of appropriate services and improve quality of care; give consumers and families increased confidence in the system's ability to respond effectively to recipients' requirements; and position Michigan as an exemplary state for national emulation.	A.2., A.5., A.10.
11.	As a first step in assuring a full array of services for children and youth with serious emotional disturbance and adults with serious mental illness, the state policy plan should identify, fund, and assure adequate core service options available on a 24-hour basis to adults and minors who qualify for enhanced access within Michigan's publicly funded mental health system (see material on enhanced access in the recommendations under Goal 2) and crisis response services available to any person experiencing psychiatric emergency.	A.2., A.5., A.10.
12.	Any appropriate service required by a recipient's circumstances may be reasonably accessed, regardless of where one lives, his/her reimbursement status, and who is managing the service.	A.2, A. 5., A.10.
13.	All array components should be available, consistent with Medicaid requirements, within 60 minutes/miles of a recipient's residence in rural areas and 30 minutes/miles in urban areas, and the MDCH should assure that best-practice standards and guidelines are developed for each.	A.2, A. 5., A.10.
14.	Individuals anywhere in the state should have access to inpatient psychiatric or secure residential treatment when appropriate and as close to their residence as possible.	A.2, A. 5., A.10.
15.	If it is not feasible to provide inpatient psychiatric care within these guidelines, then transportation services should be provided by CMHSPs, as necessary, and mobile intensive treatment teams should be deployed to help local hospitals provide this care.	A.2, A. 5., A.10.
16.	The array should provide maximum comparability across Medicaid and non-Medicaid populations.	A.2, A. 5., A.10.
17.	The state should create a mental health institute to develop evidence-based practices and research at both the community and state level, supporting implementation of the model array of high-quality services.	A.2, A. 5., A.10.
18.	Strengthen the MDCH quality management system, building on the mission based performance system and other existing quality management endeavors, so that it better integrates compliance and quality measures, which the department should set with input from consumers, PIHPs, CMHSPs, and providers.	A.2, A. 5., A.10.
19.	Michigan's public mental health system should be supported by a Web-based information infrastructure, beginning with a simple system and slowly improving it using feedback from stakeholders.	A.2, A. 5., A.10.
20.	Michigan's interagency approach to prevention, early intervention, and treatment for children should be strengthened.	A.2., A.4., A.5., A.6., A.7., A.9., A.10.

21.	A stakeholder group of academic institutions and mental health provider agencies (perhaps through the Mental Health Institute) should be convened to assess Michigan's capacity to serve older adults with mental health needs, to encourage and develop mental health and aging curricula in academic institutions, and to help providers identify methods to retain the current workforce.	A.2, A.4., A.5., A.10.
22.	Specific outreach efforts need to be targeted to older adults, persons with dementia, and their caregivers.	A.2., A.5., A.7., A.10.
23.	CMHSP screening and intake systems should be revised where necessary to assure that they are "elder-friendly."	A.2., A.5., A.7., A.10.
24.	Screening tools should be identified to increase the ability of medical providers to identify depression and other mental health problems in older adults.	A.2., A.5., A.7., A.10.
GOAL 4: Diversion		
25.	The array of mental health services (see Goal 3) must be available and accessible to eliminate use of the juvenile and criminal justice systems as "providers of last resort."	A.2., A.5., A.7., A.9., A.10.
26.	The legislature, the executive branch, the judiciary, and law enforcement should require effective and measurable, evidence-based pre- and post-booking diversion programs, including formalizing the shared legal duty of CMHSPs, law enforcement, and jails for diversion by revising law to include "diversion from the juvenile justice system" and expanding mental health and drug courts throughout the state.	A.2., A.5., A.7., A.9., A.10.
27.	Joint training should be ensured across CMHSPs, first responders, service providers, law enforcement, defense attorneys, prosecutors, judiciary, and corrections and probation officers on the implementation of established and required pre- and post-booking diversion programs throughout the state.	A.2., A.5., A.6., A.7., A.9., A.10.
28.	State and local law enforcement, including police, corrections, and judicial authorities, and the MDOC should ensure screening and assessment for mental health at their point of entry, booking or reception for children and adults, and at first contact with the juvenile and criminal justice systems.	A.5., A.7., A.9., A.10.
29.	The legislature should clarify responsibility for the provision of mental health diversion services where the "county of crime" is not the "county of residence" by directing that the CMHSP of the county in which a crime is committed is responsible for the provision of diversion services, including arrangements with the county of residence, where appropriate.	A.2., A.5., A.6., A.7., A.9., A.10.
30.	The transition from detention or incarceration to community-based treatment and services should be strengthened by initiating pre-release programming at the point of reception or intake, and training for release supervisors on what to expect from mental health clients. Pre-release planning should address the person's mental health and other need.	A.2., A.5., A.6., A.7., A.9., A.10.

GOAL 5: Structure, Funding and Accountability	
31. Create a true mental health system through a structure that better clarifies and coordinates state, regional, and local roles, responsibilities, and accountability for services to persons with mental illness and emotional disturbance. Such a structure should consist of (a) state leadership, with input from all stakeholders, to improve and enforce statewide standards for administration, performance (see below), and eligibility determination; (b) regional coordination of functions that include, but are not limited to, health plan–like administrative and information infrastructure; reporting and quality programs; assurance of equitable access to services; and shared components of some clinical services that would offer economies of scale without sacrificing access; and (c) preservation of local control, including CMHSP application of eligibility criteria and assessment of needs and service delivery. The state should develop a specific plan for regionalization of appropriate mental health system functions in the next two years.	A.2., A.3.
32. The state should offer financial incentives to counties that coordinate and streamline the regional functions described in the previous recommendation.	A.2., A.3., A.10.
33. Invest more resources for MDCH to (a) continue setting standards for payment, performance, and other administrative functions (billing, computer systems) and (b) provide training in these areas so that accountability is achieved without micromanagement.	A.2., A.3., A.10.
34. The state should set a range for acceptable administrative costs for PIHPs, CMHSPs, and providers. In addition, PIHPs and CMHSPs should be required to report to MDCH all financial information, including employee salaries and fees to contractors such as consultants and attorneys, so that the department can effectively monitor adherence to the established standards.	A.2., A.3., A.10.
35. Amend the Mental Health Code to strengthen MDCH enforcement. MDCH currently has little recourse when CMHSPs or PIHPs fail to meet statutory and contractual requirements.	A.2., A.3., A.10.
36. Strengthen the role of the current MDCH medical director of mental health so that s/he becomes the leader in the development and adoption of evidence-based practice in the mental health system.	A.2., A.3., A.5., A.10.
37. Expand the charge of the current MDCH Advisory Council on Mental Illness to assist the MDCH director and the governor with implementation of the commission's recommendations. The MDCH director should appoint advisory council members.	A.2.
38. By January 2006, MDCH should issue a progress report on outcomes related to recommendations 31–36. For recommendations that have not been achieved, the report should specify a timetable for completion.	A.2.
39. The governor and the legislature should adopt a new funding strategy for services to state residents with mental illness and emotional disturbance.	A.2., A.7., A.11.
a. Dedicated state funding	A.2., A.7.
b. Use of federal funds	A.2., A.7.
c. Budget policy	A.2., A.3., A.9.
d. County matching funds	A.3.
e. Private funds	A.11.

40.	By January 2006, and after consultation with stakeholders, MDCH should complete a comprehensive analysis of whether the state's various mechanisms for determining allocations across CMHSPs can and should include to some degree a case rate funding methodology.	A.2.
41.	To address disparities between urban and rural areas, establish a work group to examine the delivery and financing of mental health services in rural areas. This group should recommend changes to the current structure to assure that rural residents' needs are met. Assure funding among and within CMHSPs to provide and fund a comparable and quality array of services in each region.	A.2., A.10.
42.	Payment for mental health services should be driven by incentives for delivering high-quality care, which is the model toward which physical health has been moving in recent years.	A.2., A.10.
43.	Develop specific sustainable models of collaboration at the state and local levels. Maximize resources earmarked for providing mental health services across all public agencies.	A.2., A.4., A.6.
44.	Within MDCH's mental health division, there should be an office following and working on policy and clinical issues pertaining to mental illness and emotional disturbance and another office following and working on policy and clinical issues pertaining to developmental disabilities.	A.2.
45.	The director of the state Office of Recipient Rights should report directly and solely to the director of MDCH (requires a state Mental Health Code revision).	A.2., A.5., A.10.
46.	Medicaid Fair Hearings related to public mental health services should require a clinical consultation component.	A.2., A.5., A.10.
47.	The designated appeals division within MDCH for Medicaid Fair Hearings should also oversee a corresponding hearing process for non-Medicaid CMHSP recipients and applicants, also including a required clinical consultation component.	A.2., A.5., A.10.
48.	To further strengthen accountability for rights protection, the recipient rights portion of the state's Mental Health Code should be amended.	A.2., A.5., A.10.
49.	The state rights office should develop uniform methodologies and programs for statewide use in the protection of recipient rights under the state's Mental Health Code.	A.2., A.5., A.10.
50.	The state rights office, in collaboration with local rights offices, should review and revise current forms, handouts, brochures, booklets, and other materials that are used within the system to inform consumers and families about their rights and available programs, in order to make these materials more user-friendly, culturally appropriate, and uniform across the state.	A.2., A.5., A.10.
51.	The state and local rights offices should engage in education, training, evaluation, and assistance to primary and secondary mental health consumers in navigating the public mental health and other human service systems.	A.2., A.5., A.10.
52.	MDCH should lead a review and revision of recipient rights policies to ensure culturally competent practices sensitive to ethnic, racial, economic, disability, sexual preference, and gender differences.	A.2., A.5., A.10.

53.	MDCH should establish a standard database and statewide reporting system to track applicants who are denied service. MDCH should also revise the existing quality improvement plan to more comprehensively address issues related to access to services for persons who are not currently part of the mental health system.	A.2., A.5., A.10.
54.	The state rights office should examine recipient and applicant fatalities and sentinel events for issues of possible rights violations.	A.2., A.5., A.10.
55.	Licensing agency and state agency reviews related to publicly funded mental health providers should require documentation of policies/procedures for training, quality improvement, and the grievance process for individuals who may not have had their rights respected.	A.2., A.5., A.10.
56.	Legislative changes should be made that would permit the state rights office to investigate and make recommendations to the MDCH Bureau of Health Systems regarding the recipient rights programs of licensed hospitals.	A.2., A.5., A.10.
GOAL 6: Service Integration		
57.	MDCH should promote and facilitate efforts to create collaborative models to integrate and coordinate mental health services with primary health care and broadly disseminate the results for implementation.	A.2., A.4., A.5., A.7., A.10.
58.	MDCH should develop a plan to reduce barriers to treatment for people with co-occurring disorders, with a focus on integrating the care provided, perhaps through consolidation of regional and community substance abuse and mental health services and the development of plans to implement model treatment programs.	A.2., A.4., A.5., A.7., A.10.
59.	The Michigan Department of Education should promote education policies that proactively identify children with disabilities and children exhibiting risk indicators and lead an evaluation of the state's school discipline code to determine the effects of zero tolerance education policy, including the disparate impact on children of color. The department should promote clear standards for alternative education.	A.2., A.4., A.5., A.7., A.10.
60.	The Michigan State Housing Development Authority should consider expansion of the Housing Trust Fund to address housing issues of individuals eligible for community mental health services, leveraging additional funding from Community Developmental Financial Institutions of the U.S. Department of Treasury for such strategies as enhancing opportunities for home ownership or to make permanent supportive rental housing more affordable.	A.2., A.4., A.5.
61.	MDCH should use SAMHSA's *Blueprint for Change* to work with CMHSPs and other local community agencies to implement appropriate programs and supports to address homelessness among individuals with serious mental illness.	A.2., A.4., A.5, A.10.
62.	MDCH should promote compliance with the Americans with Disabilities Act (ADA) to reduce barriers to housing, education, and employment and facilitate recovery.	A.2., A.4., A.5. A.10.
63.	MDCH should promote compliance with the Michigan Persons with Disabilities Civil Rights Act (1990 P.A. 220) and work with the Michigan Department of Civil Rights to assure enforcement of its tenets to assist persons with mental illness to secure housing, education, and employment and facilitate recovery.	A.2., A.4., A.5, A.10.

64.	MDCH, FIA, and other appropriate state agencies should implement an interagency process to review prior interventions for appropriateness and effectiveness before determining placement.	A.2., A.4., A.5.
65.	All CMHSP programs serving adults diagnosed with a serious mental illness should offer supported employment services.	A.2., A.4., A.5., A.10.
66.	MDCH should review the efforts of other states (e.g., Indiana and New York) to explore the possibility of implementing a coordinated statewide effort to providing supported employment.	A.2., A.4., A.5., A.10.
67.	MDCH should work with colleges and universities to disseminate and expand the Michigan Supported Education Program throughout the state.	A.2., A.4., A.5., A.10.
GOAL 7: User Involvement		
68.	MDCH should require that CMHSP boards must have at least one representative from each of the following populations: individuals with developmental disabilities, individuals with mental illness, and children with emotional disturbances.	A.2., A.5.
69.	MDCH should develop and require implementation of a formal mechanism to utilize service recipient and family feedback on user satisfaction and outcomes in an ongoing quality assurance process.	A.2., A.5.
70.	MDCH should require service providers to formally offer and strongly encourage the establishment of advance psychiatric directives; directives should ideally include consumer preferences regarding release of records to family, domestic partners, or agents named in the directive in the event of death, and in the absence of any preference, records should be available to closest surviving family member(s).	A.2., A.5.
71.	MDCH should take the lead in assisting CMHSPs in utilizing Medicaid for family advocates.	A.2., A.5., A.10.

Appendix C:
Work Group Reports

WORK GROUP REPORTS

As approved by the work group chairs

July 26, 2004

WORK GROUP I: EDUCATION, RIGHTS, OUTREACH, AND ADVOCACY

Chair: Guadalupe Lara

Report

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
Recommendations: Public Attitudes, Awareness, and Stigma				
1. Public misconceptions about mental illness produce a public stigma that results in fear, discrimination, and mistreatment. • The stigma of mental illness prevents individuals from seeking treatment for themselves or family members (impeding timely diagnosis and appropriate treatment) and increases the risk of suicide, results in significant economic loss, and harms family relationships. • Stigma is rooted in the erroneous historic premise that mental illness is qualitatively different from other physical illnesses. • There is no unified, authoritative voice delivering the truth about mental illness.	A. Form an independent organization consisting of representatives of state and local government, including the Michigan Surgeon General, consumers, advocacy organizations, and advertising and public relations industries to create a continuing campaign to educate the public that mental illness is physical illness. • Activities should include the creation of a central Internet site containing all the materials and information produced for this effort. • The campaign should use people who have experienced mental illness to tell their stories and provide accurate information. It should include the use of video interviews, stories, and short documentaries that can be made available to schools, organizations, businesses, and the website. • The campaign should create speakers bureaus in each county utilizing the skills of people who have experienced mental illness.	A. Increase awareness about mental health and mental illness; alter public perception. B. Make information about mental illness widely available. C. Increase political awareness. D. Increase interest in and funding for brain research. E. Promote acceptance of and increased opportunities for those with mental illness. F. Incorporate mental health issues into early education programming in school curricula. G. Foster more holistic treatment in health care settings. H. Promote better understanding by police and corrections workers. I. Clients, providers, and the	Multiple parties: • Surgeon General • Executive branch can launch an independent group (in a similar fashion to the way MPHI was begun)	Short-term action for launch; long-term implementation

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
	• The campaign should include targeted marketing to reach students, educators, news media, health workers, police/corrections workers, business and community leaders, and others. B. Review the utility, suitability, and readability of the literature and forms distributed to consumers and families receiving or applying for services.	public will be better informed by forms and publications that are understandable.		
2. During the last 20 years there has been a systematic erosion of mental health insurance benefits in the private sector. Over this same period there has been an explosion of new knowledge about mental disorders, which has translated into major advances in treatment. Insurance discrimination based upon stigma about mental illness should no longer be tolerated by the people of Michigan; equal reimbursement for recognized medically necessary services by providers that are currently licensed and certified by the state makes sense. The commission should strongly advocate on behalf of state	Support legislation that requires all insurers to offer coverage for the treatment of mental illnesses and addiction disorders that is equivalent to the coverage for all other disorders. That is, the legislation should prohibit the use of higher co-pays and deductibles, lower maximum coverage dollar limits (annual and lifetime) for both inpatient and outpatient treatment, and arbitrary outpatient visit limits and/or hospital stays. The legislation should assure coverage of medically necessary treatment for all disorders listed in the DSM-IV, in the categories of both mental health and addictive disorders.[1]	A. Eliminate insurance discrimination against persons with mental illness and addiction disorders. B. Reduce indirect costs to employers caused by reduced productivity, increased absenteeism, and employee turnover. C. Eliminate the economic burden on patients and their families caused by the out-of-pocket burden resulting from insurance discrimination. D. Reduce the number of persons with mental illness that become disabled as a result of their illness. E. Offer small businesses the same access to the same types of mental health insurance coverage that large	Legislature (passing legislation) Governor (signing legislation)	Immediate

[1] "Addictive disorder" is defined as (1) any behavior that an individual recurrently fails to control, and (2) any behavior in which an individual continues to participate, despite significant harmful consequences.

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
parity legislation.		businesses use to provide protection and security for their employees, improving productivity while reducing health care costs, absenteeism, disability, and workers' compensation. F. Reduce the cost shifting that results when persons with mental illness lose their mental health coverage and/or job and cannot afford treatment due to insurance discrimination, thus becoming clients of the public mental health and/or Medicaid systems.		
3. Michigan is not utilizing the world-class resources it has for brain research and related business and education opportunities. A primary focus of the "Life Sciences Corridor" should be on diagnosing and treating diseases of the brain, including addictive disorders and co-occurring disorders.	A. Encourage the state's four public medical schools (U of M, WSU, MSU-CHM, MSU-COM) to work cooperatively on research projects: • Assist the medical schools in seeking public and private grant funds for research and treatment • Serve as a liaison between the medical schools and private sector corporations • Work with the medical schools to develop pilot projects in the public mental health system B. Enlist the support of the MEDC and local economic development groups to embellish the "life sciences corridor" by attracting to Michigan pharmaceutical and other related private industries that will capitalize on research into the	A. Michigan will become a recognized center of excellence for research into brain structure and function, the causes of mental illnesses, and successful treatments. B. The public and private mental health systems will benefit from the "local" access to cutting-edge research and best practices. C. State medical schools will have increased access to research funding. D. This positive emphasis on brain research and the treatment of brain disorders will help to eliminate stigma.	MDCH, a state mental health advocacy organization, or a combination thereof	Long-term

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
	causes and treatments of mental illness. C. Encourage mental health–related organizations located in Michigan to work cooperatively.	E. The retention and creation of high-tech jobs will be fostered.		
4. Despite having good information about populations at risk for mental illness, there is no mechanism for reaching out to assist those with mental illness who are not receiving treatment.	A. Increase early identification/screening and prevention efforts to match those of other health conditions, possibly through schools. B. Restore of prevention demonstration services within MDCH. C. Increase screening and outreach through non-health care human service programs for low-income and homeless individuals (i.e., The Servant Center in GR, PORT program in Washtenaw). D. Support parity legislation so those identified through screening have adequate treatment options.	A. Identification of and early interventions for at-risk youth B. Cost savings due to early identification and appropriate treatment	Legislative and executive action	Short- and long-term
Recommendations: Accountability				
5. Compliance with evidence-based practices and client satisfaction are not always taken into account (nor always done properly) in assessing provider and manager fulfillment of contractual obligations. In addition, there is no way of consistently measuring and evaluating contract compliance across the state.	A. The state rights office will develop uniform methodologies and programs for monitoring the use of evidence-based practices; evaluating program outcomes, service quality, and the appropriateness of services delivered; auditing fund management; and client and applicant satisfaction. The rights office (perhaps through an ombudsman section) will work with representatives from CMHSPs across the state, consumers, family members, advocacy groups, providers, and other stakeholders to develop these programs, which will be designed to measure any service and/or outcome	A. Consumers will gain information important to recovery and experience greater empowerment by learning outcomes of contractual compliance issues that they or their representatives have raised. B. Client surveys will yield more reliable information about consumer perspectives on system performance. C. All parties concerned with the public mental health system	Legislative and executive action; latter to include involvement of state rights office ombudsman section	Short-term action toward long-term implementation

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
	disparities by geographic region, race and/or ethnic group, sex, or age. B. The state rights office will contract with an independent party (e.g., a public university, foundation, or nonprofit advocacy group) to assist with these programs, including the collection and analysis of client surveys and other data, and the preparation of an annual statewide report. Client surveys not be performed by CMHSP staff to avoid the potential for conflict of interest or coercion. C. Methodologies for monitoring funding needs and budgets will be designed to more accurately assess the "true" costs and benefits of public mental health services rather than measuring within individual program "silos." D. All MDCH-CMHSP contracts, and all contracts within a CMHSP network, will be required to designate both Medicaid and non-Medicaid applicants and recipients as third-party contractual beneficiaries.	will have better information for evaluating and improving key aspects of the system.		
6. Medicaid "Fair Hearings" have no requirement for clinical input and therefore have limited efficacy; non-Medicaid individuals have no effective service appeal mechanism.	A. The state rights office administers Medicaid Fair Hearings and a corresponding hearing process for the non-Medicaid population, assuring clinical consultation for both. B. CMHSPs will maintain a standard database, created by the state rights office, on non-Medicaid applicants that were denied service. The information from it will be provided to the state rights office on a quarterly basis.	A. Hearing outcomes will have a basis in treatment. B. Non-Medicaid individuals (both recipients and applicants) will have better options to appeal service decisions, and those options will be medically/clinically based.	Executive branch and legislature	Immediate action for short-term implementation

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
Recommendations: Inadequate Protection				
7. Rights protection is currently offered by the same entity responsible for service management and provision, creating a real or perceived conflict of interest.	A. State Recipient Rights Office (possibly with new name) is made a Type I/ autonomous agency within the MDCH or another part of the executive branch (e.g., Department of Management and Budget or Governor's Office). B. Local recipient rights offices (currently part of CMHSPs) are turned into local or regional offices that are staffed by and totally responsible to the state office.	Real or perceived conflict of interest will be eliminated.	Executive branch and legislature	Immediate action for short-term implementation
8. The Office of Recipient Rights doesn't have authority to correct case-specific and systemic instances of noncompliance by either CMHSPs or their end providers, including the levying of sanctions.	A. Regarding systemic noncompliance issues, the state rights office and a CMHSP would initially pursue remediation through collaborative dialogue in which the CMHSP is involved in seeking solutions, after which state rights office would determine the success of such steps. Once dialogue is concluded, remedies recommended by the state rights office would be binding. B. The administration of any CMHSP whose network, after a series of graduated steps toward remedy, exceeds prescribed ceiling of noncompliance with rights protocols, requirements, and performance on a systemic level, will be placed under receivership by the state.[2] Contracts between CMHSPs, middle managers, and end providers must address rights protection and compliance, including financial sanctions for inadequate rights	Sanctions will deter noncompliance. Receivership as a final enforcement measure would allow the services to be provided without interruption and obviates the need for state to de-fund an entire CMHSP and find another entity to replace it.	Legislative action and executive branch policy supplementation	Immediate action for short-term implementation

[2] The evaluation criteria for CMH compliance would not necessarily be those in place today.

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
	performance.			
9. The procedures and mechanisms currently in place to address rights issues are potentially duplicative, confusing, and sometimes conflicting, and do not address all legitimate client complaints.	A. The state rights office becomes a "one-stop-shopping" center for all mental health and substance abuse rights matters, regardless of Medicaid eligibility: • All possible violations of rights accorded applicants, recipients, and families under law • All service appeals • All other consumer grievances for which negotiated dispute resolution is a response option (This option is also available, at consumer's discretion, for previously named matters.) B. The rights agency will examine recipient and applicant fatalities and sentinel events for issues of possible rights violations. On behalf of a deceased recipient or applicant, an executor, administrator, or other person having authority to act should be given legal standing to initiate a grievance of a denial of service. If permitted by federal law, such standing should also be available to the deceased individual's family members (as presently defined in the MH Code) or agents designated through an advance psychiatric directive.	*All* complaints and investigative requirements will be addressed and processed in a more simplified, streamlined, and effective manner.	Executive branch and legislature	Immediate action for short-term implementation
10. The interpretation and application of rights law,	A. Local/regional recipient rights offices (staffed by and totally responsible to the	A. Institute uniformity and minimize variation in the	A. Executive branch	Immediate action for short-term

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
rules, and policy by DCH and CMHSPs are not uniform. Current forms, handouts, brochures, booklets and other materials that are used within the system to inform consumers and families about their rights and available programs are not "user friendly."	state office) would provide regular education and training to all providers and service managers. B. The state rights office (perhaps through an ombudsman function) would engage in education, training, evaluation, and assistance to primary and secondary mental health consumers in navigating this and other human service systems. C. The rights office, perhaps in conjunction with an independent organization, will review current forms, handouts, brochures, booklets, and other materials that are used within the system to inform consumers and families about their rights and available programs and evaluate them for readability, utility, suitability, and cultural sensitivity. As necessary, the rights office will develop new materials in appropriate formats. D. Legal counsel from the state rights office will be available to all regional offices (as is done in New York).	handling of rights issues, consistent with the Michigan Administrative Procedures Act and relevant case law. B. Make service and rights information and paperwork easier for consumers and families.	and legislature B. For analysis and revision of information and forms, the independent organization referenced in key issue #8	implementation

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
11. Consumer preferences for treatment and the involvement of family and others are often disregarded, particularly during times of psychiatric crisis. Court-appointed medical guardians may approve (solely) of any medically necessary and recommended health care procedures for their wards, excepting inpatient psychiatric care not desired by a ward. This forces courts to become involved in commitment proceedings, and contributes to the significant phenomenon of persons with severe and persistent mental illness not receiving treatment. Person- and family-centered planning are not conducted well, nor do they follow the person throughout treatment.	A. Adopt legislation to sanction the preeminence of consumers and their families in the development and maintenance of their treatment experience. Such legislation could include (1) promoting and governing use of advance psychiatric directives (APD) for adults, overseen by the state rights office; (2) allowing medical guardians to approve of inpatient psychiatric care; or (3) requiring that family-centered planning be used with adult recipients who desire and request the involvement of willing family members B. Service providers regulated by the MH code must formally offer and strongly encourage the establishment of such directives for those who don't have one in place.	A. Consumer preferences and desires for responses to psychiatric crises and other future circumstances are documented in advance and can be honored. B. Family access to a deceased consumer's records is enhanced without eliminating the consumer's opportunity while still living to proscribe against that. C. Some court time is freed up. D. Mental illness will be further recognized as a physical illness. E. There will be a lesser need for policymakers to explore approaches as controversial and divisive as the currently proposed "Kevin's Law" for assisted outpatient treatment. F. Person- and family-centered plans are better established and implemented; family members of adult recipients are better engaged in situations where both the consumer and family desire such engagement; and existing plans are more likely to follow consumers and families to new service providers.	Legislature	Immediate

WORK GROUP II: SERVICES AND SUPPORTS FOR CHILDREN AND FAMILIES

Chair: Joan Jackson-Johnson

Report

Key Issue A

The children's mental health system is significantly underfunded. Consequently, children (aged 0–18) with emotional and mental health issues are underserved due to the level and structure of funding for mental health services. (Ranking: 19 high, 7 moderate, 1 low)

Efforts to contain cost result in state and local policies and procedures that encourage inappropriate cost- and service-shifting among systems, including, but not limited to, mental health, juvenile justice, child welfare, substance abuse, and education.

The needs of many children with emotional and mental health issues are not being met, nor are we acting upon the increasing knowledge of the mental health field to identify the early antecedents of mental illness. The level and structure of the funding of mental health services is the most significant factor limiting the promotion of mental health in children, screening and assessment, and provision of services and supports.

Children who do not meet income or severity criteria for Medicaid have reduced access to the public mental health system. For those children who are covered by Medicaid, current funding levels are inadequate to meet their mental health needs. There is also uneven geographic access to services for children due to variations in funding among community mental health service programs.

Question: Would the work group provide further explanation of what is meant by "inappropriate handoffs?"

Answer: Inappropriate cost- and service-shifting

Question: Would the work group consider the issue of accurate screening and diagnosis to set the stage for the issue regarding the lack of a continuum of services?

Answer: Yes. This would be the basis for data for key issues B and C.

Supporting information for the above statements comes from the Bazelon Center's "Making Sense of Medicaid for Children with Serious Emotional Disturbance."

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
1. Maximize use of Medicaid funding by identifying all bona fide sources for matching and identifying and removing legal and other barriers to Medicaid waivers.	Increased availability of funds to support children's mental health services	MDCH, FIA, local courts, counties, ISDs, federal government	FY 05

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
2. Pilot the creation of joint purchasing and alignment of mental health services among local CMHSPs, family courts, and local FIA offices that results in the development of a common provider network in three counties	Improved collaboration with opportunities for blended/braided funding	MDCH, CMHSPs, family courts, FIA, schools, ISDs	1 year
3. Increase the amount of state general fund dollars appropriated for mental health so that CMHSPs can serve children who need services but do not meet current income or severity criteria.	Increased availability of funds to support children's mental health services	MDCH, FIA, JJ, CMHSPs	Lobby the legislature for increased GF for mental health services in FY05
4. Eliminate disparities in allocation of funding (Medicaid and general fund) among and within CMHSPs to provide and fund a comparable array of services in each region.	Creates equal access to services throughout the state.	MDCH and the legislature	FY 05
5. Support mental health parity legislation.	Mental health parity increases access to services for many individuals who currently have trouble affording mental health services.	MDCH, FIA, JJ, CMHSPs	Lobby the legislature in 2005
6. Establish a single entity responsible for assessing and forecasting mental health treatment needs for Michigan children and families across departments and publicly funded programs. This would assist the state of Michigan in developing a target for adequate funding for children's services and a plan for reaching this target.	Flexible and fiscally responsive mechanism for ongoing accountability, targeted funding more closely aligned with changing demographics, age/stage and regional needs	Independent research entity	6 months to establish the group. Feasibility analysis and administrative strategic plan—6 months; data partnership and first run and analysis—6 to 9 months; full operation and first annual review/ dissemination—18 months

Key Issue B

Michigan lacks a comprehensive system of care for children's mental health services: Stroul and Friedman define a system of care as "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families." (Ranking: 19 high, 7 moderate, 1 low)

There are many barriers to accessing children's mental health services that must be eliminated in order to close the gap between the number of children who receive services and the number of children in need of services.

- The current service system lacks a uniform strategy for screening and early intervention.
- The current mental health system operates to limit access to services by virtue of its fragmentation.
- Many professionals who work with children lack the necessary knowledge and tools to screen and refer children for mental health services.
- Current mental illness diagnoses for children are inadequate contributing to an inability to plan well for their service needs.
- Families are not consistently involved in planning the system of care for children.
- Limited capacity exists to treat and follow up with children who have been determined to need services.
- Services provided are often inappropriate to the needs of the child and family.
- Families become caught between systems when involved with mental health as well as child welfare, juvenile justice, education, or substance abuse. Fragmented funding can make it difficult or impossible to coordinate services and funding to address dual or multiple needs.
- Serious gaps exist in the current array of available services; for instance, prevention and early intervention, respite and crisis care, and residential treatment. Outpatient treatment restrictions force many children into higher levels of care than are necessary.

Creating a system of care involves the organization of public and private service components within the community into a comprehensive and interconnected network in order to accomplish better outcomes for children and families. It involves joint planning and shared funding to accomplish such interconnections as proactive screening, smoothly functioning access to assessment and appropriate service, coordinated service planning across systems, and shared information.

Comment: Consider adding the barrier of inadequate diagnosis of disorders in children, noting that better diagnosis of children is needed before we determine what kind of services they need.

See barriers above and the issue is addressed in the proposed options.

Supporting information for the above statements comes from the Bazelon Center's "Relinquishing Custody: The Tragic Result of Failure to Meet Children's Mental Health Needs"; the National Health Policy Forum's "Children with Mental Disorders: Making Sense of Their Needs and the Systems That Help Them"; Many Youths Reported Held Awaiting Mental Help" from the July 8 *New York Times*; and NAMI's "Stop Putting Sick Kids in Jail."

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
7. Establish and fund a system of care (see attached "Components of the System of Care") and make available a comprehensive array of services at a distance within 60 minutes (one way) of every Michigan citizen.	Greater level of service availability statewide	MDCH	2–5 years
8. Select and implement a specific mental health screening instrument for EPSDT. Screen and refer for assessment at school entry, middle and high school transitions, first suspensions, removal from home by FIA, first court appearance. Coordinate with EPSDT.	This may require a policy analysis and review of EPSDT mandate, developing program integration, rollout, and cost.	MDCH, MCCAP, Michigan AAP	Analysis and planning—one year; roll out—1 year; evaluation and reporting—6 months
9. Explore more appropriate diagnostic tools such as the Zero to Three Diagnostic Classification tool for young children.	Children will be more appropriately diagnosed and the ability to plan for services will be improved.	MDCH, CMHSPs	Immediately
10. Develop a comprehensive coordinated system of care for children aged 0–5 incorporating all state funded services. See attached "Components of Education, Prevention, and Early Intervention."	Aggregate data for study of effectiveness, elimination of program redundancies.	MDCH, Infant mental health, Early On, FIA, Head Start, ISDs, EPSDT	1 year
11. Provide easy, consumer-friendly, timely access to public mental health services at multiple entry points (no wrong door). Establish and monitor a reporting system to track those who attempt to receive services but are denied treatment.	Access to mental health services will be greatly improved.	MDCH, FIA, juvenile justice, CMHSPs	6 months to 1 year

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
12. Create an education campaign to inform stakeholders of the existence of information and disseminate information through state offices, professional associations, universities, and all organizations that have contact with child- and family-serving professionals.	Greater availability of information necessary to address the mental health needs of children and families	??	1 to 2 years
13. Increase the number of child and adolescent psychiatrists, social workers, psychologists and infant mental health specialists across the state by providing incentive programs to locate in Michigan, provide services to clients of the public system, and receive training and continuing education programs. Support the AACAP and APA at state/national levels on workforce issues.	Increased child and adolescent psychiatry access across the state. Retain quality practitioner participation in public sector mental health. Increase early detection and intervention.	MDCH, universities, professional organizations	Immediately upon identifying appropriate incentive programs
14. Review alternatives to the 20 outpatient visit benefit within the MHPs and promote Medical Health Plans contracting with CMHSPs or consolidate the outpatient benefit within CMHSPs to provide appropriate services for mildly and moderately emotionally disturbed Medicaid children. The capitation amount per child should be increased.	Improved/expanded services for children with mental health issues.	MDCH	Immediately

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
15. Implement an interagency process to review prior interventions for appropriateness and effectiveness before considering out-of-home placement or change in placement.	Ensures that juvenile justice children get appropriate services		
16. Explore court funding for treatment if a child referred to a CMHSP does not meet mental health criteria for services.		State court administrative office, county commissioners, family division circuit court	??
17. Establish and disseminate fiscal and administrative policy and guidelines that provide for blended funding, screening, assessment, access, services, and sharing of information.	Coordinated service system with improved access to appropriate services for children and families	MDCH, FIA, substance abuse, courts	1 to 2 years
18. Address issues of confidentiality in ways that respect a family's right to privacy but encourage coordination among providers in different systems.	Coordinated service system with improved access to appropriate services for children and families	MDCH, FIA, substance abuse, courts	1 to 2 years
19. Strengthen the resource capacity of schools to serve as a key link to a comprehensive, seamless system of school- and community-based identification, assessment, and treatment services.	SED will be recognized by teachers and appropriate referrals made.	MDCH, ISDs	Begin in 6 months to 1 year and expand over time statewide
20. Mandate in-service training for teachers throughout Michigan to help them recognize mental health issues and provide them with the information they need to make the necessary referrals for care.	SED will be recognized by teachers and appropriate referrals made.	MDCH, ISDs	Begin in 6 months to 1 year and expand over time statewide

Key Issue C

Children and families receiving public mental health services encounter inconsistent use of standards of care and best practices. (Ranking: 14 high, 13 moderate)

There is variation across the state in the use of best practices by agencies (MH, FIA, schools, juvenile justice) providing mental health services to children and families. Barriers to addressing the variation in the consistent use of best practices include:

- Limited capacity to identify, disseminate, and apply increasing knowledge about the nature of emotional disorders in children to public and private screening, diagnostic, and treatment efforts, e.g., inadequate training programs to standardize care and assure the use of evidence-based practices
- Lack of consistent standards of care for children's mental health services, e.g., lack of a clear definition of "family centered practice," which makes it difficult to require all public and private providers to include the child and family in all decisions about their care
- Insufficient efforts to offer culturally competent services that assure individualized care with regard to race, ethnicity, disability, gender, sexual orientation, socio-economic status, geography, and the culture of families of children with serious emotional disorders
- Lack of strong connections between the mental health system and entities that could support the use of best practices, e.g., higher education
- Little public recognition of the connection between symptoms in childhood and adult mental illness

Question: What data supports the issue statements?

Answer: Information supporting the above statements can be found in the Surgeon General's report on Children's Mental Health.

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
21. Specify use of evidence-based best practices, when available, in contracts (cf. Dr. Robert Friedman and Dr. Kay Hodges) and experiential based practices already proven and implemented in Michigan (e.g., Intensive home-based services and wraparound services). Require adherence to values and principles of system of care (Stroul and Friedman, 1994).	Increased use of evidence- and experiential-based practices	MDCH	Immediately

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
22. Convene a representative work group to explore use of evidence based and experiential based best practices for children involved in child welfare and juvenile justice leading to requiring feedback evaluation of experiential-based best practices as the first step in evaluating the impact of promising policies and programs.	Collaborative effort at policy and practice levels Documentation of expected statewide standard of care for children and adolescents with mental health needs	MDCH, FIA, with representation from courts, CMHSPs, professional organizations, and local child and family serving agencies	6 months to complete document.; 1 year from documentation to implementation
23. Enhance graduate training within colleges and universities regarding best practice methods for children and families.	Consistent practice standards will be disseminated throughout the state through a variety of outlets	MDCH, FIA, universities, colleges, department administrators, professional associations	Begin immediately and integrate into the system over time
24. Assess current training options and determine the need for implementing a training institute for the state to provide training on best practices to a broad audience, including but not limited, to staff of CMHSPs, FIA, and private child- and family-serving agencies. Link training institutions to be sure that information provided is consistent.		MDCH, FIA, universities, colleges, department administrators, professional associations	Begin immediately and integrate into the system over time

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
25. Develop a clear consensus-based definition of, and guidelines for, "family-centered practice," outlining implications and action items and revise MDCH policies on person-centered planning to specify *family-centered* practice when children are the identified consumer so that the child and family are included in any/all decisions about their care Include children in treatment planning by offering them direct information in developmentally appropriate ways about service options.	Clarity of mission and all groups working with children and families will be using same language and participating in development of policies/procedures	MDCH, CMHSPs	Immediately
26. Specify in MDCH contracts that representatives of families of children receiving services be included in governance bodies.	Involving families in system governance will assure increased use of family centered practice	MDCH	Immediately
27. Use family advocates, such as family members with prior experience, to assist families in interacting effectively with complicated service systems.	Family advocates will lessen the confusion of new families entering the system.	MDCH, CMHSPs	Immediately
28. Develop and require implementation of a formal mechanism to utilize service recipient and family feedback in an ongoing quality assurance process.	Assures family/child input into system development	MDCH, CMHSPs	1 year
29. Increase efforts to recruit and train minority providers.	Enables culturally competent care with regard to race	MDCH, CMHSPs, public and private agencies providing mental health services, universities, other training institutions	Immediately

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
30. Review recipient rights policies for sensitivity to cultural competence issues.	Assures culturally competent care	MDCH	Immediately
31. Licensing agencies and state agencies should require documentation of: policies/procedures, training, quality improvement, grievance process for individuals who have not had their rights respected.	All child/family serving agencies will follow the law	Governor's office through state agencies	3 months to inform applicable agencies and establish working plan for review with implementation to follow
32. Adopt common community and individual indicators as measures of outcome.	Common measures provide direction for improving services.	MDCH, FIA, substance abuse, courts, education	1 year

COMPONENTS OF THE SYSTEM OF CARE

Mental Health Services

Prevention services
Early identification and intervention
Infant mental health services, including infant-parent assessment and intervention
Comprehensive assessment of care and treatment needs
Medication assessment, review and management
Outpatient services
Home-based services
Day treatment
Emergency services
Therapeutic foster care
Therapeutic group care
Therapeutic camp services
Independent living services
Residential treatment
Crisis residential services
Acute care hospital inpatient treatment

Social Services

Protective services
Financial assistance
Home aid services
Respite care
Shelter services
Adoption services

Educational Services

Assessment and planning
Resource rooms
Self-contained special education
Special schools
Home-bound instruction
Residential schools
Alternative Programs

Health Services

Health education and prevention services
Screening and assessment services
Primary care
Acute care
Long-term care

Substance Abuse Services

Prevention
Early intervention
Assessment
Outpatient services
Day treatment
Ambulatory detoxification
Relapse prevention
Residential detoxification
Community residential treatment and recovery services
Inpatient hospitalization

Vocational Services

Career education
Vocational assessment
Job survival skills training
Work experience
Job finding, placement, and retention services
Supported employment

Recreational Services

After-school programs
Special recreational projects

Operational Services

Wraparound services (including systems and services coordination mechanisms for multiple needs children and adolescents)
Transition services for older adolescents and young adults
Case management
Juvenile justice services
Family support and self-help groups
Advocacy
Transportation
Legal services
Volunteer services

COMPONENTS OF EDUCATION, PREVENTION, AND EARLY INTERVENTION

- Infant mental health services with an emphasis on enrollment during pregnancy or first months of infancy
- Parent education
- Social emotional component within child care and schools
- School curriculum (Michigan Model)
- Proactive intervention in child care (MH services in Head Start); schools (bullying and other violence prevention); and CMHSPs (integrated services making children part of the service plan
- Mental health services through school health clinics

WORK GROUP III: SERVICES AND SUPPORTS FOR ADULTS

Chair: Michelle Reid, MD

Report

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
ARRAY OF SERVICES				
1. MDCH will assure an array and continuum of acute, intermediate and long-term services that are standardized statewide in quantity and quality with a goal of recovery (to be defined). These services will be determined by an appointed, on-going committee representing all stakeholders. It will provide continuous assessment and accountability for services based on both process and outcomes.	Governor will appoint a Mental Health Committee to address the services to be delivered and provide the oversight for quality.	Mental Health services will be provided with geographic and population equity across the state. There will be accountability for the delivery and outcomes of services.	MDCH and Mental Health Committee	Short-term: 1 year Long-term: continuous
2. There will be a quality component for all services. This will include clinical accountability, peer review, an appeals process, and customer satisfaction. The overarching goal is uniform access to a core set of high-quality services.	A. MDCH and the Mental Health Committee will develop the standards and methods to attain a quality improvement plan for the state. B. Communities will implement and provide input for ongoing improvement through the Mental Health Committee.	There will be continuous quality improvement for mental health services to citizens in Michigan.	MDCH, Mental Health Committee and CMH entities	Short-term: 1-2 years Long-term: continuous

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
EQUITABLE				
3. Services must be equitable. The public needs to be informed of mental health benefits and eligibility and "safety net" services.	Develop a communication plan and tools that clearly describe the benefits and resources available.	Community partners will be aware of services and work more effectively and collaboratively on behalf of the client. May increase access to services. Public will be better informed and more supportive of needs in the community.	MDCH with input from local entities	Short-term: 6–8 months
PATIENT SAFETY				
4. Treatment, community and residential services must be provided safely.	Guidelines for medication for specific diagnosis must be developed, selected, implemented, and monitored. Information and education must be provided on a statewide basis for all providers and caregivers.	Consistent and safe treatment and living conditions; decreased variations in care and services	State, CMH, Pharmacy Board, Flinn Steering Group, DUR	Short-term (process): 1 year and Long-term (statewide implementation): 5 years
PERSON-CENTERED CARE				
5. Person -centered care must be the hallmark guiding treatment, services, and supports in the system	A. Increase availability of a safe, supported housing and treatment continuum for adults and older adults. B. Adopt a "recovery vision" as the overriding vision for system planning, services, and support.	Improved quality of life for clients, decreased hospitalizations, increased access to care, and more equitable distribution of resources	MDCH/CMH (policies, practices and education of providers)	Long-term 3-5 years

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
CONTINUITY				
6. Continuity of care: Integration and continuity of primary care services, mental health and substance abuse services.	Use information technology systems with widespread secure access to gain integration of services and continuity of care.	Reduce redundancy, reduce relapse, reduce cost, increase quality of life, achieve appropriate treatment and services, and improve patient safety.	MDCH/CMH	Long-term: 3–5 years
EQUITABLE & CONTINUUM OF CARE				
7. *Continuum of safe and affordable housing options that support the recovery model must be available.	A. Design housing policy to move people to higher-level housing independence, as they are capable. B. Create incentives for group homes to participate in new housing policies. C. Create monitoring and oversight of the complete housing continuum (including unlicensed housing). This new design for monitoring must be carried out in collaboration with other state and local agencies.	Improved health and safety for individuals with mental illness	MDCH, FIA, CMH, legislature	Long term: 3–5 years

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
CONTINUUM OF CARE				
8. *A continuous support for the continuum of services must be in place at the state and local levels.	A. Review admission criteria for entry for the most severe levels of care. B. Assure adequate number of facilities and their locations.	Improved outcomes of care for the individual	MDCH, CMH	Proposed for Action A: Short-term: 6 months Proposed for Action B: Long-term: 3–5 years
9. *Supportive employment and supportive education must be components of the recovery model.	A. Same issues as continuity of care and continuous supports above. B. Criteria for participation in these programs must be reviewed and revised. Staff in these agencies and programs must receive education about the unique needs of the MH population.	A. Better coordination with other funded groups (vocational, education); education about issues of quality and stigma, in particular B. Emergence of a seamless system of services	MDCH, CMH, State and local vocational and education agencies	Long-term 3-5 years for statewide impact
PREVENTION				
10. *Prevention A. Integration of MH treatment with primary care for early detection and intervention B. Smooth transition for services from childhood and adulthood for both screening and treatment C. Prevention of relapse/re-hospitalization	A. Expand models currently used in the Federally Qualified Health Centers. B. Basic health care should be available at CMH sites where appropriate. C. Assure continuous communication between agencies and programs serving children and adult programs in the community.	Outreach for early identification and intervention for persons with mental illness (ex: schools, PSAs, primary care physicians) Columbia Model is one example.	MDCH, Medicaid, CMH, schools; qualified health plans, local public health	Short-term: 1–2 years

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
INFORMATION AND INFRASTRUCTURE				
11. A statewide infrastructure is needed to operationalize data and information related to mental health services, projects, best practices sharing, etc.	Design and implement a statewide, state-of-the-art information system that is coordinated across state and local agencies, transparent, accessible to all CMHs and ties together access to standards, services, education/training; a partnership through which to readily exchange data, information, ideas, best practices.	Information for increased quality, efficiency, improved access, and seamless service transfer	MDCH	Short-term: 6–9 months
EDUCATION AND TRAINING				
12. There is an overall lack of consistency in education and training statewide across providers, consumers, family members, and staff.	Develop a uniform infrastructure that is standardized using a Web-based curriculum for training and education on a statewide basis (but accessed at the local level, including work sites.	A. Improved quality of services; potential improved recruitment and retention of providers, staff. B. Increased support for family and caregivers.	MDCH, FIA, CMH	Short-term: 1–2 years
DEFINITIONS OF SERIOUS MENTAL ILLNESS				
13. A consistent, well-articulated definition of “serious mental illness” is needed, along with application of that definition in determining eligibility and services.	A definition will be developed that addresses the idea that there is “no wrong door” for any adult with mental illness. There will be uniform access to PMH services for adults with mental illness on a statewide basis.	Uniform access to services	MDCH with advice from governor-appointed committee	Short-term: 3–6 months

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
SERVICES FOR OLDER ADULTS				
14. Services for older adults A. There are unique treatment implications for older adults with mental illness related to their treatment and relationship to the incidence of multiple chronic diseases and their simultaneous treatment. B. Older adults reside in various facilities in the community that impact their eligibility for mental health services. C. There is a lack of providers appropriately trained, as well as in supply, for mentally ill older adults (long-term care/nursing home, gero-psych prepared providers; special needs related to depression and dementia are not addressed. D. Older adults in nursing homes have difficulty accessing mental health services.	A state plan will be developed to assess and address the needed workforce for the mentally ill older adult regardless of residence in the community; areas of assessment will include workforce development, payment standards, scope of practice, enhancement of the primary care and advanced practice nurse workforce.	Increased number and distribution of appropriate providers and improved access to care and services for older adults in MI	MDCH	Short-term: 6–12 months

WORK GROUP IV: CRIMINAL JUSTICE AND HUMAN SERVICES INTERFACE

Chair: Nick Ciaramitaro

Report

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
Area One: Pre-Entry (Prevention and Early Intervention)			
1. We do not adequately assess or utilize early risk factors or symptoms of mental illness, or protective factors (strengths) in order to address problems before they become more serious. Access to those who are not seriously mentally ill is limited, because private sector mental health is prohibited from interacting optimally with public sector mental health. (Access to Medicaid type 10 and type 11 providers (and/or QHP provider panel) is limited due to availability; services are limited to persons with the most severe levels of disability); private practitioners are contacted with requests to provide services, but are not	1. Line item funding, with maintenance of effort, to provide for primary prevention and early intervention; in order to impact, through diversion, upon the juvenile and criminal justice systems.	1. Legislature; Governor's Office	1. Immediate
	2. Identify appropriate screening and assessment tools and processes, and identify at-risk individuals.	2. DCH; New Best Practices Entity	2. Short -term
	3. Ensure training for first responders in recognizing risk factors, and in the use of the screening and assessment tools and processes.	3. Legislature; DCH/CMH/MHP; FIA; MSP; MSA; Medical Control Authority; MFFTC; MCOLES; ISD	3. Short -term
	4. Provide appropriate services in accordance with Evidenced-Based Practices (EBP).	4. DCH/CMH/MH; Private Providers; Public School System	4. Short-term

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
on the provider panel or cannot be reimbursed for services provided.)	5. DCH should expand the definition of Rule 10 & 11 providers.	5. DCH/MSA	5. Immediate
Area Two: Pre-Entry (Diversion)			
2. There are too many children in the juvenile justice system who ought to be served and supported in the mental health system.	1. There needs to be a full array of services available and accessible 24/7, including publicly run secure facilities other than jail and those operated by the juvenile justice system, in order to prevent use of the juvenile justice system as 'provider of last resort'.	1. Legislature; DOC/OCC; FIA; DCH/CMH/MHP/ODCP/SA; Schools; Private Health Plans	1. Short-term
	2. Require real and measurable pre- and post-booking diversion programs, and identify potential decision points for diversion, that can be based on the screening and assessment; including statewide expansion of the availability of mental health courts.	2. Legislature; DCH/CMH/SA; DOC/OCC; MSA; Local Law Enforcement; Counties and Courts	2. Immediate
	3. Ensure joint training efforts between CMH and other appropriate parties (first responders, service providers, law enforcement, defense attorneys, prosecutors, judiciary, and corrections and probation) for implementing established and required pre- and post-booking diversion programs throughout the state.	3. DCH/SA; Counties; Representatives of the Listed Parties.	3. Immediate
	4. Establish a formal mechanism for the evaluation and monitoring of diversion programs, and for enforcing program sanctions where expectations are not met.	4. Legislature; DCH/SA	4. Short-term
	5. Eligible governmental units should be more aggressive, and work collaboratively, in seeking funding grants for diversion programs.	5. Governmental Units	5. Immediate

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
	6. Direct DCH to modify administrative rules and Medicaid agreements to re-evaluate their policy on seclusion and restraint, in order to allow children with mental health needs to be served in Child Caring Institutions (CCI), with appropriate safeguards; and to provide additional resources for training, monitoring and services.	6. Legislature; DCH/SA; CMS; Congressional Delegation	6. Short-term
3. There are too many adults in the jail and prison system who ought to be served and supported in the mental health system.	1. There needs to be a full array of services available and accessible 24/7, including publicly run secure facilities other than jail and those operated by the criminal justice system, in order to prevent use of the criminal justice system as 'provider of last resort'.	1. Legislature; DOC/OCC; FIA; DCH/CMH/MHP/ODCP/SA; Schools; Private Health Plans; Sheriffs; Counties	3. Short-term
	2. Support continued efforts by the MDOC in reforming its Mentally Ill and Developmentally Disabled offender policies, and the its collaborative efforts with DCH. Examine the impact of, and responses to, the high number of offenders who are detained/sentenced in local jails and sentenced to prison who are Mentally Ill or Developmentally Disabled; focusing on more effective assessment and service delivery *(MDOC Five Year Plan to Control Prison Growth)*.	2. DCH; DOC	2. Immediate
	3. Require real and measurable pre- and post-booking diversion programs, and identify potential decision points for diversion, that can be based on the screening and assessment; including statewide expansion of the availability of mental health courts.	3. Legislature; DCH/CMH/SA; DOC/OCC; MSA; Local Law Enforcement; Courts; Sheriffs; Counties	3. Immediate

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
	4. Ensure joint training efforts between CMH and other appropriate parties (first responders, service providers, law enforcement, defense attorneys, prosecutors, judiciary, and corrections and probation) for implementing established and required pre- and post-booking diversion programs throughout the state.	4. DCH/SA; DOC/OCC; Counties; Representatives of the Listed Parties; Sheriffs; Counties	4. Immediate
	5. Establish a formal mechanism for the evaluation and monitoring of diversion programs, and for enforcing program sanctions where expectations are not met.	5. Legislature; DCH/SA; DOC/OCC; Sheriffs; Counties	5. Short-term
	6. Eligible governmental units should be more aggressive, and work collaboratively, in seeking funding grants for diversion programs.	6. Governmental Units; DOC/OCC; Sheriffs; Counties	6. Immediate
Area Three: During Detention or Incarceration (Pre- and Post-Adjudication)			
4. There are problems with timely and accurate clinical screening and assessment (and therefore, treatment) within the jails, prisons, and juvenile detention facilities. A. Adults B. Children	<u>Adults</u>: A1. Develop best practices for screening and assessment of adults at entry into incarceration, in collaboration with agencies such as the: National Institute of Corrections (NIC); American Corrections Association (ACA); Department of Community Health (DCH); Community Mental Health (CMH); and, the American Psychological and Psychiatric Associations (APA).	A1. DCH/CMH; New Best Practices Entity	A1. Short-term
	A2. Implement screening at booking, and assessment, based on the best practice models.	A2. DCH/CMH/SA; DOC/OCC; Jails	A2. Short-term
	A3. Formalize legal responsibility placed on CMH (Section 207) and jails, for citizens who are placed in jails.	A3. Legislature	A3. Immediate

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
	A4. Develop a state monitoring mechanism to assure timeliness.	A4. DCH; DOC; Counties; Sheriffs; Jails	A4. Short-term
	<u>Children</u>: B1. Develop best practices for screening and assessment of juveniles at entry into incarceration, in collaboration with agencies such as the: Council on Accreditation (COA); Family Independence Agency (FIA); Commission on Accreditation of Rehabilitation Facilities (CARF); National Center for Mental Health and Juvenile Justice; Public School Systems; and, American Academy of Child and Adolescent Psychiatry.	B1. DCH/CMH; FIA; New Best Practices Entity	B1. Short Term
	B2. Implement early screening and assessment of children when they first come into contact with the juvenile system, based on the best practice models, and by mental health providers in both the public and private sectors.	B2. DCH/CMH; FIA; Counties; Courts	B2. Short-term
	B3. Develop a state monitoring mechanism to assure timeliness.	B3. DCH; FIA; Counties; Courts	B3. Short-term
7. There are problems with the adequacy and appropriateness of treatment for many incarcerated adults & children.	<u>Adults</u>: A1. Develop best practices for treatment to be used in jails and prisons in collaboration with agencies such as the: National Institute of Corrections (NIC); American Corrections Association (ACA); Department of Community Health (DCH); and, Community Mental Health (CMH).	A1. DCH; DOC; New Best Practices Entity	A1. Immediate

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
A. Adults	A2. Provide a full array of evidence-based treatment services, including alternative secure residential treatment, for prisoners in jails and prisons.	A2. Legislature; DCH/CMH/SA; DOC/OCC: Sheriffs and Counties	A2. Short-term
B. Children	<u>Children:</u> B1. Develop best practices for mental health treatment of adolescents in juvenile detention and elsewhere in the juvenile system (e.g., day treatment programs) in collaboration with agencies such as the: Council on Accreditation (COA); Family Independence Agency (FIA); Commission on Accreditation of Rehabilitation Facilities (CARF); National Center for Mental Health and Juvenile Justice; American Academy of Child and Adolescent Psychiatry; and, (1 more from Anne Burns).	B1. DCH; FIA; New Best Practices Entity	B1. Immediate
	B2. Provide a full array of evidence-based treatment services, including alternative secure residential treatment, for children with emotional disorders in juvenile detention facilities and other juvenile treatment programs like day treatment centers.	B2. Legislature; FIA; DCH/CMH; Private Childcare Agencies; Courts	B2. Short-term
Area Four: In Preparation for and Upon Release from Detention or Incarceration			
6. There isn't a unified system of coordinated and collaborative support to ensure a smooth transition for individuals from detention or incarceration to community-based treatment and care.	1. Establish a pre-release planning process that begins at reception in prison or jail, and at intake at juvenile facilities, which creates an offender-specific plan that addresses an offenders' strengths, needs and risks (a prison Transition Accountability Plan (TAP); a jail Community Reintegration Planning (CRP); and, a community reintegration plan for juvenile offenders). Plans should include not just mental health, but other related needs (vocational, educational, etc.).	1. DCH/CMH/SA; DOE; DOC/OCC/TPIC; FIA; MRS; MSHDA; Jails; Private Child Caring Agencies; Courts	1. Short-term

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
	2. Collaborate with the National Institute of Corrections (NIC) and the National Governor's Association (NGA) to reduce recidivism by focusing on three areas *(MDOC Transition from Prison to Community Initiative (TPCI)/ Michigan Prisoner Re-Entry Initiative)*: A. Inmate preparation for release thru risk/need reduction; B. Improved parole plans thru collaborative efforts with other state agencies for housing, welfare, education, employment, health and improved parole guidelines; and C. Parole supervision to include more emphasis on relapse prevention.	2. Governor's Office; DCH; DCH. FIA, DLEG	2. Immediate
	3. Improve training for supervising agents on what to expect from mental health clients, similar to that which is necessary for first responders, service providers, law enforcement officers and others.	3. DCH; DCH. FIA, DLEG	3. Short-term
Area Five: Contributing Factors / Other			
7. The statutory and administrative framework is insufficient to actually yield/achieve real juvenile justice and criminal justice diversion.	1. Make the statutory and administrative changes necessary to comply with the recommendations outlined under Key Issues 1-6 across the effected systems.	1. Legislature	1. Short-term
	2. Identify revenues streams to follow.	2. Legislature; Governor's Office	2. Short-term

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
	3. Develop disincentives for arrest and prosecution, as appropriate, and incentives to move people from the criminal justice system into the service system.	3. DCH/CMH/SA; DOC/OCC; FIA; Counties	3. Short-term
	4. Add 'Diversion from juvenile justice system' to Section 207 of the Michigan mental Health Code.	4. Legislature; Governor's Office	4. Short-term
8. There is an inefficient use of taxpayer dollars as we over utilize an expensive criminal justice system, instead of providing more appropriate and cost-effective mental health assistance/services.	1. Quantify the 'cost v. savings' of diversion as a way to have the resources to implement it: "What we do or don't do" vs. "What if we did it right?" (The cost for jail/prison inmates vs. what we could have done with the same dollars if they had been appropriately diverted?)	1. DCH/CMH/SA; DOC/OCC; DMB; Counties	1. Short-term
	2. Compare the current costs of 'What is', to those of 'That which is desirable' to show savings; include community costs, such as 'lost" costs' if someone one is incarcerated instead of out working, etc.	2. DMB; U of M (or similar) Economic Forecasting Vendor; MI Dept. Treasury	2. Short-term
9. A number of people in the community do not recognize that their own mental illness may result in behaviors which may lead them into the criminal justice system.	1. Ensure an educational-approach model, including education within and of the justice system and law enforcement (first responders, service providers, law enforcement, defense attorneys, prosecutors, judiciary, and corrections and probation).	1. New Best Practices Entity; Representatives of the Listed Parties	1. Immediate
	2. Family, provider and community education.	2. DCH; DOE; Advocacy Groups	2. Immediate

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
10. There is a serious disconnect (lack of integrated treatment) between the dual diagnoses of substance abuse and mental illness (MISA). The access and entry systems of each are not integrated.	1. Identify administrative solutions and opportunities for integrated screening, assessment and treatment.	1. DCH/CMH/SA; DOC; FIA	1. Immediate
	2. Ensure cross training among first providers (cross agency), to identify and direct them to and through the integrated system.	2. Legislature; DCH/CMH/MHP; FIA; DOC; Medical Control Authority; MFFTC; MCOLES; ISDs	2. Immediate
	3. Require that mental health and drug courts be established in a manner so as to address co-occurring disorders, regardless of which 'front door' the person enters; and expand these courts throughout the state.	3. Legislature; DCH/CMH/SA; SCAO; Prosecutors; Law Enforcement	3. Immediate
	4. Develop an array of housing options specifically for persons with mental illness, substance abuse and co-occurring disorders who are being diverted or reintegrated (two separate populations) into the community.	4. Legislature; DCH/CMH; DOC/OCC; FIA; MSHDA/HUD	4. Short-term
11. Outside the criminal justice system, public policy provisions regarding involuntary treatment are not adequate to permit the mental health system to treat many seriously ill people. There is no clear and generally accepted understanding (or agreement) regarding:	1. Direct that all those involved in the involuntary commitment process be trained toward an accurate and consistent understanding and application of the current law.	1. SCAO; DCH/CMH; Law Enforcement; Prosecutors; Courts; MCOLES	1. Immediate
	2. Ask that the Legislature re-evaluate the law, with regard to inpatient and outpatient involuntary commitment.	2. Legislature; Governor's Office; DCH	2. Immediate

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
1. Who has the right to compel treatment; 2. Under what circumstances may treatment be compelled; or, 3. What types of treatment may be compelled?	3. Consideration shall be given for expanded authority by criminal courts to direct persons to mental health services, as an alternative to criminal penalty, based upon clinical assessment and with appropriate safeguards.	3. Legislature; Governor's Office; SCAO; DCH; DOC	3. Short-term
12. There is no effective mechanism to translate established national 'Best Practices' into Michigan operations.	1. Create a new 'Best Practices Entity' (type to be determined) with the following elements for the identification, collection and dissemination of best practices:	1. Governor's Office; Legislature	1. Immediate
	A. <u>Information about Current Practice</u>: How are we providing various treatments within our system- to whom, for what, with what effect, etc.? An expert conference and clinician-administrator focus groups will be held to determine what elements of data need to be collected. Data collection instruments will be finalized, process of data entry and storage determined, the infrastructure to support the process developed, and the management structure to coordinate this process organized.		

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
	B. Formulating and Updating Best-Practices: What is the current evidence-based best practice for the treatment of adults with serious mental illnesses and children with serious emotional disturbances? How is this evidence base operationalized into a defined practice algorithm? How can defined best practices be translated into a disease management plan for each individual? Towards this end, national and international expert consensus panels and colloquia will be held, state and local guideline review panels organized, and national/international and state-level algorithm conferences conducted.		
	C. Quality Assurance: Is current practice consistent with best-practice standards? How are different service plans and individual practitioners providing various treatments? Which practitioners or service programs deviate most significantly from best practice? How can we develop an efficient system of obtaining such information in a timely manner? Methods and principles of outlier analysis will be developed and formal feedback mechanisms will be operationalized.		
	D. Education Function: How can we disseminate information about best practices, efficient and effective treatments, etc? Approaches will include district and state-level conferences, telephone consultations, dissemination of electronic and published materials, etc.		

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
	E. Liaison and Consultation Function: Regular interactions with various stakeholders individually and collectively will be held to obtain necessary input and feedback.		
	F. Statewide Innovative Practice Projects: A mechanism to support innovative projects around the state that are directed towards more effective and efficient treatment will be developed.		
	2. Explore best practices of public/private partnerships, to extend treatment opportunities for individuals who do not meet the priority population requirements of the CMH's, and therefore are ineligible for CMH services.	2. DCH/CMH/MHP; Professional Associations; Private Providers	2. Short-term
13. The County of adjudication (where a crime is committed) may not be the county of residence for the person charged. The county of residence is responsible for the financial piece of providing the mental health services.	1. Direct that the CMH of the county in which a crime is committed, is responsible for the provision of diversion services, including arrangements with the county of residence, where appropriate. Clarify how responsibility for the provision of mental health services is to be settled in these incidences.	1. Legislature	1. Immediate

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
14. There must be a state-level capacity for monitoring and evaluating the impact of the Work Group's and MMHC's recommendations.	1. Standardization of data collection and compilation, statewide analysis, and distribution of the results.	1. New Best Practices Entity; DCH/CMH; Jails	1. Short Term

KEY ISSUES FOR REFERRAL TO OTHER WORK GROUPS:	
Work Group II: Services and Supports for Children	Direct DCH to modify administrative rules and Medicaid agreements to loosen their policy on seclusion and restraint, in order to allow children to be served in Child Caring Institutions (CCI), with appropriate safeguards; and to provide additional resources for training, monitoring and services.
Work Group V: Governance, Finance, Structure and Accountability of the Publicly Supported Mental Health System	Offenders lose Medicaid coverage while incarcerated, which creates a major barrier to successful re-entry.

WORK GROUP V: GOVERNANCE, STRUCTURE, FINANCE, AND ACCOUNTABILITY

Chair: Milton Mack

Report

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
1. Structure and governance: State, regional, and local roles and responsibilities in the public mental health system should be driven by need and function. In other words, who is best suited to performing or overseeing which functions to assure effective and efficient treatment and supports for persons with mental illness? Michigan's public mental health system is not structured to deliver care effectively, efficiently, and in a timely fashion to people with mental illness. The current structure—that is, the relationships and responsibilities shared among the state, PIHPs, CMHSPs, providers, and consumers—has fostered the following problems:	A. Consolidate CMHs into at most 18 regional authorities/PIHPs. These 18 authorities will integrate mental health and substance abuse services and collaborate with physical health, public health, FIA, corrections, and education to deliver services effectively and efficiently to persons with mental illness. Alternatives to consolidation: • Create a true mental health *system* through a shared governance structure that better coordinates state, regional, and local roles and responsibilities for services to persons with mental illness.	Allows one entity in each of the 18 regions to manage both Medicaid and general fund monies for public mental health services. Standardize administrative functions, which will reduce administration layers and lower administrative costs. Eliminate county match and county government control. Address the wide variation in funding and access across counties and regions. Address the large population with co-occurring mental illness and substance abuse.	Legislature and MDCH, with input from consumers, CMHSPs, PIHPs, and providers on composition of regions, standardization, and simplification.	Immediate to short-term. A Section 1115 waiver from the federal government could accomplish this change in structure. In the absence of such a waiver, state law would have to be changed.

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
• Huge variation in funding and therefore service provision and access. • Inefficiency because of variation in regulation between the two major funding sources. PIHPs struggle to manage two dramatically different major sources of funding for public mental health services: Medicaid and general fund. These sources have very different requirements, which confuse and frustrate people needing services and drive unnecessary duplication of effort in PIHPs that must conform to these regulations.	Such a structure depends on (a) improving and enforcing statewide standards for administration and performance (see below); (b) coordinating these functions regionally; and (c) preserving CMHSP local assessment and delivery. 1. Establish a task force or work group to examine the delivery and financing of mental health services in rural areas. This group should address the inequitable funding for mental health in rural Michigan and recommend changes to the current structure (PIHPs, CMHSPs) to assure that rural residents' needs are met.			

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
• While there has been some progress recently with clinical uniformity and data submission, there is inefficiency from an overabundance of uniform statewide administrative requirements and the absence of a standard method of collecting information from PIHPs, CMHSPs, and providers to meet administrative requirements. The state lacks the staffing and resources to monitor and enforce statewide standards when doing so will reduce administrative costs and improve quality.	2. Restore the locus of responsibility for public mental health services to MDCH and have an MDCH contract management unit—with monitoring and compliance authority—directly administer contracts with core providers at the local level.			
• Too much variance in the quality of mental health care. In addition, federal and state regulations have been the basis of an accountability	B. Develop demonstration projects that link public mental health services and physical health services through FQHCs.	Links mental and physical health care at one site for the uninsured and Medicaid beneficiaries. FQHCs receive enhanced reimbursement for services delivered to the uninsured.	MDCH working with the Michigan Primary Care Association	Short-term: 3–5 years

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
system that does not measure the things that matter most to consumers and reflect the commission's values. A quality management system must integrate accountability with quality measures that should be set by MDCH with input from consumers, PIHPs, CMHSPs, and providers. (The early work of MDCH's quality improvement council is promising in this regard.)				
An optimal structure should preserve consumer involvement in governance and address *local control* [Mental Health Code, section 204(b)] and guaranteed access to treatments and supports in communities.	C. Make the regional mental health authorities responsible for the 20 outpatient mental health visits now delivered through Medicaid health plans.	Makes more sense for regional MH authorities to coordinate mental health services.	State legislature; MDCH working with consumers, regional mental health authorities, providers, and Medicaid health plans	Legislature must change the Insurance Code. Once consolidation has occurred, this can be accomplished immediately.
	D. Support for legislation (SBs 591, 1076, and 1079) establishing a Detroit-Wayne County Community Mental Health Agency		State legislature/ governor	Immediate

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
2. The role of PIHPs and managed care: Does the PIHP model need maturing to function optimally or is the PIHP model itself the issue?				
3. Funding: Michigan's long tradition of progressive public policy for mental health services has been undermined by inadequate funding. State policy decisions to (a) maximize federal revenue through Medicaid and (b) diminish general fund appropriations to public mental health services have resulted in a two-tiered system of coverage and services, with people eligible for Medicaid much more likely to receive public mental health services than those without coverage who must rely on the general fund. Even so, Medicaid does not cover many people (approximately 45 percent) with serious mental illness because eligibility requires meeting a restrictive definition of	Investigate waiver options, with the goal of giving the State the greatest flexibility in benefits and covered populations and the least risk of losing current and future funding, including federal matching dollars. For details on these options, see Morna Miller's May 19 memo on Medicaid expansion options, which appears at the end of this document. THE WORK GROUP REPLACED THIS RECOMMENDATION WITH THE ONE ABOVE, BUT IT REMAINS IN HERE FOR REFERENCE. Secure a Section 1115 from the federal government (HHS) that allows consolidation of all federal funding into one benefit package.	Gives the State maximum flexibility in benefits and covered populations and the least risk of losing current and future funding, including federal matching dollars. Allows consolidation of Medicaid, GF, ABW, and other benefits packages so that there is a single benefit for all who receive public mental health services. Gives the state maximum flexibility in the use of federal and state dollars to fund mental health services. Extends the benefit to more people with mental illness. Standardization and simplification leads to greater consumer understanding of what is covered and easier, less costly administration, leaving more funds for direct treatment and supports.	MDCH, working with all mental health stakeholders	

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
disability and restrictive income requirements. The effect of this two-tier system is exacerbated by the dramatic differences in general fund support for mental health services per capita among Michigan's counties. These inequities mark a crisis in the delivery of appropriate and effective services and supports throughout the state.	Pursue additional general fund appropriations for mental health services to rectify the absence of COLA increases. Investigate new, dedicated funds through special fees and assessments.		State legislature and MDCH State legislature and MDCH	
4. Accountability: Who should be held accountable for what? Which measures should be used for evaluation? Should there be financial incentives for performance? There is too much unproductive variance in quality of care, payer reporting requirements (Medicaid vs. GF), and	A. Invest more resources for the state to set standards for regional accountability; standardize payment, performance, and other administrative functions (e.g., computer systems) so that accountability is achieved without micromanagement.	Standardization and simplification will reduce the burden on regional mental health agencies and providers.	MDCH working with stakeholders.	Short term (1-3 years)

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
other administrative requirements				
	B. Reduce regional variations in clinical care through the identification, adoption, and measurement of evidence-based practices and centers of excellence. Move to financial incentives for high performance according to widely accepted, evidence-based measures of quality care.	Improve quality of care across regions.	MDCH working with Michigan leaders in the field of quality improvement and performance measurement.	Short-term (1-3 years)
5. Longer term psychiatric care: More longer term (two weeks to six months) psychiatric care—how can we best deliver it? The future of state hospitals: aging infrastructure, lack of geographic balance Licensure changes needed to create new kinds of facilities to meet longer-term needs of persons with mental illness.	A. Forge partnerships between CMHs and private psychiatric hospitals and psychiatric units of general hospitals to coordinate care of persons with mental illness needing longer term care (and emergency care, step-down, follow-up, etc., as these consumers need an array of services).	Closer partnerships will allow for better coordination of care. CMHs may be able to redirect some public monies to gain access to Medicaid matching dollars.	MDCH, in cooperation with the legislature to make changes to existing law, and other stakeholders (CMHs, providers, consumers).	Short-term

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
Private psychiatric beds: units are closing; many beds are occupied only because patients are waiting for community care	B. The state should specially license beds in private psychiatric hospitals, psychiatric units of general hospitals, and other facilities to provide longer term care where and when they are needed, recognizing that 2-3 levels of care may be necessary. No person should have to travel more than one hour from his/her home to receive this care.	Special licensure (possibly intensive secure residential facilities) will allow the state to meet unmet need for longer-term care in the community. State hospitals are aging and available only in a few communities. Eventually, the state facilities—except for the Forensic Center—would not be necessary.		
Medicaid does not pay for IMDs	C. Pursue a Section 1915b waiver, as Hawaii and Iowa have worked around the IMD exclusion through this waiver.	Gives the state more flexibility with persons needing longer-term care.	MDCH applies for waiver.	Short-term
6. Involuntary treatment: The current process for involuntary commitment poorly serves consumers and the public interest. Involuntary treatment should be used only as a last resort. An alternative is needed that preserves self-determination while creating a sensible, effective, clinically driven process to provide care to persons who do require involuntary treatment because they are a	Consistent with person-centered planning, develop a process with several steps—including advanced psychiatric directives—that make every effort to avoid involuntary treatment unless the consumer is a danger to herself/himself or others.	Preserves self-determination while streamlining process for care for persons who are a danger to themselves and others. Allows clinicians, not judges, to make decisions about appropriate treatment.	MDCH, consumers, CMHSPs/PIHPs, and the courts should work together to develop the process.	Immediate

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
danger to themselves or others.				
7. Prevention and early intervention: Prevention and early intervention are essential and have been underfunded. Moreover, the Mental Health Code is a barrier to early intervention. Now, you have to be in crisis to get into the system. Helping people early on can prevent the onset of more serious mental illness later on.	Principle: Prevention and early intervention must be part of the continuum of care. Community mental health is not only for the care of the severely mentally ill. A. The Ticket to Work and Work Incentives Act of 1999 established two new optional eligibility groups to help states cover the working disabled. The TWWIIA provisions directly address some of the problems with covering people with mental illness under Medicaid, and Michigan is not currently utilizing any of the options or funds available.	There is ample evidence that people with chronic illness in general—and mental illness in particular—benefit from early intervention; it may, in fact, fundamentally alter the course of the illness.		

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
	The *medical improvement option* was created explicitly to help states cover people with severe and persistent mental illness that responds to psychotropic drugs, among other things. The federal law limits eligibility to those with a "severe medically determinable impairment," but the impairment does not have to meet the disability test. Federal law also limits eligibility to those between 16 and 64 who are either working 40 hours a month or meet some alternate definition of employment approved by HHS. The state sets income and resource standards.	Allows the State to cover more people with mental illness under Medicaid. The State must also cover their physical health needs as well.	MDCH applies to federal government.	Immediate
	B. Fully implement EPSDT	Alerts children, families, and professionals to early signs of severe emotional disturbances.		Immediate
	C. Direct the State Board of Education and the Department of Education to enforce IDEA, which requires schools to arrange for and fund	Improves identification of and treatment for children with emerging mental illness.	State Board of Education and the Department of Education	Immediate

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
	services to children with severe emotional disturbances. D. Establish Schizophrenics Anonymous and dual diagnosis support groups in every CMH.	Prevents relapse.	Consumers and CMHs	1-2 years
8. Parity: Parity laws' effect on the resources and demands made on public mental health: To what extent does parity lead to private health insurance coverage of services that would otherwise be the responsibility of the public system?	Support SBs 4-5.	Reduce demands on the public mental health system because more people with private health insurance will have their mental health care covered.	State legislature/governor	Immediate

(Work Group V, Continued)

MEMORANDUM

To: Pat Babcock
From: Morna Miller
Office of Congressman Sander M. Levin
Date: May 19, 2004
Subject: Medicaid expansion options

Based on preliminary research, Michigan has a number of options that would potentially increase the number of people in need of mental health services that we could cover under Medicaid. None of the options alone is a silver bullet that solves all our problems, since most are limited to expanding coverage to certain groups, and most have some financial downsides, either requiring/generating an increase in state Medicaid costs or reducing future federal Medicaid contributions.

TWWIIA Basic Coverage/Medical Improvement Groups

The Ticket to Work and Work Incentives Act of 1999 established two new optional eligibility groups to help states cover the working disabled. The TWWIIA provisions directly address some of the problems with covering people with mental illness under Medicaid, and Michigan is not currently utilizing any of the options or funds available.

The *basic eligibility option* allows states to set their own income and resource standards for Medicaid eligibility for anyone who otherwise meets the SSI standard of disability and is not under 16 or older than 65. To qualify, the beneficiaries must be ostensibly be working, but the state can't establish a minimum earnings or hours threshold. Essentially, this would allow us to qualify anyone whose mental illness was severe enough to qualify for SSI on non-income grounds. Of course, if they qualified for Medicaid coverage, the state would be obligated to provide physical, as well as mental health coverage.

The *medical improvement option* was created explicitly to help states cover people with severe and persistent mental illness that responds to psychotropic drugs, among other things. The federal law limits eligibility to those with a "severe medically determinable impairment," but the impairment does not have to meet the disability test. Federal law also limits eligibility to those between 16 and 64 who are either working 40 hours a month or meet some alternate definition of employment approved by HHS. The state sets income and resource standards. As with the other Medicaid expansions, if the state elects the option, the state is required to provide full Medicaid benefits to people who qualify under this option.

To date, Michigan has not taken up either option. 25 states have elected one or both of these eligibility categories.

It seems likely that Michigan could qualify a significant number of the adults currently ineligible for Medicaid for federal reimbursement under one or both of these options. The state can also apply for a federal **Medicaid Infrastructure Grant,** which would provide federal funds for manpower and other administrative costs of implementing the new eligibility groups. Medicaid Infrastructure Grants are competitive grants awarded only to states that apply. Michigan is one of only 13 states that do not currently have a Medicaid Infrastructure Grant. The solicitations for Medicaid infrastructure grants are issued each spring, and a minimum of $40 million total is available. The grants remain available until 2010.

Early, Periodic Screening, Diagnosis and Treatment for Children (EPSDT)

The poorly enforced EPSDT requirement has always been part of Medicaid regulations and was codified into law in 1989. It requires states to provide periodic health assessments (physical and mental health) for all **Medicaid eligible** (not Medicaid enrolled – in Michigan and in other states, there are large numbers of low-income children who are eligible for but not enrolled in Medicaid) children. The state is then required to provide all health services the screening identifies a need for **even if they are not normally Medicaid-covered**. Essentially, EPSDT provides a mechanism for providing (and collecting a Medicaid match on) children's health care services (including mental health) that states can't normally provide through Medicaid.

On the other hand, EPSDT also creates a requirement that the state provide (and pay the state share of) a number of other, non-mental health (although needed) health care services. Aggressive use of EPSDT is almost sure to lead to an increase in state Medicaid spending for needed services to children, which will have a state budget impact.

An EPSDT strategy is also only useful with children in families below 150% of the federal poverty level (about $28,000 for a family of four). It doesn't provide avenues of coverage for adults or higher-income children. It also doesn't pay for population-based interventions, only individual health services. It would, however, expand the number of mental health services Michigan could provide for children using Medicaid funds.

Section 1115 waivers (called HIFA waivers for Medicaid/S-CHIP)

Section 1115 (enacted in 1962) gives the Secretary of HHS broad authority to authorize any demonstration project likely to "assist in promoting the objectives" of state grant programs under the Social Security Act (and thus covers a range of programs in addition to Medicaid and the Children's Health Insurance Program (S-CHIP)) In practice, the "demonstration" component is loosely enforced, and HHS has frequently approved identical "demonstrations" in multiple states for long periods of time.

The advantage of an 1115 waiver is that it often allows states to use Medicaid or Children's Health Insurance program funds to provide services not normally covered by Medicaid or to serve populations that are not eligible for Medicaid or S-CHIP and to waive various other program rules that make it difficult to blend the funds with other funding sources. The waivers also allow states to circumvent Medicaid rules that require states to provide the same level of benefits to all Medicaid beneficiaries (normally, states can choose to exclude an optional population or service from Medicaid entirely, but if they include a service, they have to offer to all populations, and if they include a population, they have to offer complete services.)

Because the executive branch has such broad authority to modify existing program rules without Congressional consultation or approval, use of Section 1115 waivers tends to reflect that administration's policy priorities. The current Administration has signaled a preference for testing two things – capping the federal contribution in exchange for flexibility (block grants) and component that allows people to purchase private insurance instead of enrolling in Medicaid or other public programs. (Connecticut and Florida have block grant applications pending, and all HIFA waivers are required to include at least a feasibility study of "premium assistance" for private health insurance.)

Two things, however, are constant across Administrations.

Budget neutrality requirement. Demonstrations operating under Section 1115 waivers cannot generate higher federal Medicaid spending than would occur without the waiver. As a practical matter, this usually means states either agree to a cap on federal contributions or are required to make explicit cuts in benefits or eligibility for current populations. Because total state allocations under S-CHIP are capped (not open-ended like Medicaid), the S-CHIP requirement is usually just that the changes not increase S-CHIP spending beyond the state's allotment, which sometimes allows an increase over current spending. Prior to the Adult Benefit Waiver and some reversions of S-CHIP funds to Treasury, Michigan had about $400 million in unspent S-CHIP funds.

Reporting requirements. Nominally, Section 1115 waivers are research projects to test the efficacy of new approaches. As a result, they come with reporting and evaluation requirements.

Because of the strictness of the budget neutrality requirements, I believe a Section 1115 waiver is unlikely to increase the amount of federal funding available for mental health care (although it could allow us to spend it on different populations) and in fact, could well reduce available federal funding in the long term, since Michigan's "baseline" for federal funding would be based on the system before Commission-recommended reforms that might increase the number of people eligible for or enrolled in Medicaid or their utilization of services. Although an S-CHIP waiver might be able to tap into any remaining funds in Michigan's allotment, S-CHIP funds are currently declining, and a waiver that merges S-CHIP and Medicaid funds would require Michigan to accept a lower match (about 51% federal instead of 65% federal) for the entire project.

While it would reduce some kinds of accountability and reporting by waiving rules, it would create new reporting requirements, since we would be required to evaluate it as a research project.

Section 1115 waivers also come with a relatively high level of uncertainty when they do expire, since a change in HHS Secretaries often results in changed priorities for the use of such flexible authority (and they're technically demonstration projects), and Congressional watchdogs (including the Senate Aging Committee and the General Accounting Office) have recently singled out the waivers as an inappropriate use of Medicaid and S-CHIP funds.

Section 1931 expansion

Prior to 1996, adults were generally only eligible for Medicaid if they were receiving welfare or Supplemental Security Income (SSI). Waivers were needed to cover other adults. Under the 1996 welfare law, eligibility for Medicaid and welfare were "de-linked." Although each state's eligibility level was technically fixed at the 1996 welfare income level, states were given broad latitude to set their own "earnings disregards" and their own asset tests for low-income parents. (Many people who would otherwise be eligible for assistance have some property or personal savings that disqualifies them.) Essentially, states can dramatically raise the income and asset levels for Medicaid eligibility by "disregarding" income and assets, and can do so without special federal permission or waivers.
The advantage of using Section 1931 is that it doesn't require any kind of federal waiver, and the option is not likely to disappear. The clear disadvantage is that, since it's a welfare reform provision, it's targeted at parents with earned income, so it doesn't help the state expand to cover people with mental illnesses that prevent them from working or childless adults. The other issue is that a 1931 expansion would require additional state investments, since the state would have to put up its share of not only the mental health treatment, but also of the physical health treatment, since without a waiver, if you expand Medicaid eligible, you have to provide the newly Medicaid-eligible population all Medicaid services that they need.

Section 1619(b) eligibility

In order to encourage Supplemental Security Income (SSI, the federal cash assistance to the poor disabled) recipients who can work to attempt to do so, Section 1619(b) of the Social Security Act requires states to provide Medicaid coverage to people who have already qualified for SSI and continue to have the impairment that qualified them for disability benefits but subsequently have more than $800 a month in earnings (usually the disqualifier for SSI/Medicaid coverage.) These people remain eligible for Medicaid so long as their gross earnings are determined to be less than the value of the sum of SSI, state supplemental disability payments, Medicaid benefits, and publicly-funded attendant care they would be eligible for if they weren't working. In Michigan, that threshold is $22,250 a year. While that's a relatively low threshold, it's much higher than the general

income threshold for SSI-based Medicaid – 74% of the federal poverty level, or about $7,000 a year for a household of one.

The use of this section does not require a waiver of any kind, but is relatively limited, since it only applies to people who are currently receiving SSI and return to work.

Appendix D:
Recommendations Related to Children

The following recommendations are excerpted from Part 1 of the Mental Health Commission report.

Goal 3: A full array of high-quality mental health treatment, services, and supports is accessible to improve the quality of life for individuals with mental illness and emotional disturbance and their families.

11. As a first step in assuring a full array of services for children and youth with serious emotional disturbance and adults with serious mental illness, the state policy plan should identify, fund, and assure adequate core service options available on a 24-hour basis to adults and minors who qualify for enhanced access within Michigan's publicly funded mental health system (see material on enhanced access in the recommendations under goal 2) and crisis response services available to any person experiencing psychiatric emergency.

20. Michigan's interagency approach to prevention, early intervention, and treatment for children should be strengthened by the following actions:

    A. Michigan's developing early childhood comprehensive system of care for children from birth to age five should coordinate and connect early childhood services and supports with the mental health services in the model array.

    B. The State Board of Education should enforce IDEA and mandate in-service training for teachers throughout Michigan to help them recognize mental health issues.

    C. The legislature should mandate in-service training for teachers throughout Michigan to help them recognize mental health issues.

    D. The governor should assign responsibility to MDCH to assess and forecast mental health treatment needs for Michigan children and families across departments and publicly funded programs.

    E. The governor should charge MDCH, FIA, and other appropriate state agencies to develop an integrated policy and plan for children with serious emotional disturbances and at risk for mental illness. This should include a collaborative interagency process to review prior interventions for appropriateness and effectiveness before determining placement.

    F. In partnership with Michigan universities, the State of Michigan should provide incentive programs to increase the number of child and adolescent psychiatrists, social workers, psychologists, advanced practice nurses, and infant mental health specialists across the state. Michigan should pursue federal Nurse Reinvestment Act funds to support new traineeships to help address the nursing shortage, particularly in the area of mental health. Another strategy that should be considered is forgiving college loans of those who agree to practice in child and adolescent mental health specialties.

Goal 4: No one enters the juvenile and criminal justice systems because of inadequate mental health care.

25. The array of mental health services (see Goal 3) must be available and accessible to eliminate use of the juvenile and criminal justice systems as "providers of last resort."

26. The legislature, the executive branch, the judiciary, and law enforcement should require effective and measurable, evidence-based pre- and post-booking diversion programs, including formalizing the shared legal duty of CMHSPs, law enforcement, and jails for diversion by revising law to include "diversion from the juvenile justice system" and expanding mental health and drug courts throughout the state.

27. Joint training should be ensured across CMHSPs, first responders, service providers, law enforcement, defense attorneys, prosecutors, judiciary, and corrections and probation officers on the implementation of established and required pre- and post-booking diversion programs throughout the state.

28. State and local law enforcement, including police, corrections, and judicial authorities, and the MDOC should ensure screening and assessment for mental health at their point of entry, booking or reception for children and adults, and at first contact with the juvenile and criminal justice systems.

Goal 5: Michigan's mental health system is structured and funded to deliver high-quality care effectively and efficiently by accountable providers.

36. Strengthen the role of the current MDCH medical director of mental health so that s/he becomes the leader in the development and adoption of evidence-based practice in the mental health system. In this role, the medical director should work closely with the CMHSP and PIHP medical directors to help MDCH reach the following goals. Incorporate into Michigan's quality improvement plan evidence-based and experiential-based best practices for children involved in child welfare and juvenile justice.

    D. Incorporate into Michigan's quality improvement plan evidence-based and experiential-based best practices for children involved in child welfare and juvenile justice.

39. The governor and the legislature should adopt a new funding strategy for services to state residents with mental illness and emotional disturbance. The following could provide a seamless matrix of funding support for community-based services.

    C. Adoption of a new executive branch budget policy

        (1) Braid funding streams through state agency compacts, including special education, child welfare, workforce development, and other funding streams.

        (2) Pilot the creation of joint purchasing and alignment of mental health services among local CMHSPs, family courts, and local FIA offices.

        (3) Fund mental health services for children at levels authorized in special education and school aid appropriations.

(4) Fully utilize the Early Periodic Screening, Diagnosis, and Treatment Program to serve children with emotional disturbance.

Goal 6: Recovery is supported by access to integrated mental and physical health care and housing, education, and employment services.

59. The Michigan Department of Education should promote education policies that proactively identify children with disabilities and children exhibiting risk indicators and lead an evaluation of the state's school discipline code to determine the effects of zero tolerance education policy, including the disparate impact on children of color. The department should promote clear standards for alternative education.[3]

64. MDCH, FIA, and other appropriate state agencies should implement an interagency process to review prior interventions for appropriateness and effectiveness before determining placement.

Goal 7: Consumers and families are actively involved in service planning, delivery, and monitoring at all levels of the public mental health system.

68. MDCH should require that CMHSP boards must have at least one representative from each of the following populations: individuals with developmental disabilities, individuals with mental illness, and children with emotional disturbances.

[3] Zero tolerance: school discipline practice that mandates automatic suspension and/or expulsion from school for offenses perceived to be a threat to the safety of other children, school employees, or the school community itself; Ruth Zweifler and Julia De Beers, "The Children Left Behind: How Zero Tolerance Impacts our Most Vulnerable Youth," *Michigan Journal of Race and Law*, University of Michigan Law School, Fall 2002, vol. 8, issue 1.

Appendix E:
Overview of Michigan's Public Mental Health System

THE INSTITUTIONAL ERA

Initially, the state fulfilled its constitutional commitment through the establishment of state psychiatric asylums. In the mid-19th century, the development of mental asylums was considered enlightened and progressive public policy and a humane response to the plight of those with mental disorders. Michigan's first state institution for persons with mental illness, the Kalamazoo Asylum for the Insane, began accepting patients in 1859, and over the next forty years, similar facilities were established in Pontiac, Traverse City, and Newberry.

For much of the 19th century, public asylums in America generally housed a relatively modest proportion of long-term or chronically incapacitated patients, and these facilities had not yet assumed the role of custodial care institutions. Many patients entering public asylums during this period did not have prolonged lengths of stay at the facility, and they were eventually discharged back into the community. The circumstances that produced this diverse patient mix were complex and involved legal issues, divided responsibilities among levels of government, and certain financial liabilities and incentives.

By the end of the 19th century, however, these circumstances had changed, precipitating a steady increase in the proportion of chronically disabled, elderly, and disordered individuals with underlying somatic conditions among the population of state- and county-operated psychiatric hospitals. This trend continued into the 20th century, and the average length of stay at public hospitals increased dramatically, with a concomitant decrease in discharge rates. The changing utilization patterns swelled the resident census at state facilities, necessitating the expansion of existing facilities, the establishment of additional state psychiatric hospitals, and a gradual shift in the role of the facilities from supportive and restorative treatment to custodial care.

The changing characteristics of the resident population (greater chronicity, more age-related psychiatric impairments, refractory symptomatology related to underlying physical causes) and the changing role of the public psychiatric hospital (provision of long-term custodial care) fostered an overly pessimistic perception of serious mental illness among the general public. Mental illness came to be regarded as a lifelong, gravely disabling malady with little prospect for recovery or remediation of the illness. This gloomy perspective, in turn, diminished public support and legislative concern for state psychiatric facilities, and the hospitals steadily became more overcrowded, understaffed, regimented, bureaucratic, drab, and impoverished. By the mid-1950s, there were more than 559,000 individuals in publicly operated psychiatric hospitals across the United States. In that same period, over 20,000 Michiganians with mental illness were residing in state- or county-operated psychiatric facilities.

SEEDS OF CHANGE

Despite prevailing negative stereotypes regarding mental illness and the seemingly pervasive indifference to the conditions in public institutions, there were other

developments that were harbingers of new perspectives and treatment approaches for serious mental disorders. The National Mental Health Act of 1946 established the National Institute of Mental Health (NIMH) and authorized grants to states to support existing outpatient clinics that served individuals with mental illness, or to establish new clinics or programs for this purpose. In 1953, the American Medical Association and the American Psychiatric Association recommended a national study regarding the treatment of persons with mental illness. Congress adopted this recommendation and passed the Mental Health Study Act in 1955.

At the same time, scientific developments and psychosocial treatment modifications were changing institutional care for individuals with serious mental illness. In 1952, the antipsychotic property of the drug chlorpromazine (Thorazine) was discovered, and the introduction of this medication (and other drugs of similar efficacy) into the treatment regimen at state facilities produced significant symptomatic improvement in many patients. Innovations in hospital milieu therapy were also being developed, reemphasizing the therapeutic (rather than custodial) orientation of state facilities.

With the widespread use of antipsychotic agents, improvements in the hospital milieu, and a growing professional recognition of the adverse effects of prolonged institutional care, the patient census at public institutions gradually began to recede, not just in Michigan but also across the United States. In Michigan, there was initially only a modest flow of patients out of state facilities (the year-to-year census in Michigan's state-operated hospitals declined 16 percent from 1955 to 1965). Over time, however, this slow trickle became a mass exodus. While the advance in pharmacological treatment was not the sole factor responsible for the incremental census reduction, the new antipsychotic medications had clearly engendered a sense of hope regarding serious mental disorders and had altered public sentiments about these conditions.

As these changes were unfolding, the Joint Commission on Mental Illness and Health (operating under the auspices of the Mental Health Study Act of 1955) completed the study authorized by Congress and published its findings. The report, *Action for Mental Health* (1961), recommended changes in archaic state hospital systems (smaller facilities, better staffing) and suggested development of local centers to address the needs of individuals with mental illness returning to the community. The report stated that:

> The objective of modern treatment of persons with major mental illness is to enable the person to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the debilitating effects of institutionalization as much as possible, (2) if the patient requires hospitalization, to return him to home and community life as soon as possible, and (3) thereafter to maintain him in the community as long as possible. Therefore, aftercare and rehabilitation are essential parts of all services to mental patients, and the various methods of achieving rehabilitation should be integrated into all forms of service.

In 1963, in response to this report, President Kennedy formed an interagency task force on mental illness to determine priorities for action and proposals for implementation. The same year, reflecting the joint commission report and interagency task force recommendations, Congress passed, and President Kennedy signed, the Community Mental Health Centers (CMHC) Act. President Kennedy had previously (in a February

1963 address to Congress) called for a 50 percent reduction in state hospital census over the next ten years, and the CMHC Act provided funds for the development of community-based care centers to help achieve this objective. The act had some controversial aspects, however, since federal funding to establish CMHCs would bypass state government and go directly to grantees selected by the federal government. This created a split in authority and responsibility between the state hospital system and the new federally funded CMHCs.

The federal government went on to establish a number of ancillary social programs in the 1960s and early 1970s—medical assistance, income support, housing subsidies, and vocational rehabilitation services—that became instrumental in the successful transition of individuals with serious mental illness from institutional care to community settings.

While Michigan had expanded institutional capacity during the first half of the 20th century, the state had also established a limited number of community-based programs to meet the needs of persons with mental illnesses. Community aftercare clinics had been established in various parts of the state under the auspices of nearby state psychiatric hospitals. Several child guidance centers had been founded by private organizations, and some of these later received state and/or local operating subsidies or contributions. In 1944, legislation was enacted to allow local county boards to appropriate funds for operation of child guidance centers and adult clinics.

In April 1963 (six months before the enactment of the federal CMHC Act), the Michigan Legislature passed Public Act 54. The intent of the legislation was to stimulate development of community mental health services throughout the state. Act 54 permitted counties—either singly or in combination—to form Community Mental Health Boards and to receive state matching funds for the operation of these agencies. In its original form, Act 54 allowed state match funds of 40 percent to 60 percent of the cost of an approved county program. The law was later amended to set the rate of state match for an approved program at 75 percent. By 1969, there were 33 Act 54 boards, covering 49 counties. State policy at that time promoted the gradual inclusion of other local publicly supported mental health services and clinics under the scope of the Act 54 boards.

The federal CMHC grants and state support for community mental health boards spurred development of community programs and service capacity, consistent with the emerging perspective that serious mental illness was an enduring disorder with periodic exacerbation, reoccurrence, and residual impairments (like other chronic disease states), but that the condition was amenable to ameliorative, restorative, and rehabilitative treatments and supports. Some individuals with serious mental illness might require episodic state hospital care during acute phases of the illness, but these individuals could (and should) be released back to their community and local “aftercare” programs, as soon as their condition stabilized and acute symptoms had receded.

Practice patterns in Michigan began to reflect this revised conception of mental illness, with the emphasis on more limited utilization of state facilities and greater reliance on community clinics and services. Between 1965 and 1975, the patient census at state psychiatric hospitals fell from 17,000 to roughly 5,000 patients. The national policy of

deinstitutionalization had taken firm hold in Michigan. Exhibit E-1 shows state-operated institutions and dates of closures since 1972.

EXHIBIT E-1
State-Operated Institutions

Programs Serving Persons with Mental Illness
Riverside Psychiatric Hospitals, Ionia 1974
Wayne County Training Center, Northville* 1974
Metro Regional Psychiatric Hospital, Eloise 1980
Oakland Medical Center, Pontiac 1980
Michigan Institute for Mental Health, Dimondale 1981
Traverse City Psychiatric Hospital, Traverse City 1989
Ypsilanti Regional Psychiatric Hospital, Ypsilanti 1991
Coldwater Regional Mental Health Center, Coldwater 1992
Lafayette Clinic, Detroit 1992
Newberry Regional Mental Health Center, Newberry 1992
Caro 1997
Clinton Valley Center, Pontiac 1997
Detroit Psychiatric Institute, Detroit 1997
Northville Psychiatric Hospital 2003

Programs Serving Persons with Developmental Disabilities
Fort Custer, Battle Creek 1972
Alpine Center, Gaylord 1981
Hillcrest Center, Howell 1982
Northville Residential Training Center, Northville 1983
Plymouth Center, Plymouth 1984
Coldwater Center, Coldwater 1985
Macomb-Oakland Regional Center (Inpatient Services) 1989
Oakdale Center, Lapeer 1991
Muskegon Regional Center, Muskegon 1992
Newberry Regional Mental Health Center, Newberry 1992
Southgate Center 2001

Placement Agencies
Southwest Michigan Community Living Services, 1992
Wayne Community Living Services, 1992
Macomb-Oakland Regional Center, 1996
Specialized Contract Nursing Homes*
Clintonaire Nursing Home, Mt. Clemens 1983
Ogemaw Valley Care Center, Rose City 1984
Oshtemo Care Center, Kalamazoo 1985
Warren Village Nursing Home 1986
Beecher Manor, Flint 1990
Mt. Pleasant Total Living Center, 1990
Wayne Total Living Center, 1991
Taylor Total Living Center, 1992
Kalamazoo Total Living Center, 1994

Programs Serving Emotionally Disturbed Children
Arnell Engstrom Children's Center, Traverse City, 1991
York Woods Center, Ypsilanti 1991
Lafayette Clinic, 1992
Fairlawn Center, Pontiac 1996
Detroit Psychiatric Institute, Detroit 1997

Current MDCH Directly Operated Hospitals and Centers
Centers Serving Persons with Developmental Disabilities
- Mount Pleasant Center

Hospitals Serving Adults with Mental Illness
- Kalamazoo Psychiatric Hospital
- Walter Reuther Psychiatric Hospital
- Hospital Serving Children with Mental Illness
- Hawthorn Center

Center for Forensic Psychiatry

SOURCE: Michigan Department of Community Health.
NOTE: Date following an institution is the date of closure. Italics indicate hospitals and centers that became private. An asterisk indicates non-MDCH-operated hospitals and centers.

In the early 1970s, changing societal views and perceptions regarding mental illness triggered numerous legal and advocacy challenges to existing civil commitment standards, inadequate hospital conditions, certain treatment methods, violations of constitutional rights, and overly restrictive care arrangements. Complaints regarding inadequate community care emerged at the same time, with critics citing frequent readmissions (the "revolving door" phenomenon) among discharged patients, faulty coordination between the state and community agencies, insufficient community service capacity, and diffuse accountability for recipient care.

THE SHIFT TO COMMUNITY-BASED CARE

To address these issues and to provide a new framework for the organization and operation of Michigan's public mental health system, the legislature passed Public Act 258 in 1974. This statute—popularly known as the Mental Health Code—was a "tipping point" in the conversion from an institutional care system to a community-based treatment and supports model. The statute modernized civil commitment standards and due process procedures, clarified the roles and responsibilities of the state department and county-sponsored community mental health services programs (CMHSPs), designated priority populations for service and core program requirements, established the principle of "least restrictive setting" for care and treatment decisions, specified the rights of service recipients, and devised a monitoring and protection system. The legislation increased state match for approved county community mental health programs to 90 percent and stipulated that

> it shall be the objective of the department to shift primary responsibility for the direct delivery of public mental health services from the state to a community mental health services program whenever the community mental health services program has demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of that service area. (Section 116[2][b])

Despite passage of this landmark legislation and its sweeping prescription for change, implementation of many code provisions lagged in the years following enactment of the statute. Coordination between hospital and community agencies continued to be problematic, discharge plans and community placement arrangements were often incomplete and haphazard, and local service capacity remained inadequate. To ensure more rapid transformation of the system, Governor Milliken established the Governor's Committee on Unification of the Public Mental Health System in 1979. In its final report, *Into the 80s*, the committee recommended

> establishing a single point of responsibility for voluntary and involuntary entry into Michigan's public mental health system, for determination and oversight of the services it provides, for system exit, and for the resources that support service delivery. That single point of responsibility is to be located in the community. It is designated as a local mental health authority encompassing one or more counties.

Following publication of the report, the state assumed a more aggressive posture toward system restructuring and the pace of change accelerated. The Department of Mental Health (DMH) devised a new arrangement—referred to as "*full management*"—to effect

the shift of responsibility, authority, and fiscal resources for public mental health services from the department to the county-sponsored community mental health services programs. Under full management, the CMHSPs became the single entry/single exit point for the entire public mental health system. Funding related to utilization of state psychiatric hospitals and developmental centers (as well as funding for community-based services) as allocated to the CMHSPs, which in turn "purchased" inpatient services from state institutions as needed. If a CMHSP could reduce its utilization of the state hospital, it retained the savings (referred to as "*trade-off*" dollars) for expansion of community programs and capacity.

Beyond the structural, fiscal, and contractual changes, DMH promoted the adoption of innovative community treatment and support programs for adults and children with serious mental illness and emotional disorders. The department provided expansion funding to CMHSPs to develop, implement, or replicate service models such as the Fairweather Lodge Program, Assertive Community Treatment (ACT), Psychosocial Rehabilitation (PSR) Programs (Clubhouses), Home-Based Services for Children, Wraparound, Supportive Independent Housing, and Supported Employment.

At the national level, federal policy on mental health shifted in the 1980s. In 1977, President Carter had established a Presidential Commission on Mental Health to review mental health care in America and make recommendations for improvement. The commission's findings generated ambitious and far-reaching strategies for change and called for significant federal involvement in addressing the problem of serious mental illness. However, this approach was not pursued by the new administration, and federal involvement in mental health policy and funding gradually receded. Despite the more limited participation of the federal government in mental health policy, the National Institute of Mental Health continued its efforts to promote improved programs for adults with serious mental illness and children with serious emotional disturbances through the Community Support Program (CSP) and the Child and Adolescent Service System Program (CASSP).

By the end of the 1980s, the direction of Michigan's public mental health system (progressive deinstitutionalization, admission diversions, gradual facility downsizing, development of community-based alternatives and investment in programmatic innovations) was broadly accepted and generally enjoyed bipartisan legislative support. DMH policy emphasized continued reduction in state facility utilization and the establishment of a "continuum of care" (comprehensive service array) within each CMHSP. The "dollar follows the patient" concept ("trade-off") encouraged community placement and reductions in facility utilization, and the funds retained by the CMHSPs were used to expand local service capacity and options.

At the same time, however, Michigan (like other states) began to rely increasingly on Medicaid coverages and federal reimbursement to support its community-based treatment services and rehabilitative programs. The establishment and gradual expansion of optional Medicaid services targeted to the needs of persons with serious mental illnesses provided additional revenue for the public system and increased the fiscal stability of community programs. However, the introduction and growth of Medicaid reimbursement

also increased the complexity of funding arrangements, and encouraged certain budgetary adjustments that slowly compromised state-county collaboration on mental health care.

PUBLIC MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS

Establishing a coherent public policy for children's mental health services posed persistent challenges for Michigan's mental health system throughout the 1970s and 1980s. Public institutional care had not been as frequently or extensively used for children as it had been for adults with serious mental illness, hence the ability to finance increased community service capacity for children through the "trade-off" mechanism was much more limited. Most state psychiatric hospitals for children had been established adjacent to existing state adult facilities, and total bed capacity of these facilities was limited. In addition, Michigan had been an early pioneer and proponent of community-based child guidance clinics, which were supported by private donations, state funds, and/or local government allocations.

A number of national evaluations regarding the need for and the availability of mental health care for children and adolescents had estimated significant prevalence of mental disorders among this population, documented limited service capacity and availability, and revealed low rates of treatment and service utilization. The first of these reports emerged from the work of the Joint Commission on the Mental Health of Children, which published its report, *Crisis in Child Mental Health,* in 1969. In 1978, the Task Panel on Infants, Children and Adolescents, a subcommittee of President Carter's Commission on Mental Health, found that children continued to receive inadequate mental health care, and noted that recommendations contained in the joint commission report of 1969 had never been implemented. In 1982, the Children's Defense Fund (CDF) published an extensive and highly unfavorable study of the provision of mental health care to children and adolescents in state mental health systems. The report, *Unclaimed Children*, concluded that the vast majority of severely emotionally disturbed children and adolescents were not receiving adequate mental health care, and many received no treatment at all.

In Michigan, the *Report of the Child Mental Health Study Group* (1982) came to many of the same conclusions. Responding to these and other findings, Department of Mental Health policy and funding strategies in the 1980s emphasized the development and expansion of community mental health services for children and adolescents. Legislation passed in 1984 required the establishment of a Children's Diagnostic and Treatment Services Program within each CMHSP, to provide comprehensive evaluation, diagnosis, and disposition arrangements for children in urgent or emergent need of mental health care. The legislature also provided additional categorical funds to CMHSPs for expansion of intensive home-based services, therapeutic foster care, respite care programs, and prevention initiatives. Finally, the state began to promote the development of local "systems of care" for children and adolescents, an approach first articulated through the federal CAASP initiative.

An enduring issue affecting the provision of mental health services to children and adolescents during the 1980s was the problem of coordinating service efforts and care

responsibilities among different child-serving agencies and systems. Many children in non-mental health systems (e.g., education, child welfare, juvenile justice, primary care settings, Head Start, etc.) exhibited signs of emotional disturbances and mental disorders. Determining service responsibilities, reconciling statutory mandates, and coordinating complicated funding arrangements often strained relations between agencies and drained energy and resources from service provision. Dissatisfaction with this state of affairs led to proposals for a state "superagency" for children's services, which would house and reconcile multiple programs directed toward the well-being of children and families. These proposals were controversial, however, and were never acted upon by the legislature.

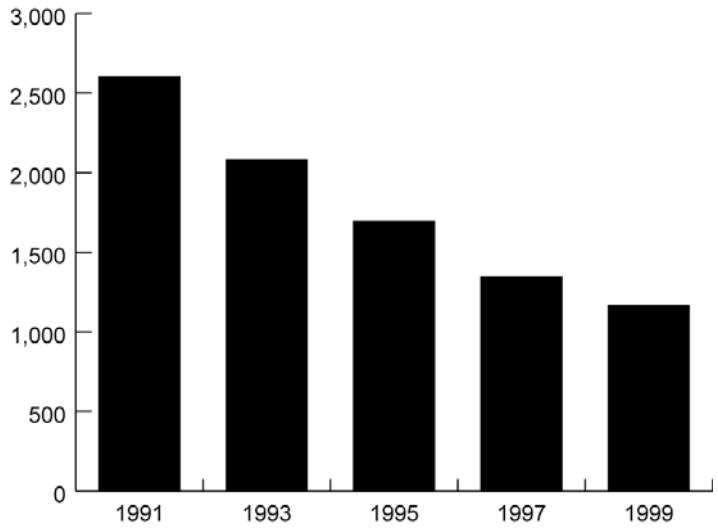
ACCELERATING CHANGE AND NEW DIRECTIONS: 1991 TO 1996

At the beginning of the 1990s, the transition of the public mental health system from institutional care to community-based service arrangements was significantly accelerated. Although the tension between institutional care and community-based services is not an either/or contest, resource limitations and funding constraints often press states to make choices regarding where to spend the bulk of their mental health budget. In Michigan, the recession of the early 1990s and ensuing shortfalls in state revenues precipitated an executive branch decision to close a number of state facilities, triggering a decisive shift in resources away from state hospitals and toward the community-based system.

The extent and pace of facility closures was controversial and strained the general consensus regarding state mental health policy that had characterized the 1970s and 1980s. Between 1991 and 1997, the state closed six state psychiatric hospitals for adults with serious mental illnesses, and five state psychiatric facilities for children with serious emotional disturbances (see Exhibit E-2).

As the state withdrew from the provision of mental health care, county-sponsored CMHSPs assumed the lion's share of treatment and support obligations for persons with serious mental illnesses and children with serious emotional disturbances. While the county-sponsored CMHSPs received some additional funding during these years, much of this growth was attributable to facility closures ("trade-off"), the shift of responsibility from the state to the counties, and the assumption of new service obligations, rather than true economic increases or cost-related adjustments.

EXHIBIT E-2
Persons in State Adult Psychiatric Hospitals, 1991–1999



SOURCE: Michigan Department of Community Health.

For CMHSPs located in less populated areas of the state, these changes generally did not produce any dramatic consequences. The number and needs of individuals with serious mental disorders within the catchment area of these CMHSPs was manageable, and many of these agencies had already significantly reduced their utilization of state institutions. However, certain CMHSPs in more populous areas of the state faced significant problems adapting to the closure of the institutions.

Beyond the closure of multiple state facilities and the transfer of care responsibilities to the CMHSPs, the public mental health system encountered other changes and challenges during the 1990s. The Department of Mental Health, which operated state facilities and directed, funded, and monitored the CMHSP system, was abolished by executive order and subsumed within the Michigan Department of Community Health (MDCH). Some feared that this development would eventually reduce visibility, interest, and financial support for mental health services.

The creation of the Department of Community Health reflected a changing state posture and presence in the public mental health system. The system was becoming increasingly decentralized as more authority and responsibility devolved to county-sponsored community mental health services programs. In a decentralized system, community programs were now executing many of the functions and activities previously performed within the state bureaucracy.

Responding to these changing circumstances, the legislature enacted major revisions to the state's Mental Health Code. Key provisions of the legislation (P.A. 290 of the Public Acts of 1995) included

1. the establishment of a new type of CMHSP entity—the "Authority"—which had greater administrative independence and operational control than previous CMHSP organizational options;

2. a requirement that CMHSPs be "certified" by the department, or achieve accreditation through a nationally recognized accreditation organization;

3. the inclusion of primary consumers and family members on CMHSP governing boards;

4. a new obligation for the CMHSPs to provide jail diversion services; and

5. the requirement that the individual plan of service for all recipients of the public mental health system be developed through a "person-centered" planning process.

The legislature also pressed the department (through boilerplate provisions in the Appropriations Act) to improve CMHSP data reporting and to establish a performance indicator system to assess CMHSP activity on key dimensions. The department implemented its Mission Based Performance Indicator System in 1997.

In regard to mental health services for children, the department promoted the expansion of multipurpose collaborative bodies (MPCBs) throughout the state to encourage greater interagency collaboration, to promote a "systems of care" approach for seriously emotionally disturbed (SED) children, and to facilitate pooled funding arrangements for children and families involved with multiple public systems. Pilot projects (Michigan Interagency Family Preservation Initiative or MIFPI) were carried out in several communities within the state. Funding for prevention and early intervention services declined, however, and many CMHSPs scaled back local initiatives.

IMPLEMENTATION OF MANAGED PUBLIC MENTAL HEALTH CARE IN MICHIGAN

Shortly after its creation, the new Department of Community Health announced major changes in the operation of Medicaid, the state-federal entitlement program that covers a wide array of specialty services for beneficiaries with serious mental illnesses. Medicaid reimbursement, introduced into the funding framework of the public mental health system during the 1980s, played a major role in underwriting the cost of community services and programs. MDCH indicated that it would move most Medicaid recipients and Medicaid benefits into capitated, risk-based "managed care" arrangements, and that it was proceeding with the submission of federal waivers to effect these changes. The state elected to "carve-out" Medicaid specialty mental health benefits and proposed that CMHSPs administer and deliver these benefits under a capitated, shared-risk, managed care program. MDCH submitted a 1915(b) Medicaid managed specialty services waiver to the federal government in 1998, along with a request for an exemption from federal procurement requirements. The waiver and exemption were granted and the program was launched in October 1998.

Managing Medicaid specialty benefits under a federal waiver and on a shared-risk basis introduced additional complexities into the public mental health system. The CMHSPs

had evolved and historically operated under the "community model" of organization and service provision. This model was predicated on geographic catchment areas, grant funding, priority populations for service provision, relational contracting between governmental units, and a stable noncompetitive network of providers, responsive to governmental policies and priorities. Under Medicaid managed care, however, CMHSPs were forced to operate more like an insurance entity or health plan, with entitled beneficiaries, defined benefits and service obligations, medical necessity standards, stringent due process requirements, and increased administrative responsibilities.

These challenges were compounded by federal stipulations that the state develop a plan for moving to "open and full competition" for management of Medicaid specialty services. After tumultuous debate within the state, MDCH submitted a revised plan to the federal government that successfully argued the "impracticality" of competition for management of these Medicaid services. The federal government accepted this argument and the state was allowed to continue sole-source contracting, albeit with some significant changes. CMHSPs in less densely populated areas of the state, with small numbers of Medicaid beneficiaries within the catchment areas, were required to affiliate as a condition of participation in the Medicaid managed specialty services program.

ADDITIONAL DEVELOPMENTS IN THE LATE 1990S

In July 1990, President Bush proclaimed the 1990s as the "decade of the brain." Neuroscientific research over the course of the decade expanded our understanding of the etiology of mental disorders and pharmacological research produced a number of new medications to treat major mental illness. By the later part of the decade, these new therapeutic agents (atypical antipsychotics) were being widely used within the public mental health system and were rapidly replacing older medication regimens used to treat serious mental illness.

In 1996, Congress passed the Mental Health Parity Act, which prohibited (with certain exceptions) insurers and group health plans from placing annual or lifetime dollar limits on mental health benefits that are lower than annual or lifetime dollar limits for medical and surgical benefits offered under the plan. The federal legislation was far more symbolic than substantive, containing numerous practical deficiencies. The inability of Congress to act more meaningfully prompted many states in the period since to adopt their own parity laws. It also prompted President Clinton to give comprehensive mental health and substance abuse parity coverage to 9 million federal employees through Executive Order.

Promotion of mental health issues and concerns was further bolstered in the late 1990s by the publication of *Mental Health: A Report of the Surgeon General* (1999). This landmark examination and study of mental illness established that mental disorders are pervasive, disabling, amenable to a range of effective treatments, and deserving of greater attention and consideration in national health policy.

Finally, during the late 1990s, the *recovery* concept of mental illness emerged as the guiding theme for mental health policy and practice. While defined in different ways by different parties, the recovery model emphasizes that persons with serious mental illnesses can regain control over significant aspects of their life and develop a sense of

identity and purpose, despite experiencing exacerbations and/or the persistence of symptoms and impairments. The recovery vision emphasizes both positive individual expectations (hope, empowerment, and self-directedness) and organized interventions (treatment, rehabilitation, and environmental supports). The concept looks beyond symptom alleviation to the kind of life experiences and situations—including social, vocational, educational, relational, and residential—needed and desired by a person with a serious mental illness.

PUBLIC MENTAL HEALTH CARE IN THE NEW CENTURY

The Surgeon General's 1999 Report indicated that roughly 20 percent of the U.S. adult population is affected by mental disorders during a given year. A subpopulation of 5.4 percent of adults is identified as having a serious mental illness (SMI), applying a definition of SMI established in federal regulation. Roughly half (2.6 percent) of those with SMI are considered even more seriously impaired, and are described as having "severe and persistent" mental illness.

There are high rates of comorbity (individuals with co-occurring mental illness and a substance abuse condition) among those with a mental illness. Individuals with co-occurring disorders typically utilize more services than those with a single disorder, and they are more likely to experience a chronic course in their illness.

Annual prevalence rates of mental disorders for children and adolescents have not been as well established or documented as those for adults. Current estimates are that 20 percent of children and adolescents experience a mental disorder in a given year, and approximately 5 percent to 9 percent of children and adolescents between the ages of 9 and 17 have a "serious emotional disturbance" (SED), again applying a definition of SED established in federal regulation.

The Michigan Mental Health Code has a more circumscribed definition of serious mental illness (SMI) and serious emotional disturbance (SED) than those found in federal regulations. Using the more liberal federal definition, however, the National Mental Health Information Center estimated that there were 403,930 adults with serious mental illness and 67,586 children and adolescents (aged 9–17) with serious emotional disturbance in Michigan in 2002.

Michigan has a relatively evolved public service system to address the needs of individuals with mental illness. However, by statutory intent and design, Michigan's public mental health system is configured to serve individuals with the most serious forms of mental illness and emotional disturbance, and those experiencing an acute psychiatric crisis. The Mental Health Code explicitly directs that priority for service be given to individuals with the most severe conditions and those in crisis.

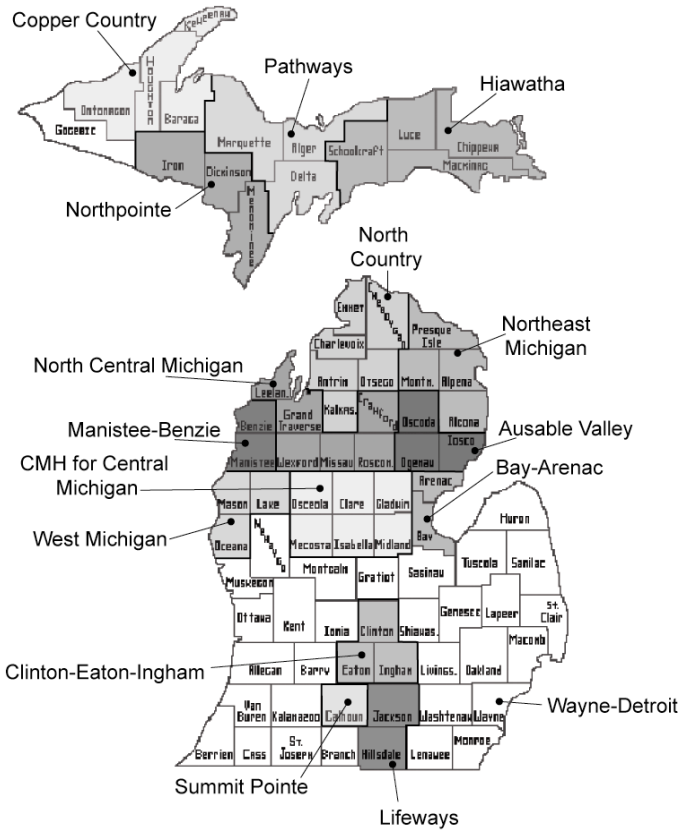
The state maintains three regional state psychiatric hospitals for adults (in Westland, Caro, and Kalamazoo) and one state psychiatric facility for children and adolescents (Hawthorn Center in Northville). On any given day, there are roughly 600 adults in state regional hospitals and 80 children and adolescents at the Hawthorn Center. The state also operates the Center for Forensic Psychiatry in Ann Arbor, a 210-bed facility that provides both diagnostic services to the criminal justice system and psychiatric treatment for

criminal defendants adjudicated incompetent to stand trial and/or acquitted by reason of insanity.

Community-based mental health services are organized, administered, provided, and arranged through 46 Community Mental Health Services Programs, which cover all 83 counties in the state (see Exhibit E-3). Forty CMHSPs have adopted the Authority form of CMHSP structure, five remain agencies of county government, and one is formed under the Urban Cooperation Act as a CMHSP organization. CMHSPs are required by the Mental Health Code and through their participation in the Medicaid program to provide a comprehensive array of mental health services and supports, and they fulfill these requirements by providing these services directly, contracting with nonprofit providers, or through a combination of these two approaches. Each CMHSP is required to have a pre-screening unit to assess individuals being considered for psychiatric hospitalization, and to provide alternatives to hospitalization whenever appropriate.

EXHIBIT E-3

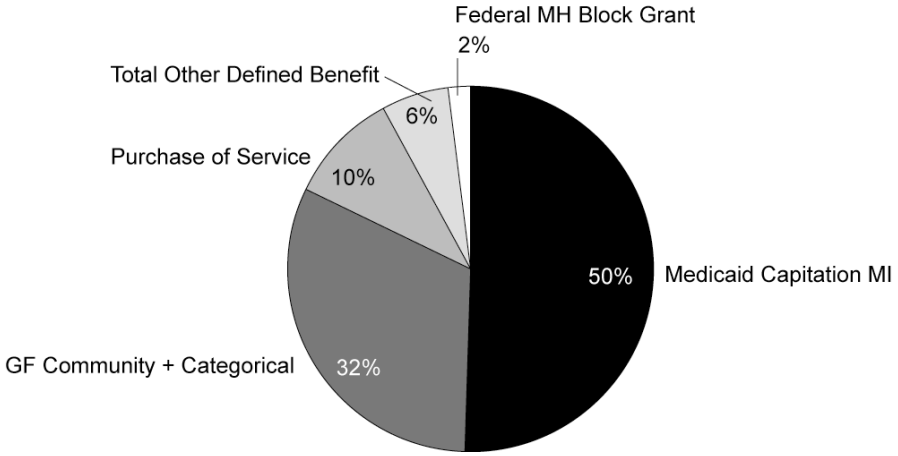
Michigan Community Mental Health Services Programs



SOURCE: Michigan Department of Community Health.
NOTE: Shaded areas represent multicounty community mental health services programs.

Community mental health services are funded through a complex mix of general fund allocations, purchase of service dollars (to pay for any utilization of state facilities), and capitated payments for the Medicaid Managed Mental Health Care Program, the Adult Benefit Waiver Program, and the MiChild program (see Exhibit E-4).

EXHIBIT E-4
Community Mental Health Funding Sources



SOURCE: Michigan Department of Community Health.

According to the Senate Fiscal Agency, funding for community mental health has been tightly constrained over the past six years, with very limited adjustments. In fiscal year 2003–2004, roughly $870,000,000 of state appropriations for community mental health was available to fund services to adults and children with serious mental illness. Further confounding the mental illness funding picture (and also historically noted by the Senate Fiscal Agency) is the fact that Michigan's public "mental health" system serves persons with developmental disabilities as well as individuals experiencing mental illness, and system expenditures are much lower proportionally for mental illness consumers than for those with developmental disability.

Exhibit E-5 shows the number of persons with mental illness, developmental disability, substance abuse, and dual diagnosis receiving services by program eligibility status in FY 2003.

EXHIBIT E-5

Numbers and Percentages of Persons with Mental Illnesses, Developmental Disability, Substance Abuse, and Dual Diagnosis Who Received Services from CMHSPs, Fiscal Year 2003, State of Michigan

Demographic Characteristic	MI Consumers		DD Consumers		Substance Abuse Consumers		Dual Diagnosis (MI & DD) Consumers		Unknown Disability		Total Served	
	#	%	#	%	#	%	#	%	#	%	#	%
Program Eligibility*												
Habilitations Supports Waiver (only DD)	77	0.05%	5,965	22.22%	0	0.00%	1,519	21.37%	28	0.26%	7,589	4.05%
Adoption Subsidy	732	0.52	296	1.110	2	0.08	182	2.55	7	0.006	1,219	0.65
Medicare	26,306	18.77	11,329	42.20	133	5.33	2,739	38.53	466	4.25	40,973	21.84
Medicaid (except Children's Waiver)	71,750	51.19	20,156	75.08	414	16.59	5,783	81.36	3,566	32.53	101,669	54.20
MIChild	1,105	0.79	76	0.28	6	0.24	20	0.28	71	0.65	1,278	0.68
Medicaid Children's Waiver	50	0.04	240	0.89	0	0.00	59	0.83	9	0.08	358	0.19
SDA, SSI, SSDI	23,948	17.09	11,896	44.31	199	7.97	2,773	39.01	422	3.85	39,238	20.92
Commercial Health Insurance	18,654	13.31	4,904	18.27	267	10.70	1,043	14.67	1,100	10.04	25,968	13.84
Other Public Sources – not MDCH	30,627	21.85	2,252	8.39	666	26.68	1,761	24.77	3,936	35.91	28,242	20.92
Not Eligible for Program/Plan	26,916	19*.20	2,126	7.92	1,091	43.71	397	5.59	1,693	15.45	32,223	17.18
State Medical Plan	3,337	2.38	73	0.27	118	4.73	34	0.48	48	0.44	3,610	1.92
Unknown/ Unreported	26	0.02	0	0.00	0	0.00	0	0.00	13	0.12	39	0.02
	140,157		26,846				7,108		10,961		187,566	

* Counts can be more than one group.

SOURCE: Michigan Department of Community Health.
NOTE: Not eligible for program plan are those individuals who have no health care insurance and who are not eligible for any public health care assistance that would cover the cost of mental health services.

Exhibit E-6 below displays the number of children and adults with mental illness served by the CMHSPs over a four-year period (1999–2002).

EXHIBIT E-6
Number of Children and Adults with Mental Illness Served by Michigan's Public Mental Health System, 1999–2002

Fiscal Year	Individuals with mental illness						
	Children		Adults		Age not reported		
	N	%	N	%	N	%	Total
1999	40,998	23.7	125,814	72.9	5,885	3.4	**172,697**
2000	35,994	23.8	110,826	73.4	4,264	2.8	**151,084**
2001	29,365	21.6	101,799	74.9	4,809	3.5	**135,964**
2002	36,732	23.7	117,174	75.5	1,394	0.9	**155,300**

SOURCE: Community Mental Health Service Programs Demographic and Cost Data, FY1999–FY2002, November 2003.
NOTE: Mental Illness: An individual is determined to have mental illness if he/she has DSM-IV diagnosis of mental illness, excluding mental retardation, developmental disability, or substance abuse disorder.
Children are those consumers who are 18 years of age or younger during the fiscal year of reporting.
Individuals who were dual eligible during FY2001 or FY2002 are not included in this table.

CURRENT CHALLENGES

Public mental health systems across the nation are in distress. The title of a recent report by the Bazelon Center, *Disintegrating Systems: The State of Public Mental Health Systems*, aptly captures the mood of dissatisfaction and the sense of urgency. The President's New Freedom Commission on Mental Health has declared that "the mental health delivery system is fragmented and in disarray."

Multiple funding streams now support public mental health care, each with varying eligibility standards, differential access policies, different service obligations and benefits, and sundry appeal processes. This has introduced tremendous complexity into the administration of mental health programs. In addition, mental health–related activities are increasingly performed through many other agencies of state and local government, funded by sources outside the control of the formal public mental health system. This produces fragmentation in the state's efforts to address the mental health needs of its citizens. Finally, a significant number of individuals lack health insurance, and those with private coverage often discover that their mental health benefits do not adequately cover services needed by persons with serious mental illnesses.

Increasingly, individuals with significant mental health problems are showing up among the clientele served by other public systems (child welfare, juvenile justice, law enforcement, courts, corrections, education). These other agencies and entities are frequently ill-equipped to deal with such mental health needs, and these settings do not represent adequate or appropriate treatment venues for such conditions.

A recent national analysis concluded that access to care for persons with serious mental illnesses has generally been maintained, but access and services for individuals with less

severe conditions (which constitute a relatively large group) have declined considerably.[4] The latter is widely accepted as applicable to Michigan; the former is more open to debate. Several related assessments in recent years from in-state and out-of-state organizations and the media have given Michigan low marks in policies, service access, and results.[5] Prevention and early intervention services have also been greatly diminished. A key challenge over the next several years will be to devise strategies that can enhance access for individuals across all stages of mental illness, including persons with less severe disorders, and will promote prevention and early intervention efforts.

[4] David Mechanic and Scott Bilder, "Treatment of People with Mental Illness."

[5] See, for example, Barrett et al., "A Case of Neglect," *Governing* (February 2004); Krupa and Brooks, *Detroit News* special series on mental health, July 20–22 and August 8, 2003; National Mental Health Association, *Can't Make the Grade: NMHA's State Mental Health Assessment Project* (2003); Bernasek et al., *Case Study: Michigan's Medicaid Prescription Drug Benefit* (Kaiser Commission on Medicaid and the Uninsured, January 2003); and Alliance for the Mentally Ill of Michigan, Association for Children's Mental Health, Mental Health Association in Michigan, Michigan Association for Children with Emotional Disorders, and Michigan Psychiatric Society, *Evaluating the Provisions of Long-Term Psychiatric Care in Michigan's Publicly Funded Mental Health System: An Assessment Tool for Consumers, Families, Advocates, Providers, and Policymakers*, June 2001.

Appendix F:
Summary of Public Hearings

Michigan Mental Health Commission
Summary of Public Hearings

May 24, 2004

Prepared by Michigan Department of Community Health

Binder Overview

The Mental Health Commission held four public forums across Michigan during April 2004. Commissioners heard verbal testimony from over 230 people throughout the forums, and many more individuals attended the hearings to observe. In addition to the public forum opportunities to comment, 59 documents were received via Internet website, mail, fax or hand-delivery.

While a majority of commissioners were able to attend at least one of the forums, these binders have been assembled to provide all Commissioners with information gathered at all forums.

The binders are organized as follows:

- Key Findings from public forums as well as submitted written testimony
- Grand Rapids, April 7, 2004
  - Forum summary providing an overview of the verbal comments received
  - Written testimony collected in Grand Rapids
- Detroit, April 14, 2004
  - Forum summary providing an overview of the verbal comments received
  - Written testimony collected in Detroit
- Flint, April 20, 2004
  - Forum summary providing an overview of the verbal comments received
  - Written testimony collected in Flint
- Marquette, April 29, 2004
  - Forum summary providing an overview of the verbal comments received
  - Written testimony collected in Marquette
- Web Comment summary
  - Summary of comments received to the Commission website of *www.michigan.gov/mentalhealth* from April 22 through May 19.
  - Summary of comments received to the Commission website and previously presented to Commissioners at the April 26th meeting.
- Other
  - Compilation of written comments submitted to the Mental Health Commission by either mail, fax or hand delivery.

Key Findings

Overwhelmingly, people expressed gratitude at having the opportunity to speak on matters of mental health in Michigan. They were extremely appreciative that Governor Jennifer M. Granholm took the initiative to appoint the Commission and that Commission members took the time to come to them to hear their thoughts and concerns.

Some individuals traveled long distances to attend the forums and some waited hours to comment on Michigan's mental health system. Many individuals commented that the Commission is charged with a difficult task, but expressed hope and encouragement that the system can be improved to better meet people's needs.

Throughout the forums and submitted written comments, common themes were evident. They include:

- Status of the Current System
- Funding, Insurance and Medicaid Coverage
- Service Improvement and Unmet Needs
- Criminal Justice System Interface
- Need for Children's Services

Status of the Current System

Several speakers and writers shared personal stories, both good and bad, about their experiences with the current mental health system. Quite often individuals urged the Commission not to go back to the days of institution-based mental health care, and continue to rely on a community-based approach. While people recognize the current community-based system needs improvement, they do not want to see these services taken out of their local settings.

- An individual with previous suicide attempts stated she had received good person-centered planning from the local Community Mental Health Service Provider, and the plan was modified to meet her needs based on changes in her life.
- A mother spoke about the differences in insurance for mental illness versus physical conditions. She no longer has private insurance because it did not adequately cover the services her son needs. As a result she must live in poverty to ensure she qualifies for Medicaid. Without Medicaid, her son would not have access to the health care services he needs. *"The CMH system isn't broken, but it is in transition."* She asks the Commission to address parity, to develop partnerships in the community among existing agencies, and to support person-centered planning and self-determination.
- A consumer expressed thanks for being able to attend local and state conferences, and spoke highly of her person-centered plan. She enjoys working with fellow consumers and stated these supports helped in her recovery process. *"The weekly treatment sessions with my social worker, monthly appointments with my psychiatrist and therapy are all very important."*
- Speaking as a parent concerned for his daughter, who has a severe mental impairment, this individual stated, *"the system is broken."* He has to take his daughter across the city to obtain the best services for her. He feels resources must be

provided to serve all consumers' needs. Mental health also must be coordinated with school services. The system is not serving all who need assistance and consumers must come first.

- An individual whose daughter had been killed in a house fire discussed his history as he became depressed and homeless and was hospitalized at Northville for six months. Now he participates in psychosocial rehab and he takes medication. He hopes that people can continue to receive the services he received, and asked that the Commission think about people who are on the edge and keep services available for them.
- A nurse stated her hospital has approximately 350 psychiatric admissions per month, most are uninsured or on Medicaid. Because Community Mental Health Service Programs do not see people fast enough after their discharge, many are readmitted. More follow-up services will keep people in the community, and she feels consumers leaving a hospital must be seen by Community Mental Health within 72 hours of discharge.
- A National Alliance for the Mentally Ill (NAMI) Chairperson thanked the Commission for timely notice of the meetings and the 'oneness' of the process. She stated that local providers have been very much supportive of the NAMI chapters and people have benefited greatly from this support.
- *"Access to services is like a game of best-kept secrets. While my son qualifies for the county's indigent health care program, he must get his meds through a primary care physician. He waited several months for his first appointment with that individual. After many phone calls, you start to lose hope. It doesn't take long to realize that people don't want you to get help."*
- A consumer who attends a drop-in center stated he really likes the way the program helps people. "*Community Mental Health has been very helpful. Thank you. As a long-time consumer with severe depression, I have nothing but good things to say about my local CMH. They should be the poster child for CMH services."*
- "My son's ADHD was diagnosed when he was three years old, and was successfully treated until a year ago (he is now 22). After he turned 21, he was no longer under our insurance. Five days after being off stimulant medication, he committed a crime for which he is now on probation. I know that if he can get appropriate treatment, he will be able to get a decent job with mental health benefits. Not treating ADHD is far more expensive than its treatment."

Funding, Insurance and Medicaid Coverage

Consistently the public has commented on their concerns that there is a lack of funding for mental health services. Common issues include:

- Frustration that services are being cancelled due to a lack of funding
- Lack of coordination between providers
- Need for parity for mental health coverage
- High out-of-pocket expenses for services insurance does not cover
- The great need that exists to provide a safety net for those without insurance

- Home help services are seen as a cost-efficient service that is inadequately funded
- The need for dental, podiatry and hearing aids in light of the Medicaid cuts
- The continuing need for safe, dependable transportation services
- The impression that basic human needs for food, clothing and shelter are not being met
- Insurance coverage is too limited and the number of visits allowed is inadequate
- Self-help groups were mentioned as a cost-effective adjunct to other services
- Medicaid spend-down causes people to receive unnecessary health services in order to qualify and receive medication coverage. When individuals cannot meet the spend-down, they go without medications, which can lead to emergent health situations requiring expensive hospitalization. Spend-down was also mentioned in conjunction with substance abuse (self-medicating) and legal problems.
- The need for increased federal, state, local and private funding is critical. It was suggested that more General Fund support to Community Mental Health Service Programs would result in more Medicaid and federal support.
- The Commission is urged to work to protect and increase funding for prevention, education, early intervention and recovery.
- Providers are dropping out of the system, others aren't being paid timely and payments/services are not equitable across geographic areas.
- Clubhouses were mentioned often in a very positive light; several speakers asked for additional funding for these services.
- The way the system is funded has caused a short-term/crisis stabilization focus that is not oriented to chronic conditions, or funding prevention services. People with low to moderate level problems are underserved, or not served at all.
- People felt staffing had been impacted as a result of funding in recent years. Several speakers and writers asked that the Commission concentrate on ways to improve staff training, recruitment and retention.
- Group homes are not well monitored, direct care staffs are not paid enough to care and because of low salaries, quality staff cannot be attracted. High worker caseloads, and staff who are inappropriately placed into their roles may exacerbate these problems. Some staff who testified stated there was too much bureaucracy, unreasonable caseloads, and too much paperwork, which leads to burnout and frustration.

Service Improvements/Unmet Needs

Many people reported that there is not a continuum of supportive services in the community, continuing from early childhood through adulthood. More outreach is needed about what services are available, and this needs to be presented in a variety of formats that are understood by consumers. Others reported a lack of prevention services. People asked that the Commission and providers ask consumers what they want, and then really listen to them.

- Frustration that people must 'fail' in order to receive a higher level of services. There were reports about having to battle providers in order to receive services. Some

persons stated that staff does not listen, they do not follow-through and they do not treat people with respect. There seems to be a disconnect between administration and providers, and poor communication was mentioned several times.

- The need for quality jobs for both people with mental illness and veterans was mentioned, as was a living wage for persons who work. The need for safe, affordable housing, without the need to relocate to be housed at all, was mentioned by several speakers. Some asked that housing be better regulated, including room and board homes, and that predatory landlords be stopped. Access to health care and poverty are other areas of grave concern, as are people being put on medications who are then not monitored.
- Other issues raised were: Stigma, politics interfering with service delivery, the need for more research—with 'what works' being put into practice, and the lack of services/qualified providers in rural areas. Finally, people feel too much data is collected and mined without justification.
- Several persons testified about the need for services and supports for persons with developmental disabilities, persons with co-occurring disorders (mental illness and substance abuse) and for many services to be delivered in a more timely way. As an example, by seeing people sooner when they are released from a hospital, high readmission rates could be lowered.
- Administratively, people stated that there is confusion about the appeals and grievance processes and the ability to pay/sliding fee scales. Community Mental Health Service Programs should be audited regularly to ensure that services are delivered adequately and that people are appropriately placed.

Interface with the Criminal Justice System

A number of people testified that jail diversion services must to be expanded.

- Crisis intervention, medication monitoring and treatment are needed.
- Better training in mental health issues among jail staff statewide, and closer working relationships between jails and Community Mental Health Service Providers are both desired.
- Mental health courts should be put in place like drug courts as part of a jail diversion/criminal justice interface.
- Concern was raised that prisons and jails do not provide person-centered planning or self-determination.

The Need for Children's Services

Several people testified as to the need for training for both parents and providers on children with severe emotional disturbances; this includes teaching staff and administrators.

- Parents asked that the system work to develop people's capabilities while they are still in school.
- Parents and providers alike requested comprehensive school-based mental health services.

- Many parents asked that Michigan provide 'real support and advocacy for families; it should not be superficial.'
- The lack of respite care for families is of grave concern. Caregivers and parents asked for consumer and family-centered services, including those for foster and adoptive children. Prevention and funding issues were raised a number of times.
- Some parents noted that having to relinquish custody to get care for their children needs to stop. Referrals take an inordinate amount of time; a few people reported waits of six to ten months to actually receive services. Limitations of commercial insurers, the need for infant mental health (especially for children whose mothers have a mental illness), access to such services in remote areas, lack of insurance/Medicaid payment for these services and the needs of indigent children not being met were mentioned a number of times.
- Parents generally reflected challenges in trying to meet their children's needs at home, in conjunction with the school system, and in concert with mental health providers.

Appendix G:
Key References and Technical Papers

The following materials are available from the commission upon request. Many of them are available online at *michigan.gov/mentalhealth* or at the websites provided below.

1. Legal Mandates—Excerpts from federal case law and Michigan statutory law
2. Citizens Research Council of Michigan, *Funding Community Mental Health in Michigan*, Report No. 318, January 1997. *www.crcmich.org*
3. Nancy N. Bell and David L. Shern, State Mental Health Commissions: Recommendations for Change and Future Directions. *www.michigan.gov/documents/statementalhealthcommissions_1_83580_7.pdf*
4. Robert M. Friedman, "Child and Adolescent Mental Health: Recommendations for Improvement by State Mental Health Commissions." *www.michigan.gov/documents/ChildMHcommissions_1_83537_7.pdf*
5. The President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America—Executive Summary. *www.michigan.gov/documents/NewFreedomMHReportExSum_83175_7.pdf*
6. U.S. Department of Health and Human Services, Mental Health: A Report of the Surgeon General—Executive Summary. *www.michigan.gov/documents/Ex Summary-Final_1_83177_7.pdf*
7. Michigan Department of Mental Health, Into the 80s—80 Recommendations. *www.michigan.gov/documents/Intothe80s_83250_7.pdf*
8. John Inglehart, "The Mental Health Maze and the Call for Transformation." *New England Journal of Medicine*, 350 (5): 507-514.
9. David Mechanic, "Policy Challenges in Improving Mental Health Services: Some Lessons from the Past." *Psychiatric Services*, September 2003, 54 (9): 1227–32.
10. Howard H. Goldman, Sten Thelander, and Claes-Goran Westrin, "Organizing Mental Health Services: An Evidence-Based Approach." *The Journal of Mental Health Policy and Economics. 3 (2000): 69–75. www.michigan.gov/documents/OrganizingMHServices_1_83533_7.pdf*
11. William A. Anthony, "A Recovery-Oriented Service System: Setting Some System Level Standards." *Psychiatric Rehabilitation Journal* 24, No. 3 (Fall 2000): 159–68. *www.michigan.gov/documents/anthony2000_1_83536_7.pdf*
12. Holly Kenny, Leah Oliver, and Julie Poppe, "Mental Health Services for Children: An Overview." National Conference of State Legislatures Children's Policy Initiative, June 2002. *www.michigan.gov/documents/MentalHealthServices forChildren_83540_7.pdf*

13. Laura Lee Hall et al., Shattered Lives: Results of a National Survey of NAMI Members Living with Mental Illnesses and Their Families. TRIAD Report, July 2003. *www.michigan.gov/documents/NAMI_TRIAD_Report_FINAL_83539_7.pdf*

14. Judi Chamberlin, "Citizenship Rights and Psychiatric Disability." *Psychiatric Rehabilitation Journal* 21, No. 4 (Spring 1998): 405–08. *www.michigan.gov/documents/chamberlin1998a_1_83534_7.pdf*

15. House Fiscal Agency, Community Health FY 2003–04 Line Item and Boilerplate Summary. *www.michigan.gov/documents/HFAAnalysis03MHAppropriation_83551_7.pdf*

16. Steve Angelotti, Senate Fiscal Agency—State Notes: Topics of Legislative Interest. September/October 2003. *www.michigan.gov/documents/SFANotesSepOct03onMH_83553_7.pdf*

17. Jeffrey A. Buck, "Medicaid, Health Care Financing Trends, and the Future of State-Based Public Mental Health Services."

18. NAMI, Medicaid Basics: Key Facts About the Program. *www.michigan.gov/documents/NAMI-Medicaid_Facts_83538_7.pdf*

19. Government Performance Project, *Governing Magazine*, "Mental Health: Promise Unfulfilled." *www.governing.com/archive/2004/feb/mental.txt*

20. Bazelon Center for Mental Health Law, "Disintegrating Systems: The State of States' Public Mental Health Systems."

21. Bazelon Center for Mental Health Law, "An Act Providing a Right to Mental Health Services and Supports." *www.bazelon.org/issues/general/publications/newvision/modellawcontents.pdf*

22. Mental Health Commission Seminar, April 12, 2004 (Materials presented available on CD-ROM)

23. Judith Taylor, "CMH Financing History: Summary of 20 Years of the State Financing Strategy for CMH." Presented to the Mental Health Commission on May 20, 2004.

Appendix H:
Materials presented to the Mental Health Commission by Judith Taylor, May 20, 2004

1. CMH Financing History—Summary of 20 Years of the State Financing Strategy For CMH
2. Lost Opportunities—Decreased Funding to Meet Increasing Demands
3. State GF/GP Funding for Community Mental Health

1. CMH FINANCING HISTORY

Summary of 20 Years of the State Financing Strategy for CMH

It is not about Medicaid funding it is all and always has been about **state funding and state support** for public mental health services

PREMISE:

By moving to community-based services, the CMH system has saved the State hundreds of millions of dollars and improved quality of services over the past 20 years.

HOWEVER

Savings created by this movement were not retained in the CMH system to support consumers in the community

Contents:

FUNDING STRATEGY HIGHLIGHTS FROM THE PAST 20 YEARS

- The state financing strategy for CMH for 20 years is based on a poor economic premise.
  - CMH system has been expected to provide services with no state fund increases for unavoidable cost increases
  - CMH system has been required to serve more needy customers with flat state funding
- The Advent of Medicaid federal funding for CMH services in 1983 allowed the CMH system to increase resources/services by expanding Medicaid, with the same or lower state funding
- In the 1980s the additional federal funds earned by CMHBs were used in the state appropriation to finance additional categorical services for targeted consumers thus limiting the resources for serving its priority community population
- Over 20 years the CMH funding base has received very few cost increases to support continuation of services
- Over 20 years the CMH state funding base has been eroded by state financing strategies
- Since 1983, DMB funding strategy has been to maximize federal funds and reduce or keep flat state funding
- CMHBs have been in partnership with the state in pursuit of other funds and being good managers of limited state resources, thereby saving the state hundreds of million in state funds. In the mid-late 1990s these options began to dry up for many CMHSPs as they had maximized Medicaid billing and maximized full management.
- Medicaid fee screens saw limited increases for cost increases in the 1980s, and in late 1980s the fee screens were frozen, even though the CMH system had the state match needed to cover the Medicaid cost. Thus, CMH used GF to cover these additional cost increases.
- In 1993, DMB instituted an annual fee screen adjuster for CMH Medicaid, which allowed some of the costs above fee screen to be billed to Medicaid, with the state keeping 80% of the additional federal funding. As of FY98, this was $35 million per year.
- Funds follow the individual as they exit from state facilities, but once the funding is in the CMH base it is eroded due to the lack of economics
- Up to 1996, state financing recognized that there were overlapping costs as individuals were placed from state facilities. As of 1996, full management was required to be cost neutral in the same year that placements occurred. As the state facility census dropped this makes little economic sense as the remaining residents are more needy/costly
- When the state moved all of the Medicaid to managed care it removed one of the financing tools used by CMHSPs to finance cost increases, namely increased Medicaid billing.
- As of FY99, with the Medicaid now capped, the state financing strategy for the past 16 years should have changed – it did not.

- The waiver included and HCFA approved rate increases of 3-5% per year to address cost increases
- The Medicaid specialty services waiver called for a) increased access, b) increased flexibility, and c) slow growth in rates. The first 2 occurred, the last did not.
- It was expected that CMH Managed Care would receive rate increases (just like other state supported services), but this did not happen.
- CMH Non-Medicaid GF continues to be redirected (e.g., ABW) to maximize federal funding and create savings for the state, not for increase in services to non-Medicaid consumers
- CMH Non-Medicaid GF is more vulnerable to reductions than Medicaid
- CMH got no funding benefits from the 1990s economic recovery (but it did experience cuts) – but since FY01 it did share in reductions as the economy slowed and as taxes were reduced.

CMH FUNDING:

Base Cost Increases = Funding Needed to Continue Services Each Year

Base Funding Reductions Outweigh Increases:

20-year average:	Increase of 1.0% per year
	Decrease of 1.2% per year
10-year average thru FY00:	Increase of 0.8% per year
	Decrease of 1.1% per year

Years with appropriated cost increases for CMH:	
FY85	2.0%
FY86	2.0% (in part funded by Medicaid FFP)
FY87	2.5%
FY88	2.8%
FY89	0.4%
FY90	1.0%
FY91	Residential increase of 2%
FY98	Direct care wage pass through (in part funded by FFP)
FY99	Direct care wage pass through - appropriated as all GF, later DMB substituted FFP
FY04	Medicaid rate increase 1.6% funded by CMH GF redirection
Years with reductions for CMH base funding:	
FY88	0.5% reduction, 0.75% reduction
FY88	$6.5m redirection due to FFP gains
FY89	CMH GF reduction to fund OBRA (gross $38.4, GF loss $17m)
FY89	0.5% reduction
FY91	0.75% reduction
FY91	Approximately 2.5% reduction
FY92	Approximately 2.2% reduction
FY97	$15m reduction, approximately 2%
FY99	$35m reduction in CMH GF (DMB fee adjuster share)
FY99	Under-funded Medicaid hospital budget transfer, CMH GF redirection approximately $28m
FY00	Reduction in CMH-GF $3.5m for Medicaid pharmacy

Years with reductions for CMH base funding:	
FY00	Reduction in CMH-GF $0.6m (SA eligibles)
FY01	Executive budget added pharmacy to CMH Medicaid at $26m, final appropriation removed to MSA at $42.4m, i.e., GF loss at $7.1m
FY01	Elimination of spend-downs, GF loss at $16m, Medicaid loss of $34.5m (3%)
FY02	Reduction in multicultural and prevention funds $1.7m
FY03	CMH Non-Medicaid GF reduction of 2.5%
FY03	CMH Medicaid rates reduced by 1.1%
FY03	Reduction in SED Respite by $3.3m ($1m restored in FY04 by legislators)
FY04	Reduction in CMH GF by $40m for ABW (Net loss of GF $17.6m)

CMH FUNDING: GENERAL FUNDS AND MEDICAID AS OF FY99

MEDICAID FUNDING BASE 10/1/98:

Based on FY96 fee-for-service base, trended forward for CMH continued increase in Medicaid to maximize federal revenues, along with transfers into CMH base (community inpatient and partial hospitalization, state residential services, state facility placements).

DD	$733.4m
MIA/SED	$367.7m
CMH Medicaid total	$1,100m
State share (approximately)	$598m
SA	$24m

DD was 67% of the total due to the national efforts in the 1980s to expand the Medicaid benefit for persons with developmental disabilities. This included community supported living arrangements, Alternative Institution Services (AIS), and Home and Community Habilitation waiver.

Even though MH was 37% of the total, Michigan enjoyed one of the broadest array of Medicaid state plan services compared to other states. Michigan had actively pursued the Rehabilitation Option that allowed many MIA/SED services to be Medicaid covered.

The MIA/SED base:

Community based CMH services	$226.4m
Community inpatient, partial hospital and related services	$141.3m

Under the new program, CMHSPs shifted from earning federal Medicaid through fee for service (FFS) billing, and were instead paid a pre-payment each month. Under the combined 1915b/c waiver, HCFA required the Managed care program to use a payment methodology based on Medicaid eligibles. The state actuary set up a rate cell structure and computed the rates. The DCH financing strategy for distribution of the prepayments to the 50 CMHSPs was to keep payments close to what they would have been under FFS. The exception to this was a movement of 10% towards the state average for MIA/SED geographic factors/rates. In large part this was due to the uneven distribution of the community hospital benefit.

CMH NON-MEDICAID FUNDING BASE FY99

CMH GF/GP funding base from FY98 (projected forward to full year) was $924.6m. This includes community and state facility funding. After the removal of state match needed for Medicaid, and reduction for DMB share of fee adjuster ($34.8m), the funding available for non-Medicaid was $411.4m (of which $109.4m was for state facility purchase of services and $302m for community).

This $411.4m was distributed to the 50 CMHSPs using a 10% movement to state average on 4 factors, a distribution of $5.7m from the top end CMHSPs (15) to the other 35 CMHSPs.

At that time, DCH estimated that the community GF was used:

- 10% for persons with developmental disabilities ($30m)
- 15% for children with serious emotional disturbance (approximately $45m)
- 75% for adults with mental illness (approximately $227m)

Estimates for purchase of service funding:

DD	$21m	(19%)
SED	$10m	(9%)
MIA	$78m	(72%)

Estimate of Funding Splits in FY99

DD	$784.4m	(52%)
MIA/SED	$727.7m	(48%)

MEDICAID HISTORY – HIGHLIGHTS

In 1980, the only DMH Medicaid funded mental health services were DD Centers, ICF-MR Residential (AIS homes), and State Psychiatric hospitals (under 22 and over 65).

There were additional Medicaid coverages through the then DSS for psychiatric inpatient and partial hospitalization services and physician/psychiatrist services. Michigan had elected to cover persons under age 22 for psychiatric hospitalization (a federal optional service)

In 1980 Medicaid Personal Care for persons in licensed foster care and group homes was added to the Medicaid state plan.

Implementation of Section 116 (full management) as well as pressures on state budget resulted in community based services being covered by Medicaid through a 2-year 1915b waiver implemented in 1983. In addition there was expansion of the AIS (DD) system of services.

Under the 1915b waiver CMHBs could bill for a limited set of services that had been 100% GF services. The initial set of services was the traditional Medicaid services: therapy and clinical services. DMH was also able to get certain day programs covered.

In 1985 the 1915b waiver turned into a Medicaid State Plan coverage through the Clinic Services option

The CMHBs billed for the cost of the service through the fee-for-service system. They were paid at the fee screen for the service, and at the same time the state deducted the state share from their GF. The net gain to the CMHB was the federal share only.

It was this gain in federal funding by CMHBs that promoted the state financing policy of Maximizing Medicaid, as well as the state policy to not fund increases in CMH GF, a practice that escalated in the 1990s.

In the mid-late 1980s and throughout the 1990s, CMHBs had three funding options to offset the lack of state funding for cost increases: Maximize Medicaid billing, place persons from state facilities, and/or cut back services to persons who were non-Medicaid.

In the late 1980s, DMB imposed a freeze on Medicaid fee screens for all Medicaid services. This meant that CMHBs had to use GF to subsidize the cost of Medicaid services. In 1993, DMB implemented an annual fee screen adjuster on CMH costs above fee screen. This drew down additional federal funds, 80% of which DMB retained.

DMH also obtained a 1915c Home and Community Habilitation waiver for persons with developmental disabilities. This provided a more flexible array of services than that covered by the 1915b waiver. This waiver picked up the CSLA persons when that option ended. This waiver also picked up persons in AIS homes that were decertified as well as providing a funding base for persons exiting state DD Centers. This has grown to 8000 individuals as of 2004.

Starting in FY87, the state plan was expanded significantly due to federal options for Medicaid state plans. Targeted Case Management was added in 1987.

Additional expansion occurred through the Medicaid Rehabilitation Option in 1991. This added services to the coverage, including:

- Assertive Community Treatment
- Psycho-Social Rehabilitation services (Clubhouses)
- Home-Based services

In 1995, the state plan was expanded to cover Crisis Residential and Intensive Crisis Stabilization services. This was done in conjunction with the DSS-DMH joint plan whereby CMHSPs managed admissions and authorizations for Medicaid hospital based services.

The federal government also opened up a program called Community Supported Living Arrangements. This was targeted to persons with developmental disabilities living at home or in their own residence.

In 1996 the Mental Health Code was amended to include person-centered planning.

In 1995, Governor Engler asked the directors of DSS and DMH to each develop a statewide plan for health care using managed care as the foundation. The plans were to cover: basic health services, long term care (nursing homes, services to the aged), children's special health care, and behavioral health (MH/SA). A 5th component for DD was added later. In 1996, DCH was created as the combination of Medical Services

Administration, Public Health, and Mental Health. The DMH Director was appointed DCH Director.

Mental Health and Substance Abuse divisions/bureaus begin to lose staff within DCH structure (a continuing trend to present). Responsibilities for CMH funding, policy and contracts get dispersed within Department.

The managed care plans recognized the importance of carving out certain specialized services, including: nursing homes, services to the aged; children with special health care needs; specialty services for persons with developmental disabilities, specialty services for persons with mental illness including children with serious emotional disturbance, and limited services for persons with addictive disorders.

Basic health services had been provided through fee-for-service, through an optional primary care manager model, as well as through optional capitated HMOs. In 1997 enrollment in a Qualified Health Plan became mandatory for about 75% of the Medicaid population. Exemptions: Medicare-Medicaid eligibles, spend-downs, retro-eligibles, children in foster care. It should be noted that persons who are exempt from mandatory enrollment are in general the high users of health services.

QHPs were responsible for the basic mental health needs of their enrollees (20 outpatient visits) as well as psychiatric inpatient. In July 1997 the inpatient responsibilities were removed from their scope. In January 1998, substance abuse services were removed from their scope. Payment reductions were not consistent with the reduction in responsibilities —in general QHPs lost the responsibility but not the funding.

Initial planning, as directed by Governor Engler, had called for one plan for MH/SA and one for DD. These were combined into a single 1915b waiver in late 1997.

This waiver was one of a kind nationally as it was a combination of a 1915b and 1915c waiver. This was needed to create a single blended comprehensive system including the then 7000 persons on the Home and Community Habilitation waiver. In addition, this was the only waiver that covered the whole state and all the Medicaid eligibles (i.e., no fee-for-service for specialty services remained)

The goals of this original waiver were:

- **Slow growth – HCFA approved 3-5% per year increases in rates**
- **Flexibility in service provision and how CMHSPs can use Medicaid funds**
- **Improved access for all Medicaid eligibles – no waiting list for access**
- **No savings in Medicaid – spend at the Upper Payment Level, no efficiencies for managed care taken off the top by the state**
- **Carved out all Medicaid specialty services**
- **Blends Medicaid and GF at the local level**

The waiver built upon the Code required Person centered planning. Both waivers (1915b and 1915c) allowed for Medicaid funds to be used to provide a flexible array of alternative services.

The waiver built upon the public accountability and stewardship of the Michigan public mental health system, This also allowed for flexibility between GF and Medicaid needed for persons who move in/out of Medicaid eligibility due to their illness.

The waiver was truly comprehensive. No fee for service remained (except for the Children DD waiver). It covered all Medicaid eligibles, including spend-downs and retro-eligibility.

This waiver was recognized nationally as a break-though waiver, although the state administration never acknowledged that or used this to recognize Michigan's efforts.

While the waiver provided opportunities for a more flexible use of Medicaid funding, it did require CMHSPs to manage access and plans of services differently. In the past they could manage demand that exceeded resources though the creation of waiting lists. Medicaid as an entitlement does not permit waiting lists for needed services.

Under managed care, the annual appropriation financing strategy should have been simple:

- Rate changes— are increases needed to cover increased costs to provide the coverage as required?
- Are their changes in eligibles (i.e., covered lives)?
- Are their changes in policy with respect to the benefit package?
- Rate Changes for 6 years:
  - NO increases FY00 through FY03 from state funding
  - In FY02 CMHSPs agreed to use local funds ($25m) for a rate increase (draw-down federal funds, increase of $31m, 2.6%)
  - Reduction of 1.1% in FY03
  - Increase of 1.6% in FY04
  - Approximately 2% proposed in FY05.

Note as of FY05 rate increases based on assumptions of increased cost for services are required by BBA for actuarial soundness

- No increase budgeted in appropriation FY00 to FY02 for eligibles trends although payments did increase; FY03 budgeted increase was way low compared to what actually happened in FY03; FY04 base was seriously under budgeted for eligibility increase (other Medicaid lines increased through supplemental) – by at least $30m; FY05 budgeted for 0.5% increase – actuary trended it higher than that.
- DMB removed various eligible groups from payments in FY01, primarily spend-downs. CMHSPs still required to cover these persons. Loss of revenues to CMHSPs at $34m
- Funding does support policy with respect to persons exiting state DD Centers. This was not implemented until FY01, as DMB would not support increasing federal share of payments.

Note: There is no MIA equivalent mechanism as there is very limited federal fee-for-service funding for state psychiatric hospitals, unlike DD Centers, which qualify under ICF-MR rules

- Attempts to change policy and funding for children has not been successful
- Attempts to transfer in under-funded pharmacy benefit was also rebuffed by the legislators

Medicaid funding for MH/DD has grown from $1.1 billion as of 10/1/98 to $1.272 billion in FY04 (which was about $35m less than should have been budgeted for eligible trend and DD placements). This growth of approximately 2% per year was almost solely due to eligible growth (i.e., increased demand on the service system) at $30m the first few years and $50m in FY03. Some of the increase was funds following individuals exiting from state DD Centers. The FY04 rate increase (1.6%) was $23m. The FY03 rate decrease was $13.4m. The loss of eligibles in FY01 was a reduction of $34m.

The BBA of 1997 required changes to all Medicaid managed care waivers. These changes went into effect in FY04:

- Alternative services are provided under 1915 B(3)
- Rates must comply with BBA requirements
- Rates were re-based using FY98 FFS
- Rate structure changed to include c-waiver payments through enrollment not Medicaid covered lives
- Rates for FY04 were reduced by 5% for MH/DD and 9% for SA by the actuary in order that the new rates were under the FY04 appropriation.
- Medicaid payment distribution across PIHPs changed due to FY98 FFS base. Variance from FY03 payments: Gain of 16% to loss of 3.5%. DCH partially offset Medicaid losses by redistribution of $7.2m GF as of 1/1/04

Rates for FY04 included 4% for administration costs of the c-waiver, and 8% for the 1915b services. (Rates for Michigan's Health Plans received 12-14% for administration)

The BBA requires annual rate increases (actuarial soundness). If the state complies, then the third element of the initial (FY99-00) CMHSP based specialty waiver will be met (i.e., slow growth)

MICHIGAN'S MEDICAID HEALTH PLANS: SOME OBSERVATIONS

- The Health Plans appear to have more influence on their funding
- Health Plans have threatened withdrawal from Medicaid
- Responsibilities (scope) have been reduced without equivalent offsetting rate reduction. In some instances the state asked the Health Plans to identify how much they were spending on the benefit to be removed.
- Elimination of Medicaid psychiatric inpatient and hospitalization services in July 1997

- Elimination of Substance Abuse benefit in January 1998
- Reduction in responsibilities for psycho-pharmacology (FY00) for all their Medicaid enrollees, not just those in CMH
- In the late 1990s, Health Plan Medicaid rates were reduced as DMB set the ceiling on rates based on the lowest bid
- Medicaid Health Plans have received rate increases through the appropriation process since 2000.
- Health Plans provide very little basic mental health outpatient services (as reported from their encounter data)
- Some Health Plans default on their 20 Mental health Outpatient benefit, with CMHSPs having to pick up these services
- Health Plans have dropped out of the Medicaid program, leaving some counties with only one plan and no fee-for-service alternative. MSA has not pursued adequate capacity, so CMHSPs have picked up these services.
- Some Health Plans have long waiting lists/times
- The state actuary uses a 12-14% factor for Health Plan administration

GENERAL ACCOUNTING OFFICE REPORTS

The GAO and CMS have cited concerns with several of Michigan's Medicaid Programs over the past 5 years. Notably missing is CMH services.

- Special Financing, particularly through use of intergovernmental transfers
- School-based Services
- Quality Assurance Provider Tax
- MiChoice Waiver Renewal
- Health Plans
- ABW Implemented prior to federal approval

CMH STATE FUNDING DISTRIBUTION

Funding distribution across the 46 CMHSPs is based primarily on each CMHSP history on key factors, along with several redistribution efforts.

CMHSP Non-Medicaid funding is the combination of Community Funds and State Facility funds (Purchase of Service).

Each CMHSP funding is based on:

- How well they fared under expansion funding in the 1980s. This was in part driven by the availability of local match
- The use of state facilities at the time they became full management – the later the better for funding base as the state facility rates increased but community base stayed flat
- Where DCH developed community-based services as placements for persons exiting state facilities. This is primarily a DD funding factor (both AIS and CLF).

There are no reliable measures for determining need, which should be the foundation of funding.

There have been several redistributions of state general funds:

- While some base reductions (primarily due to tradeoff problem) in the late 1980s and early 1990s were made across-the-board, there were attempts by DMH to target reductions to those viewed as higher funded.
- In FY97 a base reduction of $15 million was required, again due to tradeoff problems. This was accomplished using a funding factor strategy developed by Citizens Research Council that used: number of all Medicaid eligibles, estimate for uninsured, estimate for adults with serious mental disorder. In addition, $1.1m was redirected to the 4 lowest CMHSPs. The $16.1m was reduced from 14 CMHSPs (out of 52).
- In FY99 a modified funding formula was applied to the non-Medicaid GF. This used: population (10% factor), poverty under age 18 (15%), poverty over age 18 (35%) and estimate of serious mental disorder (40%). This was applied across all CMHSPs, shifting each CMHSP 10% towards state average. This resulted in distributing $5.7m from 15 CMHSPs above the average to those 34 CMHSPs below the average.
- Note: In FY99, Medicaid MH was also subjected to a 10% shift towards state average
- In FY02, as part of the local funded Medicaid draw-down, 7 CMHSPs (all at the high end of funding factors) gave up $5.9m in GF to provide increased funding to 20 CMHSPs at the low end.
- As of January 2004, an additional $7.2m is being redistributed to offset the state share of the Medicaid funding decreases. 7 CMHSPs gave up GF funding, and 28 gained GF funding.
- The ABW deduct has also impacted CMH-GF distribution. At $40m, this was an 8.9% reduction in CMHSP community and POS GF funding. The range of loss was 3.3% (from one of the CMHSPs above average on funding factors) to 14.3% (from one of the low end CMHSPs)

CMH FINANCING HISTORY: DETAILED

1980

CMH funding base:

- State Funding for community services
- Local match required at 10% for community and state facility services
- Fees

Medicaid funding ONLY for DD services in DD Centers and AIS community based ICF-MR program

Gross appropriation	$565,511,900			
Federal Funds		$78,280,900	13.8%	
State GF/GP		$479,125,000	84.7%	
CMH Community GF/GP		$113,144,900	23.6% of state GF/GP	
Pilot Boards (state facility funds)		$7,466,500		
DMH Executive (1475 FTE)		$41,512,200		
State Facilities:				
	8,051 beds			
	$313,191,700			

1980S

- State economic recession in 1980-81; CMH funding reduced by approximately 6.5%. Resulted in service/program reductions as CMH had no other funding options.
- Pilot Boards evolve into Full Management (section 116)
- Changes in Mental Health Code provide relief to county 10% match (residential services exempt, use of fees as source of local funds)
- Medicaid community waiver implemented in 1983. Services provided using GF/GP could be billed to Medicaid. Increase in funding to CMH was the federal share only.
- Federal revenues (FFP) to CMH used as basis for no need for increases in state funding
- Increases to CMH were usually tied to program expansion (e.g., waiting lists, community demand)
- FY84/85 authorized CMH base increase of 2%; FY85/86 base increase of 2%, partially funded by Medicaid FFP; FY86/87 base increase of 2.5%
- 1985 Medicaid no longer 1915b waiver as services added to Michigan's Medicaid state plan under Clinic Services
- FY87/88 State plan added Targeted Case Management
- Medicaid fee screens increased slightly each year. Frozen in late 1980's.
- FY87/88 Community GF base reduced by $6.5m (approximately 2%) as assumed FFP increases would cover loss. Funding was added back as expansion.
- FY87/88 Community GF base reduced twice (0.5%, 0.75%)
- FY89-90: Community GF reduced by approximately $17m and redirected to OBRA Nursing Home initiatives
- Under full management CMH community base grew as state funds followed placements. CMH could then use these state funds to expand Medicaid services.
- Once funds are transferred into the CMH base, in general there is NO increase in state funding for unavoidable cost increases.

- Most years there was a problem in budgeting the tradeoffs earned by CMHBs as persons exited state facilities. This resulted in underfunding of the tradeoffs and/or under funding of state facilities. CMHB base funding was cut several times to offset this gap
- State run residential services increased as persons were placed from state facilities into these programs (primarily DD).
- State and community increased participation in 1915c Home and Community Habilitation waiver for persons with developmental disabilities. Redirection of CMH and state residential GF to support these waivers.

1990S

- FY91 appropriated increase for residential services at 2%
- State economic recession. FY91 budgets cut by 9.2%. CMH state funding cut approximately 5%. Various state facilities closed – placements to CMH funded in year of placement (but no economics the following year).
- Medicaid State Plan expanded through Rehabilitation Option
- Medicaid fee screens frozen. State provides no increase to fee screens for Medicaid services. CMH covers the cost above fee screen through their GF/GP
- 1993 DMB implements fee screen adjuster for CMHSPs through intergovernmental transfer mechanism. State computes what fee screen should have been; computes the difference between what paid at fee screen and what should have paid. Bills Medicaid for the difference and draws additional FFP. CMHs earned 20% of additional FFP. State keeps the rest.
- Economy recovers
- No base increases for CMH state funding FY93 through FY97
- Tradeoffs from state facilities were under calculated. FY97 reduction in CMH GF by $15 million (approximately 2%) taken from approximately 15 CMHSPs with funding above the state average (CRC study).
- FY98 appropriated increase for residential direct care staff wages ($0.72/hr) with FFP funding about 40% of the cost (approximately $28m total). Legislative intent was a 3% increase for all CMH services but was insufficient funding for increase to any other CMH services.
- CMH financing strategy in 1990s: given no increase in state funding CMHSPs needed to maximize Medicaid FFP, increase in c-waiver participation, increase in state facility placements, maximize billing.
- August 1995, CMHSPs assume management of Medicaid hospital based services. Medicaid retains payment responsibility.
- FY96 fee screen adjuster – rebased rates used, increases total from $40m to $75m per year. Increased FFP by $20m/year; state share increased by $16m (i.e., doubled)
- FY99 Implementation of Medicaid 1915b/c waiver:
    - Intent of Managed Care program in 1998 waiver submission:
        - Slow growth – HCFA approved 3-5% per year increases in rates
        - Flexibility in service provision and how CMHSPs can use Medicaid funds

- Improved access to service system
- No savings in Medicaid – spend at the Upper Payment Level, no efficiencies for managed care taken off the top by the state
- Carved out all Medicaid specialty services
- Blends Medicaid and GF at the local level

- Financing:
  - CMH Medicaid funding at $1,100 million; Substance abuse at $24m
  - DMB transferred $67.2 million for hospital related services – base computed by actuary was $133m in FY98. CMH GF used to finance the state share of $65.8m (approximately $28m)
  - Fee adjuster was included at $80 million for costs previously covered by GF. CMH GF reduced by $35m for State share of the IGT.
  - All state funding required as state match (approximately 45%) came from CMH GF base, except for under-funded hospital transfer from Medicaid budget.

- FY99 appropriation included a second wage pass through ($.50/hr) for residential and paraprofessional day program staff. Originally all funded as GF (i.e., annual about $26m). Later was added to Medicaid program at $20m, which created approximately $11m in GF savings that was removed from CMH funding
- FY00
  - No rate increase for Medicaid specialty managed care.
  - Medicaid eligibles increase – impact of $30 million
  - No increase in CMH GF base, other than state facility tradeoffs
  - $3.5m transferred out from CMH GF for pharmacy in MSA budget
  - Economy still doing well; other Medicaid lines get rate increases
- FY01
  - No rate increase for Medicaid specialty managed care
  - $16.4m loss of Medicaid appropriation due to funding for pharmacy
  - Eligibility trend continuing at $30m (approximately 2.7%)
  - January 2001, DMB eliminates payments for spend-downs. Loss of $34m in revenues annually for CMHSPs
  - April 2001, DMB attempted to remove payments for retro-eligible months, potential loss of $50m in revenues. Legislators intervene. Months removed but rates increased to off-set
  - Economy still doing well but impact of tax cuts being felt; other Medicaid lines get rate increases
- FY02
  - No rate increase for Medicaid appropriated
  - Executive Order reductions in multi-cultural and prevention
  - CMHSPs volunteer to provide local funds to finance Medicaid rate increase
  - Impact of tax cuts being felt

- FY03
  - No rate increase for Medicaid appropriated
  - Appropriated increase for eligibles
  - Executive Order: Reduction in Medicaid rates by 1.1% (all Medicaid managed care received this cut)
  - Elimination of certain Medicaid eligible groups
  - Reduction in CMH GF by 2.5%
  - Elimination of SED respite (tobacco tax)
- FY04
  - Medicaid rate increase of 1.6%, with state share from redirected CMH GF ($10m)
  - Appropriated increase for eligibles understated by at least $30m due to 2003 trend. (Note other lines received a supplemental in Fall 2003)
  - CMH GF reduced by $40m in the appropriation to finance the ABW.
  - ABW uses 70% FFP, so $40m created $28m in savings in state funds.
  - ABW implemented before federal approval, so no FFP for 3.5 months. CMH GF used to cover this loss. (Other ABW components covered by state funding or other federal funds).
  - State facility budgets are short by $10m, even with supplemental transferring $17.1m from CMH GF.
- DCH submits waiver renewal in Fall 2003. Medicaid rates required to comply with BBA. This requires the actuary to apply a cost increase each year.
- FY04 new Medicaid rates implemented in January 2004. Due to appropriation understating the eligibility trend, the actuary applies a 5% managed care savings (reduction) to MH rates and 9% to SA rates.
- FY05 As Proposed
  - Medicaid rate increase at 2.08% for MH/DD and 2.8% for SA.
  - Eligibility trend does not cover the loss in 2004 ($30m for MH/DD and $2.5m for SA), and projects only 0.5% increases.
  - ABW proposed at same $40m. Actually running at $49.6m. Assume CMH GF will be reduced by $9.6m, though only need state funds of $2.9m to finance the increase.
  - State facility budgets are still short $10m

2. CMH Financing History
Lost Opportunities

Reduced Funding to Meet Increasing Demands

It is not about Medicaid funding; it is and always has been all about **state funding and state support** for public mental health services.

PREMISE

By moving to community-based services, the CMH system has saved the state hundreds of millions of dollars and improved the quality of services over the past 20 years.

HOWEVER

Savings created by this movement were not retained in the CMH system to support consumers in the community.

Total Lost Opportunities
Base Funding Due to Underfunded COLA

		CMH GF should be with COLA		
	CMH GF was		Lost opportunity	
FY99 Base GF	$747,925,600	$893,085,299	**$145,159,699**	19%
FY99-FY05	**CMH GF base is**	**CMH base should be with COLA**	**Lost opportunity**	
GF	$317,015,200	$369,921,271	**$52,906,071**	17%
	Medicaid base is	**Medicaid base should be with COLA**		
Gross	$1,410,290,900	$1,645,412,050	$235,121,150	17%
GF			**$105,545,884**	
TOTAL GF LOST FOR FY05			**$303,611,655**	
FFP LOST FOR FY05			**$129,575,266**	
TOTAL FUNDING LOSS IN FY05 due to COLA			**$433,186,920**	**25%**

Total Lost Opportunities
Cumulative

	Unfunded GF COLA	Reductions in GF	Unfunded Medicaid COLA	Medicaid Reduction
Through FY98	$154,952,258	$89,930,723	$165,856,766	
FY99–FY05	64,003,709	145,977,412	246,511,035	107,800,000
TOTAL	**$218,955,968**	**$235,908,135**	**$412,367,801**	**$107,800,000**

Lost Opportunities FY81–FY98

	CMH GF per Sec 2	Base Plus Unfunded COLA	COLA @3%	COLA Approved	UNFUNDED GF COLA	REDUCTION CMH GF	State Facilities Purchase of Service		Medicaid FFP	Med FFP with COLA	COLA on FFP @3%	Estimates of Fee screen FFP adjust	CMH Lost FFP
FY81	$140,956,800		$4,228,704				$236,030,800	8051 beds					
FY82	184,355,000		5,530,650	$12,057,300			256,966,000						
FY83	174,250,000		5,227,500		$5,227,500	$ (10,000,000)	273,005,796		$28,000,000				
FY84	204,985,900	$210,213,400	6,306,402		6,306,402		294,491,600		22,000,000		$660,000		$660,000
FY85	197,400,100	208,934,002	6,268,020	7,608,000			380,106,800		23,633,000	$24,293,000	728,790		728,790
FY86	232,181,000	243,714,902	7,311,447	7,560,800		(6,433,100)	386,970,800		25,000,000	26,388,790	791,664		791,664
FY87	281,218,300	292,752,202	8,782,566	10,085,100			372,699,600		30,000,000	32,180,454	965,414		965,414
FY88	286,435,700	297,969,602	8,939,088	8,946,500		(10,015,229)			40,138,300	43,284,167	1,298,525		1,298,525
FY89	310,385,600	321,919,502	9,657,585		9,657,585	(1,432,179)	403,728,100		38,714,900	43,159,292	1,294,779		1,294,779
FY90	340,028,800	361,220,287	10,836,609	3,634,100	7,202,509	(17,000,000)	438,406,200		51,079,900	56,819,071	1,704,572		1,704,572
FY91	364,156,500	392,550,496	11,776,515		11,776,515	(11,550,216)	441,976,700		65,692,900	73,136,643	2,194,099		2,194,099
FY92	369,046,900	409,217,411	12,276,522		12,276,522	(18,500,000)	442,899,500		93,159,600	102,797,443	3,083,923		3,083,923
FY93	447,153,700	499,600,733	14,988,022		14,988,022		348,986,900		124,193,800	136,915,566	4,107,467	$16,750,000	13,735,000
FY94	513,537,600	580,972,655	17,429,180		17,429,180		333,936,000		189,067,100	205,896,333	6,176,890	20,000,000	16,400,000
FY95	508,328,200	593,192,434	17,795,773		17,795,773		340,260,000		229,873,900	252,880,023	7,586,401	19,000,000	15,580,000
FY96	575,996,100	678,656,108	20,359,683		20,359,683		290,831,900		286,619,600	317,212,123	9,516,364	38,000,000	31,160,000
FY97	614,980,600	738,000,291	22,140,009		22,140,009	(15,000,000)	275,743,600		326,096,600	366,205,487	10,986,165	41,000,000	33,620,000
FY98	747,925,600	893,085,299	26,792,559	17,000,000	9,792,559		202,198,000		429,656,100	480,751,152	14,422,535	52,000,000	42,640,000
LOST OPPORTUNITIES FY81–FY98					**$154,952,258**	**$ (89,930,723)**							**$165,856,766**

Lost Opportunities FY99–FY05

	CMH GF (+ multicultural)	Base plus unfunded COLA	COLA @3%	COLA approved	Unfunded GF COLA	Reduction CMH GF	POS	Medicaid capitation	Medicaid with COLA	COLA @ 3%	COLA approved	Unfunded COLA	Reductions
FY99	$302,065,481		$9,061,964	$7,000,000	$2,061,964	$ (79,700,000)	$ 202,198,000	$1,101,142,980		$33,034,289	*$0*	$33,034,289	
FY00	316,756,200	$318,818,164	9,564,545		9,564,545	(4,100,000)	155,560,700	1,206,321,800	$1,239,356,089	37,180,683	*0*	37,180,683	
FY01	315,649,500	327,276,009	9,818,280		9,818,280		166,918,500	1,182,449,100	1,252,664,072	37,579,922	*0*	37,579,922	($16,400,000)
FY02	$317,671,200	$339,115,990	$10,173,480		$10,173,480	(1,700,000)	170,157,400	1,196,433,900	1,304,228,794	39,126,864	*0*	39,126,864	($34,600,000)
FY03	$320,833,400	$352,451,669	$10,573,550		$10,573,550	(10,800,000)	174,651,000	1,232,138,500	1,379,060,258	41,371,808	*(13,553,524)*	54,925,331	($6,800,000)
FY04	$314,949,900	$357,141,719	$10,714,252		$10,714,252	(40,000,000)	114,231,800	1,372,625,900	1,560,919,466	46,827,584	*23,000,000*	23,827,584	($50,000,000)
FY05 proposed	$317,015,200	**$369,921,271**	$11,097,638		$11,097,638	(9,677,412)	120,813,800	1,410,290,900	**$1,645,412,050**	$49,362,361	*$28,526,000*	20,836,361	
TOTAL			**$64,003,709**				**$246,511,035**						**($107,800,000)**

NOTES

General Fund: INCREASES

1. Used GF for CMH identified in Section 2 of appropriations.
2. There were inconsistencies over the years as to what was included/excluded in that line E.g., Family Subsidy, OBRA.
3. Appropriation made assumptions about tradeoffs earned that were often understated
4. In the 1980s the CMH line was increased for categorical expansion areas—usually partially/all funded from increased FFP. The CMHBs thus experienced increases while at the same time did not have funds to continue prior year services due to lack of COLA.
5. Method applied a 3 percent as average COLA to the Section 2 amount.
6. Method took into account COLA on unfunded economic increases as well as funded
7. In the 1980s economic increases were sometimes funded from Medicaid FFP not state funds.
8. Direct care wage passthroughs in FY98 and FY99 are counted as COLA though only applied to part of CMH funding.
9. Direct care wage passthroughs in FY99 initially all GF, later was changed to use FFP (saved $11m GF).

General Fund: DECREASES

1. In the 1980s and 1990s the tradeoffs were often understated. This led to "overauthorizations" compared to appropriation. This resulted in reductions to CMH that were not reflected as appropriation reductions, but were lost GF to CMH.
2. FY88: 0.5 percent reduction, 0.75 percent reduction, plus base reduction of $6.5m offset by FFP used for categorical expansion.
3. FY89: 0.5 percent reduction
4. FY90: Reduction to fund OBRA, estimated at $17m (approx. 2 percent)
5. FY91: Overall state line item reduction of 9.2 percent
6. FY91 and FY92: As part of overall 9.2 percent reduction CMH line was reduced several times/ways: 2.5 percent reduction, 2.2 percent reduction, 2.4 percent reduction, special projects reduction of 9.2 percent
7. FY97: Tradeoff under funding at $35m, 15 CMHSPs reduced by formula $15m
8. FY99: Base adjust of $3.7m; DCW#2 federalized = loss of $11m GF; $35m CMH GF transferred out as DMB share of fee-screen-adjuster CMH GF used for under funded Medicaid hospital services transfer—approximately $30m
9. FY00: $3.5m reduction in CMH GF (risk funds) for MSA pharmacy
10. FY02 Executive Order reduction in multicultural/prevention $1.7m
11. FY03 Executive Order reduction of 2.5 percent, plus base adjustment of $2.4m
12. FY04 Reduction of $40m (11 percent) to finance ABW, Medicaid rate increase, and $17.6m transfer out from CMH
13. FY04 and FY05 as proposed: ABW additional $9.7m reduction in CMH GF
14. FY04 hospital base funding increased by $17m transferred out from CMH GF; in addition hospitals running a $10m shortfall and loss of FFP.

Purchase of State Services

1. Excludes State Funding for Forensic Center and for State Corrections Facility
2. Computation used by DMH/DCH/DMB varies over time
3. Represents the net state funding for these services: MIA facilities at about 70 percent, SED at 50 percent, DD at 40 percent
4. Excludes costs associated with forensic patients in state facilities (e.g., IST), an increasing percent of use

5. Does include increased economics. In the 1980s rate increases were usually double digit.
6. State facility budgets, net rates, and POS calculation were independent of tradeoff calculations, although these are more closely tied in the past few years
7. Net cost (i.e., GF) per bed in FY81 $29,260, net cost per bed in FY05 $146,082; 400 percent increase, 16 percent per year.
8. If the 8,051 beds appropriated in FY81 were priced at FY05 average rate, cost would be $1,176,000,000.

Medicaid

1. Until FY99 the Medicaid FFP appropriation was an estimate not a cap on what could be earned by CMH.
2. Medicaid clinic services fee screens were set in 1983 and during the 1980s had very small increases (usually less than 1 percent).
3. Medicaid fee screens frozen in late 1980s.
4. AIS services (approximately 20 percent of Medicaid) were not subject to fee screens, were cost based services.
5. If fee screens had been adjusted annually to reflect medical cost increases, by 1998 the Medicaid revenues would have been $95m higher (FFP at $52m), i.e., 11 percent funding loss per year.
6. Instead of making annual fee screen increases consistent with medical pricing, DMB initiated aggregate fee screen adjustment in 1993. This process generated additional FFP based on CMH costs above fee screen. DMB retained approximately 82 percent of extra FFP earned.
7. FY99 Medicaid capitation rates included services formerly budgeted in MSA. The transfer was underfunded by $66m (GF at $29m).
8. Waiver was approved by HCFA with 3-5 percent rate increase.
9. CMHSPs no longer have option to bill more Medicaid to cover increased costs.
10. FY00 though FY03, NO rate increases
11. FY01—$16.4m reduction in appropriation for pharmacy (loss of GF at $7m)
12. FY01–FY02 Payments for spend-downs eliminated by DMB. Loss of $34m in actual payments to CMHSPs
13. FY02 CMH provides the match for FFP increase (not reflected as a state funded COLA). Net impact 2.7 percent increase.
14. FY03 Executive Order, 1.1 percent rate reduction and elimination of some eligibility groups.
15. FY04 CMH GF used for 1.6 percent rate increase.
16. FY04 appropriation was understated for eligibility increases in 2003 and DD FY03 placements, and for actuarial rates. Loss of funding for rate setting $50m, resulted in rate reductions of 5 percent (9 percent on SA) as of January 2004 compared to what the rates should have been.
17. FY05 proposed at about 2.1 percent rate increase.

3. State GF/GP Funding for Community Mental Health Economic Increases

Year	GF/GP Economic Increase for CMH Community Services	GF/GP Reductions to CMH	Comments
FY83/84	0.0%		Appropriation increase of 4.0% was for expansion and may have been added Medicaid revenues
FY84/85	2.0%		Appropriation increase of 3.6% was for expansion and may have been added Medicaid revenues
FY85/86	2.0%		Appropriation increase of 3.4% was for expansion and may have been added Medicaid revenues
FY86/87	2.5%		Appropriation increase of 3.6% was for expansion and may have been added Medicaid revenues
FY87/88	2.8%	0.5% reduction 0.75% reduction Base GF reduction of $6.5m (approx. 2%)	Part of increase from FFP. $6.5m reduction to fund categorical offset by Med Case Mgt FFP
FY88/89	0.4%	0.5% reduction	
FY89/90	1.0%	Reduction for OBRA (est $17m) 2%	
FY90/91	0.0% Residential increase 1%	0.75% reduction $9m reduction approx. 2.5%	Residential increase was 2%, approx. 1% of CMH Part of 9.2% reduction
FY91/92	2.3%	$1.5m special projects reduction, 0.5% $8m reduction, approx. 2.2% $9m reduction, approx. 2.4%	Part of 9.2% reduction
FY92/93	0.0%		
FY93/94	0.0%		
FY94/95	0.0%		
FY95/96	0.0%		
FY96/97	0.0%	$15m reduction, approx. 2%	
FY97/98	3% used for DCW#1		3% used for DCW#1 and shortfall DCW1 at $28m, with FFP of $11m
FY98/99	0.0% DCW#2 $27m GF (approx. 2%)	$3.7m, approx. 0.4% DCW#2 Federalized, GF reduced $11m	DCW#2 effective 4/99, added GF $17m. CMHs provided GF for underfunded MSA services and 2.7% Medicaid cost/use increase $23.6m GF added for eligibles

Year	GF/GP Economic Increase for CMH Community Services	GF/GP Reductions to CMH	Comments
FY99/00	0.0%	$3.5m, approx. 0.4% $0.6m	Reduction for pharmacy Reduction for SA eligibles correction $7.3m GF added for eligibles
FY00/01	0.0%	$7.1m, approx. 1.0% ** spend-downs 9 months – $20m	Reduction for Medicaid pharmacy
FY01/02	$14m added to Medicaid 0% increases $31m FFP local match	$31m estimate full year spend-downs EO $0.8m reduction in multicultural funds EO $0.9m reduction prevention	Exec. budget proposed 2% GF and 3% Medicaid increases that did not survive the approp process Final: No increase, +$14m base adjustment, no retro loss, pharmacy not in
FY02/03	$11.3m GF—eligibles 0% rate increases 0% GF cost increase $31m FFP local match	EO $8.4m GF reduction $2.4m GF reduction—underappropriation 1.1% Medicaid rate reduction ($13.4m) Eliminate caretaker eligibles ($6.8m) Eliminate tobacco tax respite ($3.3m)	$24m gross increases Medicaid eligibles CMH funds for FFP increase (gross at $56m, FFP at $31m)
FY03/04	1.6% Med rate increase no new GF Restored $1m in respite	Full year impact of FY03 EO Reduction of $17.6m GF for adult waiver	$41m gross increases Medicaid eligibles Med rate increase net impact 0.9% FFP ($12.7m) REDIRECT $40m GF to ABW
FY04/05 PROPOSED	2.08% Medicaid rate increase (GF at $12.3m, 0.9%) Eligibles $7.7m. 0.55%	?Further reduction for ABW	
20-Year Average thru FY03	**1.0%**	**–1.2% per year**	
10-Year Average thru FY00	**0.8%**	**–1.1% per year**	
5-Year Average 10/98 to 9/03	**No rate increases** **Medicaid eligibles/mix increases** DCW#2 net GF $16m Respite restoration $1m	**$105.6m in reductions** **Approx. $93.2m GF**	

Appendix I:
Model Array

Publicly Funded Service for Mental Illnesses and Emotional Disorders

Defining eligibility, or "who should be served" (see Goal 2 discussion) is a necessary first step in structuring our public mental health system. The next step is matching eligible consumers to an appropriate array of treatment services. These services should be based upon:

1. The concepts of "recovery" and "resiliency"
2. Current evidence-based practices and practice-based evidence
3. A model for lifelong service availability is fundamental in serving anyone with a chronic severe illness (see "Service Selection Guideline Principles")
4. A model is also necessary for responding to psychiatric emergencies, within the confines of available resources to persons experiencing mild or moderate mental disorders (see "Service Selection Guideline Principles")
5. Prevention services are available and targeted to persons at risk of mental illness and emotional disturbances.
6. Services are collaborative and person- and family-centered.
7. Services are best provided in the context of multidisciplinary teams
8. Services must include a broad array of modalities, settings, and intensities
9. Services must coordinate and collaborate with service systems (public and private) outside of public mental health

The following array should form the core of service options available to adults and minors who qualify for enhanced access within Michigan's publicly funded mental health system (see description under Goal 2).[6] Crisis response services listed would be available to any person experiencing psychiatric emergency, and those categories or items marked by an asterisk would constitute the public mental health service benefit that should be available (as resources permit) for adults and minors experiencing mild or moderate mental and emotional disorders.

[6] The array (excluding the prevention component) was developed by representatives of 11 statewide entities and two primary consumers in 1999 (published 2000). The entities were Mental Health Association in Michigan; National Alliance for the Mentally Ill of Michigan; Michigan Psychiatric Society; Michigan Psychological Association; Michigan Department of Community Health; Michigan Association of Community Mental Health Boards; Association for Children's Mental Health; Michigan Association for Children with Emotional Disorders; Michigan State Medical Society; Michigan Protection and Advocacy Services; and Michigan Health and Hospital Association. The array appeared in the report "Long-Term Psychiatric Care in Michigan's Publicly Funded Mental Health System: Review, Analysis, and Recommendations for Improvement," 2000.

The array is divided into four sections: Mental Health Treatment and Support; Systems Coordination; Administrative Support for Constituent Services; and a special section recognizing the importance of preventing emotional disorders among minors as well as special problems among at-risk adults.

While the proposed array is not otherwise divided by age groupings, it was designed to incorporate all requirements that might come into play for minors, nongeriatric adults, and senior citizens. Included is recognition of the importance of assisting individuals in making significant age transitions (e.g., from late teen to early adult).

Most of the items in the recommended array can be found somewhere in Michigan's public mental health system, but not necessarily within each CMHSP catchment area. There is considerable variation among some items regarding degree of accessibility. Michigan has been a national leader in quantity of assertive community treatment programming and the development of person-centered planning processes; many consumer clubhouse programs have been established across the state; and MDCH has shown commendable interest in balancing pharmacy cost containment with consumers' psychotropic medication access needs, and in having greater integration of mental illness and substance abuse services. Access to inpatient care, however, has been problematic (most especially, but not exclusively, regarding non-acute options);[7] there are relatively few safe and appropriate living arrangements available through the public mental health system;[8] evidence suggests that Michigan may have a high prevalence of adults and minors with mental illness or emotional disturbance in jails and juvenile justice facilities;[9] few publicly funded adult consumers with mental illness receive supported employment service;[10] less than half of mental illness consumers (adult and child) were internally categorized as "serious" by MDCH receive case management service;[11] and legislative appropriations for multicultural and pilot prevention programming have been extremely small or nonexistent (prevention line defunded since Fiscal Year-2002).[12]

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[7] Excluding the Forensic Center, there are approximately 600 state psychiatric hospital beds presently operational. In numbers and geographic disbursement, they do not offer adequate availability or accessibility to Michigan citizens.

[8] MDCH preliminary reporting for 2003 indicated that, for mental illness, the CMHSP system had access to a quantity of residential and supported living beds, which equated to less than 4 percent of that year's adult and minor mental illness population. By contrast, the bed level for persons with developmental disabilities equated to over 40 percent of the year's CMHSP developmental disability population. Additionally, the Commission heard considerable testimony from consumers and families about the lack of safe and affordable independent housing creating a significant barrier to recovery.

[9] Among other evidence, MDCH's 1998–1999 study of county jails in Wayne, Kent, and Clinton Counties found a mental illness prevalence rate (exclusive of addiction disorder) of 51 percent, and a 34 percent rate for the diagnoses of major depression, bipolar disorder, or schizophrenia/psychotic conditions. The U.S. Justice Department's 1999 national average projection for any mental illness in local jails was 16 percent.

[10] The figure was 2.6 percent in 2002, per MDCH reporting.

[11] In 2002, 58 percent of "serious" cases lacked case management, per MDCH reporting. For minors, 63 percent lacked case management, and for adults the figure was 57 percent.

[12] In its 25-year history, the mental health prevention demonstration unit was instrumental in testing numerous projects that took hold in Michigan, including but not limited to infant mental health programming, school success initiatives, and multiagency collaborative efforts. Regarding multi-cultural services, this line in the CMHSP section of the MDCH budget has commonly received about $3 million annually over the past several years.

Identifying a specific mental illness service or service area as the one most in need of immediate attention in Michigan is a daunting task. It is compounded by several factors: (a) the state has numerous problems in mental illness service delivery, including several not mentioned above; (b) some of the major problems confronting us (such as justice system diversion and coordination or integration between mental health and substance abuse) require support from multiple systems, not just mental health; and (c) mental health budget expenditures in Michigan are much lower proportionally for mental illness consumers than for those experiencing developmental disability.[13]

To suggest one immediate attention area for which expenditures would come primarily from the mental health system, the commission advances subacute protected and therapeutic care for persons whose clinical needs require a hospital or specialized residential facility stay of greater than acute length. As indicated in the explanations for footnotes 49 and 50, Michigan has too few resources in this regard.[14] As a result, state and local policies have forced many individuals into lower levels of care before their clinical situation was suited for such care. This has contributed to significant problems in criminal and juvenile justice system matters, homelessness, substance abuse, emergency room utilization, noncompliance with treatment regimens, recidivism, and other social areas. It is important to note that in enhancing subacute protected and therapeutic care, Michigan is—absent a federal waiver or change in national-hampered—Medicaid's prohibition against funding care for those aged 21–64 in 17-bed (or greater) "institutions for mental disease."

The model array is based on the following assumptions:

- Excepting services designated for specific populations, all array items are potentially applicable to persons with enhanced access
- Crisis response services are applicable to any consumer experiencing psychiatric emergency
- Categories or items marked with an asterisk (*) are potentially applicable to persons with mild or moderate mental illness or emotional disorder

[13] Preliminary 2003 reporting from MDCH shows a per client CMHSP expenditure of $26,204 for developmental disability; $5,509 for adult mental illness; and $3,212 for children's mental illness. These figures do not incorporate Medicaid pharmacy expenditures that come out of the Medical Services portion of the MDCH budget.

[14] Looking solely at what MDCH terms nonsupported living "Specialized Residential," preliminary 2003 data indicate the availability of 2,513 beds for adult mental illness; 294 for children's mental illness; and 9,357 for developmental disability. (With supported-living slots added, the respective totals are 3,585; 335; and 11,797.)

I. Mental Health Treatment and Support

A. Mental Health Clinic Services*

(1) Identification of recipient needs by screening, assessment, and diagnosis

(2) Development of an individualized service plan[15]

(3) Psychiatric evaluation; face-to-face assessment with a psychiatrist[16]

(4) Medication assessment, prescription, administration, review, and management

(5) Psychological testing[17]

(6) Individual, group, family, and/or child therapy

(7) Level-of-function management services designed to strengthen self-control, reduce maladaptive responses, and improve adjustments to environmental changes

(8) Physical and occupational evaluation and therapy

(9) Hearing, speech, and language evaluation and therapy

(10) Health assessment and enhanced health services, which may include nursing, nutrition, hygiene, health promotion, and health education as it relates to psychiatric care

(11) Nursing home monitoring/screening

(12) Other assessments, including follow-up of closed cases (adults and minors)

B. Emergency Services

(1) Crisis line, with 24-hour, 7-day-per-week availability

(2) Crisis assessment and intervention

C. Inpatient Psychiatric Services

(3) Acute

(4) Intermediate

(5) Long term (directly under auspices of state)

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[15] Service planning should be person-centered and culturally competent, and should include contingency planning for changes in recipient circumstances, as well as life-stage transition planning (from late teens to adulthood; from middle-age to geriatric; and for end-of-life issues). Service assessment and delivery should be provided by age-appropriate specialists, and family-centered planning should be utilized for minor recipients, within the confines of applicable state law and appropriate confidentiality practices.

[16] Assessing recipient clinical status including: presenting problem; relevant recipient and family histories; personal strengths and weaknesses; and mental status examination.

[17] With the use of objective or projective standardized instruments to measure intelligence, mental abilities, attitudes, motives, traits, and behaviors for purpose of psychodiagnosis, as given by a licensed psychologist.

D. Alternatives to or Step-Downs from Hospitalization
   (1) Crisis residential
   (2) Secure residential (pilot), meeting all related state-established criteria
   (3) Specialized residential
   (4) Semi-independent and supported independent living

E. Intensive Support to Maintain Community Tenure
   (1) Extended observation beds in a hospital setting for up to 23 hours of evaluation and/or stabilization prior to service selection and possible recipient transfer to another service
   (2) Partial hospitalization
   (3) Crisis stabilization that combines community-based treatment and support provided to persons in crisis as an alternative to hospital emergency room services and/or inpatient psychiatric care
   (4) Intensive outpatient therapy[18]*****
   (5) Diversion program from entering or returning to juvenile justice centers and/or jails*****
   (6) Home-based services
   (7) Other services to special populations at risk*****
      a. Juvenile and criminal justice systems
      b. Homeless shelters
      c. Foster care
      d. Intensive, therapeutic foster care for persons ages 0 to 18

F. Targeted Support for Community Inclusion and Integration
   (1) Case management and supports coordination
   (2) Assertive Community Treatment (ACT) or Community Treatment Team
   (3) Community living training and support
   (4) Skill-building assistance*
   (5) Integrated employment services, including older minors and seniors
   (6) Family skills development*
   (7) Respite care
   (8) Housing financial aid
   (9) Wraparound service to minors which is multiple community-based treatment and support for a minor and his/her family, delivered through collaborative interagency planning and implementation
   (10) School-based and supported education services
   (11) Mentoring and behavioral aid by a trained paraprofessional regarding activities of daily living such as shopping, banking, bill-paying, etc.

[18] A structured program that includes combinations of individual and group process therapy, meeting at least three times per week, and delivering at least four hours of treatment per week.

G. Psychosocial Rehabilitation and Recovery

(1) Clubhouse programs

(2) Peer-delivered/operated support such as Schizophrenics Anonymous self-help*[Schizophrenics Anonymous and support groups for co-occurring mental illness/substance abuse minimally mandatory]

(3) Consumer-run programs, e.g., Project Doors and Drop In Center

H. Transportation

(1) Transport to mental health appointments/treatment
(2) Transport to other medical appointments
(3) Transport related to activities of daily living such as shopping, prescriptions, banking
(4) Transport to employment

II. Systems Coordination

A. Coordination and/or Joint Programming with Other Human Service Systems*

(1) Primary medical physician
(2) Substance abuse, including specialty care for dually diagnosed MI/SA
(3) Developmental disability, including specialty care for dually diagnosed MI/DD
(4) Family Independence Agencies
(5) Aging networks
(6) Multipurpose collaborative bodies that are state-sanctioned human service agency consortiums, at county or multicounty levels, which engage in collaborative efforts to improve services and outcomes
(7) Community-based supportive housing coalitions

III. Administrative Support

A. Constituent Services*

(1) Orientation of new consumers
(2) Information for families
(3) Consumer participation in planning, program development and performance review, in addition to consumer involvement in governance
(4) Consumer appeals, grievances, rights
(5) Advocacy and education

Special Needs Consideration: *Prevention*[19]

A. Interventions Targeted to Infants, Youth & Adolescents at Risk of Emotional Disorder

(1) Parent training
(2) Child and adolescent training/bonding

[19] Should include restoration of appropriations for prevention services demonstration (pilot) function within mental health section of the MDCH budget.

(3) School programming/services
(4) Child care programming/services
(5) Other

B. Additional At-Risk
(1) Persons at risk of criminal behavior
(2) Persons at risk of homelessness
(3) Seniors
(4) Suicide (any age)
(5) Other

Appendix J:
Potential Revenue Options (Estimated 2005 Revenue/Michigan Treasury)

Options	Gross (000)	MH Fund (000)
Cargo aircraft use tax	$30,000	$20,000
Commercial Domestic Aircraft use tax	5,000	3,335.
Imported property	3,600	2,400
Intestate Trucks & Trailers use tax (est.)	19,000	12,730
International telecommunications use tax	35,992	24,100
Rail Rolling Stock use tax	1,664	1,100
Communication & Telephone use tax	37,000	25,400
Arts, Entertainment & recreation sales tax *	212,000	36,100
Vehicle & aircraft transfers sales tax *	94,473	15,116
Administrative support & waste management sales tax*	883,300	150,240
Real estate rental & leasing sales tax*	379,000	64,430
Transportation & warehousing sales tax (profit)*	38,300	6,511
Equalize taxes on marginal oil wells and oil & gas severed from public owned lands	5,000	5,000
Total	**$1,744,409**	**$340,162**

* Assumes that payment to local government from new sales tax revenues will be capped at the constitutional minimum.

SOURCE: Michigan Tax Code.

Appendix K:

"Background Information on Mental Health Issues," by Steve Angelotti, Michigan Senate Fiscal Agency, September/October 2003

State Notes
TOPICS OF LEGISLATIVE INTEREST
September/October 2003

Senate Fiscal Agency

Background Information on Mental Health Issues
by Steve Angelotti, Fiscal Analyst

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

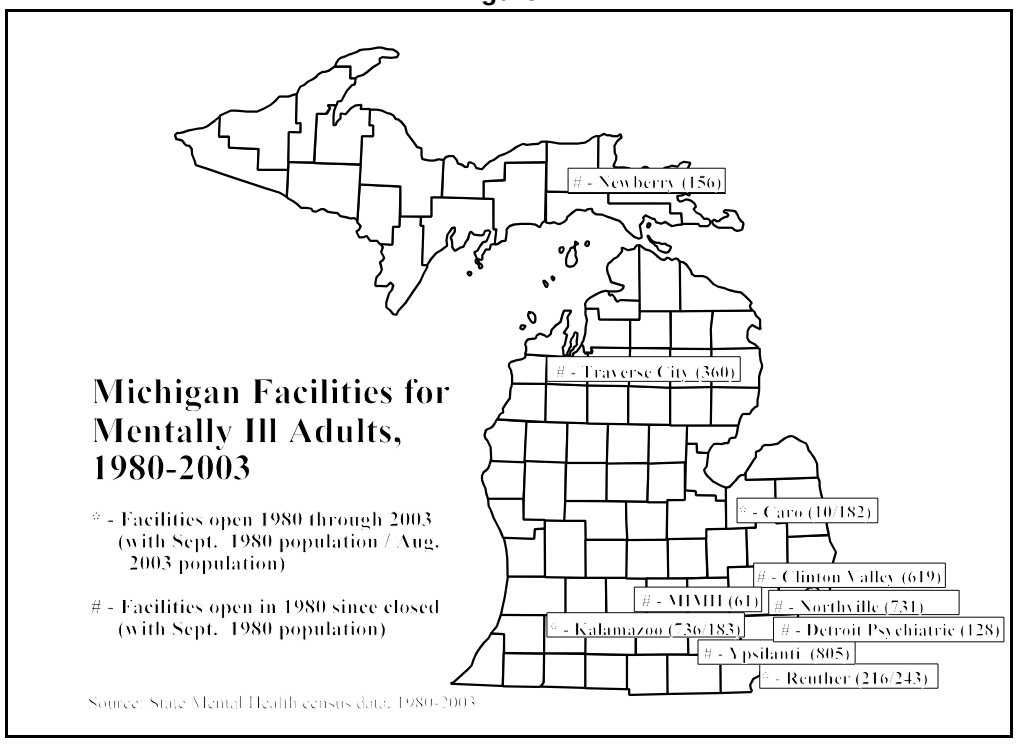

Figure 2

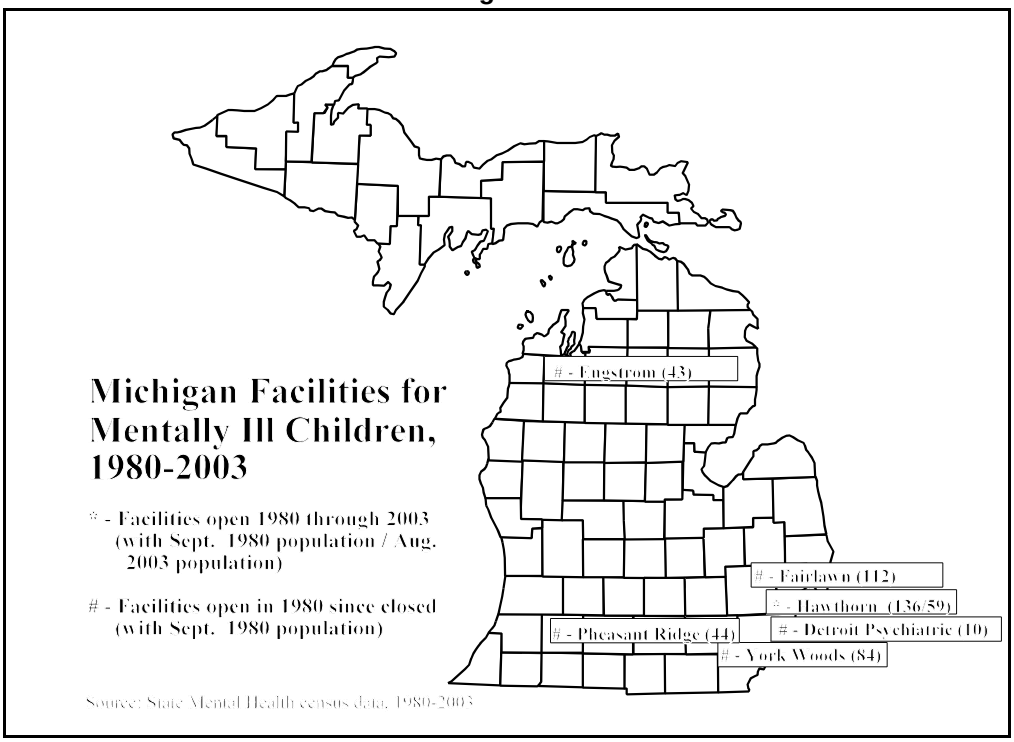

Figure 3

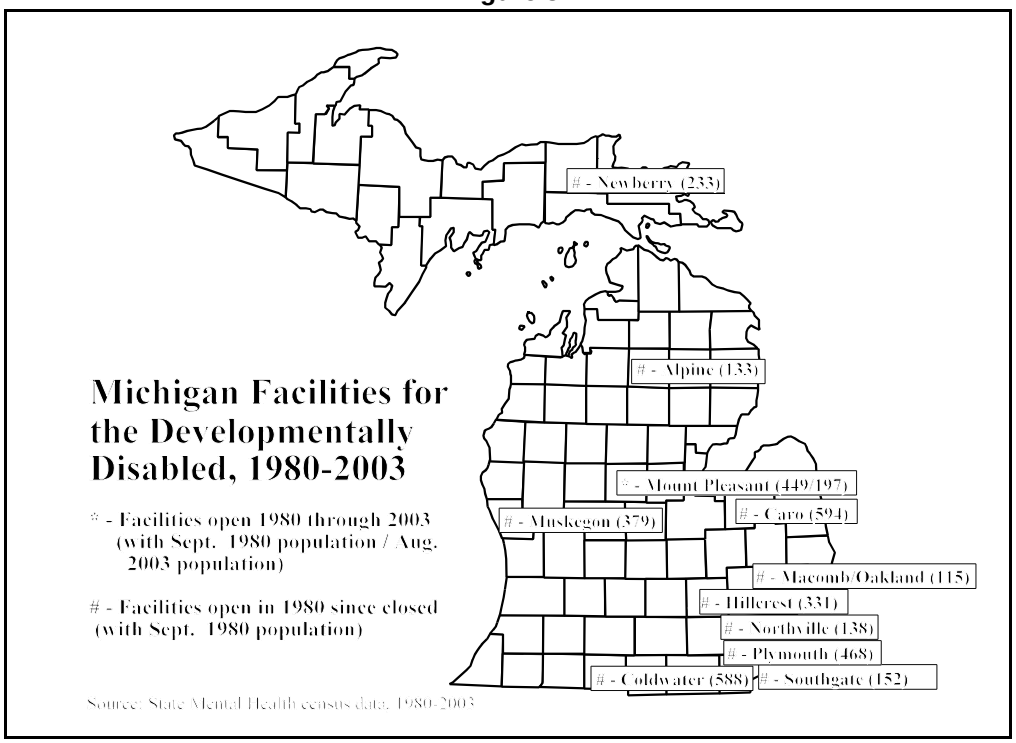

Figure 4